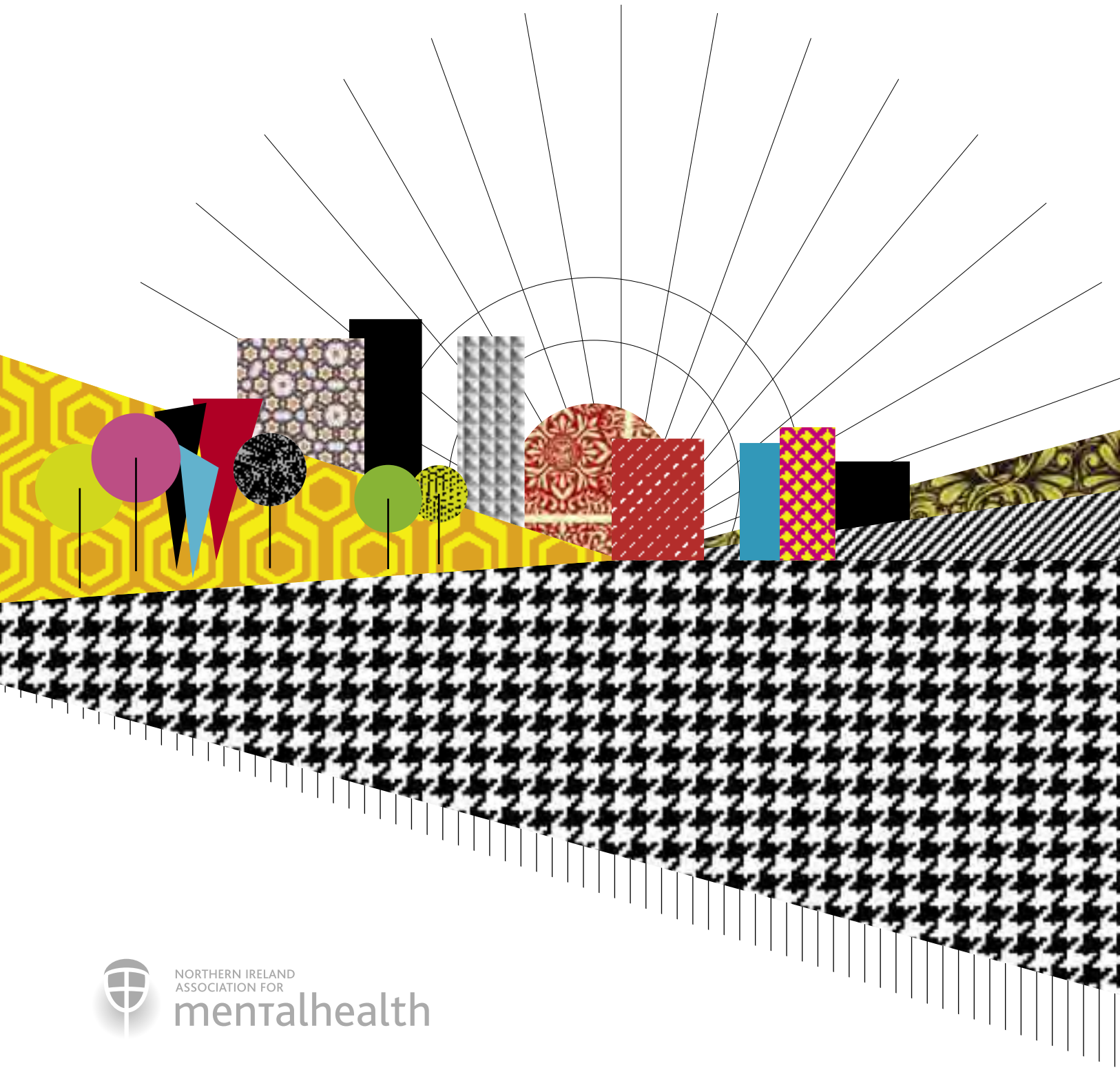
A Flourishing Society

Aspirations for Emotional Health and Wellbeing in Northern Ireland



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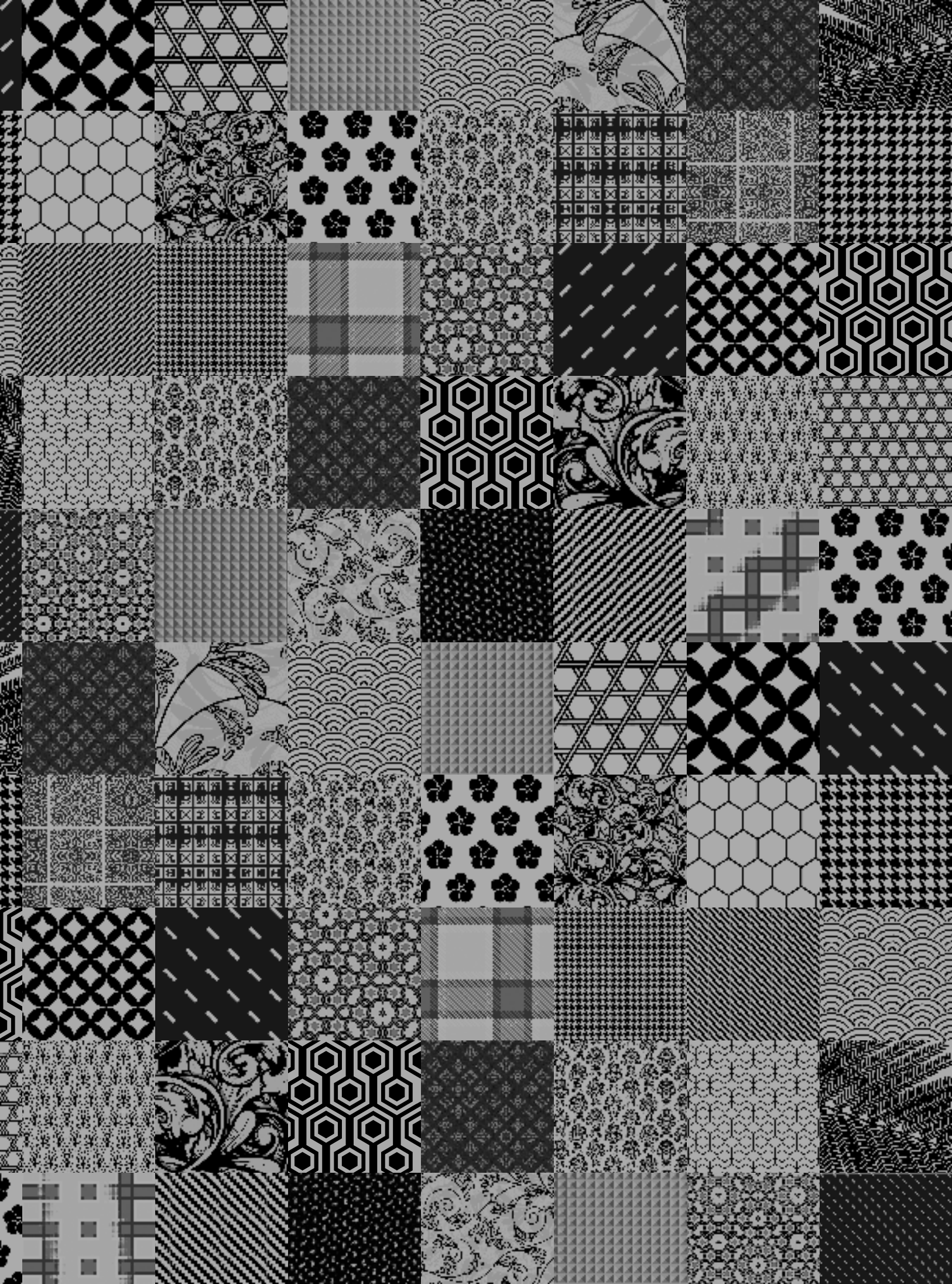

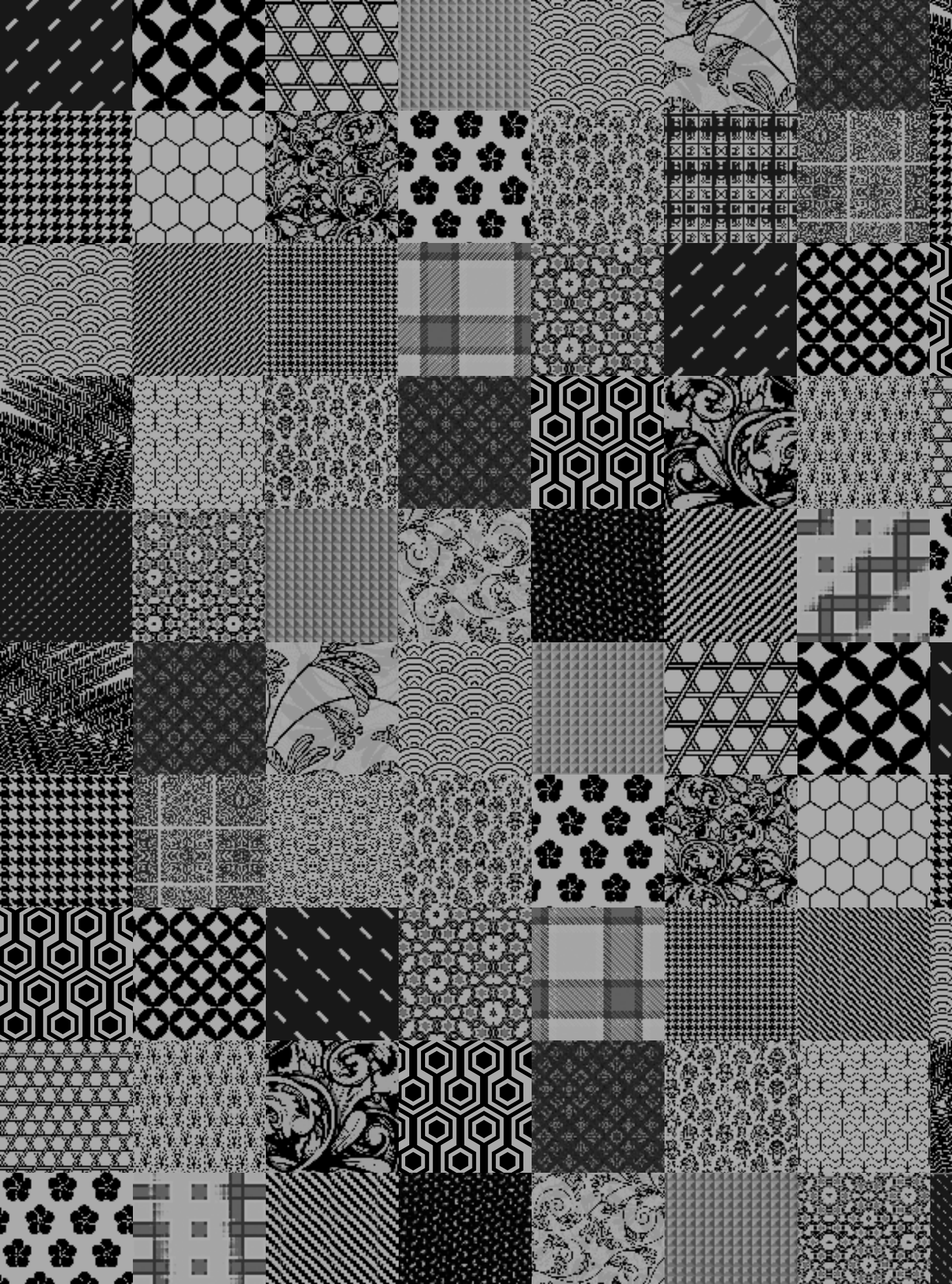

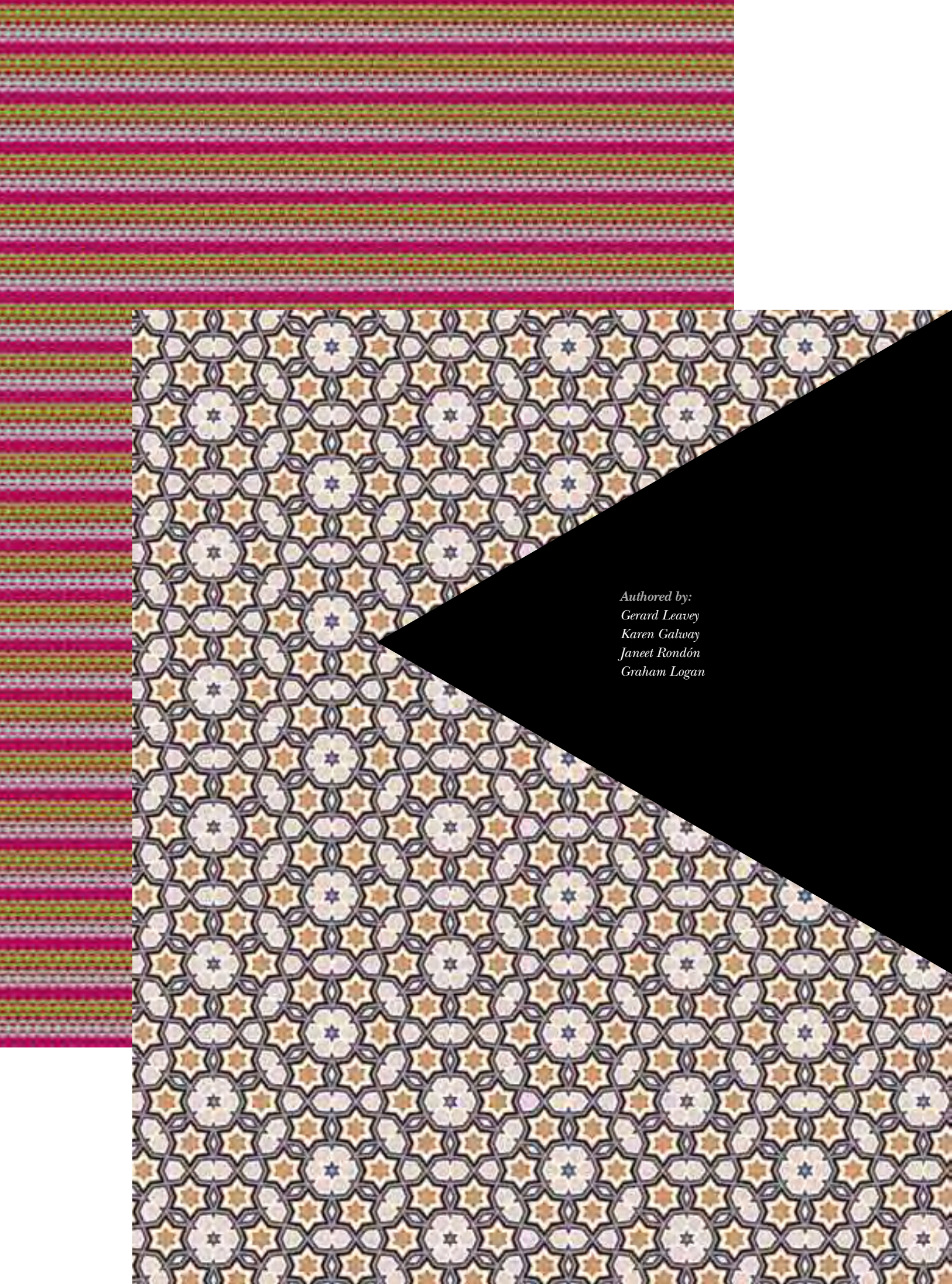

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Foreword
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These are difficult times and the economic and social costs of mental ill health are considerable. According to the World Health Organisation (WHO), by 2020, depression alone will be the second biggest contributor to the total disease burden. However, in addition to this, we must consider the cost of people, who while not clinically ill, are not able to fully contribute to life, family, community and work to the best of their ability. Moreover, it is now well accepted that, due to a broad range of factors, some individuals and groups face tougher life journeys than others; people, who have fewer inner resources are less able to stand up to setbacks and stress. For many people too, the financial and emotional support that can be derived from jobs, family and friends is unavailable. People who are unemployed, living in poverty or experiencing life as an outsider – people who are treated differently in terms of race, religion, sexuality, disability – can face exclusion from things that the majority of us take for granted and face an increased vulnerability to emotional distress and ill health. This is costly in terms of human suffering and wasted talent.

While improved access to treatment is very important, clinical care can never be the whole solution. It makes sense then to tackle and reduce the determinants of poor health and take steps to improve the resilience and sense of wellbeing for all. But, how can this be achieved? This report sets out a vision for flourishing emotional health and wellbeing in Northern Ireland (NI). The report draws upon the published literature, current policies and practices elsewhere in addition to current policies and practices in NI, and the particular needs that are relevant to our local context.

Our recommendations are offered in the full recognition of the financial difficulties faced by government and society. Thus, we emphasise the need for efficiency and better use of existing resources underpinned by evidence, transparency and accountability. The strategy that we propose requires collective responsibility and collective action – from all branches of government through to schools, businesses, trade unions, and the voluntary sector. Importantly too, there is much that we as individuals and communities can change and achieve and there is much that government can do to empower us.

Finally, my thanks to all those who have contributed in any way to this report and in particular to Dr Michael McBride, the Chief Medical Officer for commissioning NIAMH to produce this report.

Professor Alan Ferguson O.B.E.
Chief Executive, Northern Ireland Association for Mental Health

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Executive Summary

The Northern Ireland Association for Mental Health (NIAMH) was commissioned by the Chief Medical Officer (CMO) in December 2008 to undertake a review of the current mental health promotion and suicide prevention strategies in Northern Ireland (NI). Specifically, we aimed to undertake the following:

1
To consider progress against the delivery of the actions and recommendations within the existing Mental Health Promotion Strategy 03-08, Protect Life: A Shared Vision 06-11, and The Bamford Report; Mental Health Improvement and Wellbeing – a Personal, Public and Political Issue.

2
To identify those actions and analyses within the existing Mental Health Promotion Strategy 03-08 which will need to be carried forward to a new strategy.

3
To highlight any gaps in the existing Mental Health Promotion Strategy 03-08 which will need to be catered for in the new strategy.

4
To carry out an appraisal of the relevant evaluative research, including drawing on the international evidence base, in order to advise on its transferability at a local level.

5
To consider opportunities and approaches to build resilience at both an individual and community level.

6
To consider the development of population metrics in order to demonstrate improvement in mental health levels.

7
To provide advice and strategic direction to the Department of Health, Social Services and Public Safety (DHSSPS) to assist with the development of a new mental health and emotional wellbeing strategy.

Section 1

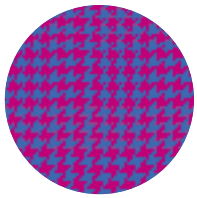
Living and Wellbeing

The aspiration for a healthy and emotionally flourishing population cannot be isolated from the wider social goals of prosperity, stability and cohesion. Our children and young people are increasingly vulnerable to mental illness, self-harm and suicide. Moreover, the prevalence of obesity is rising rapidly as is the harmful use of alcohol and illicit drugs. However, while we argue that improving the wellbeing of everyone should be fundamental to all modern societies it is also crucial to understand that vulnerability to social exclusion and illness is not evenly distributed.

Again, such problems are costly to individuals and society but they should not be viewed as inevitable. Thus there is an urgent need to look to solutions that harness the energies and creativities of all sectors of society – communities and families in partnership with employers and trade unions, the voluntary sector and professionals from all branches of government. There is much that can be accomplished by building resilience within individuals and communities across the life course, targeting our resources and energies in settings where they will be most effective.

Section 2

Review of the Current Strategies



A consultation exercise on the current mental health promotion and suicide prevention strategies in NI was undertaken amongst a wide range of actors and stakeholders involved in commissioning and delivery of community-based programmes and interventions. Opinions were sought on their understanding and level of acceptance of the documents and their suitability in terms of mental health promotion and reduction of self-harm and suicide. We explored whether the balance between central control and local implementation operates effectively. We also queried the funding arrangements, the level of collaborative efforts and the practicalities and administrative arrangements currently in place to deliver on the strategies.

Drawing on this consultation exercise, our analysis and what is known about the relatively young disciplines of mental health promotion and suicide prevention, a set of recommendations are given on the most effective and efficient use of mental health promotion resources for NI. These are, in part, supported by the perspectives which emerged from our independent symposium of mental health promotion academics and other experts.

The Consultation Exercise

A broad reference group including representatives from statutory, voluntary and community sectors involved in the promotion of mental health and wellbeing in NI was consulted. The research team collected data via consultation interviews carried out individually, via telephone and in focus groups (n=53); consultation emails targeted to a wider reference group (n=75); and a public notice placed in the local press.

Key Findings

- There is a considerable degree of overlap between the mental health promotion strategy and the Protect Life (Suicide Prevention) strategy.
- The MHP Strategy 03-08 was viewed positively by a broad spectrum of stakeholders, considered strong in terms of actions and collaborative requirements.
- The Protect Life document provoked mixed reactions. It was generally praised for further developing the standard of the MHP Strategy, by providing clearer and more concise action points, although the overlap between it and mental health promotion strategy was considered to be confusing and generally problematic.
- The framework for the implementation of the Protect Life strategy has been robust and exemplary.
- It was generally agreed across all sectors that there is a need for a consolidation of mental health promotion and suicide prevention strategies which would help to reduce duplication of effort, while continuing to improve mental health literacy.
- There are extensive mental health promotion activities across NI but these efforts

appear fragmented and inconsistent. It is extremely difficult to quantify these activities or any degree of success these have.

- There are difficulties arising from a lack of a standardised and simplified system for commissioning, governance (including audit and evaluation) and reporting. Commissioning should continue to be tailored according to evidence-based need.
- There is a perceived lack of available data to guide both the need for and the impact of MHP on the population in NI – viewed as a lack of effort to recognise and address this urgent need through population-based government surveys and independent research.
- In addition to a renewed focus on school-based mental health promotion, there was considerable support for early years and parenting programmes.

Section 3

Review of Effective Interven-tions



The rationale for mental health promotion is based on the case for preventing mental illness and for promoting positive mental health. The evidence of mental health promotion effectiveness is still emerging; however, two principles can be applied: risks and protective factors can be reduced or enhanced by interventions; a population health approach to mental health promotion aims to improve mental health across the lifespan, from birth to death. In our review we covered the following areas:

Support and Actions for Families and Early Years of Life
Investment in a healthy start in life is directed towards positive development in childhood, adolescence and adulthood. Positive and engaged parenting can increase children's self-esteem, their social and academic competence, and protect against later disruptive behaviour and substance use disorders. Likewise, pre-school education enhances children's lives at many levels. A number of studies, mainly from the United States[2] have shown the effectiveness and financial benefits of parenting and early intervention strategies.

Education and School-based Actions
The evidence indicates that attempting single-issue health promotion within schools is generally unhelpful and inefficient (e.g. dealing with drugs and alcohol, bullying, obesity, self-harm and suicide). The whole-school approach is widely acknowledged as crucial to wellbeing – engaging

students, teachers and parents through both curriculum and policy is more effective than short-term interventions focused on specific topics related to self-esteem, self-concept and individual coping skills[3].

Wellbeing in the Workplace
The workplace as a source of enhancing public health and wellbeing has been a key area of discussion and policy at both national and international level in recent years. It is worth stressing that employment is generally considered to be good for health and wellbeing[4]. The role of employers in promoting not only physical health, but also mental wellbeing, has led to the recognition that the workplace is an effective site for interventions to improve health and reduce health inequalities[5].

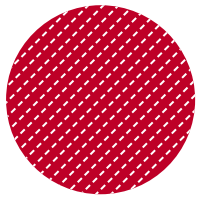
Support for Later Years
Five key factors affect the mental health and wellbeing of older people: discrimination (for example, by age or ethnicity), participation in meaningful activity, relationships, physical health (including physical capability to undertake everyday tasks) and poverty[6]. Addressing those factors as well as the risk factor of isolation, particularly for those in rural areas and for people older than 75 who may be widowed or live alone, are priorities for this age group. Best evidence suggests that interventions such as volunteering, regular physical activity in a safe environment and community befriending programmes should be the subject of further evaluations.

Training and Awareness Initiatives
In order to aid and support the promotion of positive wellbeing and improve the mental health literacy of the population it is vital that those involved at all levels in all sectors receive appropriate training and information and advice. Successful training programmes implemented in other parts of the world which have also been implemented and piloted in NI such as the Applied Suicide Intervention Techniques (ASIST) and the Mental Health First Aid (MHFA) should be encouraged and properly evaluated in order to assess their impact in the NI context. Other local initiatives that promote the mental health literacy of young people (Mood Matters) deserve the support and encouragement of those involved in the promotion of mental health.

Improving the Lives of People with Mental Health Problems and Learning Difficulties
The aspiration towards a flourishing society must truly mean wellbeing for all including people whose lives have been negatively impacted by mental health problems and learning difficulties. The 'recovery approach' is a viable model to achieve this.

Section 4

Recommendations for a New Strategy



A single, coherent wellbeing strategy would be a major step towards achieving greater effectiveness in the development of a healthy, resilient and flourishing population. The new strategy should incorporate elements of the current suicide prevention strategy.

Life Course and Settings

- We need to invest in the wellbeing of our population from the earliest stages of life. The research suggests that we target our resources to those most in need in order to tackle health inequalities and reduce social exclusion. While a life course approach acknowledges the importance of wellbeing for all, there is a need for mental health promotion strategies that reflect the needs of people within specific settings.

Early Years

- We support the establishment of parenting programmes targeted at young mothers from deprived backgrounds. Where families have complex and challenging need, intensive home visiting by health visitors and school nurses, using regionally agreed specific evidence-based interventions/programmes should be introduced for children of all ages. The outcomes of work being led by the Department of Health (DH) in relation to the Family Nurse Partnership should be considered within the menu of services for the most 'Hard to Reach' families.

Education

- Schools and colleges could be better supported in making a significant contribution to the wellbeing of children and young people, parents and communities through the promotion of 'extended' schools – offering childcare provision, reading clubs, 'green gyms' and adult education.
- We also recommend the widespread adoption of a 'whole-school' approach to wellbeing through policy and practice, early recognition and management of emotional and psychological distress and effective collaboration with Child and Adolescent Mental Health Services (CAMHS).

Employment

Across the employment sectors there remains too much emphasis on individual sickness and discipline rather than creating healthy environments and practices. Thus, there is a need for deep cultural and structural change. Small to medium enterprises lack resources to develop good wellbeing practices or Employee Assisted Programmes (EAPs).

- We support the recommendations set out in the report by Dame Carol Black (Working for a Healthier Tomorrow) in particular that people absent from work through illness should be encouraged and supported through stepped return.
- There is a need for government to support the smaller enterprises and the need for a

new business-led information, advice and consultancy service. Likewise, smaller enterprises could be encouraged to develop information and advice partnerships.

Training and Awareness

- In order to ensure that the statutory, voluntary and community sector are equipped with the required skills to deliver the strategic action points of a future mental health and wellbeing strategy, a range of adequate and ideally, accredited training must be available and accessible.
- An equally high level of specialism is required to develop training packages designed for other professional groups such as general practitioners and nursing and support staff working within the prison population.
- We also recommend that provision of training be commissioned through independent, arms length agencies, such as those situated in the voluntary or private sector, including professional bodies that have knowledge and hands on experience within the specific fields of relevance to the training requirements.
- Training and support relating to research and evaluation for voluntary and community sector agencies should be funded and established through an independent body or within the university or higher education sector.

Community Involvement

While communities are central to mental health promotion and our review of the strategies suggests that substantial and high quality work is delivered by the voluntary sector in NI, their work should be strengthened by improved resourcing from government and enhanced capacity and evidence building among community groups.

- We propose that before community groups are commissioned to undertake work in the field of mental health promotion that they must demonstrate that an evaluation plan is central to their proposals.
- With respect to improving social capital among and between communities in NI, commissioning organisations should strongly encourage applications that can demonstrate cross-community engagement. Additionally, programmes that show meaningful involvement with older people and marginalised groups.
- Faith-based organisations (FBOs) offer considerable opportunities for building social capital and supporting community wellbeing. These resources are poorly understood and greatly underutilised. We recommend that government agencies seek to build collaboration with this sector.

Monitoring

- All government funded programmes and projects should be recorded centrally to facilitate transparency, opportunities for learning and continuity of provision. A regularly updated, easily accessible, standardised public database would be ideal for this purpose.
- Standardised commissioning processes could be developed for NI with associated reporting conventions to ease the burden of administration for all organisations and to reduce duplication of effort.

Research

There is a significant evidence gap in research related to mental health promotion, prevention and early intervention. There is a pressing need to inform and thus, strengthen future wellbeing strategies.

- A programme of research is needed to support the development of emotional wellbeing
- We recommend building on existing and proposed activities by universities and other appropriate arms length agencies.

Measurement

Current measures of mental illness, while generally useful, are not relevant to understanding and improving the wellbeing of the population. The measurement of wellbeing is still in the early stages of development. There is a need for measures of wellbeing that are appropriate and acceptable in NI.

- Appropriate measures of wellbeing should be considered for piloting and possible

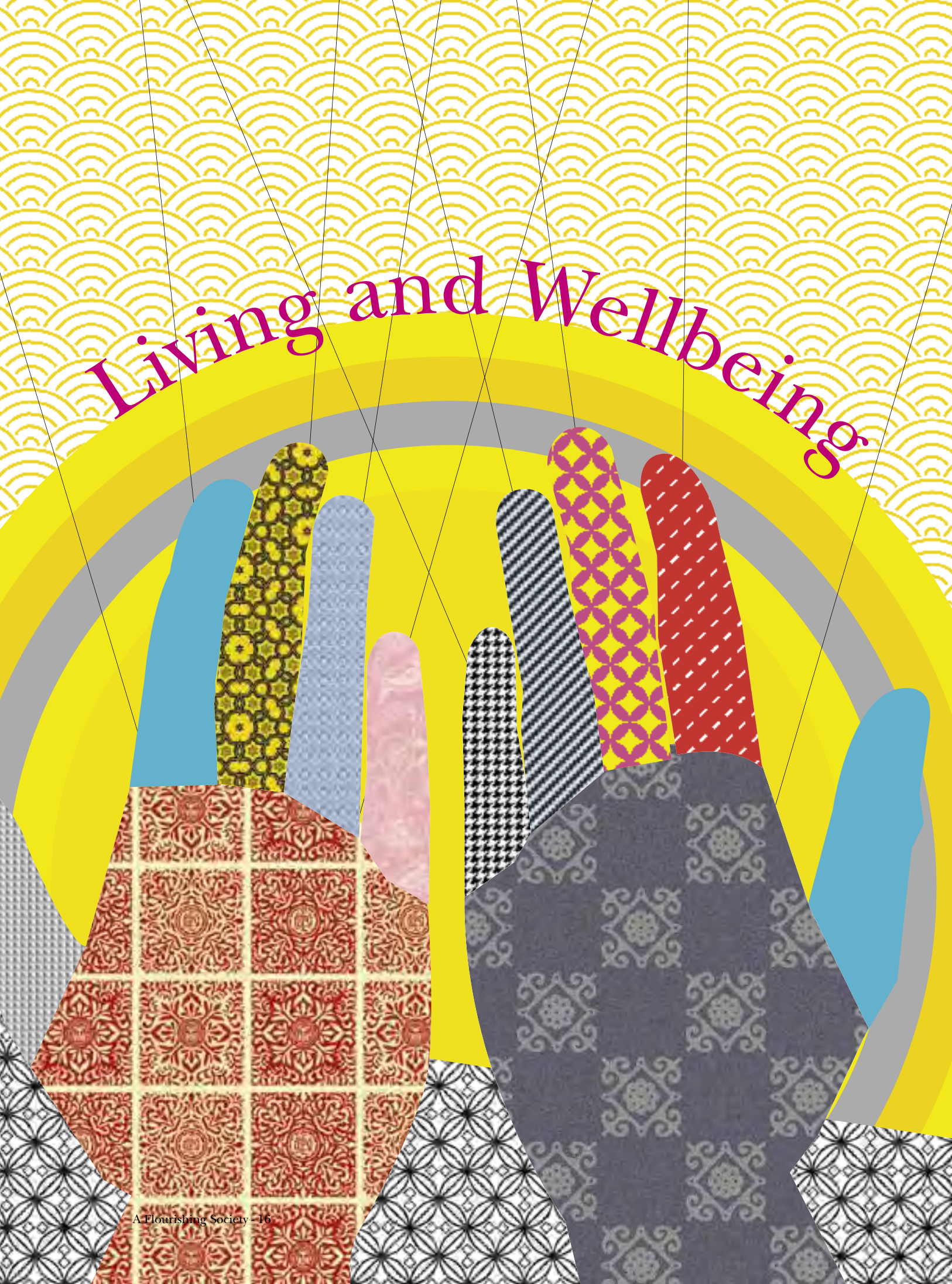
adoption in NI, in addition to other measures of life satisfaction and in conjunction with measures of social capital.
- NI should coordinate with other countries and collaborate in the development of new measures.

Implementation

Mental health is important for all aspects of human activity and is therefore important to all sectors of government. Much of the necessary activities proposed within a wellbeing promotion framework must not be assumed to be the responsibility of the Department of Health. To do so would acutely diminish any likelihood of success. Therefore there is a need to seek commitment for a new wellbeing strategy within the Northern Ireland Executive in order to build creative and collective agreement across department leadership.

- Dialogue and recognition about the importance of wellbeing must begin among those who are in the most senior positions of public administration in NI. Implementation also requires the early and sustained consultation and collaboration with agencies and people on the ground – the community groups and voluntary sector organisations, which are vital to making implementation happen.
- Wellbeing and mental health promotion is still developing and requires a degree of flexible supervision. While we can draw upon the many useful programmes and interventions that have proved successful elsewhere there is still a need to examine their effectiveness and acceptability in the context of NI.
- We recommend that the government establish systems to monitor and assess the framework and processes for delivering the strategy at national level.

Living and Wellbeing



Section 1
LIVING AND WELLBEING

Much quoted but worth repeating, the World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" and mental health is described as "a state of wellbeing in which the individual realises 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 to his or her community"[7]. More recently, the European Commission Green Paper on mental health[85] restated the case that "for citizens, mental health is a resource which enables them to realise their intellectual and emotional potential and to find and fulfil their roles in social, school and working life". Overall, the document outlined the relevance of mental health for some of the EU's strategic policy objectives (prosperity, solidarity and social justice, quality of life of citizens, etc), proposed the development of a strategy on mental health at community-level and brought forward possible priorities and suggestions for actions.

In NI the vision of government is to develop "a peaceful, fair and prosperous society"[8]. At the heart of this desired change and growth is the need to build our economy and to ensure its solidity – making NI a better and prosperous place to live in, to build strong families and communities in an atmosphere of peace. However, to give substance to this vision it is necessary that everyone is able to share the benefits of prosperity. Equally, we all need to feel that we have something to contribute, that we play a useful role in our communities and feel optimistic about our own future and that of our children.

People in NI have come through many difficult years. Lives have been damaged and lost. There remains a great deal of trauma, hurt and anger – problems that are likely to be passed on to our children unless we find new ways of dealing with them. Nevertheless, there is a growing sense of optimism that NI will become a great place in which to live and work, a place where we can all achieve a sense of positive wellbeing.

On a universal level, throughout human history people have confronted many different sorts of threats and challenges from flu epidemics to nuclear destruction, global warming and famine. While the nature of these threats may change what really matters are the resources, both personal and communal, that we create, nurture and draw upon in order to comprehend and manage these threats more effectively.

However, during years of economic growth and affluence, many people in western societies remain burdened by worries; few people could honestly say that they have never faced periods of stress or sadness or that the world made perfect sense. We often worry



The response to the EU green paper highlighted that promotion of positive mental health and prevention of disorder can benefit actions of stakeholders from other policy areas in the EU.

Employment

Europe has been experiencing changes in the form of employment, resulting in increased pressure on individuals and volatility of employment. Positive mental health promotion could contribute to diminishing of stress at the workplace.

Productivity and Employability

Investment in positive mental health in children and adolescents will enhance the development of their self-esteem and coping skills. In the labour market of present times persons equipped with those skills are more likely to succeed (or be more employable) and add to the productivity growth.

Social Cohesion

Positive mental health, leading to greater social participation – in the social networks and the labour market would positively contribute to increased social cohesion – one of the European Union's strategic objectives.

about our jobs – if we are fortunate enough to have them – and about balancing the pressures of work and home life.

For those with children, there are worries about their education, their future and how best to bring them up. For many children and young people in our society, feeling confused and alienated is a constant. They report feeling frightened about the expectations of adults and uncertain about fitting in, their bodies, sexuality and identity – about being accepted and being loved. In the past few years there has been a tremendous increase in the mental distress among our young people – depression and anxiety, self-harm, suicidal ideation and suicide. Other problems that we may not immediately connect with mental wellbeing, such as smoking, drug and alcohol misuse, teenage pregnancy, obesity and anti-social behaviour are associated with, and often exacerbated by low self-esteem and lack of emotional literacy. In NI and elsewhere, the suicide rates for young males aged 18-24 years have risen dramatically. The reasons remain unclear but it seems obvious that we are failing to provide future generations with the vital support they need in order to cope with the demands of modern life.

Moreover, there is mounting evidence that our society is increasingly alone, overweight, alienated from political and social engagement, generally dissatisfied with life and more dependent on drugs and alcohol. On the latter point it is disturbing to note that 750 people die prematurely in NI each year as a direct result of alcohol related harm[9] – three times the number of people who take their own lives.

In our modern age, sometimes the feelings that we describe as depression, are simply a natural response to loss and hurt. Importantly too, they are often a useful warning signal that our life is out of balance. It is important to bear in mind that anxiety and sadness are a normal and expected element of life. However, increasingly, we appear to be unable to tolerate sorrow and suffering – we have difficulty accepting this as part of being human, as part of change and growth and instead we seek medical solutions to the problems of existence. For many people this is unlikely to be the solution to the problem.

Moreover, while it can be argued that life expectancy has increased in the past 50 years in Western societies perhaps what should be of greater concern is the impaired quality of these additional years. As we get older the chances of developing cognitive impairment greatly increases along with the need for institutionalised care. Of course, old age is the natural and inevitable future for most people in Western societies but it doesn't have to be a frightening or negative prospect if we equip ourselves appropriately and as early as possible. It is certainly the case that many people are able to draw on some inner strength to resolve the problems they face and indeed, some people seem to handle adverse life events emerging from them stronger and wiser. What makes some people resilient to such stressors while others in similar circumstances struggle, remains unclear. However, there are some clues to this.

Many would disagree with the notion that happiness is necessarily obtainable or desirable. For example, in the context of global warming and other threats, happiness might seem an 'odd' or inappropriate state of mind. However, the concept perhaps points to other factors related to a sense of wellbeing. Thus, drawing from large-scale surveys, the economist Lord Layard highlighted seven factors that contribute to happiness within a Western context:

- Health
- Family relationships
- Work and job security
- Financial situation
- Community and friends
- Personnal freedom
- Personal values (eg. a religious or spiritual aspect to life).

For adults, the factors that have the largest negative impact on happiness are marriage breakdown, becoming unemployed, perceived poor health and low personal freedom. Layard argues that this helps to explain why increased wealth has not improved happiness in society. Thus, "while average wealth has doubled, marriage breakdown has increased significantly. Community trust has

Lord Layard's seven factors that contribute to happiness within a Western context.



decreased, job security has been sacrificed in favour of increased productivity and as people are flooded with media images of perfection, self perceptions of health and wellbeing have plummeted"[10]. Layard's perspective dovetails and confirms evidence from elsewhere that social capital is strongly linked to subjective wellbeing through a range of independent routes and social concerns[11-15]. Family and social connections, bonds to friends and neighbours, workplace ties, civic engagement (both individually and collectively), trustworthiness and trust; all appear to be strong predictors of happiness and life satisfaction, both directly and through their impact on health.

Some people might question whether the mental health and wellbeing of individuals and families should be the responsibility of government or why it should be in the interests of employers and communities to become involved in promoting health and wellbeing. The next sections briefly outline some of the hard financial costs of mental illness and the related significance of health inequalities and social exclusion.

1.1 The Cost of Mental Illness

A sound economy requires an educated, healthy and dynamic workforce. We need people who have the energy and drive to contribute positively throughout their lifetime. However, reduced functioning arising from mental illness and low levels of wellbeing may be the greatest undermining factors to achieving NI's full potential.

While this review focuses on promotion and prevention, it is also necessary that we discuss

the current incidence of mental illness in our community in order to illustrate the benefits of promoting a *wellness* perspective. The prevalence of mental and behavioural disorders is about 10% for the adult population worldwide. Twenty percent of adolescents under the age of 18 suffer from developmental, emotional or behavioural problems, and one in eight has a mental disorder[16]. Often the costs associated with these problems are disproportionate to their origins. For example, antisocial behaviour in childhood often leads to lifelong social exclusion. It imposes considerable costs in childhood, followed by high public expenditure and personal distress in adulthood. The impact on public spending is substantial. In a study by Martin Knapp and colleagues, 3% of their population sample was classified with conduct disorder and a further 9% with conduct problems, values that are typical for the United Kingdom and United States. This 12% of the population accounted for around half of the public expenditure assessed[17].

In NI there is evidence to suggest that we have up to 30% higher levels of psychiatric morbidity than the rest of the UK. In part, this may be due to the fallout from 30 years of sectarian violence and is likely to reflect relatively high levels of deprivation[18].

Estimates from WHO indicate that in the UK mental illness accounts for more disability adjusted life years (DALYs)* lost per annum than any other health condition. The figures for 2002 show that 20.0% of the total burden of disease in the UK was attributable to mental illness, compared with 17.2% for cardiovascular disease and 15.5% for cancer. The economic cost of mental disorders is therefore substantial – impacting on individual, families and communities. Many other costs associated with mental illness are indirect and not readily measurable. Indirect costs include loss of productivity and costs related to morbidity, premature death, incarceration and the costs to caregivers. The hidden costs reflect the consequence of social isolation, humiliation, stigma and other human rights violations.[19]

The King's Fund has estimated that costs arising from mental ill health in the UK reached £48.6 billion in 2007. This figure includes 'service costs' – both direct and indirect – and the costs of lost employment. Other estimates have put the costs of mental illness to be higher than the total costs associated with crime[20]. In NI, work commissioned by the Northern Ireland Association for Mental Health (NIAMH) indicated that mental illness costs about £2.7 billion per year.

1.2 Health Inequalities and Social Exclusion

In this section we discuss the importance of health inequalities in relation to wellbeing, drawing attention to the links between

Perhaps the most significant finding is that one in every eight households in Northern Ireland, excluding pensioner households, has no one in paid work. This denies these households access to adequate material resources and severely restricts their integration into a range of social and civic activities.

It impacts on the future as well as the present children in the household and it has wide-ranging social costs in terms of ill-health, relationship breakdown and other problems. Social exclusion in whatever form has widespread implications which go beyond the individual to neighbourhoods and social order as a whole.

Bare Necessities, 2003 [86]

* DALYs are the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

A recent report indicates that one in 10 young people think that life is not worth living. Of the 2,004 young people polled, 12% said that life was meaningless, and over a quarter claimed that they were "often" or "always" depressed. According to the research, two-thirds of young people actually claim to be "always" or "generally" happy with their lives. However, very strikingly, dissatisfaction with life apply disproportionately to a small underclass that this society is failing: those not in employment, education or training (Neets).

Almost one-fifth of the young Neets feel that life isn't worth living as opposed to one-tenth of the general population. Similarly, 37% of Neets claim to be often or always depressed as opposed to 27% of the younger population as a whole.

Prince's Trust Report [87]

poverty, social exclusion and the deep lingering costs that these have for communities and society.

Health inequalities have been defined as "the systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent"[21.22.23]. It is now well established that social and economic policies influence the life chances of our children – whether they are able to live full and flourishing lives, or whether their lives are to be directed towards a dead end and poor health. Aside from wealth, our societies are also judged "by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health"[24].

However, this is an issue which is not simply about social justice but rather is about improving health and the quality of life for all; our society is shared – the problems affecting one community or another cannot be quarantined. Thus, the costs of ill-health (physical and emotional) are felt by the healthcare system, families and carers, businesses, schools and the criminal justice system. It is also a major loss to our society and economy when we fail to harness and optimise the full potential of all individuals. We all suffer. For example, longitudinal research shows that adolescents with conduct problems have a poor long term prognosis in adult life[25.26]. Conduct problems in adolescence are associated with leaving school earlier or with fewer qualifications, becoming a parent at a young age, unemployment, divorce or separation, substance abuse, other psychiatric disorders including depression and anxiety, and suicidal behaviour.

Social exclusion has been defined as "a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, unfair discrimination, poor housing, high crime, bad health and family breakdown"[27].

Importantly, while many people have benefited from rising prosperity in NI, a minority of people and their children remain trapped in a cycle of deprivation, and deeply excluded from many of the life-enriching social activities and benefits that most of us take for granted; this cycle shows up in various ways. For example, the daughter of a teenage mother is twice as likely to become pregnant in her teen years. This will impact on educational attainment and employment prospects. Often, the associated disadvantages, such as greater vulnerability to emotional and mental disorders persist throughout adulthood and old age. Equally, we now know that growing up in a difficult and abusive environment increases the chances of perpetuating an abusing

environment later in life. We know that people who have grown up with abuse and adverse familial environments are at a higher risk of suicide[28].

Similarly, children in state care (or 'looked after children') are consistently identified by government and policymakers as 'socially excluded'. They under-achieve within education and are also particularly vulnerable in terms of poor health outcomes. Although this group represent a minority of the population – fewer than 400,000 in the UK and 2,356 in NI (2007 figures) – the dysfunction they experience will have a significant impact on future generations. Such children are four times more likely to be unemployed and 60 times more likely to be sent to prison. Between 30% and 40% of women in UK prisons have spent some part of their childhood in care[29]. It is currently estimated that approximately 80% of our prison population in NI have a long-term mental or emotional condition that affects their ability to cope with the everyday pressures of life[30].

There is a pressing need to intervene, to disrupt and break the cycle of negative outcomes and exclusion. Thus, alongside a population-based approach for all, it will be important that the strategy for wellbeing proportionately recognises the increased need in specific sectors of society.

1.3 Flourishing Mental Health - A Population-based Approach

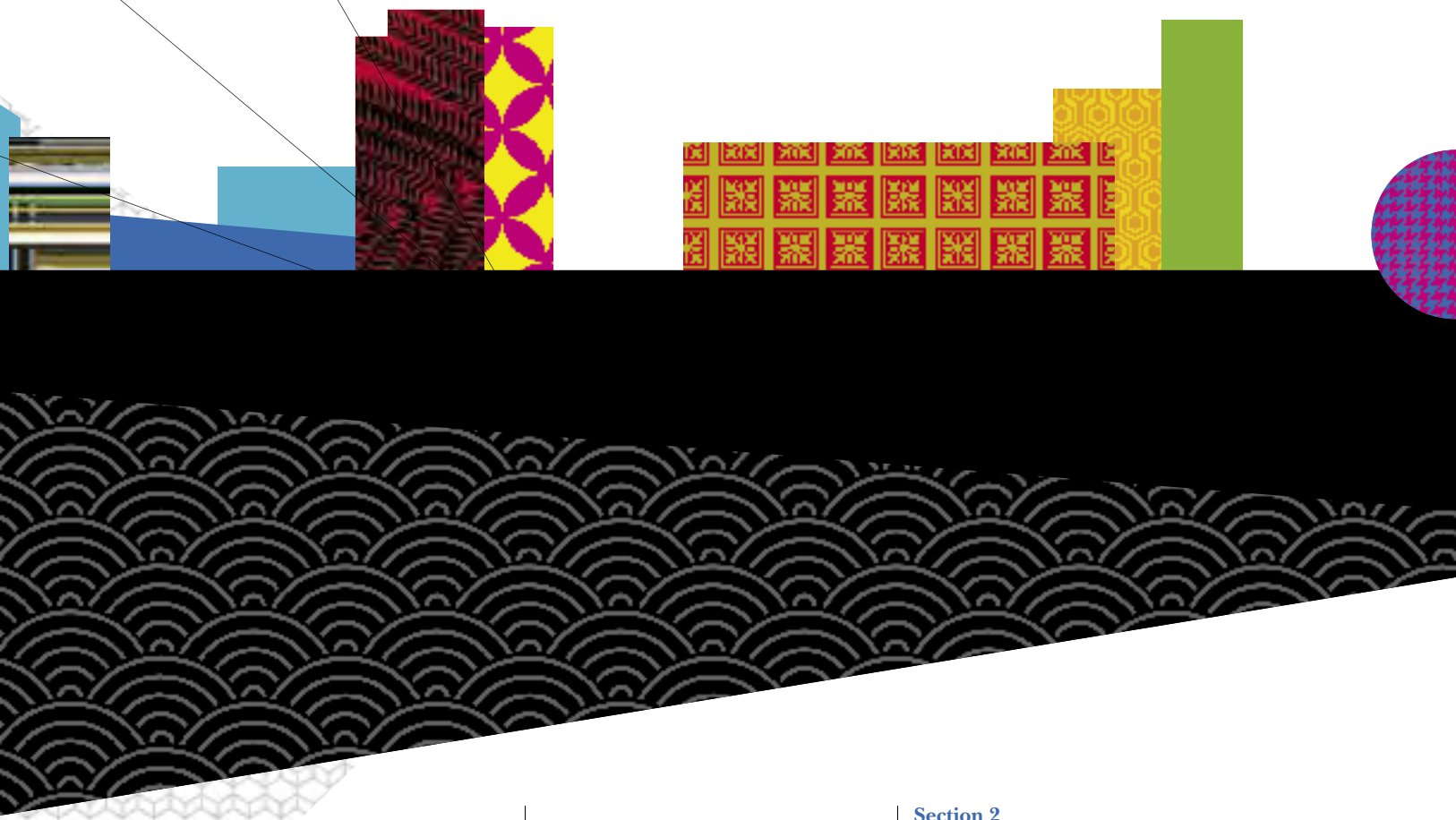
In a recent report for NIAMH, Friedli and Parsonage[2] indicate that we need more evidence to support the financial benefits of promoting positive mental health than we do to support the benefits of preventing mental illness, reflecting the thrust of research efforts to date. According to Keyes[31,32], the concept of a flourishing individual is that of a person who is contented, productive, well integrated emotionally and socially, with a sense of purpose and optimism. However, a recent survey in Scotland described 14% of the sample as having 'good mental well-being', 73% as average and 14% as having 'poor mental well-being'[33]. In other words, the majority of people, while not 'languishing', may be living at sub-optimal levels. These figures suggest that even small improvements in overall levels of population mental wellbeing in the population might result in significant benefits.

A population-based approach to promoting mental health has been used to make the case for the benefits both of improving mental health and preventing mental health problems. It has been reasonably argued that higher levels of positive mental health in any given social group, whether it be in schools, businesses, communities or families, will increase the ability to protect and support those people with, or vulnerable to, mental disorder[34].

However, in practice, the distinction between promotion and prevention is not always clear-cut. For example, mental health promotion in the workplace may prevent stress related illness, but may also result in broader positive mental health outcomes e.g. higher job satisfaction, increased morale, greater productivity. Equally, interventions designed to prevent a specific mental health problem, e.g. post-natal depression, may not reduce prevalence, but may have socio-economic benefits associated with positive affect e.g. producing better mother/infant attachment, uptake of education or increased support networks.

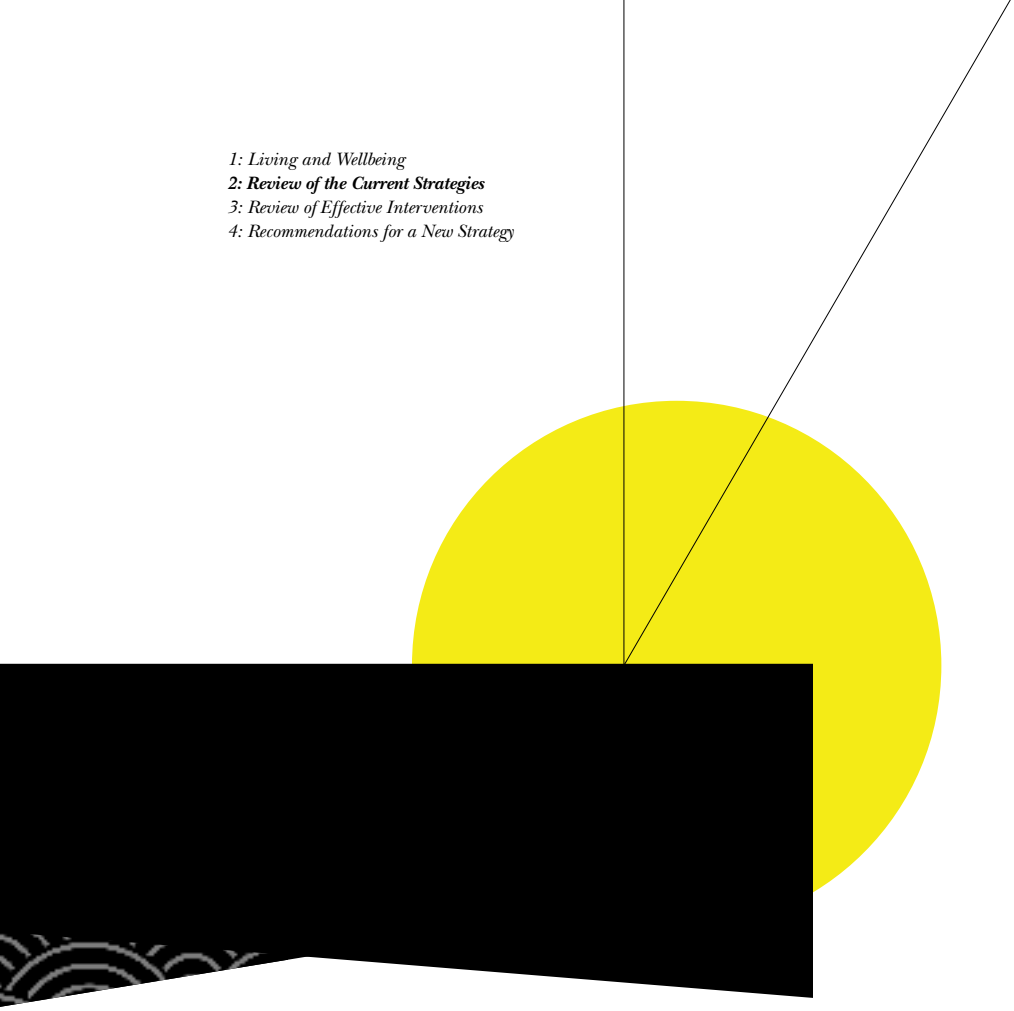
Also, it is important to bear in mind that while we can't necessarily prevent the experience of mental distress, we can at least attempt to intervene early in order to alter the course and length of illness, reducing the impact of these problems on individuals, their families, the health service and society at large.

Review of the Current Strategies



Section 2
REVIEW OF THE CURRENT STRATEGIES

The aim of this review was to provide an evidence-based foundation on which to establish and develop meaningful and measureable activities that promote mental health and wellbeing across the whole of NI. We did not intend to pursue a complete analysis of the work by agencies tasked with delivering Mental Health Promotion strategies. Equally, it was not possible to gather information on all the ongoing work related to promoting mental health. Rather, our aim was to gather evidence, views and insights from a wide range of key actors and stakeholders to assist with the development of an integrated and



positive strategic plan for the future. Our team independently considered the suitability and focus of the action points within The Bamford Report on Wellbeing, the MHP Strategy 03-08 and Protect Life 06-11, as well as gathering opinions from key stakeholders.

The consultation exercise sought opinions and considerations about: (1) whether or not the three documents considered have been understood and accepted by all and (2) whether or not these were viewed as an efficient and acceptable way to promote better mental health and reduce suicide and self-harm by professionals within mental health promotion. We explored whether the balance between central control and local implementation operates effectively. We also queried the funding arrangements, the level of collaborative efforts and the practicalities and administrative arrangements currently in place to deliver on the strategies.

Ultimately our work has focused on recommending the most effective and efficient use of mental health promotion resources by incorporating all the available knowledge and experience gained to date. Mental health promotion and suicide prevention are relatively young disciplines and much remains to be learned about effective and efficient interventions and programmes. This document provides an important step in that learning process for NI.

2.1
Key Policy Documents

We have drawn upon on a substantial body of work both in NI and internationally. In NI key documents such as The Bamford Report on Wellbeing, in addition to Protect Life 06-11 and the Mental Health Promotion Strategy 03-08 have paved the way for fresh thinking. Each generation of health promotion and wellbeing strategies has much to learn from the experiences and mistakes of the previous generation and each new strategy has benefited hugely from previous work and examples of efforts elsewhere.

We have provided a ready reference list of worldwide strategic documents concerned with the promotion of mental health between 1981 and 2009 along with a full bibliography in the appendices. [Appendix 2]

2.1.1
The Consultation Exercise

We consulted a reference group of key stakeholders, comprising professional and highly experienced personnel across NI and beyond in order to gather data on the current strategic direction of mental health promotion and suicide prevention, the progress of delivery of actions in the strategies and suggestions for the future. As requested by the Chief Medical Officer for NI, we concentrated on reviewing the following three documents:

- The Bamford Report; Mental Health Improvement and

Wellbeing - a Personal, Public and Political Issue
- Mental Health Promotion Strategy 03-08
- Protect Life: A Shared Vision 06-11

The consultation group included representatives from statutory, voluntary and community sectors, allowing the research team to gather views and opinions from a wide variety of highly motivated, knowledgeable, experienced and interested parties currently engaged in the promotion of mental health and wellbeing across NI.

2.1.2
Methods
We pursued two strands of investigation. The first strand generated data through discussions which took place between an external panel of experts with extensive experience in mental health promotion along with members of the research team. Insights were collated into a narrative account of the discussion with a write up focused on policy development, implementation structures and processes along with content and relevance of the strategy documents under review. The resulting account is presented towards the end of this section.

The second strand of investigation involved three data collection methods: consultation interviews, consultation emails and a media call for public input. Consultation interviews (n=55) were conducted individually on a face to face basis (n=38), via the telephone (n=3), and in groups (n=14). Additionally, we undertook a consultation process via email with a targeted wider reference group (n=75) forwarded by members of the steering group and participant stakeholders to additional relevant email distribution lists. A public notice was also placed in the local press to encourage as wide a response as possible via NIAMH's website and by post.

Formats for invitations to participate and topic guides for the consultation interviews, the circulated emails, the public notice and the website were established. The consultation discussions included role and relation to the strategy documents, funding arrangements, actions and initiatives underway, partnerships and collaboration, feedback and evaluation and suggestions for the future. The interviews were carried out by the research team. Permission was sought for using direct quotations in this report, although individuals are not named.

2.1.3
Results
A list of key stakeholders was provided by the DHSSPS. It was extended with additional names provided by the Strategic Development Group (see Appendix 1 for membership) and participant recommendations. All those identified through DHSSPS and the snowballing techniques were invited first by an electronic letter then by telephone to participate in the consultation. Of those contacted for face to face consultations (n=68), 80% agreed and had been consulted within four weeks of receiving an invitation. We received an additional 10 written responses by email. The face to face interviews were recorded and transcriptions provided a basis for analyses. The data were analysed for common themes and the findings are presented below.

"Particularly with regard to Bamford and young people aged 16-25 at risk, I think that it is quite useful…They [MHP Strategy, Protect Life and The Bamford Report] are quite substantial documents and there is some overlap."

NUS-USI Open Your Mind Project

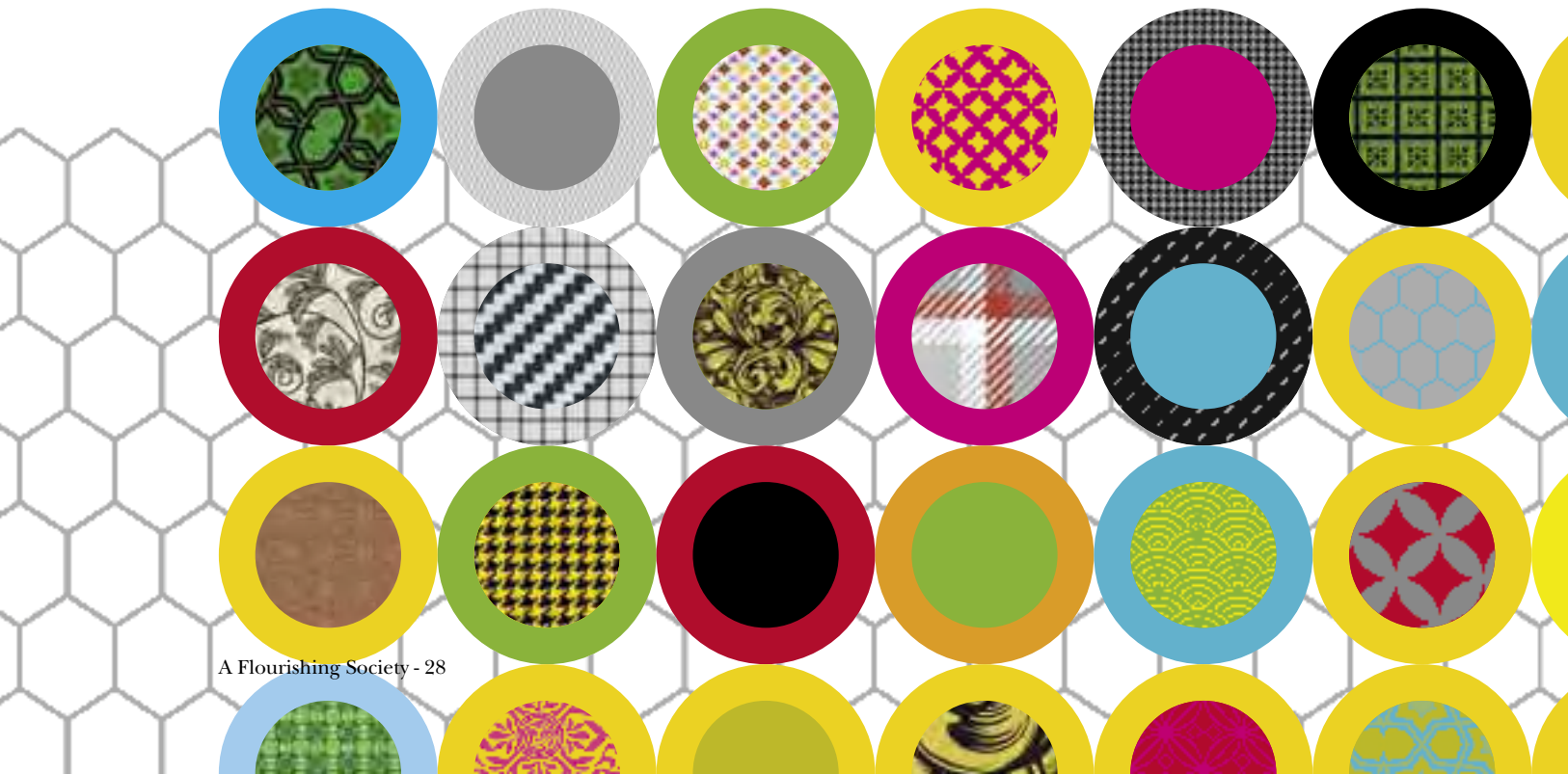
2.2 Overview of Findings

The consultation process provided a clearer understanding of how professionals engaged in this area view the strategies, and what steps should be taken to promote mental health, strengthen emotional wellbeing and prevent suicide in NI. Even though NI is relatively small, need, capacity and provision vary markedly. That said, a number of common themes emerged. The consultation revealed that a wide variety of highly valued efforts to promote mental health and prevent suicide are ongoing throughout each of the current five Health and Social Care Trust (HSCT) areas.

All the Trusts are strongly engaged with both voluntary and community sector agencies (varying according to local capacity), which in turn provide a wide range of initiatives both funded through the two main strategies, and through other independent grant arrangements. Interventions and initiatives are often based on effective, evidence based models of provision designed for the UK, Canada, Australia and beyond.

Each HSCT is responsible for producing an action plan and regular separate reports for the Mental Health Promotion Strategy and the Protect Life Strategy (amongst many other public health strategies). This tends to require additional liaison and communication and is reported to compromise efficiency where there is overlap.

The MHP Strategy 03-08 was viewed positively by most but as a product of its time, with reasonable aspirations in terms of actions and collaborative requirements. The Protect Life document provoked mixed reactions. It was generally praised for further developing the standard of the MHP Strategy, by providing clearer and more concise action points, although some were seen as too overarching with much overlap. Some participants felt there were too many action points in the strategy while statutory professionals in particular also perceived the aspiration of cross-departmental collaboration as somewhat unrealistic or overly ambitious. Moreover, it was felt that more could have been learned from past experience, in that the cross departmental aims of the MHP



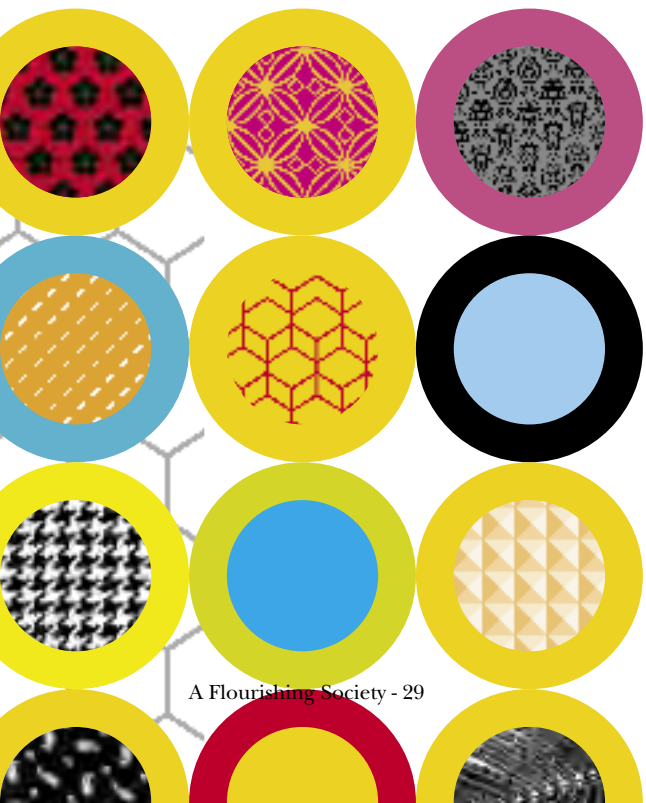
Strategy had failed to deliver, and yet there was no discernable change in the structures and processes to improve the likely success of those aims within Protect Life. There was considerable impatience and annoyance that although The Bamford Report on Wellbeing was commissioned by the DHSSPS, the emerging reports have not been adopted wholeheartedly in the form of a strategy. The Bamford Report on Wellbeing is not currently backed by resources or specific roles and responsibilities. Despite this, The Bamford Report on Wellbeing was well known and respected amongst mental health professionals.

Perhaps related to the delays in implementation of Bamford, a number of people associated the work solely with mental health services and were unaware of the report on wellbeing.

Many participants expressed a strong recognition of the level of commitment apparent behind both the production and implementation of the Protect Life strategy. The consultation exercise revealed that the implementation structures for taking forward Protect Life functioned well and thus, provided a structure to be used for future implementation of mental health promotion aims. Given the imbalance between funding provided through Protect Life 06-11 and the MHP Strategy 03-08, it was an inevitable conclusion with which most agreed that the impact of Protect Life has been felt more strongly on the ground.

"The suicide strategy has been a valuable incentive for the university in developing a proactive approach to the promotion of mental well being. It has focussed our thinking and facilitated the mainstreaming of activities which might otherwise have remained on the margins."

University of Ulster, Student Support Department



2.2.1

Scope and Terminology

One of the difficulties encountered during the review process was the almost impossible task of mapping the current mental health promotion landscape in NI. The sheer breadth of initiatives and programmes ongoing is remarkable. Funding is provided by many different agencies and departments within the statutory sector, but is also sought from other independent charitable sources such as The National Lottery. For that reason, it is difficult to maintain an overview of current and ongoing activities that relate to, and address, mental health promotion. We have selected a number of examples of good practice, but have not attempted to provide a comprehensive report on activities.

Our experience is reflected in a number of current mapping and signposting exercises that have been commissioned to facilitate delivery of the actions in the strategies e.g. Health Promotion Agency's mapping of training and accreditation, and project CLEAR based in Western Health and Social Care Trust (WHSCT). The range of activities that could be described as providing a mental health promotion function also proved to be a challenge at times, indicating that the promotion of mental health is a truly 'holistic' and eclectic venture, and as such it would be helpful to work within an agreed scope, with agreed terminology. One added benefit of investment in keeping abreast of the ongoing activities would be to provide a regularly updated tool for referral (or social prescribing) through primary care.

"There are too many meetings, too many players. It's difficult to maintain knowledge and continuity when you have a changing cast of characters."

Samaritans Ireland.

2.2.2
Commissioning

Commissioning structures were widely criticised by statutory, voluntary and community sector professionals alike, albeit for different reasons. In the statutory sector, commissioning personnel expend much time and effort in supporting those who are applying for funding as it is widely accepted that the system of commissioning involves onerous forms which are time consuming to complete. In the voluntary sector, national and cross border agencies are disadvantaged by the requirement to apply for funding from each of the five trusts separately, as opposed to one application that can be considered centrally. For the community sector the application process and the subsequent reporting process is also very time consuming, in some cases daunting and in the opinion of the vast majority, unnecessarily complex. The complexity of the five trust structures faced by national and cross border organisations is reflected at the level of strategic collaboration and implementation. National voluntary agencies in particular have difficulty keeping up with the multiplicity of meetings – thought to have doubled since the strategies on mental health and suicide were separated.

Although the larger voluntary sector organisations are generally well established, they tend to have concerns about sustained and adequate funding, whereas community-based initiatives are in a constant state of flux. By their nature they exist on generosity and volunteerism, with posts funded on a fixed term basis leading to long term insecurity for employees and for some initiatives, an inevitable failure to sustain funding. The inconsistency that results has led to perpetual efforts to maintain directories of services and to difficulties signposting people appropriately through primary care routes to a source of adequate and trusted support.

Increased funding has, in some circumstances, greatly intensified competition between agencies. Although from a business perspective this may seem positive, in the context of mental health promotion it is generally corrosive to collaboration.

One emerging suggestion for supporting small scale ventures was the creative use of commissioning structures to encourage co-operation, collaboration and where appropriate, mergers between smaller community-based organisations. This would help to prevent organisations working in isolation and would create wider networks in order to strengthen capacity, share experiences and encourage knowledge brokerage.

We propose that this would also provide an excellent opportunity to encourage networks with a cross-community focus, to direct resources towards the wider aim of strengthening social capital.

"There is a lot of commitment and good work being done, but I think we absolutely have no grounds for complacency. I would feel all along we could do better than this... I think we could be more systematic in general and not have pockets of things happening."

Investing for Health Manager, NHSSB

"The split between the two strategies really drives paranoia...the Protect Life Strategy was like a massive rush of blood to the head on suicide prevention."

Board Member, Bamford Review

"..suicide prevention is driving mental health promotion, that should not be the case."

Service Manager, Action Mental Health

"I wasn't a great fan of the suicide prevention strategy because I felt that the most important thing is to promote positive mental health."

Investing for Health Manager

2.2.3
Community Engagement
We were informed of varying levels of community capacity and engagement across both regions and smaller areas of NI. Where in one area it is appropriate to expect collaborative, well-planned community efforts that ease the burden on NHS resources, in others it may be more important to provide opportunities to encourage the development of community capacity and to remain mindful of the potential for increased burden on statutory services in the interim. This balance requires continued collaboration between those engaged in promotion and prevention and those engaged in services. Dialogue does exist but should be further encouraged between services and promotion, and amongst the Trusts to provide opportunities for shared guidance and insights.

2.2.4
Strategic Implementation
Our own independent review of the MHP and Protect Life documents concluded that very little emphasis was placed on the need for consistency, good practice, evidence-based initiatives or evaluation of the proposed actions.

Although on a more positive note, the action points addressed a wide range of known risk factors and encouraged collaboration. Despite this, it is unclear whether the Protect Life Strategy has improved or worsened the environment for partnerships.

While the influx of funding from the Protect Life Strategy was welcomed, a large majority were critical of the strategic division between mental health promotion and suicide prevention, stating that the introduction of the Protect Life Strategy had encouraged duplication of administration and a sense of imbalance.

It was recognised by the vast majority of those we consulted that many of the aims of mental health promotion overlap and complement the aim of suicide prevention. Although at first there was reluctance amongst some in the community sector to accept this, it is only those who struggle with the distinction between mental health and mental illness who remain unconvinced.

Much effort has been put into providing training and awareness to address this need. However, the lack of acceptance may reflect the views of many people in NI, reiterating the need for continued efforts to consolidate the use of terminology, and indeed to improve general understanding of mental health and emotional wellbeing in NI. Mental health literacy is improving, but continuing programmes of awareness are required.

Most people agreed that future efforts should move towards stronger strategic integration of mental health promotion and suicide prevention, while including the provision of continued support for the many successful partnerships operating and created through the Protect Life Strategy.

"Mental health and suicide prevention are part of a continuum…prevention of suicide is in many respects about promoting mental health and wellbeing."

Investing for Health Manager

"The ability to cope or not cope isn't an illness, you know you can't get a tablet for it. Some people think you can, and that's the other problem…There is now an expectation that 'the system' will sort it out, that it's not my fault, it's the system's fault."

Assistant Director of Mental Health

Equally many felt that the strategic aims of the mental health promotion and suicide prevention agenda overlap with other currently separate strategies, for example drugs and alcohol and sexual health, under the wider remit of the Investing for Health umbrella. A more systemic approach, such as that adopted in the Investing for Health model, was widely embraced.

2.2.5
Life Course Approach

The life course approach was a familiar concept amongst the participants and was considered to be a sensible and useful framework for developing and implementing strategies. In particular, the views of professionals on how to improve mental health and wellbeing for the population reflect an established evidence base that provides support for early interventions with infants and parents.

There was a general feeling that more emphasis should be placed on developing promotion and prevention in children, by providing education and support at an early age to encourage emotional awareness, resilience and good coping skills. In tandem with the need for early interventions, many expressed a feeling that promotion of mental health should emphasise resilience, self-sufficiency (independence from the statutory sector) and personal responsibility. The media were frequently cited as responsible for presenting unsound perspectives on what affects emotional wellbeing, and on natural expectations regarding life stressors that we all struggle with from time to time.

There was concern about the 'medicalisation of happiness' and a belief that social support can be the most appropriate option for many people experiencing a period of emotional distress. It was felt that referral to voluntary and community sector agencies can help to de-medicalise what are often social and emotional problems that may be best tackled through the use of social and emotional support. However in order to provide prompt referral, clear and concise information for primary care providers along with a seal of approval are essential.

"We need to lobby together for more investment in early years. If we're going to have an impact on the future that investment needs to be made and people need to see the benefit of that."

PIPS

"Early years is absolutely critical."

Assistant Director of Mental Health and Disability Services

"Education regarding mental illness needs to start at primary school. Because if it doesn't start that early people just have so many entrenched totally ignorant views that make the job of someone trying to help people with mental illness even harder."

GP/Mental health Lead, Service Delivery Unit.

"...we can overemphasise the negative impact of work on mental wellbeing... If you read the newspapers, stress might be regarded at 'the UK disease', you know? Whereas in reality what we know is that work is good for health, and work can be very good for mental wellbeing and conversely unemployment is extremely bad for mental wellbeing."

Health and Safety Executive NI



"Mainstream statutory and voluntary bodies acknowledge that to target services at mainstream level doesn't mean that you're meeting the needs of everybody … staff need specific training, for example, for those with specific needs like gay men, you need staff trained in sexual orientation issues …"

The Rainbow Project

"Prisons can get lost in strategies.

Even if we had all the money in the world, we couldn't do what we need to do … we need to invest in specialised training to recruit more staff.

Information is power in these environments, so group based initiatives although cost effective, simply aren't always appropriate."

Assistant Director of Prison Health

2.2.6
Targeted Need

The current strategies provide prevention and promotion at the population level on a life course continuum, along with targeted areas of need such as the employment sector, general practitioners, young offender institutions and prisons, older people, those with severe and enduring mental illness and specific minority groups in society where there is recognition of increased need such as black and minority ethnic (BME) and lesbian, gay, bisexual and transgender (LGBT) groups. This support is welcomed, and again many specific initiatives are underway. However, there needs to be a mechanism that will recognise the specific need for funding to allow actions to be undertaken in an appropriate fashion according to need. For example, rural as opposed to urban areas and areas with strong community involvement compared to areas where community engagement operates through other avenues such as schools and faith-based organisations.

Specific commissioning considerations are also particularly relevant for the NI Prison Service, to continue the ongoing efforts to steer away from a system of revolving doors.

A good example of specific need is training; training must be pitched correctly. What is effective for the general population will not adequately address the specific needs of target groups.

2.2.7
Development and Delivery of Training
Training and awareness activities are central to the Protect Life vision for preventing suicide and play a large part in the MHP Strategy. Arguably this programme of action has been undertaken with a limited emphasis on providing evidence that it is having the desired impact. However, professionals implementing the strategy have utilised established and evidence-based training and awareness packages such as ASIST and MHFA. Many other independently organised training and awareness initiatives have also been implemented. The DHSSPS have recently commissioned the HPA to carry out a mapping exercise to help guide a system of provision and accreditation for mental health promotion training. Training and awareness is an area where investment in planning, research and evaluation could have been used to develop a standardised training framework for a wide variety of uses, across a number of sectors prior to allocating funding for training.

2.2.8
Accountability and Collaboration
Accountability was commonly cited as a major downfall of the strategy documents in terms of delivering the actions outlined. The importance of improved collaboration across government departments was continually reiterated by statutory sector employees consulted.

It was recognised that the Department of Health does not have jurisdiction over other departments (or non-governmental bodies) and that collaboration can be challenging.

However, it was felt that these challenges could be overcome through increased efforts to improve mental health literacy perhaps through promoting the potential benefits that could be gained. Budget top-slicing was suggested as was the use of appropriate Priorities for Action (PFA) to ensure that all relevant parties become interested stakeholders in the process.

"When it comes to training for teachers and work in schools, schools like two things. They like the confidence and expertise that comes from our colleagues in Health … but when it comes to looking at schools and children and strategies, the education side is equally important."

Pupil Personal Development Team, SELB and WELB

"In the development of a mental health promotion strategy other key stakeholders such as Education should be involved from the outset, in recognition that mental health promotion does not sit solely within the remit of Health and Social Care."

Email response from Southern Health and Social Care Trust.

"Many of the actions have very specific lead organisations identified, however, within many of the organisations there doesn't appear to be anyone specifically identified to take actions forward."

Email response from Southern Health and Social Care Trust.

2.2.9
Measurement, Evaluation and the Evidence Base

A constant frustration was expressed over the lack of means for assessing the impact of mental health promotion and suicide prevention efforts on the population of NI. There was concern that the efforts regarding suicide prevention would be ultimately judged against suicide statistics, as there are so many well documented difficulties with establishing reliable mortality figures that accurately reflect incidence of suicide.

Health promotion professionals recognise that population metrics such as the GHQ-12 are inadequate for the purpose of measuring the impact of efforts to promote mental health. Furthermore, it is recognised that a wide range of population metrics should be established to reflect the holistic nature of efforts to improve emotional wellbeing.

A commissioned survey carried out in 2005 by the Health Promotion Agency to assess attitudes towards mental health in NI, provided a baseline snapshot. A wide ranging multiplicity of public awareness and information campaigns has been conducted since that time. Unfortunately the commissioning arrangements to date have not included a follow up survey to assess the impact of the substantial investment.

This example of a missed opportunity reflects a widespread lack of economic evaluation and a general lack of impetus placed on supporting a dedicated programme of research and evaluation for the promotion of mental wellbeing in NI.

Regarding an evidence base, professionals are at a loss regarding transferability of mental health promotion initiatives to the NI context. Culturally and otherwise we differ somewhat from the rest of the UK and yet we rely heavily on information from other countries rather than investing in our own need for evaluation and evidence of what works. Those working in the field recognise that funding for mental health promotion has not always been used effectively due to the lack of evidence-based practice, particularly on suicide prevention.

Current efforts to evaluate initiatives are largely limited to statistics on usage and descriptive accounts of actions funded. These are useful resources and are often summarised and made publicly available in an accessible format, however they do not provide an evidence base, and do not ensure efficient use of resources. Many organisations lack the capacity to effectively and objectively evaluate their work and independent evaluation is not commonplace.

While the Research and Development Office for NI has made powerful strides to strengthen research in NI, research on mental illness and mental health promotion has been relatively neglected. The recently established Centre for Excellence in Public Health at Queen's University Belfast has failed to incorporate a mental health strand to its work, despite the fact that mental health is possibly the biggest public health issue that we face. Regrettably, research on population-based approaches to wellbeing and mental health has also been neglected elsewhere[35]. This is an area where Northern Ireland could place a claim of major significance in mental health promotion, for application in UK, Ireland, and farther afield.

If we are to commit to long-term plans for the promotion of mental health and wellbeing for NI, current perceptions of the requirement for measurement, evaluation and ultimately cost-effectiveness require an overhaul.

"…whilst across the water there is a Labour Force Survey and there has been some research done recently looking at what people report about their workplaces … in terms of those various Management Standards …. Unfortunately we have no equivalent barometer in Northern Ireland … the size of the survey prevents analysis at the levels for us to make meaningful estimates from one year to another."

Health and Safety Executive, NI.

"One of the biggest difficulties or frustrations we have is around research and evaluation. We simply couldn't fund it .. and we can't evaluate our own work."

Pupil Personal Development Team, SELB and WELB.

"There is not enough evaluation done. We carried out our own sort of evaluation on the Protect Life money because what we were trying to say was, You're getting value for money here. So I thought, We'll do our evaluation here. Basically to say, These are the numbers of clients and this is what we've offered."

Public Initiative to Prevent Suicide (PIPS)

"…how do we know what we're doing is not counterproductive?"

Suicide Liaison Officer

The need for home-grown research was a key recommendation in the Bamford Review of Mental Health in Northern Ireland. Unfortunately, much of our understanding and consequent decisions on health and wellbeing in Northern Ireland borrow heavily on research undertaken in the UK and elsewhere.

Board Member, Bamford Review

Examples of Good Practice

Ongoing interventions and activities based on good practice and/or evidence of effectiveness include:

- *Mental Health Promotion Network*
- *MHFA Training*
- *ASIST Training*
- *Whole-schools approach*
- *Pupil Survey - emotional health*
- *Healthy Prisons Model*
- *Green Gyms*

2.2.10

Ongoing Efforts

There were many ongoing examples of good practice reported during the consultation exercise which should be further supported, encouraged, and extended where possible. It would be an excellent advancement for the field to be able to provide a comprehensive account of the ongoing activities that are evidence-based and those that employ good practice. The list opposite provides only a flavour of the excellent work underway.

A central resource would be welcomed by professionals working in the field, and could be linked to the mental health promotion network, which encourages collaboration by circulating emails throughout the statutory, voluntary and community sectors.

We found that significant investment in a centrally maintained, public access database would be widely supported by those working in the field for a number of reasons:

- To provide a transparent record of public spending on mental health promotion and suicide prevention
- To ensure accountability through mandatory reporting at realistic and manageable intervals
- To allow commissioning processes to be standardised and simplified where possible
- To provide an alternative to the Desktop Review method of assessing the implementations of strategies
- To provide a resource for research and evaluation in a local context
- To provide a source for comparison on an international level
- To allow creative new projects to be assessed appropriately against existing evidence-based methods
- To feed into future strategies for the promotion of mental health, and to allow cross comparisons with other related commissioning for wider health and social benefit
- To provide a ‘certified’ list of agencies for primary care referral (social prescribing).

2.3
Key Messages

This review has attempted to provide a flavour of the work underway, but has in no way captured the complete landscape of mental health promotion and suicide prevention activities across NI.

There are many high quality, highly valued mental health promotion programmes and initiatives underway across NI that should be nurtured, supported and expanded according to need.

As a result of our triangulated approach to reviewing the three strategic documents, independently and via consultation and collaboration with statutory, voluntary and community sectors, along with a panel of external experts, we can present a number of key messages.

1
Consolidation of Mental Health Promotion and Suicide Prevention
Enthusiasm and commitment towards mental health promotion and suicide prevention is currently at the strongest it has ever been, and momentum is growing. Where differences of opinion prevent collaboration, we need to work hard to reassure those with doubts that the ongoing efforts will be rewarded with further adequate funding and encouragement from DHSSPS in the form of a new and exciting strategy to carry the movement to the next level.

2.
Standardisation and Glossary of Terms
Scope and terminology can compromise understanding of the contrast between mental health, and mental illness, and is a barrier to harmonious collaboration where prevention (mental health promotion) and reaction (suicide prevention) overlap. A standardised glossary of terms designed to clarify levels of understanding would go some way towards what is required to surpass these challenges.

3
Merging the Strategic Aims
Duplication of effort has resulted from separating the suicide strategy and the mental health promotion strategy. There is widespread support for merging the strategies, along with including insights from the Bamford Report on wellbeing.

4
Solid and Improved Structures for Implementation
Existing communication and collaboration structures and processes are not encouraging knowledge sharing and can fuel a sense of competition and further duplication of effort. It would be beneficial to alter commissioning structures in order to encourage collaboration and mergers between smaller agencies and where possible, cross-community partnerships.

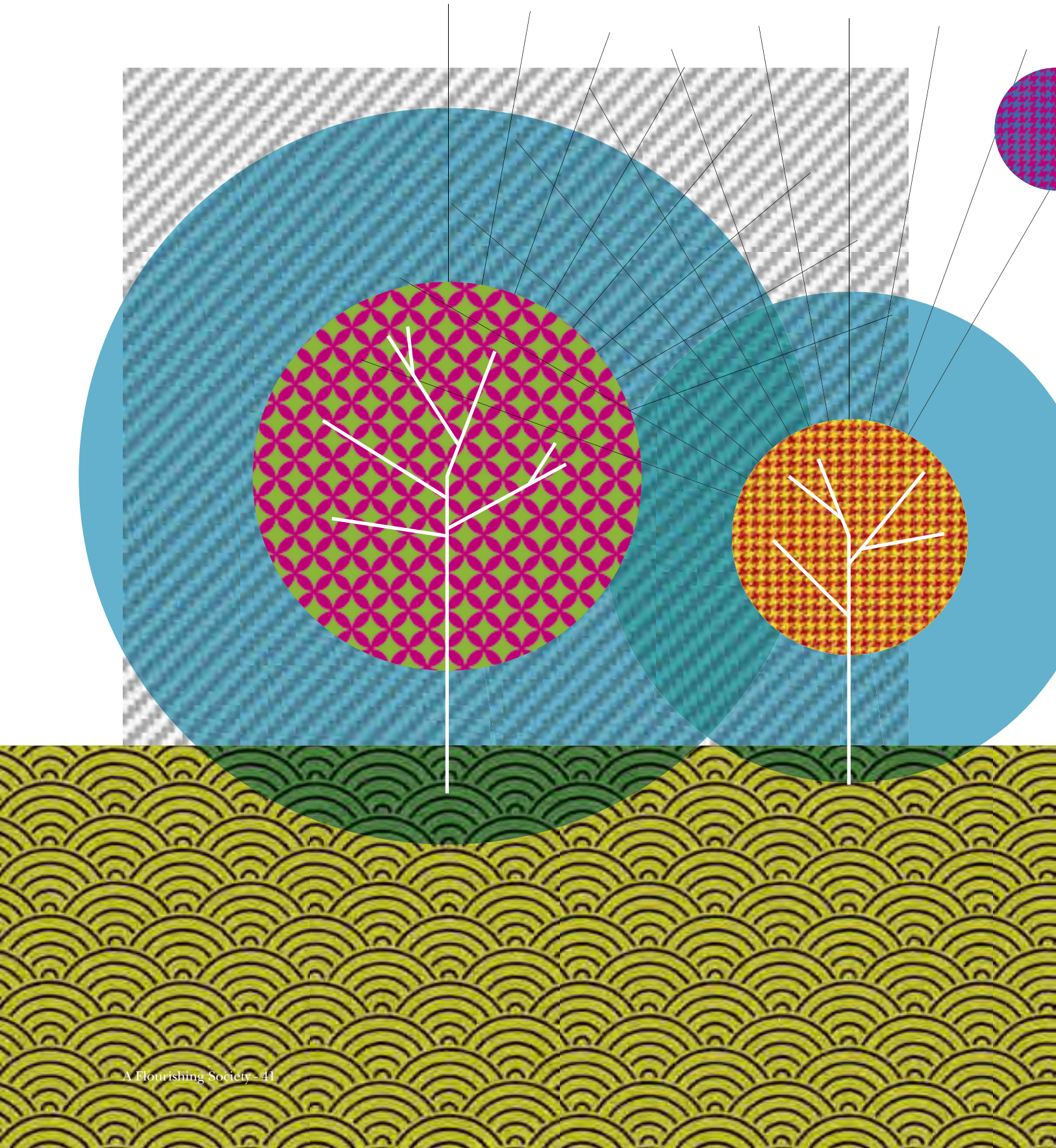
5
Systems of Transparency and Accountability
Existing accountability structures do not encourage transparency or provide the means for implementing cross departmental action points.

6
Investment in Early Years
Investment in promoting mental wellbeing does not focus resources towards early years interventions, which is widely accepted to be the best method for achieving maximum benefits throughout the life course for future generations.

7
Commissioning According to Need
Targeted commissioning structures for specific sectors of society who are at high risk of developing emotional distress (or indeed already display emotional and coping difficulties), although improving, are still inadequate for purpose.

8
Investment in Research and Evaluation
The economic and social benefits of research and evaluation have not been emphasised and encouraged through significant seed funding and ongoing investment. The potential benefits are many, including the facility to robustly assess and measure the success of the existing strategies, and the relevant data to inform the development of future strategies, including methods for implementation and specific key objectives.

9
Development of Instruments for measurement
Population and targeted indicators to monitor the impact of efforts are not currently in place. Thus, we have no meaningful method for comparing ourselves with other jurisdictions in Ireland, the UK and beyond.



2.4
Independent Expert Symposium

Panel of Experts
Prof Margaret Barry, MA, PhD, APsSI, Professor of Promotion and Public Health, Head of Department, Director of Health Promotion Research Centre, National University of Ireland, Galway (NUI-Galway)

Prof Barry has published widely in the field of mental health promotion and is responsible for a number of large-scale national, European and international research projects. Currently based at NUI Galway, previously a Visiting Fellow at the Victorian Health Foundation, Australia in 2007 and Visiting Lecturer in 2002 at the World Health Organisation Collaborating Centre at the Institute of Psychiatry, King's College, London. Co-author of the text Implementing Mental Health Promotion (Barry and Jenkins, 2007) recently published by Elsevier.

Prof Paul Fleming, PhD, Associate Dean of Faculty of Life and Health Sciences, University of Ulster (Jordanstown), Northern Ireland

Prof Fleming is an expert in the fields of public health and health promotion, based in NI. He has lectured, supervised, reviewed and published widely on these subjects. He is a professional consultant to several government bodies and holds chairmanship and membership of a range of government, professional and research committees.

Prof Phil Hanlon, BSc, MD, MRCGP, FRCP, FFPH, MPH, Professor of Public Health, Glasgow University, Scotland

Prof Hanlon undertakes teaching activities at the university of Glasgow as well as teaching and supervision roles for the MPH. He is also an Honorary Consultant in Public Health with NH Scotland, Greater Glasgow. Between January 2001 and April 2003 Prof Hanlon undertook a secondment to establish the Public Health Institute of Scotland. Current research interests include 'culture and health', uses of integrated public health data and evaluation of complex public health interventions.

Mr Gregor Henderson, BSc, MSc
Independent Consultant, Scotland

Mr Henderson is former Director of the National Programme for Improving Mental Health and Wellbeing Scottish Executive for the Scottish Health Department in Edinburgh. His career has included posts in Brent Health Authority in London, South West Thames Region, London and the South East of England, and at the Centre for Mental Health Services Development at King's College, London. He has been a special advisor to the Health Select Committee at the House of Commons and currently works for the Scottish government as an advisor on mental health improvement.

DHSSPSNI representative
Gerard Collins, Senior Civil Servant, Population Directorate.

NIAMH Representatives
Dr Graeme McDonald, Chairman
Prof Alan Ferguson, CEO
Dr Gerard Leavey, Director of Research
Graham Logan, Policy Development Manager

1. Aims of the Symposium:
A group of independent experts in public health, mental health promotion and policy from across the UK and Ireland were invited to contribute to the work of the review by attending a two day seminar which was held in Belfast on 5-6th February 2009. The two main areas the group were invited to comment on were:

- Their thoughts and views on the previous work undertaken in NI exemplified by the three key strategy and policy documents.
- Their thoughts and ideas about how work on promotion and prevention can be taken forward in NI, building on lessons learned and on the work already underway.

2. Thoughts on Work to Date: Mental Health Promotion Strategy 03-08 (MHP Strategy)
The general view was that the MHP Strategy in conjunction with the Bamford Report provided a solid base from which to progress work in Northern Ireland.
The MHP Strategy was complimented for its strong emphasis on partnership working, but there was a view that it was unclear which agency was ultimately responsible for strategic co-ordination and delivery. This may have made it more difficult to achieve ownership and delivery of the objectives and actions.

There was also a view that the strategy would have benefited from greater ownership and co-ordination across government departments. Recognising that this was often difficult to achieve, the group felt that future work would benefit from more cross departmental ownership, with one part of government responsible for overall co-ordination and leadership.

It was also felt that more emphasis on an infrastructure to support the implementation of policy would pay dividends. This approach had worked well in other jurisdictions, for example Scotland.

However, despite its shortfalls the MHP Strategy was regarded as an important step in the process of providing a high quality mental health promotion strategy for NI.

Protect Life: A Shared Vision 06-11
The symposium members viewed the suicide strategy as an extremely important one and noted that it is now at an important evolutionary stage. It was explained that the suicide strategy in Scotland for example was an important driver in highlighting the need for more extensive mental health promotion work and was one of the first areas of work (along with anti-stigma work) to form part of the overall strategic approach to public mental health.

The implementation action and coordination focus given to Protect Life was commended and a lot had been achieved in a short period of time. The experts' views were that Protect Life can be successfully built on as part of a more comprehensive public mental health approach for NI, where the aims and actions of mental health promotion with a focus on a social model of health can reap considerable benefits for mental health and wellbeing and help add to the momentum of work aimed at preventing suicide. This could be achieved by combining suicide prevention into an overall approach to promoting mental health and preventing mental health problems and suicide. As the experts noted it was often difficult to distinguish between actions that help promote good mental health and those that help prevent suicide. The experts emphasised that this important development should not be seen as diminishing the current Protect Life strategy in any way but rather enhancing and infusing it with an upstream promotion of good mental health dimension. This could help provide a balance to the current emphasis in Protect Life to a crisis response approach.

The Bamford Report; Mental Health Improvement and Wellbeing - A Personal, Public and Political Issue
The consensus of the symposium was that Bamford made a strong case for a comprehensive, integrated approach to mental health promotion and is an important marker in time.
It was noted that its three recommendations contextualised the primary recommendation, which focused on the importance of a support and delivery structure at the heart of government.
In acknowledging that these recommendations were not enacted, the experts were keen to still see the development of

a support infrastructure to help future delivery. The support infrastructure would help with the delivery of the next policy.

3. Thoughts on Future Work:
The symposium deliberated on a number of issues for the future work including influencing government processes, developing policy coherence and coordinating cross-sectoral partnership working and delivery.

Processes
It is helpful for future work to take cognisance of governmental processes and priorities and demonstrate what the contribution of promotion and prevention work will be to these wider government objectives. This may include for example, the programme for government delivered under Public Services Agreements (PSAs). The experts suggested that at least two PSAs could be dedicated to mental wellbeing. This will then help with cross departmental objectives and delivery and matching accountability mechanisms with Priorities for Action (PFA) for each government department. Locating the work firmly in the work of the government's cross departmental Public Health Strategy was also felt to be important and for taking opportunities to locate delivery support within the Public Health Agency at a national level supporting local delivery.

In regard to resourcing, the group felt that it would be important to have a good case established for the next Comprehensive Spending Review (CSR). It will be important in this to demonstrate the value and contribution of promotion and prevention to helping NI cope with the effects of the economic downturn which will have an effect on the emotional, psychological and social health of the population, particularly those vulnerable to job losses and debt. At times like these the experts expressed their view that investment in promotion and prevention will reap considerable future benefits, both for ameliorating the harmful social effects of the downturn, and for helping to build the resilience need to 'bounce back'.

It was noted that the work in NI is helping in moving the agenda towards a more comprehensive public mental health approach, which is complementary to improving services and the care, treatment and recovery of people living with mental illness and their quality of life and inclusion. This is an exciting time for mental health policy in NI and the experts were confident that significant progress can be made in developing a policy framework that helps promote wider population mental health, prevent suicide and mental health problems and improve the quality of life and inclusion of people living with mental illness.

Policy
The symposium emphasised that one of the key factors here is to influence and support policy makers. The new strategy will be part of the overall policy landscape and set out the cross-government and cross sectoral linkages required to achieve delivery. The key task is to set a future direction that is comprehensive in its scope, but that has a number of key and achievable deliverables. There will be a need for a good ongoing interaction and dialogue with stakeholders and regular reviews of progress in local areas with an emphasis on supporting local areas in achieving their objectives.

However, it was felt important not to overemphasise the role of government. They are one of a number of important actors and will be crucial for helping to set future direction and for authorising others to act in support of promotion and prevention.

An overemphasis on government will not deliver the strategy; governmental responsibility needs to be balanced with an emphasis on securing the priority of mental wellbeing in the various structures for public health under the review of public administration (RPA).

Cross-departmental and Multi Agency Partnership
It was suggested that the strategy should be seen as key to developing the mental health promotion narrative across government and across the range of public agencies required to support the strategy and its implementation

It was felt important that the new strategy is crafted in a cross-cutting, multi agency way to help achieve the ownership required.

Measuring Wellbeing
The importance of measuring the mental health and wellbeing of the NI population was stressed. This has proved helpful and beneficial in Scotland and the Republic of Ireland in setting a base point from which to measure progress and actions. Establishing this in NI will be an important element of the next strategy. This will help with supporting local areas and monitoring activity and performance

The symposium also emphasised the need for a NI wide registry (with an emphasis on each local area) of activities in the field of mental wellbeing improvement – promotion and prevention.

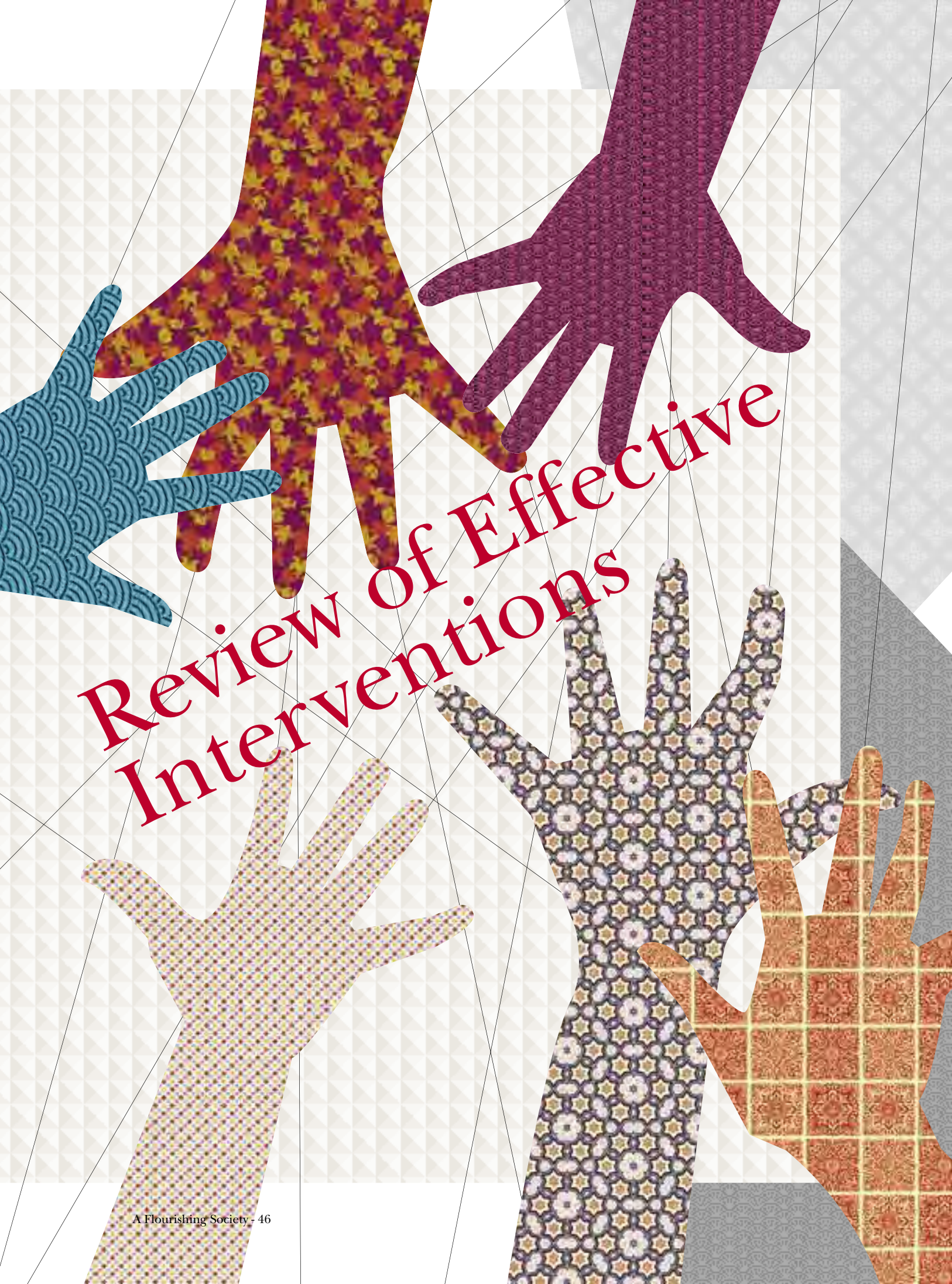
Research
The symposium stressed the importance of research – its further development and the transfer of research knowledge and evidence are important areas for future investment.

2.5 Health Impact Assessment

Alongside this review, a Health Impact Assessment (HIA) has been undertaken which will help inform the development of the Mental Health and Wellbeing Promotion Strategy for Northern Ireland. HIA is defined as "a combination of procedures, methods and tools that systematically judges the potential and sometimes unintended, effects of a policy, plan, programme or project on the health of a population and the distribution of those effects within the population and identifies appropriate actions to manage those effects"[90], and as such, complements this review.

The HIA adopted the same wider determinants of health approach which identifies the impact of environmental, social and economic circumstances on mental, physical and social health. Through the HIA we aimed to ensure that the potential health impacts (both positive and negative) of the Strategy are realised. Information gathered as part of the HIA included the development of a community profile, an analysis of the current policy environment, a literature review. This process will form an element of the community workshops which will be undertaken as the next stage of the Strategy development process.

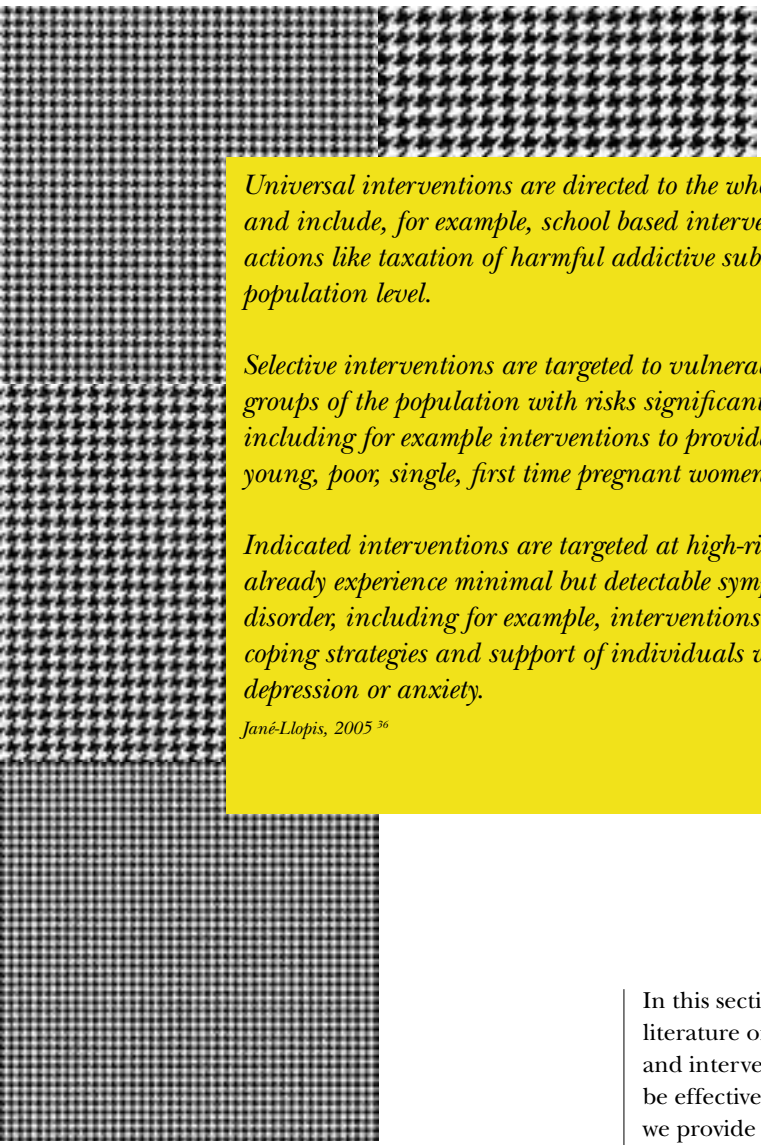
The HIA Steering Group, comprised of NIAMH, DHSSPS and the Institute of Public Health in Ireland (IPH), considered all the information and develop evidence-based recommendations in order to enhance the positive health impacts and mitigate any potential negative health impacts in the new Strategy.


Review of Effective Interventions

Section 3
REVIEW OF EFFECTIVE INTERVENTIONS

The rationale for mental health promotion is based on the case for preventing mental illness and promoting positive mental health. Equally as with physical health and physical illness, positive mental health and mental illness are determined by multiple and interacting factors – social, economical, psychological, biological and environmental. Furthermore, other life events and circumstances will interact favourably or unfavourably to contribute to health or the development of illness. Risk and protective factors can be reduced or enhanced by interventions. The focus of programmes and policies for mental health promotion should be placed on encouraging positive mental health by eradicating the individual, socio-economic and environmental risk factors (e.g. discrimination, unemployment and social isolation) and by promoting protective factors (e.g. suitable housing and adequate income).

In the last twenty years a series of literature reviews have demonstrated the effectiveness of the prevention of mental illness and the promotion of mental health across the life course. Current research suggests that the most successful strategies employ a population-based approach with programmes that focus on evidenced-based risk and protective factors. The classification for prevention and promotion according to the levels of risk is "useful to define the scope for intervention by identifying what type of collective action is required"[36]. Interventions can be identified as universal, selective and indicated.



Universal interventions are directed to the whole population, and include, for example, school based interventions or policy actions like taxation of harmful addictive substances, at the population level.

Selective interventions are targeted to vulnerable groups or sub-groups of the population with risks significantly above average, including for example interventions to provide family support for young, poor, single, first time pregnant women.

Indicated interventions are targeted at high-risk individuals who already experience minimal but detectable symptoms of a mental disorder, including for example, interventions to promote the coping strategies and support of individuals with symptoms of depression or anxiety.

Jané-Llopis, 2005 [36]

In this section we review the literature on the programmes and interventions that appear to be effective and where possible we provide information on the cost-effectiveness of specific interventions. It should be reiterated that the research evidence we present here constitutes the most common interventions that have been robustly evaluated in other jurisdictions (e.g. USA, England, Scotland, Canada and Australia), they are not necessarily directly transferable to the NI context in their original format. Because mental health and ill-health are mutually connected to historical and contextual factors, it is fundamental that they be considered in understanding the mental health of the NI population, and this should be reflected in any prospective interventions aiming at prevention and promotion.

As is usually the case, the selection of target groups and related interventions which have been subject to rigorous evaluation are biased by all kinds of factors (a main factor being research funding allocation). Thus, while we present a variety of interventions suitable for a variety of settings there are many more potentially effective and efficient interventions in existence which have not been the subject of rigorous evaluation, and therefore

are not evidence-based to date. There are gaps in the evidence which provide opportunities to encourage both creativity and further research to bolster the existing evidence base for mental health promotion.

3.1
Supporting Parenting and the Early Years

Investment in a healthy start in life influences development in childhood, adolescence and adulthood. During pregnancy and the early years of life, parents, especially from deprived backgrounds or suffering from mental disorders, are at increased risk of mental health problems and more likely to fail in providing a healthy start to life for their children; this in turn can lead to an increase in mental health problems and disorders in children that follow through into adolescence and adult life, with consequences across generations. The use of addictive substances during pregnancy can cause harm to the foetus and child, doubling the risk of low birth weight with all its subsequent consequences. Delays in language development and consequent failure to learn in primary school reduce self-efficacy, result in poor educational achievement and increase the risk of adolescent psychiatric symptoms and later mental disorders.

However, positive and engaged parenting can increase children's self-esteem, their social and academic competence, and protect against later disruptive behaviour and substance use disorders. Thus, the overwhelming weight of evidence shows that high quality pre-school experience can have positive effects on children's social, emotional and cognitive development.

Pre-school education improves children's cognitive, language and socio-emotional development and leads to long-term social and economic benefits, for the individual themselves and society at large. A number of studies from the United States[2] have shown that parenting and early intervention strategies are not only cost-effective – in that the outcomes achieved justify the cost – but are cost-saving in the longer term, as they lead to increases in employment , literacy and social responsibility, as well as decreases in teenage pregnancy, crime and arrests; early intervention programmes have been shown to provide economic gains as large as seven times the initial investment.

Actions for Families and Early Years Postnatal depression is a common form of maternal morbidity that affects about one in eight women. It is also a leading cause of maternal mortality. The UK Confidential Enquiry into maternal deaths found that psychiatric disorders contributed to 12% of all maternal deaths, with suicide being identified as the leading cause of maternal mortality in the United Kingdom[37]. Postnatal depression can also have serious consequences for the health and wellbeing of the family. Infants and children are particularly vulnerable - impaired maternal-infant interactions can affect their cognitive, emotional, social, and behavioural development. Clearly, postnatal depression is a substantial public health problem that requires attention. However, postnatal depression is frequently undetected and untreated, often because of poor recognition of symptoms, unawareness of treatment options or fear of stigmatisation. Antidepressants have been shown to be an effective treatment for postnatal depression, but many women are reluctant to take drugs, especially when breast feeding.

In a recent systematic review of psychosocial and psychological interventions for preventing postnatal depression an intervention by Dr Jane Morrell and colleagues suggested that intensive, professionally-based interventions shows promise and requires further research[38].

The Nurse-Family Partnership Program provides nurse home- visits to low-income, pregnant women, most of whom are: (i) unmarried, (ii) teenagers, and (iii) without previous children. The nurses visit the women approximately once per month during their pregnancy and the first two years of their children's lives. The nurses teach: (i) positive health related behaviours, (ii) competent care of children, and (iii) maternal personal development (family planning, educational achievement, and participation in workforce). The NFP appears to be the most thoroughly evaluated parenting programme and has achieved remarkable outcomes for both the parents and the children involved. The health and social benefits of this programme are sustained over many years. Thus, parents on the programme, compared to those in control groups, experienced less contact with the criminal justice system, spent less time on welfare and had fewer subsequent births[39,40].

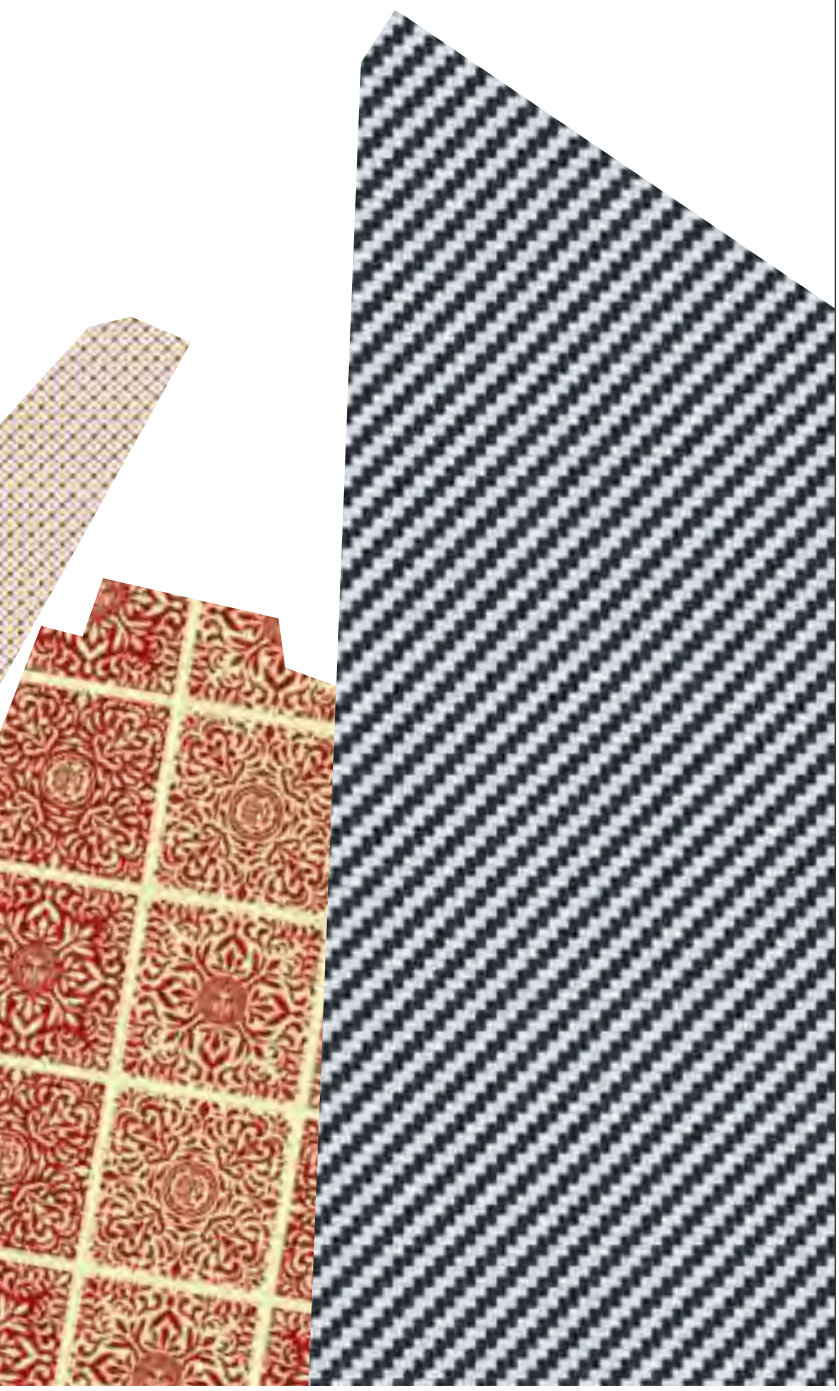
Family Nurse Partnerships, the UK version of the above US based intervention, have been shown not only to be cost-effective, but cost-saving, with every $1 spent on the programme producing savings of $2.88 in the longer term, as well as providing a range of positive health and social outcomes in the medium to long term.

The Triple P-Positive Parenting Program (TP) was developed by researchers in the University of Queensland. It is a behavioural family intervention designed to improve parenting skills and behaviours. Through changing how parents view and react to their children's behaviours, this programme is aimed at reducing child behaviour problems and teaching healthy parenting skills. Outcomes include reduced child behaviour problems and dysfunctional parenting styles; and increased parental competence[41].

A tentative economic evaluation of the Triple P-Positive Parenting Program in Australia showed that, through a reduction in conduct disorder, the program had the potential of saving more resources than it consumed[42].

The Incredible Years Basic Parent Programme was evaluated in 11 Sure Start areas in North and Mid-Wales, with parents of pre-school children at risk of developing conduct disorder. Findings from this study suggest that the programme effectively increases positive parenting practices and reduces antisocial behaviour in children at risk of developing conduct disorder. The programme works as a preventive intervention in highly disadvantaged community-based settings when it is delivered by regular Sure Start staff with high levels of supervision and support to enable the programme to be delivered with fidelity. Clinical research is underway to assess effectiveness of the programme in Galway, Ireland. The Incredible Years has influenced policy within Wales and provides lessons for England where, to date, Sure Start programmes have not been effective[43].

Mellow Parenting is a 14-week, one day a week group designed to support families with relationship problems with their infants and young children. The Mellow Parenting programme has been developed and applied in deprived populations in Scotland. It combines personal support for parents through direct work with parents and children on their own parenting problems, and has proved effective in recruiting and engaging hard-to-reach families with a variety of severe problems, particularly behavioural problems compounded by family difficulties such as parental mental illness, social isolation, domestic violence and parental literacy problems[44]. Mellow Parenting is, in part, a way of working rather than a tightly prescribed curriculum, and variants of the programme have been devised to meet varying needs (e.g. Mellow Fathers, Parenting in Prison, Mellow Babies for Infants at Risk). Mellow Parenting has been evaluated and results have shown the programme to be effective and successful in engaging families and helping them make changes in their relationships. Follow up has shown lasting gains in maternal wellbeing, parent-child interaction, child behaviour and child development. However, it has been recognised that Mellow Parenting lacks independent evaluation to date.



3.2
Education and School-based Actions

The evidence indicates that attempting single-issue health promotion within schools is generally unhelpful and inefficient (e.g. dealing with drugs and alcohol, bullying, obesity, self-harm and suicide). The whole-school approach, which engages students, teachers and parents through both curriculum and policy is more effective than short-term interventions focused on specific topics related to self-esteem, self-concept and individual coping skills[3].

Results from evaluated programmes (mostly US) have shown significant changes in interpersonal sensitivity, means-end cognitive problem-solving; general resolution strategies, the use of pro-social conflict resolution strategies, and consideration of others[45].

The National Institute of Clinical Excellence in England commissioned a systematic review of the effectiveness and cost effectiveness of whole school interventions in primary schools. In terms of effectiveness, they noted that there is good evidence to support the implementation of programmes like Promoting Alternative Thinking Strategies (PATHS), although they may need to be adapted for UK use. They also note that interventions with similar characteristics are available in the UK but have not been the subject of robust trials[46]. However, regarding potential economic advantages, there is currently no substantial evidence pointing to the cost-effectiveness of whole school approaches to mental health promotion in primary education. Further research is required[47].

In the UK the **SEAL (Social and Emotional Aspects of Learning) programme** is now being developed in secondary schools across the UK, including NI. This programme coupled with the existing Personal, Social, Health, Education (PSHE) and Sex and Relationship Education (SRE) is a good starting point to equip young people with the appropriate tools that would help them to develop a set of skills within the whole social and emotional sphere as well as to foster and promote the importance of building and sustaining meaningful relationships, having a family and understanding what is like to be a parent. Although this programme clearly addresses protective factors for mental health, further research is required to robustly assess the impact and effectiveness of this approach.

The UK Resiliency Programme is an evidence-based positive psychology programme developed by Dr Martin Seligman at Pennsylvania University. It is being implemented for the first time in the UK and it will be rigorously evaluated with support from DfES. The aim of the programme is to help children become more emotionally resilient; to prevent depression and improve emotional health, supporting children's learning and achievement. Three local authorities in England are involved in this trial. Twenty-one schools and over 3000 children will be taking part in this initiative, which is planned to last for three years. This includes six schools in South Tyneside, nine schools in Manchester and six schools in Hertfordshire. The initiative is delivered through one hour sessions (within the existing PHSE timetable). The curriculum, which has been adapted from the US originally, is designed to build resilience, prevent depression and anxiety, promote adaptive coping skills, and teach effective social problem-solving. Prior pilots (US, Australia, China) have been shown to reduce (moderate to severe) depression in at-risk children by as much as 50% and to reduce symptoms of bad behaviour (from 9% to 5%). The London School of Economics and Political Science has been commissioned to evaluate the programme in the UK and its first report is due in 2009[48].

The PATHs (Promoting Alternative Thinking Strategies) curriculum is an American programme designed to promote emotional and social competencies and reduce aggression and behaviour problems in school children. It is a universal, school-based intervention implemented by teachers to whole classes. The generalisation of skills learnt in the classroom to children's everyday lives is a major component in each unit. Curriculum units include self-control, emotional understanding, positive self-esteem, relationships and interpersonal problem-solving skills. There have been four clinical trials of PATHS. Two have involved special needs students and two have involved 'mainstream' children. Outcomes include enhanced social cognitions and social and emotional competencies; reduced aggression and depression; and improved cognitive skills[49].

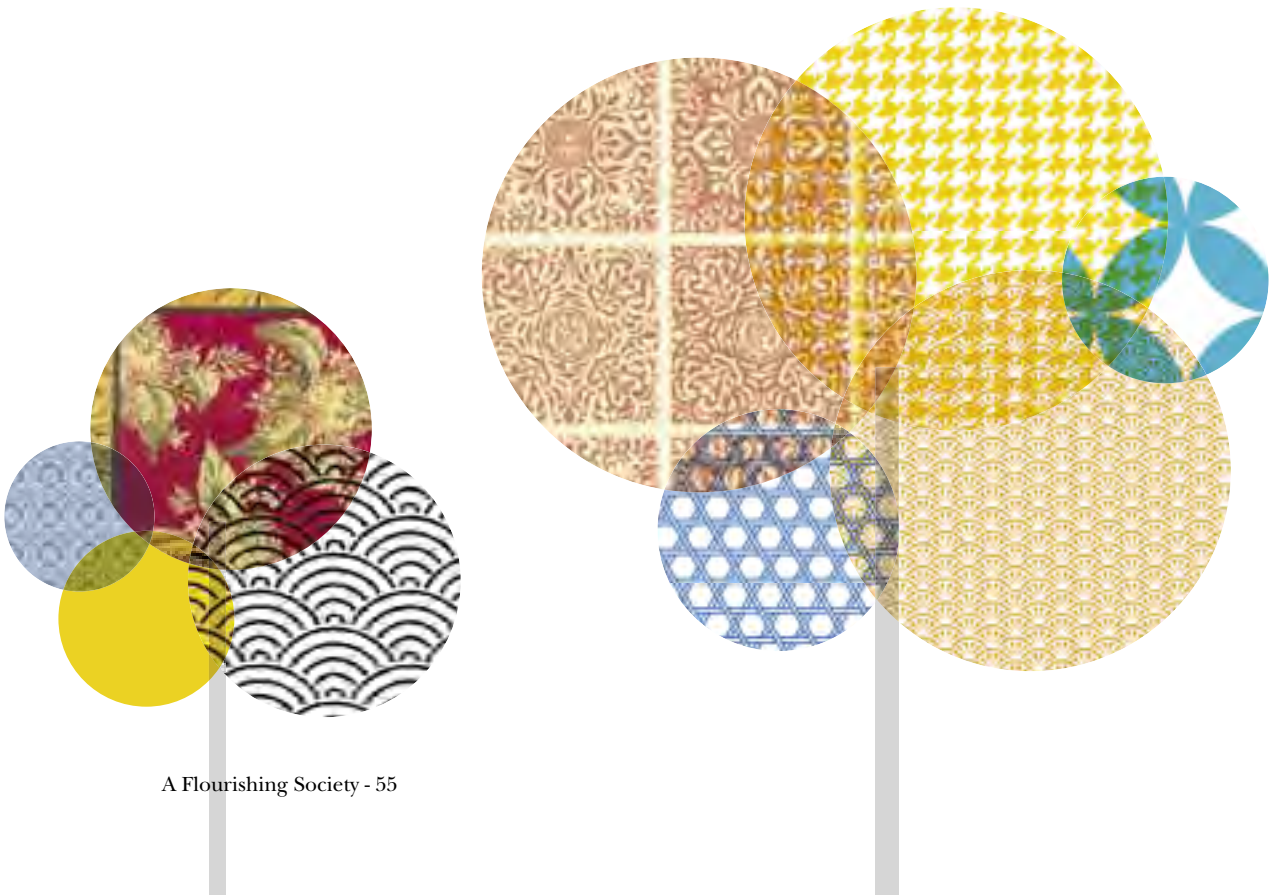
The Incredible Years Programme (see earlier insert; Incredible Years Basic Parent Programme) was developed in the 1980s by Carolyn Webster-Stratton, a Canadian educational psychologist with a public health nursing background. The Incredible Years is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 1-10 years). The interventions that make up this series— parent training, teacher training, and child training — are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems. The overall goal of the Incredible Years series is to prevent children from developing delinquency, drug abuse, and violence problems as they enter adolescence. It was used in the US Head Start programme and has been used in various Sure Start initiatives in Wales; as well as being used by service agencies in Canada, Norway and the Republic of Ireland[50].

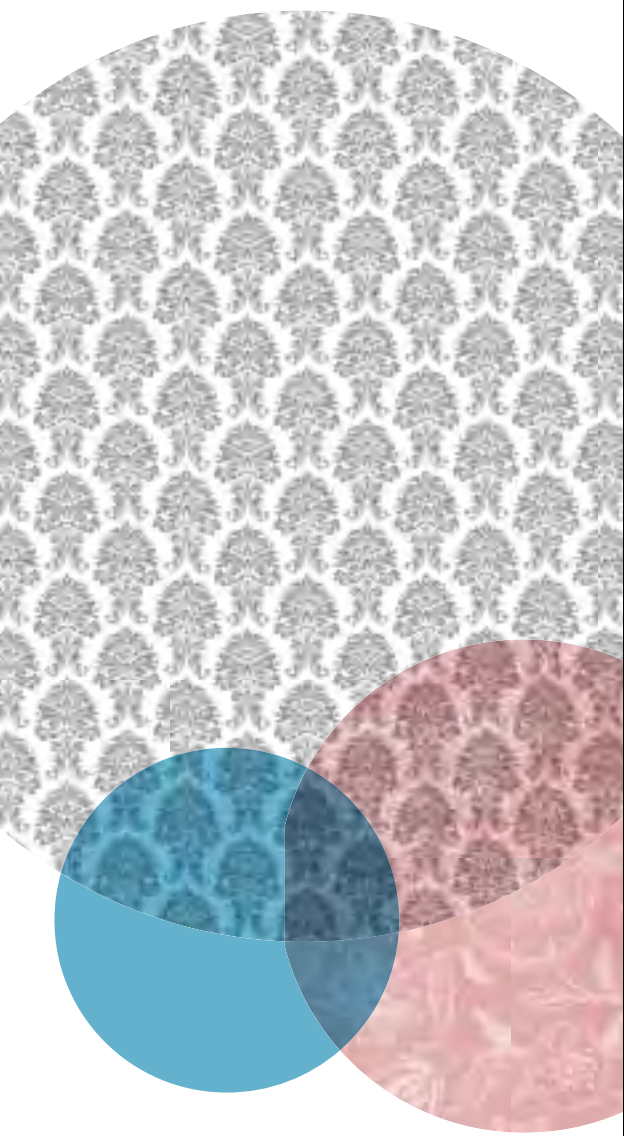
The Incredible Years Programme has been subjected to rigorous evaluation over the years. The positive outcomes of these evaluations have produced a number of separate independent reviews which have found that the programme meets the highest standard of scientific proof[51]. The parenting intervention has been demonstrated to enhance parenting skills and parental self-confidence. The teacher programme has demonstrated an increase of peer- and teacher-child interaction, bonding with parents, and proactive classroom management strategies. In relation to children, positive outcomes show an increased use of appropriate cognitive problem-solving strategies and more pro-social conflict management strategies with peers. Children have also been reported to be more socially competent and demonstrated a reduction in conduct problems at home as well as in school[44].



MindMatters is an example of an effective prevention programme for secondary schools which has been successfully evaluated. MindMatters, developed in 1997 in Australia has also been implemented in a growing number of schools in EU countries. The programme uses a whole-school approach to mental health promotion and is guided by the principles of WHO's Global School Health Initiative in which a health-promoting school is characterised as a school constantly strengthening its capacity as a healthy setting for living, learning and working. MindMatters has been designed to support schools in promoting and protecting the mental health of school communities including teachers, parents and students. The components of the programme include curriculum materials for use in a range of learning areas, a professional development programme and a website for ongoing support.

Evaluations of the programme in Australia have shown that MindMatters has had a relevant positive impact on the way schools work to enhance student mental health and wellbeing. The programme has also had a significant impact on school ethos and culture in that schools indicated that the promotion of student mental health and wellbeing has become an integral part of the school ethos and environment. The initiative has equipped teachers with the confidence and skills to better support and understand the needs of students, and to identify those children who may need additional support. Moreover, schools have reported - both by teachers and students - an increase in help-seeking behaviour as well as an improvement in their knowledge, awareness, skills and attitudes relating to mental health problems.





3.3 Community-based Interventions for Young People

Interventions aimed at young people are just as necessary as those which are aimed at the early stages of a child's development. Delinquency, substance abuse, health-risking sexual behaviours, and school failure amongst others negative outcomes are all linked to mental health problems in adolescence.

International evidence has demonstrated the effectiveness of a range of interventions. Most of this evidence comes from the USA where a 'Blueprint' of eleven 'model' programmes has been created. These programmes are concerned with violence prevention, substance abuse, emotional development and other similar issues. An example of these programmes is the Strengthening Families Programme (SFP).

The Strengthening Families Program (SFP) brings families the skills to increase resilience and to reduce risk factors for substance abuse, depression, violence and aggression, delinquency, and school failure. Designed for high-risk children ages 6-17 and their parents, the program builds on protective factors by improving family relationships and parenting skills, and increasing youths' social and life skills. The SFP has been modified for African American, Asian/Pacific Islander, Hispanic, American Indian, and rural families, and has been evaluated in these populations. Canadian and Australian versions have also been tested. Although originally developed for children of substance abusing parents, SFP is effective and widely used with non-substance abusing parents in many settings: schools, churches, mental health centres, housing projects, homeless shelters, recreation centres, family centres, and drug courts. The SFP has been proven effective in delaying the onset of adolescent substance use, lowering levels of aggression, increasing the resistance to peer pressure in youth and increasing the ability of parents/caregivers to set appropriate limits and show affection to and support of their children[52].

3.4 Wellbeing in the Workplace

The impact of mental ill health on both business and productivity is substantial. The Sainsbury Centre for Mental Health has estimated the total cost of mental health problems to employers to be nearly £26 billion per year in the UK[53,54]. In terms of absenteeism, it has calculated that in 2007 some 40% of all days lost due to sickness absence were as a result of mental ill health.

Moreover, mental ill health also represents a growing concern for the benefits system as an increasing percentage of invalidity benefits claimants cite mental health problems, with figures rising from 26% in 1996 to 42% in 2007. There is increasing recognition, that maintaining people in employment when they suffer a disability or period of ill-health is the best way to keep them in touch with work and to reduce the numbers moving onto benefits.

The workplace as a source of enhancing public health and wellbeing has been a key area of discussion and policy at both national and international level in recent years. It is worth stressing that employment is generally considered to be good for health and wellbeing[4,5]. It is beneficial for both physical and mental health for individuals to remain in employment whenever possible, particularly if the working environment provides a healthy element of emotional support. Recently published policy documents such as the Working For a Healthier Future report[55] and the Foresight Report[56], highlight the significance of workplace factors in the health of the population. Other documents aimed at employers from the Work Foundation[57] have strongly articulated the wellbeing in the workplace agenda.

This concept has drawn attention to the role of employers in promoting not only physical health, but also mental wellbeing, with increasing recognition that the workplace is an effective site for interventions to improve health and reduce health inequalities[57].

Moreover, the National Social Marketing Centre[58] suggest that if interventions to promote wellbeing in the workplace have even small effects, the public health impact could be substantial[59]. Importantly, the report outlines the tendency for employers to implement individually targeted interventions rather than addressing organisation-wide factors where most evidence of effectiveness is currently to be found. A recent review of the evidence[59] suggests that the area of organisational interventions is likely to present greater challenges for research and in implementation. Moreover, "the emphasis on individual interventions also tends to imply a responsibility on individual employees, rather than on change within the workplace".

Mental health problems often remain undiagnosed, or become apparent only when severe enough to force the individual to be absent from work for a substantial period. In part this is due to the stigma and discrimination attached to mental health problems. It is also the case that colleagues and managers are generally not trained and therefore lack confidence in the recognition of early signs of mental illness.

Linked to the Dame Carol Black report, PricewaterhouseCoopers (PwC) were commissioned to consider the economic case for employers to invest in wellness programmes for their staff. The report offers considerable evidence from literature reviews and over 50 UK-based case studies showing that health and wellbeing programmes have a positive impact on intermediate and bottom-line benefits. Intermediate business benefits include reduced sickness absence, reduced staff turnover, reduced accidents and injuries, reduced resource allocation, increased employee satisfaction, a higher company profile, and higher productivity.

For example, evaluation of London Underground's stress reduction programme for its 13,000 employees suggests that there was a reduction in absenteeism costs of £455,000 in its first two years, which is eight times greater than the cost of the scheme. In addition, improved productivity and some positive healthy lifestyle changes were observed[60].

Whilst there are some concerns regarding the adverse impacts of work on health and wellbeing

nevertheless the best approach to promote an employee's wellbeing is to help them to remain in work, because the benefits of work usually outweigh the risks[5.55].

If supportive services were more frequently employed to work together with employers (e.g. Employment Assistance Programmes [EAPs]) to reduce the flow from work to incapacity benefits by just 1%, it would save taxpayers £10.5 million. If it could help 10% of people remain in work, it would save taxpayers over £100 million. There are also potential savings to employers and the economy and of course these would likely translate into savings to the healthcare system in terms of reduced GP consultations and secondary care referrals.)

The gains of investing in the health and wellbeing of the workforce are not only financial, and many organisations have recognised this.

Additional benefits that can accrue from investment in this area include:

- corporate social responsibility; improving the quality of life of the workforce and their families as well as of the local community and society at large
- competition; in an increasingly competitive labour market there is more pressure on employers to distinguish themselves in order to attract and keep quality staff

For some employers it has become clear that, unless an initiative is introduced, the costs of sickness absence could threaten the business itself. Therefore, developing and communicating mental health messages is important and making them available to everyone is vital. Employers then, need to be provided with the relevant information and advice that would encourage their participation and investment in initiatives to promote wellbeing. The Health and Safety Executive (HSE) has made a series of recommendations for improving mental health at work and a growing number of major employers have invested in initiatives to reduce stress related sickness absence and improve wellbeing.

A programme called **Positive Mentality** recently implemented by British Telecom (BT) was the fourth health promotion campaign run by BT under their health promotion vehicle 'Work Fit'. The medium to deliver the programme was their intranet newspaper 'BT Today'. The programme contained eight modules and was designed to run over a 16-week period - October 2006 to February 2007[61].

Following the campaign, in partnership with BT, an online survey was carried out (15 questions) to find out about BT staff views on Positive Mentality, and whether the campaign influenced knowledge, attitudes or behaviour. The key findings of this initiative are summarised as follows:

- 'positive steps' to improving mental health in the workplace were viewed very favourably by some employees and were acted

Positive Mentality was aimed at raising awareness of mental health issues, tackling stigma, and promoting mental wellbeing; and dealt with the link between physical and mental health, lifestyle issues, support and relationships. The focus of the programme was on strengthening mental resilience rather than simply focusing on mental ill health, although some material was included on how to deal with problems if they arose. Quizzes were used to test participant understanding of the material.

upon, although time constraints and work pressure were mentioned as frequent barriers
- concerns about stress and depression in the workplace are common and widely understood to be influenced by working conditions, as well as by personal circumstances
- where employees feel working conditions, or management practice are stressful or damaging wellbeing, mental health messages are viewed negatively or with considerable scepticism
- levels of awareness vary considerably: for some people the messages are 'common sense' and for others completely new
- people with existing mental health problems felt reassured by the existence of a mental health campaign, which was seen as reducing stigma and taboos
- great care needs to be taken to avoid mental health messages sounding simplistic or patronising

Finally, it is also important to highlight the twofold benefits of programmes designed to assist low income unemployed groups to gain employment. This type of initiative is not only effective to enhance coping with unemployment, but also to reduce the negative outcomes for mental health.

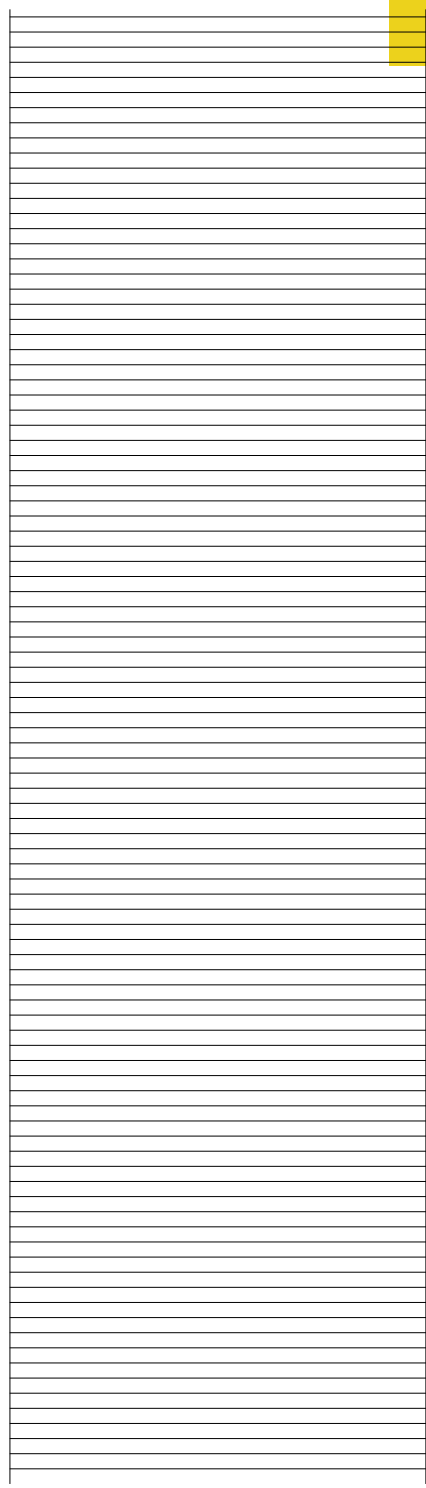
The JOBS Programme, developed in the USA (Price, Van Ryn and Vinokur, 1992 [88]), was initially designed as a preventive intervention for unemployed workers. The programme has been adapted and implemented successfully in Finland, Korea and China and more recently, in the Netherlands. In the early 2000s this programme was implemented on a pilot basis in the border region of NI and RoI where the programme will be rolled out in September 2009 under the name of Winning New Opportunities. The JOBS Programme consists of five intensive half-day workshops held over one week that focus on identifying effective job search strategies, improving participant job search skills and increasing self-esteem, confidence and motivation to persist in job search activities. The programme is delivered by two trainers to groups of 12-20 job seekers. Evaluations of the programme in the USA and Finland have shown positive effects on rates of re-employment, the quality and pay of jobs obtained and job search self-efficacy and mastery, as well as decreased depression and distress.

Jobcentre Plus is an initiative implemented by the Department of Work and Pensions (DWP) in England. The Jobcentre Plus is a government agency supporting people of working age from welfare into work, and helping employers to fill their vacancies. The Jobcentre Plus programmes are targeted at unemployed people (particularly long-term unemployed people), people with disabilities and others who may need extra help in finding work. Research is required to provide a robust evaluation of the effectiveness and efficiency of Jobcentre Plus.

3.5 Community Interventions

Better health for all will be achieved by enabling local communities to take an active role in setting priorities, making decisions, planning strategies and implementing them. Health and social outcomes are obtained through effective community interventions focused on the development of building a sense of ownership and social responsibility through the empowerment of community members. Furthermore, community settings, from a socio-ecological perspective, are key contexts for mental health promotion interventions.

A local regeneration project planned for East Belfast, the Connswater Community Greenway, is a good example of this type of intervention that has been developed through statutory, voluntary and community collaboration (more details about this project can be found at: http://www.communitygreenway.co.uk/).



The **Connswater Community Greenway** has been developed by the East Belfast Partnership, which is a broad-based social partnership with community, statutory, political and business members dedicated to the regeneration of East Belfast. The vision of the project is to develop a safe, accessible, sustainable greenway which is an inspirational living landmark that improves the quality of life for the people of East Belfast, now and for future generations. Local organisations and groups are involved in decision making to ensure that the community have a say in how the project is planned and developed in their local areas. The outcomes of this initiative include: a stronger, safer community, an improved urban environment, healthier and more active people and communities, better life chances, better access to training and development – all determinants of positive wellbeing.

Community organisations are generally well placed to work with people whom the statutory sector finds hard to reach. They have local knowledge and trust that can often prove elusive to health and social care professionals. For example, it was highlighted by a community development professional within the Health Promotion Agency "that a large number of community organisations in North and West Belfast do very valuable work in promoting positive mental health, whether they be specific counselling organisations such as New Life Counselling and Lenadoon Counselling Forum;

women's centres such as those in West Belfast provide a wide range of programmes which directly or indirectly promote positive mental health. Other community organisations provide invaluable work on drug and alcohol issues e.g. Forum for Action on Substance Abuse (FASA), Falls Community Council. Healthy Living Centres such as those in the New Lodge, Duncairn, Ardoyne and Shankill, (Health Education and Relaxation Therapy (HEART), Top of the Rock and others) provide complementary therapies as well as raft of health and wellbeing initiatives; local youth initiatives, and many others". In addition, community organisations possess specific knowledge, skills and experience in supporting vulnerable and marginalised groups such as people from traveller and minority ethnic communities.

Journey Towards Healing (JTH), funded by the Victims Unit, Office of the First Minister and Deputy First Minister (OFMDFM) and based at NIAMH, is a programme designed to support NI's faith communities in the pastoral care with those who have experienced trauma. Faith leaders in NI, within the context of bereavement and with victims and survivors of violence, are a population with high exposure to trauma and high risk for secondary trauma. JTH provides faith leaders trauma awareness training, seeking to help leaders recognise trauma and its impact on mind, body, and spirit within the lives of others, as well as themselves. Through a widely distributed booklet and its developing research strand, JTH hopes to cultivate an ongoing process of reflection on healing in NI. The programme also aims to provide an international platform to encourage dialogue about the relationships between faith, conflict, trauma and healing, in NI and beyond.

Many other examples of such projects exist across NI, and are often carried out in collaboration between statutory, voluntary, and community agencies along with business sector partners. So much so, that the breadth of opportunities and possibilities in this area warrants a separate report focused on community involvement and wider issues related to community regeneration. Many projects have a remit that extends beyond a narrow conceptualisation of mental health promotion, utilising a truly holistic approach to building a healthy society, further reiterating the need to structure government funding and implementation methods to allow for, or rather actively encourage collaboration between DHSSPS and other departments such as Department of Education, Northern Ireland (DENI), Department for Social Development (DSD), Department for Culture, Arts and Leisure (DCAL) and Department of Environment (DOE).

3.6 Support for Later Years

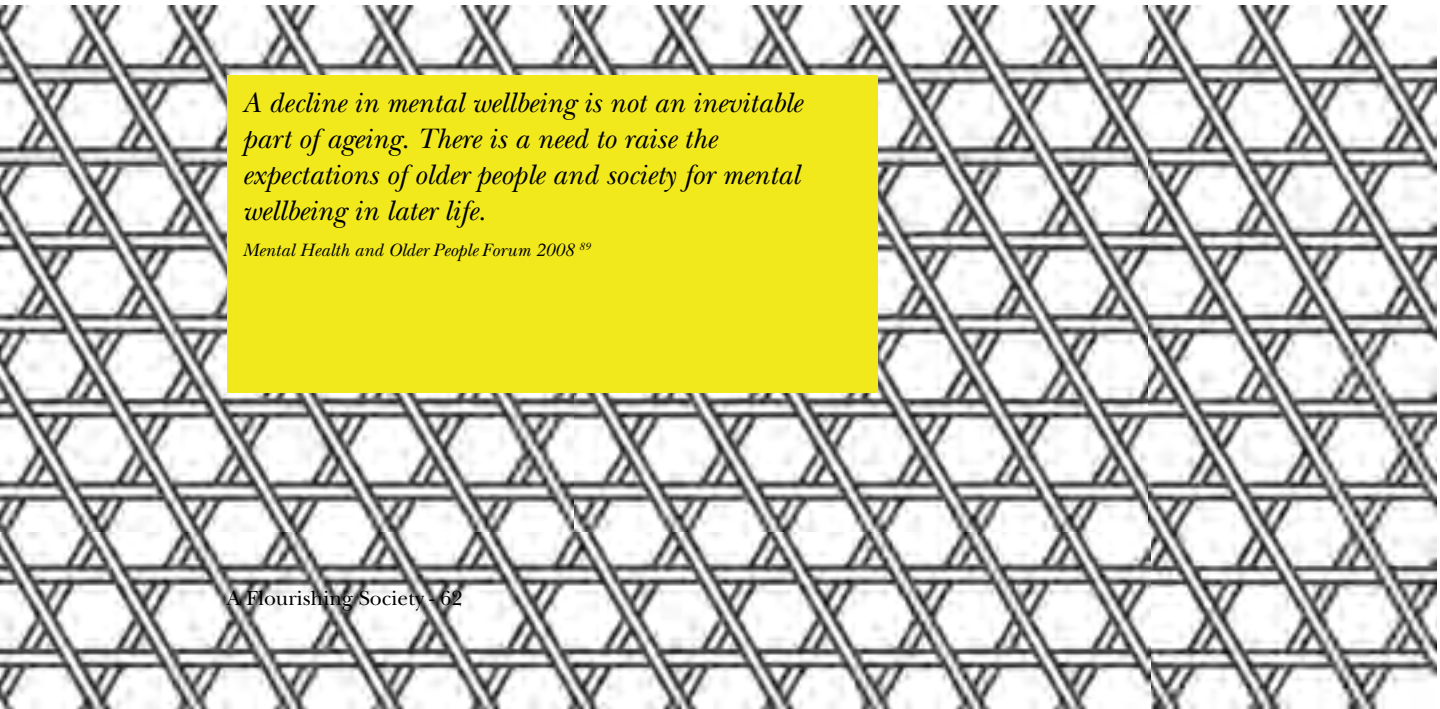
"A decline in mental wellbeing is not an inevitable part of ageing. There is a need to raise the expectations of older people and society for mental wellbeing in later life" (Mental Health and Older People Forum 2008 [89]).

The UK Inquiry into Mental Health and Wellbeing in Later Life 2006 highlighted five key factors that affect the mental health and wellbeing of older people: discrimination (for example, by age or ethnicity), participation in meaningful activity, relationships, physical health (including physical capability to undertake everyday tasks) and poverty[6].

Isolation is a particular risk factor for those in rural areas, those with mobility limitations and for those people older than 75 who may be widowed or live alone. Social activities, social networks, keeping busy and 'getting out and about', good physical health and family contact are among the factors most frequently mentioned by older people as important to their mental wellbeing[62].

According to the older participants involved in a study undertaken for the Joseph Rowntree Foundation (JRF), central to a 'good life' in old age is the value attached to inter-dependence: being part of a community where people care about and look out for each other; a determination 'not to be a burden', especially on close family; and an emphasis on mutual help and reciprocal relationships. Other work by the JRF highlighted the following:

- Much of policy and practice are still based on the assumption that older people are a 'burden'
- Health and social care services are only a small part of the support that older people value, and only a small part of the experience of growing older
- Older people are the biggest providers of support to other older people. Contrary to common perception, there is a great deal of evidence of support within communities, but these networks are often hidden and tenuous
- There is still a mismatch between what older people want and what policy and practice are delivering
- Older people are frustrated about services and society, which they saw constantly defining them in terms of loss and risk management
- Many national and local stakeholders still view older people as the passive recipients of services



A decline in mental wellbeing is not an inevitable part of ageing. There is a need to raise the expectations of older people and society for mental wellbeing in later life.

Mental Health and Older People Forum 2008 [89]

Actions for Later Years

The current financial crisis has been particularly devastating for many people approaching retirement, and those already retired, increasing the financial burden of paying for life after work. A recent UK Inquiry on mental health and wellbeing in later life highlights both the discrimination against older people and the egregious waste of their knowledge, skills and availability. The inquiry carried out by Age Concern states:

"One in four people aged 65 and over have symptoms of depression, much of which could be prevented. This demands the development of a public health approach to depression in later life ... we need to shift our attention to them, to ensure that they are supported by loved ones and enabled to care for themselves - by design, not by accident or neglect[6]."

Dealing with social isolation among older people remains an important challenge. A review of the empirical literature published over the last 20 years on the effectiveness of interventions that target social isolation amongst older people suggests there is very little evidence to show that they work. It concludes that future intervention programmes aimed at reducing social isolation should have evaluation built into them at inception, and that the results should be widely disseminated. Where possible, as a cost-effective measure, pilot or demonstration projects should precede these interventions[63].

However, the evidence available suggests that effective interventions include:

- Volunteering - enhances individual wellbeing and builds community capacity at the same time.
- Regular physical activity in supportive, age-friendly environments - reduces risk of depression and improves physical health.
- Interventions that support people with hearing loss and visual impairments;
- Community befriending programmes - provide social support, hence reducing loneliness and depression[3].

A good example of a volunteering programme for older people is **The Experience Corps (USA)**. This programme was created in response to evidence that participation in voluntary activities can improve functioning and lengthen life, along with evidence that social support, social networks and social activity in general are independently protective of health. Experience Corps was developed as a means of providing social capital to support educational needs and improve the quality of future workforces in USA. The Experience Corps places older volunteers in public elementary schools in roles designed to meet schools' needs and increase the social, physical, and cognitive activity of the volunteers. A secondary aim of the project is to foster inter-generational knowledge, experience and respect. Results of a case control study indicate benefits for students and schools, as well as Experience Corps members (older people) including:

- Students achieved better test scores and displayed improved behaviour, while teachers and principals reported customer satisfaction; and
- Volunteers developed better overall health and increased strength, had higher activity levels with more calories burned, reported less TV time, a wider social network, and participant satisfaction was measured by a 80% uptake for a second year[64].

In England, **Partnerships for Older People Projects (POPP)**, led by the Department of Health, aim to shift resources and culture towards earlier and better targeted interventions for older people within community settings. The pilots deliver a range of interventions aimed at promoting independence for older people in line with local needs. For example, they provide better access to information and peer support for older people, provide health promotion activities to support healthy living, and provide low-level or simple services for older people such as help with shopping, household repairs etc. Early findings from POPP pilot sites have shown improved access for excluded groups and greater involvement of older people within steering groups, commissioning, recruitment, provision and evaluation.

3.7
Training and Awareness Initiatives

Research evidence suggests that mental health literacy, particularly in young people and their key helpers may lead to better outcomes for those with mental disorders, either by facilitating early help-seeking by young people themselves, or by helping adults to identify early signs of mental disorders and seek help on their behalf[65].

The merits of programmes aimed at raising awareness and enhancing knowledge of mental health are widely recognised and it is commendable the amount of work and effort that has been put on in NI to develop capacity in this area.

Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST) are two well known mental health literacy training programmes implemented in NI. These programmes have been disseminated in other countries and have been evaluated. A local initiative developed to improve the mental health literacy of young people and their supporters – Mood Matters – has recently undergone an independent evaluation. The three programmes are described below.

The Mental Health First Aid (MHFA) training course was developed in Australia in 2000 with the aim of improving mental health literacy amongst Australians. This Program includes a 5-day Instructor Training Course to accredit suitable candidates to become MHFA Instructors who deliver the 12-hour MHFA course within their communities. The course is designed to provide first aid specifically in mental health issues or in a mental health crisis situation and encourage help-seeking behaviour. The programme has been disseminated nationally and internationally - for example, Scotland, Hong Kong, Singapore and Canada[66].

Evaluations of MHFA in Australia have shown several benefits such as, improved ability to recognise a mental disorder, greater concurrence with professionals about appropriate treatments, decreased social distance (stigmatizing attitudes), increased confidence in providing help and more help provided to others[67].

In NI in 2003 the Cooperation and Working Together (CAWT) subgroup identified the need to promote positive mental health among young people aged between 16-25 years and selected MHFA as a suitable approach to address this need. In 2005, a partnership of CAWT, Aware Defeat Depression and the Health Promotion Agency (HPA) initiated work to deliver a pilot programme of MHFA in the CAWT border region. This pilot programme was evaluated by the Health Promotion Agency. The evaluation was intended to assess the impact of the course on instructors and participants in order to make recommendations for infrastructure and resources and adaptations that would enable successful roll out of the programme throughout NI and Ireland. Key findings of this evaluation indicate:

- An increased confidence and motivation
- It encourages help-seeking behaviour
- The programme could be improved by introducing vignettes related to the NI context and more listening skill content.

Instructors' recommendations as follows:

- materials to be complemented with more local context, information and statistics; and audio-visual support, e.g. videos;
- content of the course to be aimed at delivering more positive messages in relation to mental health;
- delivery across two consecutive days, although intense and exhausting, is more beneficial to the participants - allows for bonding and participation;
- adequate support for instructors post-delivery as well as regular updating of materials is necessary;
- attendees should be willing participants rather than being referred by employees. Participants should be informed in advance of the content and the aims of the course;
- training relevant to the whole population;
- fee-for-service provision suggested for sustainability;
- future delivery of MHFA should be properly evaluated;
- links with other jurisdictions where MHFA (e.g. Scotland and Australia) has been implemented should be maintained in order to identify examples of best practice and sustainability.

The success of the pilot, and the growing demand for MHFA, has prompted the Health Promotion Agency (HPA) to purchase the licence for the MHFA training programme, which is currently being adapted to the NI context with the collaboration of the instructors who participated in this pilot programme[68].

The Applied Suicide Interventions Skills Training (ASIST) programme is a two-day course focused on identifying risk factors for suicide, managing the suicidal person to ensure safety, and connecting the individual with professional help, crisis teams and community support. ASIST was developed in Canada by a partnership called LivingWorks. The aim of the programme is to equip caregivers of all kinds with the skills to provide suicide first aid interventions. This programme is used in many countries[69].

Scarce evidence suggests that ASIST has been used effectively in Native Communities in the USA - including reservation and urban settings[70]. In Australia, evaluation of the programme implemented in a university setting has shown discrete improvements in mental health literacy, but no improvements in behaviour. No follow-up evaluation of the intervention was conducted[65]. ASIST has been rolled out nationally in Scotland since 2004 under the co-ordination of the Choose Life National Implementation Support Team (NIST). An evaluation of this initiative carried out in 2007 strongly suggests that ASIST "could have a sustainable future in Scotland and that to make the greatest impact suicide prevention training should be targeted at those individuals and groups who have most opportunity to use the skills because they work with, or live beside, people from sections of society most at risk of suicide - for example, people living in areas of deprivation and those affected by drug and alcohol problems[71]. As with Mood Matters (see below), evidence of the effectiveness of ASIST would be strengthened by further objective evaluation.

The **Aware Defeat Depression ('Aware') Mood Matters** project is aimed at increasing awareness of the signs and symptoms of depression and its treatment amongst secondary school children between 14-16 years-old through the provision of multi-media presentations across schools in NI.

An independent evaluation of this initiative commissioned by BBC Children in Need Northern Ireland carried out in May 2008 suggests that Mood Matters is succeeding in achieving the following:

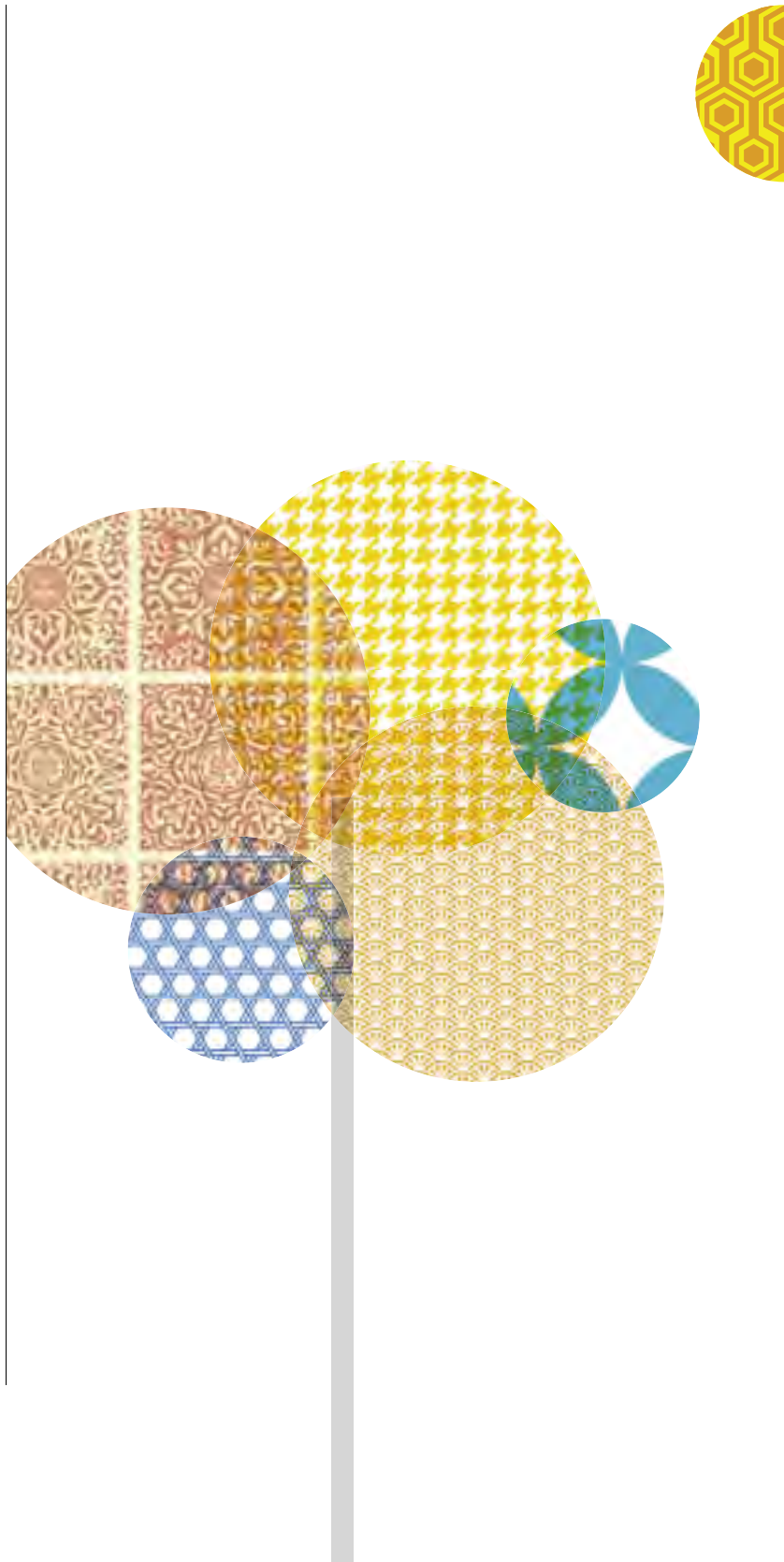
- increased knowledge and understanding of depression by young people;
- increased awareness of signs and symptoms of depression in themselves and others;
- enhanced knowledge on the part of young people on treatment and sources of help for depression;
- increased knowledge by young people on self-help strategies.

It is less clear how successful the project has been in achieving the desired outcome of providing young people with 'gain of emotional life skills', partly because the term 'life skills' has not been clearly defined. Notwithstanding, overall, the project has shown strong evidence of its long-term impact - the majority of pupils have shown evidence of retention of knowledge at 12-months follow up. Furthermore, schools have been positively influenced in terms of their general mental health and depression related issues. Teachers have described the project as an

important programme which is professionally organised and well delivered and has supported the schools in their delivery of their work in the area of mental health and depression awareness. Partly, as a result of Mood Matters, some schools have taken further steps to improve the emotional wellbeing of their students and have appointed counsellors[72]. Further evaluation would strengthen the evidence for recommending this programme of awareness for young people.

Although the above in roads are under development and have been in the main, well developed and evaluated it is necessary to point out that they are aimed at providing the knowledge and awareness required to detect mental health problems, and suicide risk. They have not been developed to inform people about the possibilities and potential of developing their own and others' positive mental health.

A training framework for mental health promotion (alongside prevention)for NI would be welcomed, and we would recommend that provision is made for assisting individuals, employers, health care providers and other relevant groups to recognise and promote positive mental health, as opposed to focussing on mental health problems or mental ill-health.



Only 24% of adults with long-term mental health problems are in work, the lowest employment rate for any of the main groups of disabled people, and only 8% of those with severe mental health problems are in employment.[1]

3.8 People with mental health problems

The aspiration towards a flourishing society must truly mean wellbeing for all - this includes people whose lives have been negatively impacted by mental health problems. The 'recovery approach' which emphasises the benefits of establishing a meaningful and satisfying life, as defined by the persons themselves, represents a shift from "a focus on pathology, illness and symptoms to health, strengths and wellness"[73].

"The recovery movement stresses the importance of finding and maintaining hope: believing in oneself; having a sense of personal agency; remaining optimistic about the future. It emphasises the benefits of re-establishment of a positive identity: finding a new identity which incorporates illness, but retains a core, positive sense of self. People are encouraged to build a meaningful life: making sense of their difficulties and finding a meaning in life, despite such problems"[74].

Importantly, a recovery approach embraces the need for personal autonomy and responsibility for one's own healthcare while also enabling people to obtain the resources needed to achieve their own recovery as far as possible - information, skills, networks and support. Similar to the position we have adopted throughout this review, the authors of a recent report on psychological health and wellbeing suggest, government departments have a key role in "developing integrated and comprehensive care plans for socially disadvantaged or excluded persons [that] must link heath and social agencies, education, the benefits and employment system, the justice system"[74]. We fully endorse the holistic perspective that services should be "addressing rather than avoiding all aspects of a person's wellbeing; such as physical healthcare, educational opportunities, housing [and] employment".

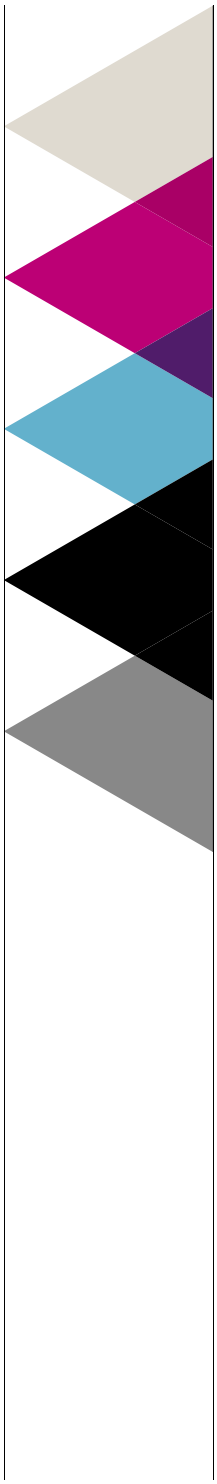
It is clear that fundamental to recovery is social integration; education, training and employment and other useful activities are central to this. This view is entirely compatible with current policy and thinking on work and wellbeing[55].

Interventions and actions directed at recovery are under development internationally. Local development in this area must be undertaken and led by those engaged with providing services, however those employed in prevention and promotion have a critical role to play. This is an area where service providers in promotion, prevention, and treatment need to work collaboratively to help people find a way to recover their balance and move forward with their lives in a meaningful and satisfactory way.

There is so much that could be done in this area. All aspects of the life of a person experiencing mental illness could be enriched when everybody works

collaboratively - housing, finances, education, employment, social networks, health and care services, etc. We could comment on all of them and add more to the list; however that would warrant a separate and dedicated report.

Unfortunately, here, we merely have the opportunity to show some examples of what might work in two aspects of life: the physical health for those living with illness and employment. The initiatives below have been drawn from the Scottish Government's experience.



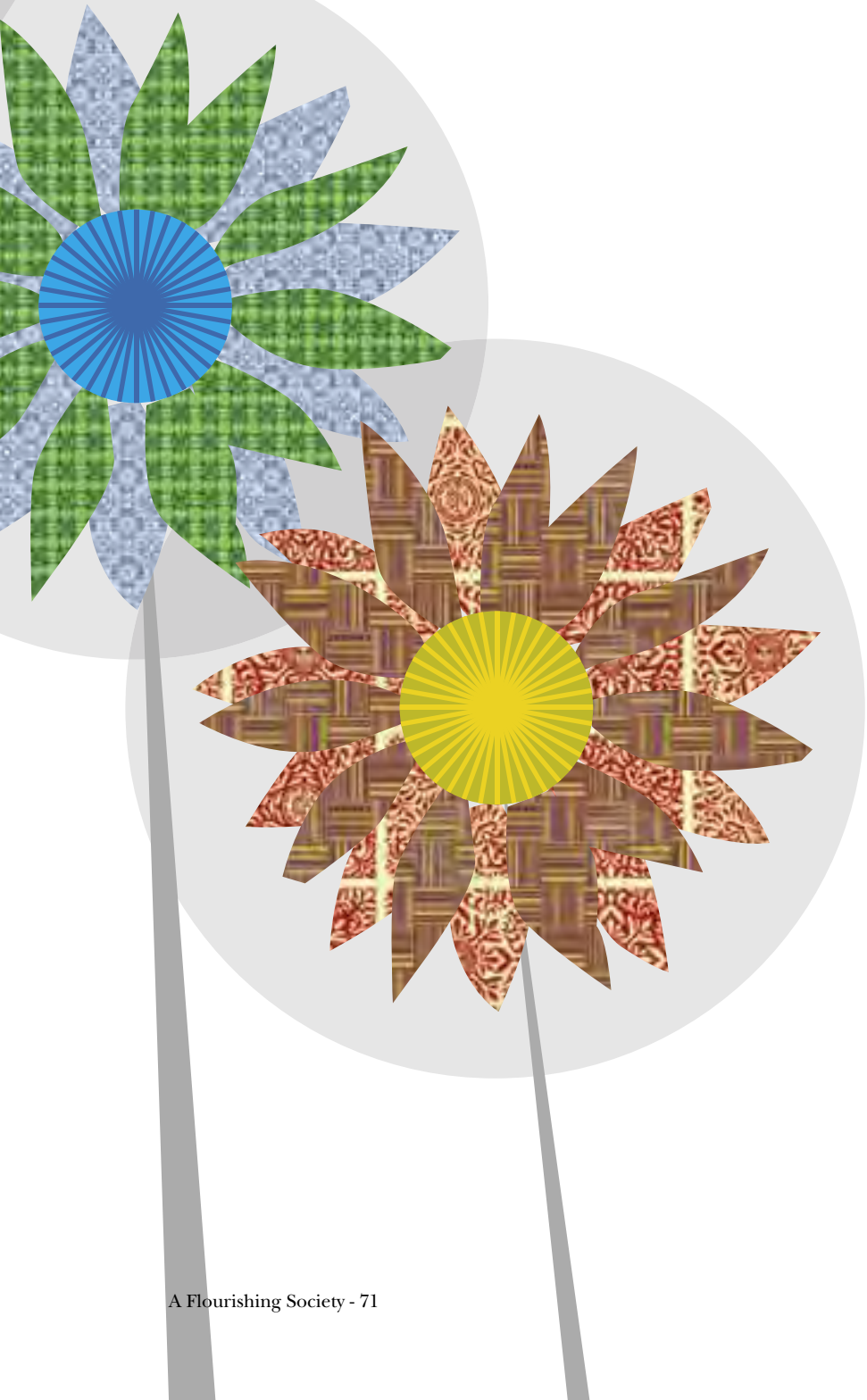
Open to All
A Healthy Living Centre in Moray is open to the whole community and promotes good health through exercise, sharing health information and a range of other activities. People concerned about their mental health can self refer, utilise a range of complementary therapies and request membership of the 'exercise on referral' scheme. This means that people have improved access to a range of ways to address mental illness and promote mental health.

Sports
A physiotherapist who works in mental health services in Midlothian encourages people to exercise and supports them to take up mainstream leisure classes. Leisure centres offer free admission to people referred by health staff, and to a supporter chosen by the person. The local Mental Health Forum oversees the project and includes representatives from education, employment and the voluntary sector.

Working Together
Mental health day services, further education and Jobcentre Plus worked together in Angus to create a work preparation course sited at the local college. Lessons have been learnt about how to market such a programme, how to create sustainable relationships between agencies and how to manage the transitions between the roles of service user, student and employee.

Recommendations for a New Strategy





Section 4
RECOMMENDATIONS FOR A NEW STRATEGY

In this section we outline the recommendations that follow from our review of the Mental Health Promotion Strategy 03-08, the Protect Life Strategy 06-11 and the Bamford Report; Mental Health Improvement and Wellbeing - a Personal, Public and Political Issue.

Our recommendations are derived from and supported by (a) a systematic review of the available evidence on mental health and wellbeing promotion and effective interventions*; (b) our analysis of the major policy documents on wellbeing from the EU, WHO and English-speaking countries worldwide; (c) information gathered from in-depth interviews with a large reference group of individuals representing key agencies and communities of interest in NI; (d) a symposium led by NIAMH with a panel of expert advisers on mental health and wellbeing.

**A number of recommendations for specific programmes and interventions have been made on the basis of the available evidence; other sound programmes and interventions may exist but lack the same level of publicity and evidence-base. It should also be stressed that many programmes have yet to be evaluated in the Northern Ireland context.*

Our recommendations for a future strategy for Northern Ireland are underpinned by the following perspectives and principles:

A Stable Economy
A successful and stable economy requires an educated, healthy, cohesive workforce; a goal which can only be fully realised when all branches of government are committed to achieving it in partnership with communities and businesses.

Building Resilience
Treating ill-health across the life-course is important but promoting wellbeing and preventing illness (or, at least, intervening as early as possible) is the best option for the individual and our economy. Building resilience and supporting children and families is clearly the most beneficial and cost efficient way of facilitating change and growth.

Tackling Inequality
Good health is not evenly distributed in our society but is determined by unequal access to goods and resources and the differential experiences of people and the conditions of daily life. For a flourishing society in which we all benefit we need to elevate the life chances of people in the most deprived communities.

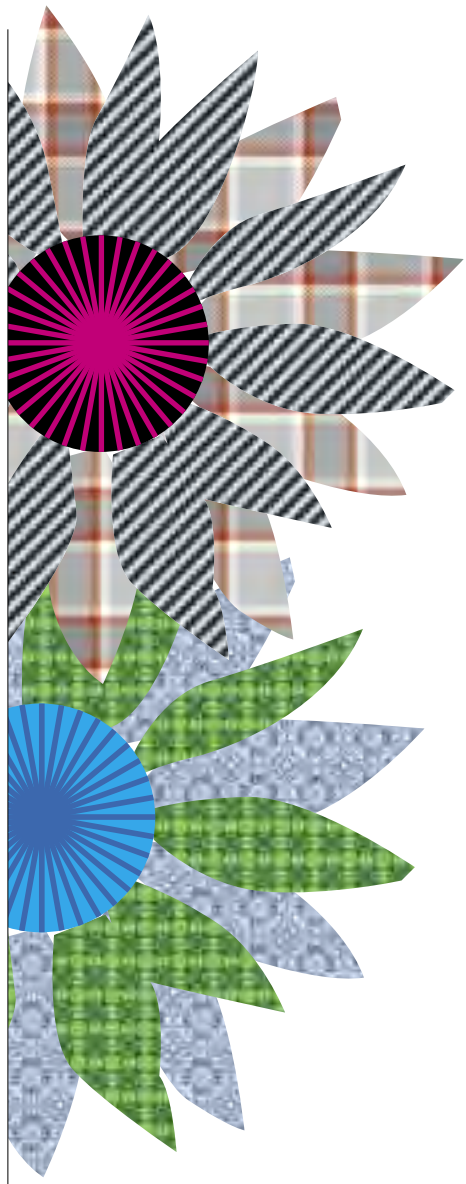
Community Involvement
Understanding local needs and strengthening community participation must be at the core of any successful strategy.

Existing Resources
We increasingly need to make more efficient use of the resources we have. There is a need to re-examine the partnership with faith-based organisations and schools. The use of volunteers, including the skills, experiences and energies of older people should be embraced.

Collective Responsibility
The creation of a healthy, confident and flourishing society is the responsibility of all sectors. Wellbeing for all can only be achieved when all branches of government and the communities they serve acknowledge their potential and unique contribution to wellbeing and act to achieve it.

Leadership and Accountability
A robust strategy to promote mental health and wellbeing must be more than just a declaration of action areas and targets. A strong framework for action demands skilled professional people aided by a dedicated, accountable leadership.

Research, Measurement and Change
In order to address our problems we need to understand and measure them. We need to seek solutions based on good evidence and measure the outcomes of our actions.



4.1
A Single Mental Health Promotion Strategy

There is growing recognition that a single, coherent wellbeing strategy would be a considerable step towards achieving accountability, transparency and efficiency in our efforts to encourage the development of healthy, resilient and flourishing individuals and communities in NI. The evidence currently available strongly suggests that we invest in the wellbeing of our population from the earliest stages of life, an investment that strengthens people throughout the life course. The research also suggests that we target our resources to those most in need, to tackle health inequalities and reduce social exclusion. It is also clear that while a life course approach acknowledges the importance of wellbeing for all, there is a need for mental health promotion and suicide prevention strategies that reflect the needs of, and opportunities within, specific settings.

In the following section we outline programmes and interventions that appear to be backed by evidence and which are likely to be of considerable valuable in NI. It is important to stress that while various programmes and interventions appear to be backed by evidence from an international perspective, most lack evidence within the Northern Ireland context and will require further evaluation.

4.2
Parenting Programmes

A Family Nurse Partnership programme is currently being piloted in other parts of the UK. However, with fidelity to the model using relatively small case-loads, they are currently produced under license and expensive. The cost is partly incurred by the use of specialist and highly trained nurses carrying relatively small case-loads. Currently, the role of health visitors and school nurses is being reviewed - it may be possible to extend their professional roles to encompass working with young mothers within specialised parenting programmes.

Where families have complex and challenging need, intensive home visiting by Health Visitors and school nurses, using regionally agreed specific evidence-based interventions/programmes should be introduced for children of all ages. The outcomes of work being led by DHSSPS in relation to the Family Nurse Partnership should be considered within the menu of services for the most hard-to-reach families.

4.3
Health Visitors and Peer Support

Pregnant women and family members need to be educated about the risk of developing postnatal depression so they can recognise the symptoms. Treatment needs to be convenient and accessible to new mothers. There is need for a coordinated multidisciplinary approach to identify postnatal depression involving all health professionals who come into contact with new mothers including midwives, doctors, nurses and health visitors[75].

New research underpins the important role of health visitors in identifying women with postnatal depression and offer effective treatment[76], while telephone peer support (mother to mother) may halve the risk of developing postnatal depression[77]. Preventative interventions are more likely to be successful if they are individually based, initiated postnatally, and target high risk women.

4.4
Educational Settings

Schools and colleges should be helped to make a significant contribution to the wellbeing of children, parents and communities. The Office for Standards in Education, Children's Services and Skills (Ofsted) make the point that the central mission of schools is to "promote their pupils' achievement and to help them to realise their potential as learners" schools are therefore concerned with the development of the whole child and young person and this is reflected in schools' statutory duty to promote the wellbeing of their pupils. In this, schools increasingly work in partnership with others to achieve these wider outcomes[78].

The rationale for promoting wellbeing, illness prevention and

early intervention in schools has gained widespread acceptance. Currently, many schools across NI appear to have adopted wellbeing initiatives. However, these are often short-term, based on non-recurring funding, and in some places, individualistically driven by single champions. Evaluation is generally lacking. Wellbeing in schools should not be an optional extra - it must be mainstreamed and appropriately funded.

An inter-departmental initiative in NI between the Department of Health (DHSSPS) and the Department of Education - Pupils Emotional Health and Wellbeing (PEHAW) - has been established. The aim of this initiative is to create a mainstreamed approach to wellbeing in post primary education schools by 2010. Various scoping exercises are underway in order to understand the resources needed and the potential barriers to implementation. We believe that this is a significant initiative, demonstrating the NI government's commitment to the wellbeing agenda and a positive exemplar of intersectoral working. A second project has been established to look at counselling and wider therapeutic Interventions in Primary and Special Schools in NI. We do not intend to pre-empt the findings of the PEHAW initiatives but we feel that some points may be made in advance.

In line with the evidence available we recommend that a whole-school approach is adopted within which resiliency programmes are implemented and evaluated. It may be the case that a 'one-size-fits-all' approach will work to a degree - however, local and particular needs should be taken into account. Schools are, and indeed should be considered as communities in themselves, and therefore engagement with teachers and pupils in the development of policies and practices is necessary to facilitate change and growth.

Implementation of wellbeing in schools must be sustainable. Policies and clearly accountable systems and structures must be in place in order to provide the support, information, advice and resources to schools needed to facilitate and maintain, in the longer term, a whole-school approach to wellbeing. We support the recognition that the promotion of wellbeing in schools prepares young people to derive the maximum benefit from education and equips them for their role in society. We propose that wellbeing in schools should be accorded the same promience as exams and test scores, and indeed the evidence suggests that the two aims will complement each other. We recommend that a measure of wellbeing for schools is chosen and its use encouraged within all schools.

To complement these efforts, we need longitudinal studies to examine associations between whole-school approaches and other health and lifestyle indicators. Wellbeing data should be published by the Department of Education allowing Education Boards and individual schools to gain appropriate recognition, and share their successes regarding achievements in wellbeing.

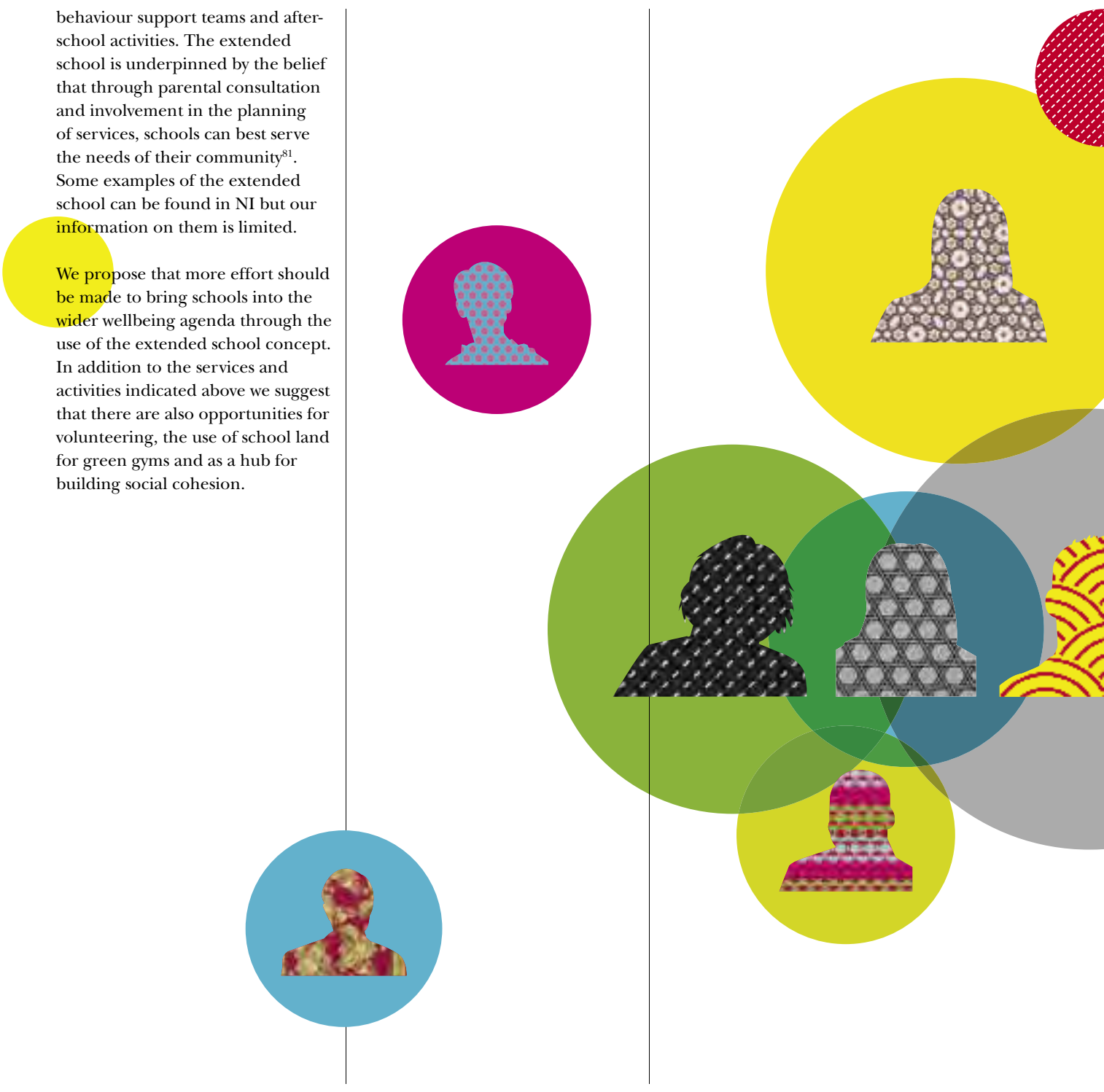
Much more could be done to assist teachers and schools in recognising and responding to pupils with mental health and emotional problems[79]. Teacher training should incorporate knowledge on mental health and wellbeing[80]. However, teachers should not be expected to become mental health professionals.

While there may be examples of positive collaboration between schools and Children and Adolescents Mental Health Services (CAMHS) we propose that much more effort is needed to establish these links and the monitoring of outcomes. Barriers regarding inter-disciplinary efforts include sharing of information (or lack thereof) and confidentiality requirements. These should be discussed openly in order to establish inter-departmental guidance and policy that will ensure that a balanced and yet collaborative approach be employed to assist our young people in a timely manner when problems do occur.

Extended schools provide a range of services and activities, often beyond the school day, to help meet the needs of children, their families and the wider community. Extended services might include childcare, adult education, parenting support programmes, community-based health and social care services, multi-agency

behaviour support teams and after-school activities. The extended school is underpinned by the belief that through parental consultation and involvement in the planning of services, schools can best serve the needs of their community[81]. Some examples of the extended school can be found in NI but our information on them is limited.

We propose that more effort should be made to bring schools into the wider wellbeing agenda through the use of the extended school concept. In addition to the services and activities indicated above we suggest that there are also opportunities for volunteering, the use of school land for green gyms and as a hub for building social cohesion.



4.5 Workplace

The evidence suggests that organisations and businesses are just beginning to understand the importance of wellbeing in the workplace but change in this area is patchy and inconsistent. There remains too much focus on individual sickness and discipline rather than nurturing healthy working environments.

The large public sector organisations, faced with high rates of absenteeism, should adopt the recommendations set out in the report by Dame Carol Black, Working for a Healthier Tomorrow, that the current sickness certification process institutionalises the belief "that it is inappropriate to be at work unless 100% fit and that being at work normally impedes recovery."

There is a need for deep cultural and structural change within all employment sectors. Government needs to facilitate direct engagement with a wellbeing agenda among public and private sector organisations.

We support the recommendation made in the report that there is "an opportunity to test the market for a new business-led information, advice and consultancy service" and that this should be business and provider-led. The evidence suggests that best practice, knowledge and expertise appear to be superior in the private and voluntary sector and, in any case, "business is more likely to listen to business than take advice from Government". The report also recommends an extension of occupational health support to the workforce, particularly among smaller organisations. Such services could be developed through regional or local partnerships to increase local employer engagement.

Large public and private sector organisations have the capacity and resources to provide training on early recognition of mental health problems and to establish organisational wellbeing. They are more likely to be able to provide Employee Assistance Programmes (counselling and help with stepped return to work). However, most small to medium enterprises (SMEs) will lack such resources - in such cases, employees and employers lose out on the help that Employee Assistance Programmes (EAPs) can provide. In NI 62% of private sector employment is based in firms of less than 50 employees[82].

We therefore propose that funding is made available to SMEs in order to provide training and education on wellbeing and to assist employees through a guided stepped return to work. We would suggest that these initiatives are best delivered in collaboration with arms length agencies that have specific experience in this area, and can fulfil wider community objectives in tandem with encouraging healthy workforces, such as Business in The Community (BITC).



4.6 Training and Awareness

In order to ensure that the statutory, voluntary and community sector are equipped with the required skills to deliver the strategic action points of a future mental health and wellbeing strategy, a range of adequate and ideally, accredited training must be available and accessible. An extensive two year review of training and awareness initiatives was commissioned by the DHSSPS and is currently being carried out by the Health Promotion Agency (HPA). It is near completion and will provide a full and comprehensive picture of the training under way, the availability of training for specific target groups, and the apparent gaps in training provision. The training elements of a new strategy ought to reflect the recommendations in the final report produced by the HPA.

A range or suite of training provision should encompass training packages for raising awareness among the general public and should also provide for specialised training for those working with specific target and at risk groups, including but not exclusively young people, lesbian, gay, bisexual and transgender (LGBTs), black and minority ethnic (BMEs).

An equally high level of specialism is required to develop training packages designed for other professional groups such as general practitioners and nursing and support staff working with the prison population

We also recommend that provision of training be commissioned through independent, arms length agencies, such as those situated in the voluntary or private sector, including professional bodies that have knowledge and hands on experience within the specific fields of relevance to the training requirements.

4.7 Communities

There is a considerable level of community involvement in health and wellbeing promotion. The excellent work of the communities within the Protect Life strategy was noted. However, much more can be done to strengthen community engagement and the role of communities in delivering the wellbeing agenda. For example, evidence gathered from our review of the strategies suggests that substantial and high quality work is delivered by the voluntary sector in NI but many such projects commonly lack an evidence base to substantiate their work. In addition, other community-based resources such as schools and churches are under-utilised. Faith-based organisations (FBOs) are central to many of the communities in NI providing material and spiritual welfare. They offer considerable opportunities for building social capital and supporting community wellbeing.

We propose that community groups and voluntary sector organisations commissioned to undertake work in the field of mental health promotion must first demonstrate that an evaluation plan is central to their proposals.

Commissioning organisations should strongly encourage applications that can demonstrate inter-community engagement; for example, programmes that involve older people and where possible and appropriate include representation from BME communities. Additionally, where possible cross-community initiatives should be encouraged in NI.

We recommend that government agencies seek to build collaboration with FBOs. To this end, research should be commissioned to explore the capacity of, and potential for, FBO collaboration on the wellbeing agenda and partnerships with the public sector.

Social exclusion not only impacts on an individual's sense of wellbeing and mental health but it also impedes recovery following a 'breakdown' - whether this is called depression, stress-related illness or schizophrenia. People diagnosed or suffering with a mental illness or learning difficulties often face their own internal struggle to 'get back into the world' but their difficulties are compounded by the negative attitudes and behaviour of others[83]. However, there is little evidence that such attitudes and behaviours are altered by anti-stigma campaigns. Rather, it is through direct contact

and personal knowledge of the individual and this can be achieved in the settings and services in which we all participate and use - schools, community, work, transport, housing and leisure.

Education, training and employment are key activities in building self-esteem and social contact. We recommend research into the education and training opportunities for people with mental health problems and those with learning difficulties.

We recommend greater access to psychological therapies such as counselling and cognitive behavioural therapy (CBT) for people with mental health problems in order to help build self-esteem and resilience.

Recovery based approaches for people with mental health problems should be developed by statutory and voluntary sector providers. Given that the Department of Health is aiming for complete community provision by 2011, the voluntary sector must begin to address provision now.

Social inclusion should be included as an important outcome of health and social care provision in its own right. Commissioners of services should begin to explore this issue with service providers.

4.8 Prison Service

The government structure for providing health services to the NI prison population has recently been changed. Responsibility for upholding the rights of prison populations to access to equal healthcare services now falls within the remit of the DHSSPS. NI does not have a dedicated high security hospital to provide services for prisoners who have severe and enduring mental illness. There is a 34 place medium secure unit that can accept prisoners with a mental illness and a 16 place low secure unit for people with a learning disability. High secure facilities for mentally disordered Northern Ireland offenders are provided, without charge, in Scotland at the State Hospital, Carstairs. Due to legal restraints, remand prisoners requiring conditions of high security currently must remain in prison until convicted. Where alternative private placements are required, these people are relocated across the UK at a cost of approximately £300,000[30] per year to the tax payer, but inevitably many remain incarcerated in inappropriate settings. Furthermore, there is evidence that it would be far more effective to refer many of these individuals to mental health support in the community[84]. However, again the step down facilities in NI which need to be provided across a spectrum of security levels, aiming towards safer community after care, requires significant investment.

Prison Service leadership should be included in all elements of the work of the DHSSPS, particularly mental health promotion and suicide prevention. To promote the holistic ethos and approach, prison leadership should be included in strategic meetings in the same way as commissioners, deliverers, educators and employers in industry are encouraged to have input.

4.9
Research

In order to address the considerable evidence gap in Northern Ireland and to underpin the development of policy and practice we encourage additional support for research. Given the current financial barriers this might be supported and sustained by government through the establishment of dedicated academic posts, fellowships and research grants with appropriate universities and arms length agencies.

The research might include the following areas:

- The development and testing of measures of wellbeing, life satisfaction and social capital
- The development of an observatory of mental health and wellbeing outcomes
- Evaluation of settings and population-based interventions to promote wellbeing
- Wellbeing and Young People in a post-conflict society
- Evidence on the pathways to care for young people and their carers
- Individual and social determinants of resilience and wellbeing
- Understanding of social exclusion processes and the use of recovery models of mental illness
- Examination of Business and workplace models in the promotion of wellbeing and early return to work
- Understanding community development and how it can be better utilised in mental health promotion
- Examination of existing resources in the community and their potential for expanding social capital and health promotion

4.10
Evaluation

Wellbeing and mental health promotion is still developing and requires a degree of flexible supervision. While we can draw upon the many useful programmes and interventions that have proved successful elsewhere there is still a need to examine their effectiveness and acceptability in the context of Northern Ireland.

To establish whether a mental health promotion strategy has been successful or not, it is essential that the aims, objectives and expected outcomes from the intervention are clearly set out at the beginning of the project

We recommend that all data concerned with the project is carefully collected and stored. This will include information on the resources required for the intervention, including staff and buildings, but more importantly perhaps, it should also record the impact of the intervention on the recipients

We propose that community groups are provided with the necessary knowledge and skills for objective evaluation and research. In-house research may not be possible for every group. Therefore, funding should be set aside on a competitive basis to provide new and existing community groups and voluntary organisations an understanding of the importance and the essentials of evaluation. University courses on evaluation and research should be made more accessible to community and voluntary organisations - this could be through improved access to, or the extension of current programmes such as The Science Shop

All programmes funded (or part-funded) through the public purse should be recorded centrally to facilitate transparency, opportunities for learning and continuity of provision. A regularly updated, easily accessible, standardised public database would be ideal for this purpose. Standardised commissioning processes could be developed for NI with associated reporting conventions to ease the burden of administration for all organisations and to reduce duplication of effort.

4.11 Measurement of Wellbeing and Other Population-based Indicators.

Measuring mental health from a positive perspective would be a significant development from the traditional measurement of negative mental health or mental illness. Current measures of mental illness, while generally useful, are not relevant to understanding and improving the wellbeing of the population. The measurement of wellbeing is still in the early stages of development. There is a need for measures of wellbeing that are appropriate and acceptable in NI.

The Department of Health are building on research commissioned by NHS Health Scotland to develop and test the suitability of a measure of positive mental health at population level. The new measure developed through this research is the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), which asks respondents to score how often a set of 14 positive statements of mental wellbeing applies to them.

WEMWBS covers most aspects of positive mental health currently in the academic literature, including both 'hedonic' and 'eudaemonic' perspectives: positive affect (feelings of optimism, cheerfulness, and relaxation), satisfying interpersonal relationships and positive functioning (energy, clear thinking, self acceptance, personal development, mastery and autonomy). Items are summed to give an overall score that can be presented as a mean score or graphically. Currently, the scale is being adapted for use with younger populations.

Although the scale is designed primarily for large population surveys, as described above, it may be used in other, smaller, community populations such as workforce groups or to examine differences between communities. It is not designed for use among users of psychiatric services. Many other such scales exist which include levels of health and social functioning.*

The WEMWBS should be considered for piloting and possible adoption in Northern Ireland, in addition to other measures of life satisfaction and in conjunction with measures of social capital.

NI, possibly through the establishment of a centre for Mental Health and Wellbeing, should coordinate with other countries and collaborate in the development of new measures.

** Increasingly, sustainable development (SD) indicators are being used at local level, too. For example, in 2000, the UK Audit Commission issued a handbook offering ideas for measuring sustainable development and quality of life in local communities (available at www.sustainable-development.gov.uk/indicators/local/)*

4.12 Implementation of strategy

Important insights have been gained through the production of this report in strong collaboration with senior representatives from the DHSSPS, our Strategic Development Group, the professionals working across the country and the external input from experts in the field. Many have related to the need for improved communication, authority and accountability. Currently there exists a significant range of interdepartmental groups and parliamentary committees with an interest in mental health and mental health promotion. While this sends a strong signal about the importance of this issue among our political leaders, paradoxically, it also suggests that implementation of mental health promotion may be undermined by the absence of clear and coherent direction and authority. Additionally, while a new strategy will provide guidance and recommendations for a mental health and wellbeing 'roadmap' we propose that these do not become rigidly dogmatic. In this section we propose a number of important steps that could improve these shortcomings and ensure that implementation structures provide the best possible chance of successful results.

Mental health is important for all aspects of human activity and is therefore, important to all sectors of government. Much of the necessary activities proposed within a wellbeing promotion framework must not be assumed to be the responsibility of the Department of Health. To do so would acutely diminish any likelihood of success. That said, cross-sectoral collaboration has proved elusive to previous administrations. Therefore, there is a need to seek commitment for a new wellbeing strategy within the Northern Ireland Executive in order to build creative and collective agreement across departmental leadership.

Dialogue and recognition about the importance of wellbeing must begin among those who are in the most senior positions of public administration in Northern Ireland. It also requires the early and sustained consultation and collaboration with agencies and people on the ground - the community groups and voluntary sector organisations, who are so vital to making it happen.

We have strongly highlighted the need for greater evaluation and reporting of outcomes among the community and voluntary sectors, it is thus incumbent upon government to monitor and assess the systems and processes for delivering the strategy at national level.

Much of the necessary actions proposed within a wellbeing promotion framework must not be assumed to be the responsibility of the Department of Health. Therefore, there is a need to seek commitment for a new wellbeing strategy within the Northern Ireland Executive in order to build creative and collective agreement across department leadership.

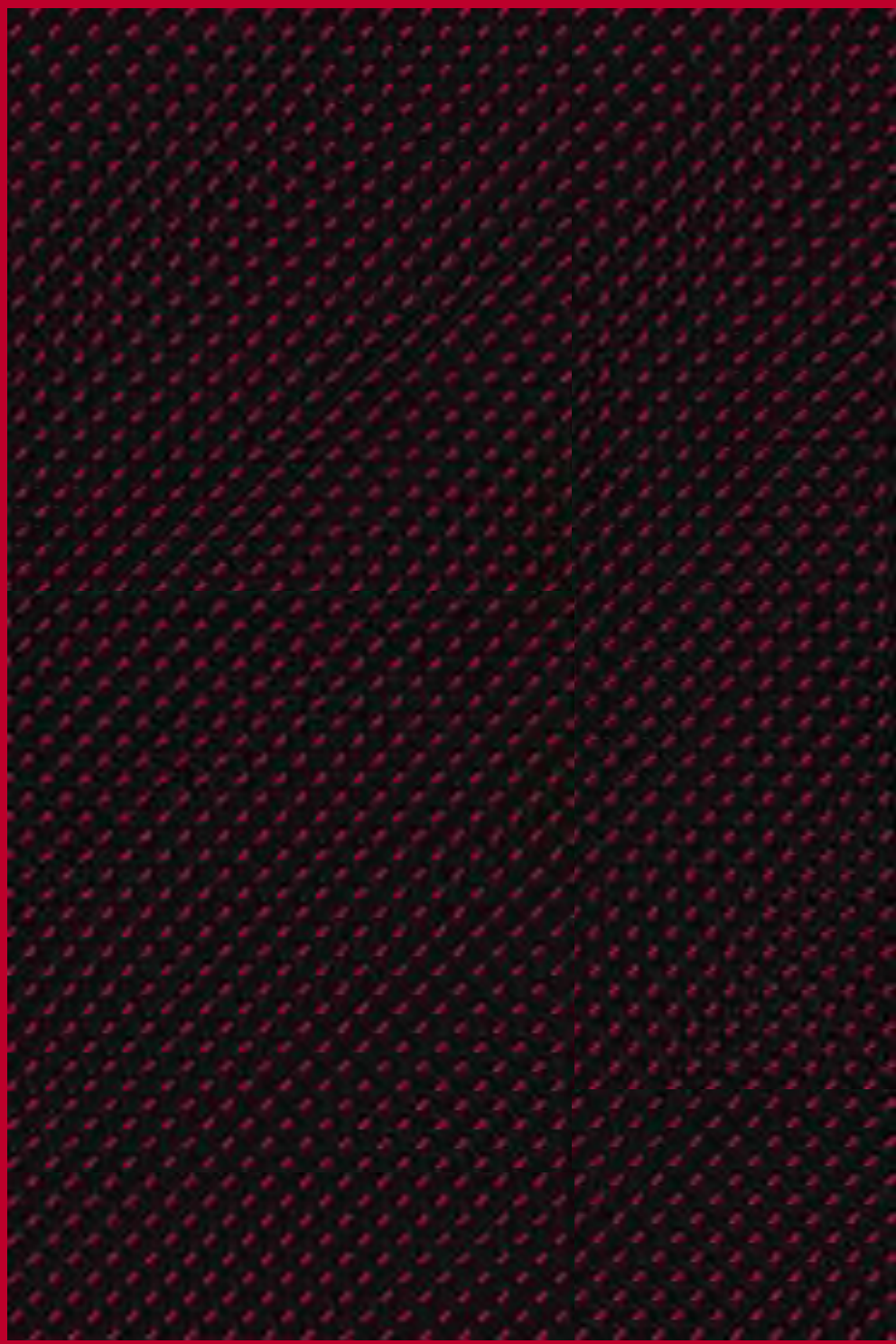
We recommend that government establish systems to monitor and assess the framework and processes for delivering the strategy at national level.

Learning from the implementation of Protect Life we recommend that a dedicated steering group, involving all the key stakeholders, should be established in order to drive forward the delivery of the new mental health and wellbeing strategy. It seems obvious that the new Public Health Agency should have a lead role in the co-ordination of such a steering group.

There needs to be a rigorous consideration as to how the strategy should best fit with the current mechanisms for delivering the Programme For Government (PFG). Key mental health promotion objectives could be included in at least two Public Service Agreements. In addition, each government department could incorporate aspects of the strategy within their annual planning programmes (ie. in DHSSPS, referred to as Priority for Actions or PFAs).

The Regional Health and Social Care Board (RHSCB) in conjunction with the Public Health Agency (PHA) should include mental wellbeing as one of their core priorities.

1: Living and Wellbeing
2: Review of the Current Strategies
3: Review of Effective Interventions
4: Recommendations for a New Strategy



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Appenidx 1

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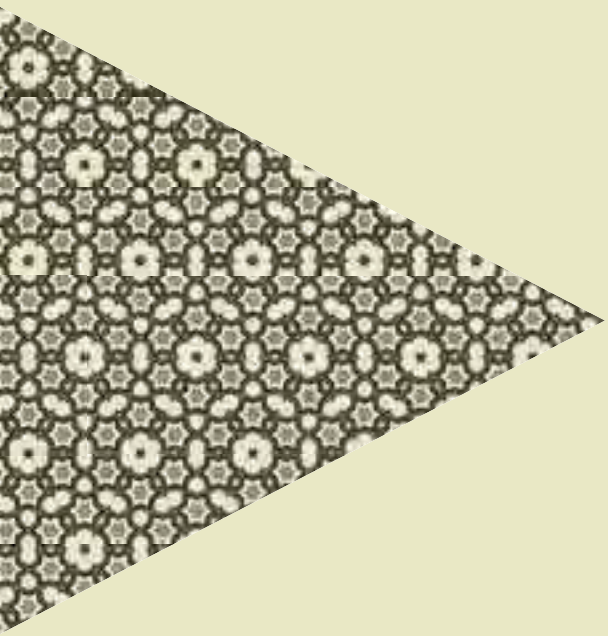

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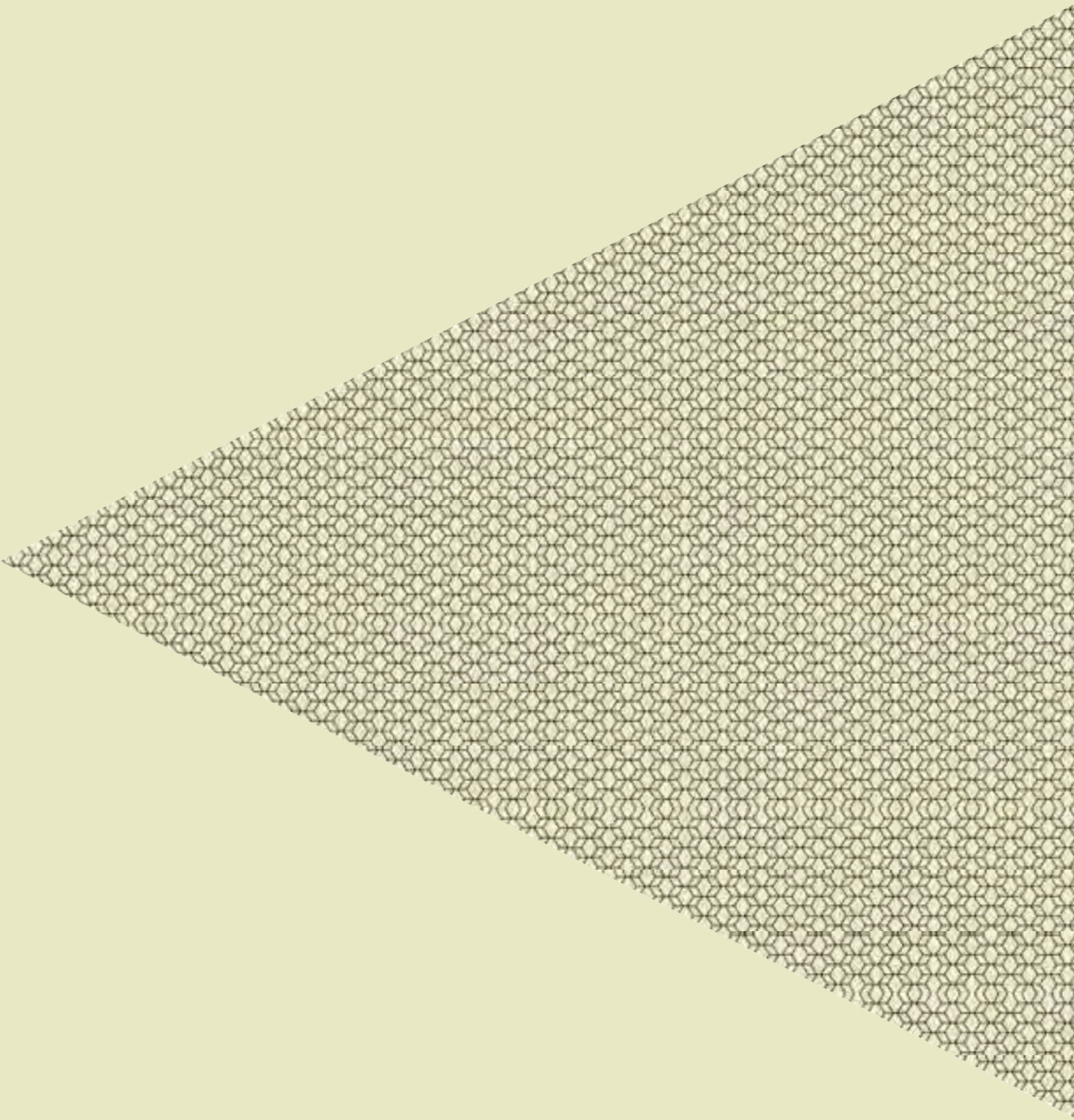


Appenidx 2

Mental Health Promotion 1981-2009:

International Strategic Documents

Policy Document and Implementing Body	*Year*	*Description*
World Health Organisation		
Health for all by the year 2000	1981	**U**nderpinned by the principles of equity, empowerment, participation, emphasis on primary, and multidisciplinary interagency working. Nine targets with implications for mental health promotion with a lifespan approach, including people with disabilities, mental disorders and suicidal ideation.
The World Health Report 2001. Mental Health: New Understanding, New Hope	2001	Focused on prevention recommending interventions in three areas: interventions targeting factors determining or maintaining ill-health, Interventions targeting population groups, and interventions targeting particular settings.
Promoting Mental Health. Concepts. Emerging Evidence. Practice	2004	Population health approach including health determinants and settings. Links between physical and mental health established. Highlighted the importance of multisectoral partnerships, collaboration and evidence-based practice. "Mental health is everybody's business."
World Federation of Mental Health		
Declaration of human rights and mental health	1989	Article 1 refers to mental health promotion as the 'responsibility of governmental and non-governmental authorities, as well as the intergovernmental system, especially in times of crisis'
Manifesto (European Regional Council)	1991	"Commitment to user involvement and to viewing mental health in a social context."
Europe		
First WHO Ministerial Conference. Mental Health Declaration and Action Plan for Europe: Facing the Challenges, Building Solutions (Helsinki Declaration)	2005	Mental health declaration for Europe signed by Ministers for Health of the 52 member states of the WHO's European Region who also endorsed the European Action Plan for Europe. A framework for action was established acknowledging that mental health and mental well-being is fundamental to the quality of life and productivity of individuals, families, communities and nations.
Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union (WHO's Ministerial European Conference)	2005	Green paper that emphasises "the importance of mental health for Europe and the need to develop a strategy at EU level."

Policy Document and Implementing Body	*Year*	*Description*
Europe Continued		
Mental Health Promotion and Mental Disorder Prevention. A policy for Europe	2005	A policy to propose the creation of a strategy with a strong emphasis on public health and a holistic approach to mental health underpinned by the principles of expansion of knowledge base, capacity building, involvement of different stakeholders, and evaluation of policy and programme impact. A structured consultation process through a series of conferences: Promotion and Prevention in Mental Health (Luxembourg, January 2006), Social Inclusion and Fundamental Rights in Mental Health (Vienna, March 2006), and Information Data and Knowledge in Mental Health (Luxembourg, May 2006).
EU High Level Conference - Together for Mental Health and Well-being	2008	The European Pact for Mental Health and Well-being is launched. The Pact states that "action for mental health and well-being at EU-level needs to be developed by involving the relevant policy makers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organisation". Four key themes emphasised: Prevention of depression and suicide; youth, education and mental health; mental health and older people; and mental health in the workplace. The theme of combating stigma and social exclusion, runs through all four.
European Parliament - Resolution on Mental Health (19 February)	2009	The Resolution ratifies mental health as a basic priority for action. The Parliament provides its own approach for actions and states a series of recommendations aimed at "combating stigma and social exclusion, strengthening preventive action and self-help and providing support and adequate treatment to people with mental health problems and to their families and carers". The parliament emphasises the importance of equal access to health, as well as to education, training and employment "in accordance with the principles of lifelong learning, in order to ensure that the persons concerned receive adequate support for their needs".

Policy Document and Implementing Body	*Year*	*Description*
USA		
US Department of Health and Human Services (1999) Mental Health: A Report of the Surgeon General.	1999	Recognises the inherent relationship between mental and physical health and well-being and that mental health and mental illness are important concerns throughout the lifespan. The Nation urges all stakeholders - communities, health and social services agencies, policy makers and citizens - to take action. To date, the United States has developed neither a national mental health policy nor a national mental health promotion and mental illness prevention policy. There are however, many initiatives in place that contribute to positive mental health, and also that address substance abuse and addictions.
Canada		
Mental Health for Canadians: Striking the Balance (Health Canada) - Framework for Support (Canadian Mental Health Association)	1988 & 1992	Seminal documents concerning mental health policy at federal level.
Out of the Shadows at Last - Transforming Mental Health, Mental Illness and Addiction Services in Canada.	2006	First ever national study of mental health, mental illness and addictions. Carried out by the Standing Senate Committee on Social Affairs, Science and Technology. Key mental health issues were considered. Ten priority areas were identified, among them the creation of a mental health commission.
Mental Health Commission of Canada	2007	Established by the Canadian government to provide a national focal point for mental health issues in response to the Senate Committee's report (see above). Priorities of the Commission were to: develop a national strategy, reduce the stigma associated with mental illness, and build a knowledge exchange centre to support the sharing of information and ideas.
Toward Flourishing for All. Mental Health Promotion and Mental Illness Prevention. Policy Background Paper	2008	Paper prepared by the Mental Health Promotion Think Tank to examine other countries' experiences in order to inform deliberations about what national- and provincial-level mental health promotion and mental illness prevention policies and plans might look like in the Canadian context. These deliberations took place in November 2008 at a national Mental Health Promotion Think Tank in Calgary, Alberta.

Policy Document and Implementing Body	*Year*	*Description*
Canada Continued		
Toward Flourishing for All. National Mental Health Promotion and Mental Illness Prevention. Policy for Canadians	2008	States eight key recommendations for a comprehensive mental health policy for Canada: "vision for a comprehensive mental health policy, a clear single point of accountability and sustained leadership, involvement of multiple sectors and stakeholders, provincial/territorial role, a common understanding, building on strengths, a strong research, knowledge and data base, an effective, wellness-based mental health system of services and supports that spans the continuum from prevention to early intervention to care and support".
UK-England		
National Service Framework (NSF) for Mental Health. Modern Standards and Service Models	1999	Focuses on mental health needs of working age adults up to 65. Developed with advice of an external reference group (health and social care professionals, service users and carers, health and social services managers, partner agencies, and other advocates). Standard One focuses on mental health promotion.
National Institute Mental Health England (NIMHE)	1999	NIMHE created to oversee implementation of the National Service Framework.
National Suicide Prevention Strategy for England	2002	Goal 2 is to 'promote mental health and well-being in the wider population"; suicide prevention is part of the wider public health and mental health promotion agenda.
Choosing Health: Making Healthy Choices Easier	2004	Mental health as a priority with a focus on improving the mental health and emotional well-being of the population.
Making it Possible: Improving Mental Health and Well-being in England	2005	Document supports Standard One of the National Service Framework for Mental Health. Priorities for action are set and linked to other policy priorities (e. g. education, regeneration and employment, National Srvice Framework Children and Older People). Identifies key mechanisms for delivery of Mental Health Promotion and measuring success.

Policy Document and Implementing Body	*Year*	*Description*
UK-Scotland		
National Programme for Mental Health and Well-being Action Plan 2003-2006	2002	Addressed the need for an integrated approach to government policies that included promotion of positive mental health, prevention of illness and suicide, and improvement of the quality of life and social inclusion for those experiencing mental illness.
Closing the Opportunity Gap	2004	Detailed objectives and 10 targets for addressing poverty, disadvantage, and health inequalities.
Being Well - Doing Well	2004	Framework for health promoting schools in Scotland. Document developed by the Scottish Health Promoting Schools Unit which is cross referenced to other relevant strategies/policies.
Equal Minds: Addressing Mental Health Inequalities in Scotland	2005	The Scottish Development Centre for Mental Health had in depth discussion of issues of health inequalities and mental health. This working document was produced.
Towards a Mentally Flourishing Scotland. The Future of Mental Health Improvement in Scotland 2008-2011	2007	The Scottish Government published this discussion paper which is intended to build on the National Programme. This paper has been described as; "part of the Government's wider strategy for improving the health and well-being of the people in Scotland". It focuses on promoting positive or flourishing mental well-being applied to themes of promotion, prevention and support; and recovery for people who experience mental health illness. Consultation process took place in 2007-2008.
Choose Life - A National Strategy and Action Plan to Prevent Suicide in Scotland	2002	The National Programme established Choose Life as a vehicle to tackle the then rising suicide rate in Scotland. Choose Life combines a broader population health and community development approach with a focus on vulnerable high-risk groups identified as: children (especially Looked After Children or LAC), young people (especially young men), people with mental health problems (particularly service users and people with severe mental illness); people who attempt suicide, people affected by the aftermath of suicidal behaviour, people who abuse substances, people in prison, people who are recently bereaved, people who have recently lost employment or who have been unemployed for a long period of time, people in isolated or rural communities; and people who are homeless.

Policy Document and Implementing Body	*Year*	*Description*
Republic of Ireland		
A Vision for Change. Report of the Expert Group on Mental Health Policy	2006	A Vision for Change adopts an holistic view of mental illness and proposes an integrated, multidisciplinary approach to address the biological, psychological and social factors which contribute to mental health problems. Four key recommendations related to mental health promotion and mental illness prevention: mental health promotion programmes should be incorporated into all levels of mental health and health services, a framework for interdepartmental co-operation cross-cutting health and social policy, designated health promotion officers should have responsibility for mental health promotion, and training and education programmes should be put in place to develop capacity and expertise for evidence-based prevention and promotion.
Reach Out: A National Strategy for Action on Suicide Prevention	2005	The strategy is action focused with a population and targeted approach with the aims to promote positive mental health and well-being and bring about positive attitude change towards mental health, problem solving and coping in the general population; and to reduce the risk of suicidal behaviour among high risk groups and vulnerable people.
UK-Northern Ireland		
Priority No 2 of the Northern Ireland Executive, Working for a Healthier People	2002	The objective of this priority was to "work to improve the health of all our people and reduce health inequalities."
Investing for Health	2002	The strategy was committed to ensure equality of opportunity and tackle social disadvantage and aimed to "initiate a dynamic, long-term process (on going) of improvement to bring our health standards up to those of the best regions in Europe". Chapter 9 of the strategy is devoted to mental health and emotional well-being and was the prelude to the January 2003 Promoting Mental Health Strategy and Action Plan 2003-2008.

Policy Document and Implementing Body	*Year*	*Description*
UK-Northern Ireland Continued		
Promoting Mental Health: Strategy and Action Plan 2003-2008.	2003	The Strategy was created under the umbrella of Investing for Health and contains four overarching aims: Improvement of people's mental health and emotional well-being, prevention and reduction of mental illness and suicide; awareness raising of the determinants of mental and emotional health, and training of those with a contribution to make. Population and targeted approach.
Protect Life: A Shared Vision. The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011.	2006	Developed in response to concern about an increase in the number of suicides, particularly among young people, the Dept of Health established a taskforce in July 2005 to develop a separate suicide prevention strategy for NI. Suicide Prevention became included in the Dept's Public Service Agreement, in the Govt's "Priorities and Budget 2006-2008". The areas for action are presented in three sections; population approach, targeted approach and overarching actions.
Bamford Review of Mental Health and Learning Disabilities	2006	In October 2002 DHSSPS initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. Between June 2005 and August 2007 a total of 11 reports were published to form the complete Bamford Review. The Bamford Report; "Mental Health Improvement and Well-being - a Personal, Public and Political Issue" dealt with the promotion of mental health and wellbeing in the NI context.

Appenidx 3

Evidence-based Interventions

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
Triple P-Positive Parenting Programme, Australia (Child Trends 2004)	Home/Parents of pre-adolescent children from birth to 12 years of age	The Triple P-Positive Parenting Program (TP) is a behavioural family intervention designed to improve parenting skills and behaviours. Through changing how parents view and react to their children's behaviours, this programme is aimed at reducing child behaviour problems and teaching healthy parenting skills.	Family disharmony; successful parenting skills; problem-solving skills.	Reduced child behaviour problems and dysfunctional parenting styles; and increased parental competence.
Family Nurse Partnership (FNP). Replicated in England from the Nurse Family Partnership Home Visiting programme (NFP) set up by Prof David Olds at the University of Colorado (Cabinet Office: 29)	Home/Mothers and infants (from pregnancy until the first two years of a child's life)	The FNP is a strength-orientated programme which is offered within the context of universal maternal and child health services. Specially trained nurses, drawn from health visiting and midwifery visit families regularly. Using a structured programme, they work towards a set of objectives. The programme taps into every parents instinctive desire to protect and do the best for their child, which is particularly strong in pregnancy and around the birth of the baby.	Positive parenting; behavioural change; isolation and alienation; self-esteem; supportive family relationships; opportunities to develop social coping skills; coping strategies.	Promotion of supportive family relationships; positive parenting; building up social support and community network.
Mellow Parenting, Scotland, (Hallam 2008)	Community/ Parents, Infants and Young Children	Mellow Parenting is a 14 week, one day a week group programme, designed to support families with relationship problems with their infants and young children. The Mellow Parenting programme has been developed and applied in deprived populations in Scotland. It combines personal support for parents with direct work with parents and children on their own parenting problems, and has proved effective in recruiting and engaging hard-to-reach families with a variety of severe problems, particularly behavioural problems compounded by family difficulties such as parental mental illness, social isolation, domestic violence, parental literacy problems. Mellow Parenting is, in part, a way of working rather than a tightly prescribed curriculum, and variants of the programme have been devised to meet varying needs (e.g. Mellow Fathers, Parenting in Prison, Mellow Babies for Infants at Risk).	Deprivation; disengagement; social isolation; behavioural problems; low education level; positive parent-child interaction; positive relationships; positive child behaviour and development.	Engaging families and helping them make changes in their relationships; lasting gains in maternal well being, parent-child interaction, and child behaviour and child development.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
The Marlborough Family Service, England, (Cabinet Office: 30)	Home/Families/ Schools	The Service is part of Central and North West London NHS Foundation Trust. It offers multi cultural and multi lingual staff as well as a family day unit where families work in groups to recreate everyday issues enabling them to discover new solutions to problematic family patterns decide on responses to different scenarios and build up positive relationships and coping mechanisms. Each family also has a key worker who works with them individually and co-ordinates their programme of support. The programme is designed to tackle blocks to learning by focusing on repeating cycles of disruptive, worrying and/or anti social behaviour. To monitor progress each child has measurable targets which are rated daily by the parents, child's teachers and the child themselves. Services for children and their families are also available in their mainstream primary and secondary schools and training and skills exchange is provided for teachers and parents.	Family disharmony; violence in the home; family relationships; extended family; empowerment; Negotiation skills; problem-solving skills; positive interpersonal interaction.	Development of resilience and family cohesion; positive strategies to tackle problems.
USA-STEEP Programme (Steps Towards Effective Enjoyable Parenting), USA (WHO 2004)	Home/First-time mothers and others with parenting problems	The aim of the programme is to enhance the quality of interactions between mother and child from infancy in order to improve the emotional, social, cognitive and physical development of children, particularly in families where mothers are faced with stress and social adversity.	Low educational level; poverty; positive interpersonal interaction; opportunities to develop social coping skills.	Reduced anxiety and depression; better organised family life; and more stimulating environments for children.
Extended Schools, England (Cabinet Office: 35)	School/Early Years	The Blue Gate Fields Infant School located in a socio-economic disadvantaged area has developed a range of initiatives to encourage parents to support their children's development in the early years. Nearly all the families have English as a second language. A 12-week programme show parents how to play games with their children and how to use English words in their play.	Poverty; unemployment; isolation; positive parenting skills; family relationships; empowerment.	Development of parenting skills; increased sense of responsibility; social and community network; development of language skills.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
The Incredible Years Programme, USA (Hallam 2008)	School/Parents, Teachers, Children	Developed in the 1980s by Carolyn Webster-Stratton. The programme consists of a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in young children (ages 1-10 years). The interventions that make up this series – parent training, teacher training, and child training – are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problems. The overall goal of the Incredible Years series is to prevent children from developing delinquency, drug abuse, and violence problems as they enter adolescence.	Social competence; conduct problems; drug abuse; violence; delinquency; positive parenting; problem-solving; social competence.	Enhanced parenting skills and parental self-confidence. Teachers outcomes: increased peer- and teacher-child interaction, bonding with parents, and proactive classroom management strategies. Children positive outcomes: increased use of appropriate cognitive problem-solving strategies and more pro-social conflict management strategies with peers; enhanced social competence reduction in conduct problems at home as well as in school.
The Carolina Abecederian Project, USA (US Department of Health and Human Services: 1999)	Sector/System and Home/High-risk Children (enrolled at birth and remaining for several years)	Children identified at birth as being at high-risk for school failure on the basis of social and economic variables are enrolled in a child-centred prevention-oriented intervention programme delivered in a day care setting from infancy to age 5 (8 hours a day for 50 weeks a year). The intervention includes an infant curriculum to enhance development and parent activities. At pre-school age, a second intervention is provided: the children receive 15 home visits a year for 3 years from a teacher who has prepared a home programme to supplement the school's basic curriculum.	Neglect in childhood; low birth weight; infant abuse; attachment; positive parenting skills; coping strategies.	Improved mothers' mental health; increased home visiting and parenting skills; improved quality of life of infant; reduced rates of infant abuse; improved infant/care giver attachment; increased intellectual development and academic achievement.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
The UK Resiliency Programme, (The Young Foundation Website)	School Children	The UK Resiliency Programme is an evidence-based positive psychology programme developed by Dr Martin Seligman at Pennsylvania University. It is being implemented for its first time in the UK and it will be rigorously evaluated with support from Department for Education and Skills (DfES). The aim of the programme is to help children become more emotionally resilient; to prevent depression and improve emotional health, supporting children's learning and achievement. Three local authorities in England are involved in this trial. Twenty-one schools and over 3000 children will be taking part in this initiative, which is planned to last for three years. This includes six schools in South Tyneside, nine schools in Manchester and six schools in Hertfordshire. The initiative is delivered through one hour sessions (within the existing PHSE timetable). The curriculum, which has been adapted from the US originally, is designed to build resilience, prevent depression and anxiety, promote adaptive coping skills, and teach effective social problem-solving. Prior pilots (US, Australia, China) have been shown to reduce (moderate to severe) depression in (at-risk) children by as much as 50% and to reduce symptoms of bad behaviour (from 9% to 5%). The London School of Economics and Political Science has been commissioned to evaluate the programme in the UK and its first report is due in January 2009.	Emotional resilience; emotional health; learning; prevention of depression.	Reduced depression (severe to moderate, by as much as 50%); reduced symptoms of bad behaviour (from 9% to 5%)
The Child Health Promotion Programme, England (DH 2008)	Sector/System, Schools and Home	The new updated Child Health Promotion Programme (CHPP) builds on the children's National Service Framework and is intended to provide preventative services tailored to the individual needs of children and families, acting as a best practice guide for children's services. The aims of the programme include a major emphasis on parenting support and integrated services, an increased focus on vulnerable children and families underpinned by a model of progressive universalism.	Positive parenting; strong couple relationships; supportive caring parents; presence of male role model (father); self-esteem; experiencing rejection; lack of warmth and affection.	Improved general health and well-being among children and families in the community.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
The PATHS curriculum (Promoting Alternative Thinking Strategies), USA, replicated in England (Dept. for Education and Skills 2001: 45)	Primary and Secondary Schools/Families and all children	The PATHs curriculum is an American programme designed to promote emotional and social competencies and reduce aggression and behaviour problems in school children. It is a universal, school-based intervention implemented by teachers to whole classes. The generalisation of skills learnt in the classroom to children's everyday lives is a major component in each unit. Curriculum units include self-control, emotional understanding, positive self-esteem, relationships and interpersonal problem-solving skills. There have been four clinical trials of PATHS. Two have involved special needs students and two have involved 'mainstream' children.	Positive interpersonal interaction, social skills; low self-esteem; academic achievement; positive school climate; prosocial peer group; conduct or behaviour disorders.	Enhanced social cognitions and social and emotional competencies; reduced aggression and depression; improved cognitive skills.
Interpersonal Cognitive Problem-solving Programme, USA (Dept. for Education and Skills 2001: 46-47)	Pre-school and Primary School Children	The class teacher implements the ICPS Programme with small groups of children. The programme begins by teaching children fundamental skills related to learning, thinking and listening and progressing to practising more complex interpersonal problem-solving through dialogues and role-playing. The ICPS has been implemented in a number of schools through the US.	Impulsivity; conflict resolution; problem-solving skills	Improved cognitive problem-solving abilities; reduced inhibition and impulsivity in children.
Hexthorpe Primary School - Doncaster, England (Dept. for Education and Skills 2001: 49-50)	Primary School Children	Hexthorpe Primary School is located in a multiethnic, mainly working class area of high unemployment, and caters for over 400 pupils aged between 4 to 11. In the school, an increasing number of pupils with emotional and behavioural problems seemed to be struggling to cope with confusion in their personal lives. This manifests itself in low self-esteem, an inability to develop positive relationships with peers and feelings about being 'picked on' by those with whom they come into contact. The school developed an integrated whole school policy based on a multi-agency approach in order to respond more effectively to the needs of these pupils. This combined circle time approaches, circle of friends, the setting up of play therapy/ nurture groups and a programme aimed at the development of parenting skills.	Positive interpersonal interaction; successful social skills; positive parenting skills; low self-esteem.	Improved co-operative and supportive relationships between pupils, parents and staff; promotion of inclusion.

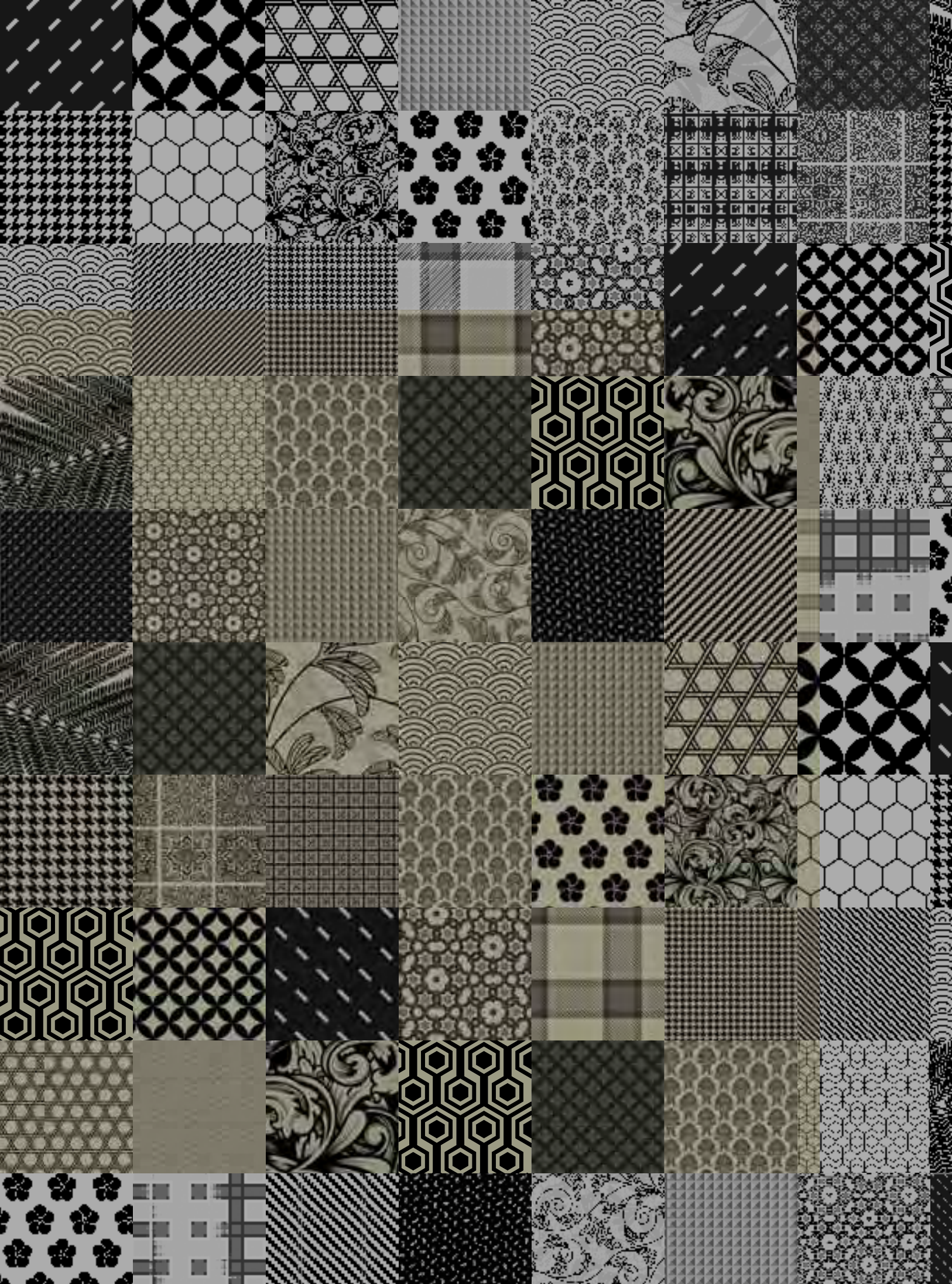
Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
Seattle Social Development Project, USA (Dept. for Education and Skills 2001: 45)	School/Families and Children	Comprehensive universal prevention programme that addresses multiple risk and protective factors within the child, school and family. The programme has a strong emphasis on creating and maintaining a strong school and family bond. It combines helping teachers to manage the behaviour of children within the class and training for parents in children's behaviour through a six-year intervention period. Teachers are trained in proactive classroom management, interactive teaching and co-operative learning. These teaching approaches are used in combination with: a) classroom-based cognitive and social skills training in the 1st grade (ICPS Curriculum/ Interpersonal Cognitive Problem-solving Programme) and in the 6th grade (refusal and life skills); b) parent training which emphasises child behaviour management in the 1st and 2nd grade, (academic support in the 2nd and 3rd grade), and c) preventing drug use and antisocial behaviour in the 5th and 6th grade.	Positive interpersonal interaction, social skills; low self-esteem; academic achievement; positive school climate; prosocial peer group; conduct or behaviour disorders.	Greater attachment to school; improved self-reporting achievement and less involvement in school misbehaviour.
Leicester, Leicestershire and Rutland Child Behaviour Intervention Initiative, England (Dept. for Education and Skills 2001: 50-52)	Pre-school and Primary School Children	The programme is heavily funded by the Health Child and Adolescent Mental Health Innovation grant and the Department for Education and Employment Standards Funding and Single Regeneration Budget. The initiative operates differently in each area. In Leicester the programme has set up three teams each of which works within an area that has been deemed to be a high priority by Social Services, Health and Education. Each of the three teams comprises a primary mental health worker, a senior family support worker, two family support workers and a senior practitioner educational psychologist. There is an additional family support worker who is working between two of the teams. One of the teams is located within a primary school where they do the following: a) carry out assessments of children's mental health	Mental health problems; social services and network support.	Provision of 'hands on' input and support for individual children and their parents often co-ordinated with interventions developed by the school; training, information and advice on children's mental health and emotional well-being.

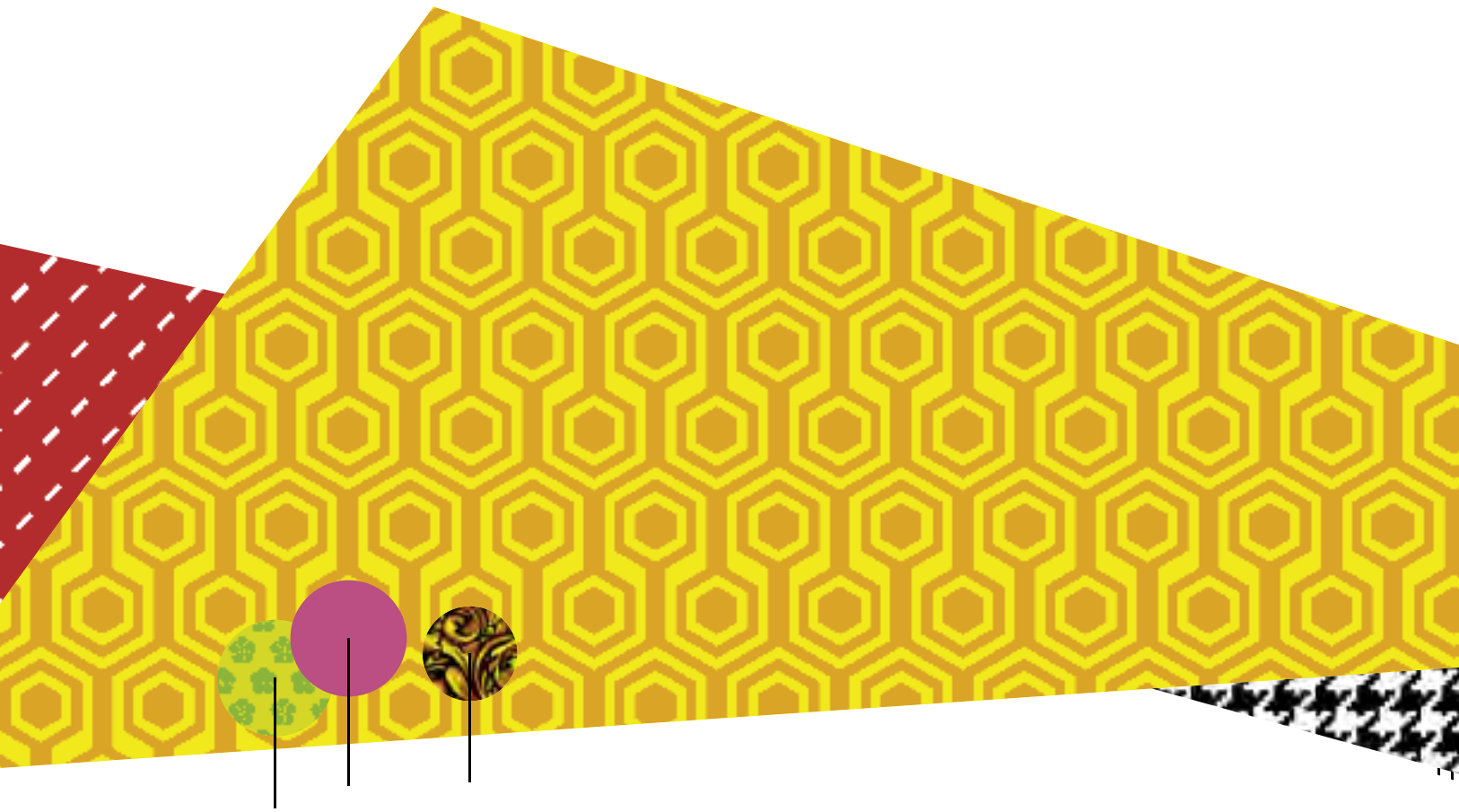
Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
		where they have been requested by parents; b) support schools in the early identification of children at risk of developing emotional and behavioural difficulties and develop programmes to promote psychological wellbeing; c) hold 'drop ins' in schools where parents can come and chat about any issue of child behavioural management with members of the team; d) run parent workshops in primary schools; and e) run social growth projects in schools at Key Stage 1 and emotional literacy at Key Stage 2.		
Excluded Children's Project - Rochdale, England (Dept. for Education and Skills 2001: 52-53)	Home-School/ Children under 12 at risk of experiencing school exclusion	The team is based within the Child and Adolescent Mental Health Services in Rochdale and comprises a team leader community psychiatric nurse, two social workers and an educational psychologist. The ethos of the team is to ensure that those children who have experienced an exclusion from school gain access to a multi-agency assessment of their needs so that an appropriate package of support is offered to them and their families. The project's main focus is to work with the child and family outside the school environment offering a range of behavioural and therapeutic interventions in order to help the child and family address their behaviour and underlying causes of such. In addition to this, the team works with the school, helping them further develop their skills and practices in relation to working with the excluded child. This two-pronged approach appears to have being extremely well received by the schools - and by the children and families.	Exclusion; Social services and support networks; Mental health problems.	Detailed multi-disciplinary assessment of the children's needs; reintegration of children in school enabling behaviourto settle and be managed; statementing issues addressed (educational psychologist); wider home issues affecting the children addressed (social work); undiagnosed mental health problems identified (health professionals); access to appropriate services (CAMHS team); management and support of pupils with complex needs (schools).

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
Nurse-led Project in Huddersfield, England (Dept. for Education and Skills 2001: 54)	School Children	With the help of the CAMHS team school nurses in Huddersfield have developed a method of screening the health needs of Year 9 pupils which prompt them to recognise specific emotional and psychological needs. On a voluntary basis, children complete a health questionnaire which covers general health information, alcohol and drug use, emotional and psychological well-being. In addition to filling in the questionnaire, each young person is offered an individual health interview with the school nurse, the basis of which is provided by the information obtained from the health questionnaire. Where difficulties are recognised the nurse will provide initial support for the young person, through basic counselling or where appropriate refer them on to the more specialist CAMHS team. This initiative allows the school to have the needs of the pupils profiled which in turn will inform its PHSE (Personal, Social and Health Education) curriculum and other support work that it undertakes.	Access to services; empowerment.	Increased skills and knowledge; enhanced support services; screening of health needs including emotional and psychological needs.
Peers Coping Skills Training, England (Dept. for Education and Skills 2001: 54)	School Children	In such projects, groups of young people who are coping well and young people experiencing behaviour problems are set up. Within the group, young people are taught pro-social coping skills in 22 weekly 50-minute sessions. The teams progress through different skills and levels of difficulty, with new skills being introduced when the group has demonstrated mastery over the previous skill. This format encourages and reinforces peer support.	Peer support; interpersonal interaction; self-esteem; resilience.	Reduced aggression; significant improvements in the young person's pro-social coping and teacher-rated social skills.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
Parenting Wisely, USA (Gordon 2003, Seagal 2003)	Community/ Parents, Children and Young People	Parenting Wisely is a self-administered, interactive, computer-based program that teaches parents important parenting and conflict management skills. The program is designed to enhance child adjustment and to reduce delinquency and substance abuse. It also seeks to improve problem-solving, parent-school communication, school attendance, and academic performance. Parenting Wisely was developed at Ohio University by Dr. Donald Gordon. The target group for this programme is low-income, at-risk families who have children ages 9 to 18 with mild to serious behaviour problems. Most of the targeted families are those who do not usually seek or complete mental health or parent education treatment for their children's problem behaviours. The programme has been widely disseminated in 45 five states of the US, it has also been used in 20 locations in England, 14 in the Republic of Ireland, 8 in Canada and 2 in Australia.	Poverty; poor parenting skills; delinquency; depression; substance abuse; behaviour problems; positive family functioning.	Reduced child problem behaviours; improved family functioning, reduced maternal depression, improved parent knowledge of positive skills and increased parent use of such skills; cost benefit based on effect ratios, compared with other parenting interventions.
Joint Working Between Jobcentre Plus and Children's Centre, England (Cabinet Office: 41)	Community/ Adults	Jobcentre Plus in a specific area of London has been working closely with Children's Centre to offer parents or a 'potential second earner' in the family, access to employment advice and support, including current vacancies and training opportunities, from within the Children's Centre. Local employers also attend the centre to approach prospective employees; this way they reach a population who otherwise do not come into contact with Jobcentre Plus.	Unemployment; low income; poverty; self-esteem; opportunities to employment.	Promoting job opportunities; increased self-esteem; increased education/skills.

Programme/ Policy	*Setting/ Target Group*	*Description/ Aims and Objectives*	*Mental Health Determinants*	*Outcomes*
The Experience Corps (USA)	Community and Schools/Older People, School Children	This programme was created in response to evidence that participation in voluntary activities can improve functioning and lengthen life, along with evidence that social support, social networks and social activity in general are independently protective of health. Experience Corps was developed as a means of providing social capital to support educational needs and improve the quality of future workforces in USA. Older volunteers are placed in public elementary schools in roles designed to meet schools' needs and increase the social, physical, and cognitive activity of the volunteers.	Social inclusion, isolation, supportive networks, learning; social capital, academic achievement, school behaviour.	Reported benefits in schools: better test scores, better behaviour, customer satisfaction. And amongst corps: better overall health, increased strength, higher activity levels, more calories burned, less TV time, bigger social network, participant satisfaction (80% participated for a second year).





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