Public Mental Health Briefing

Public Mental Health Special Interest Group

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EXECUTIVE SUMMARY

INTRODUCTION

The purpose of this document is to identify the specific contributions that Specialists in Public Health Medicine (SPHM) can make to Mental Health and Wellbeing in Ireland. This will be achieved by analysing the current WHO policy, Mental Health Action Plan 2013-2020, and considering the targets that Ireland should meet under that policy, examining the relevant skills SPHMs have, and the contribution and role envisioned by Consultants in Public Health in the UK, and identifying the priorities for the population through an examination of the epidemiology of mental health disorders and relevant health service data for Ireland.

BACKGROUND

Mental health is vital to public health; mental wellbeing is profoundly important to quality of life and the capacity to cope with life's ups and downs. Mental and physical health are inextricably linked. In Ireland; 87% of people with emotional, psychological, or mental health (EPMH) problems also have at least one other type of disability.

Mental wellbeing is a relatively new concept in public health. Public mental health is the art and science of improving mental health and wellbeing and preventing mental illness through the organised efforts and informed choices of society, organisations, public and private, communities and individuals. It is more than the absence of mental illness, and it seems likely that it is also more than the opposite end of a single continuum from mental illness or disorder as defined by psychiatric diagnosis.

GLOBAL MENTAL HEALTH ACTION PLAN

In May 2012, the Sixty-fifth World Health Assembly adopted a resolution on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.

In 2013, the WHO published a mental health action plan. This strategy is based on a life-course approach, aiming to achieve equity through universal health coverage. It stresses the importance of prevention and has a human rights perspective.

The WHO action plan relies on six cross-cutting principles, universal health coverage, human rights, evidence-based practice, a life course approach, a multi-sectoral approach and empowerment of persons with mental disorders and psychosocial disabilities. It identifies four priorities: (1)*to strengthen effective leadership and governance for mental health; (2)to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) to implement strategies for promotion and prevention in mental health; (4) and to strengthen information systems, evidence and research for mental health.*

RELEVANT PUBLIC HEALTH EXPERTISE

This includes the ability to contribute in the following areas: advocacy, epidemiology and health intelligence, health needs assessments, evidence based healthcare, research, health promotion and health education, strategic planning and management, effective governance, and effectiveness and outcome assessment. All of these skills are important in developing, monitoring and reviewing a mental health service.

THE ROLE OF SPECIALISTS/CONSULTANTS IN PUBLIC HEALTH IN THE UK

In 2015 Public Health England produced a Public Mental Health leadership and workforce development framework which aims to inform and influence the development of public health leadership and the workforce in relation to

mental health. Key competencies identified for Directors of Public Health and Consultants in Public Health are as follows;

- Integrate mental health within all policy and take action to mitigate any negative impacts of policy on mental health
- Promote the value of mental health and the reduction of inequalities across settings and agencies
- Advocate for mental health and addressing mental illness as central to reducing inequalities and creating thriving communities and economies
- Create organisations that nurture and sustain the mental health of employees
- Assess and describe the mental health and illness needs of specific populations and the inequities experienced by populations, communities and groups
- Translate findings about mental health and illness, and needs and assets, into appropriate recommendations for action, policy decisions and service commissioning/ delivery/ provision
- Influence political/ partnership decision making to maximize the application and use of evidence in achieving change
- Set strategic direction and vision for mental health and communicate it effectively to improve population health and wellbeing
- Advise strategic partners to determine priorities and outcomes to achieve improvements in quality and cost-effectiveness of treatments for mental illness and associated co-morbidities

THE PUBLIC HEALTH APPROACH

The Public Health approach emphasises prevention of ill health. Prevention can be divided into primary (health promotion and disease prevention), secondary (early detection), and tertiary (optimal treatment to prevent avoidable disability). Vision for Change has adopted an Australian model for mental health promotion that focuses on primary, secondary and tertiary prevention.

PRIMARY PREVENTION

SPHMs can provide a valuable support role in the area of mental health promotion by addressing the factors that act against good mental health. Public Health and Health Promotion can collaborate closely on the development of these health promotion initiatives. The World Health Organisation consider that mental health promotion works at three levels: strengthening individuals, strengthening communities, and reducing structural barriers to mental health.

SECONDARY PREVENTION

One of the most tragic outcomes of mental distress is suicide. If signs of this distress can be detected early, then timely interventions could take place. The vision of the Irish National Strategy for Action on Suicide Prevention is of a society where life is valued across all age groups, where the young learn from and are strengthened by the experiences of others, and where the needs of those who are going through hard times are met in a caring way so that mental illness is more widely recognised and understood, and those experiencing difficulties are offered the most effective and timely support possible.

TERTIARY PREVENTION

A person who is at risk of suicide may present to the mental health service prior to a suicide attempt. The key tasks to be carried out by the National Office of Suicide Prevention are:

- The development of ‘fast-track’ priority referral systems from primary care to community-based mental health services

- The development of an effective service response for people who have engaged in deliberate self-harm or who are acutely suicidal

EPIDEMIOLOGY

It is estimated that mental health disorders account for 14% of the global burden of disease. One in every four Irish people will experience a mental health problem during his or her lifetime, with depression in particular being a very common condition affecting 450,000 Irish people or one in ten persons at any one time. Experience of mental ill-health during adolescence in particular is a risk factor for future mental ill-health in young adulthood and beyond. Irish young adults currently have higher rates of mental health problems than similarly aged young people in other countries. There has also been an increase in both suicide and self-harm rates since the onset of the recession in 2007.

KEY POINTS

- One in every four people in Ireland will experience a mental health problem during his or her lifetime.
- In Ireland, estimates suggest that the overall economic cost of mental health problems is €3 billion per annum; only cardiovascular disease is likely to contribute more to the overall burden of illness.
- Irish young people have higher rates of mental disorders than similarly aged young people in other countries.
- Depression is a very common condition which affects more than 450,000 people in Ireland (one in ten) at any one time.
- The death rate for suicide amongst young people in Ireland has been higher than other countries. This rate has been falling in recent years.
- One in 20 persons aged over 50 years reported a doctor's diagnosis of depression, with a similar number reporting a diagnosis of anxiety.

PUBLIC HEALTH PRIORITIES FROM THE EPIDEMIOLOGY

- Suicide prevention: Current policies focus on suicide in young people, however the highest rates in Ireland are in middle aged men
- A life course approach with a strong focus on prevention, e.g. a focus on behavioural disorders, learning disability and autism in children, on deliberate self-harm, eating disorders, substance misuse, suicide, and affective and psychotic disorders in young people, on substance misuse, affective disorders and suicide in adults, and on affective disorders and dementia in older people.
- Improvement of health intelligence in relation to mental health, e.g. locality specific data for mental health to enable local prioritisation and increased public health research, development of core indicators for mental health and wellbeing (including risk factor/protective factor data), and investigation of outlier areas with regards to suicide and deliberate self-harm.
- Inequalities: minority groups, who may have more mental ill health and perhaps be unable to access services, e.g. Travellers, LGBT groups, and prisoner and ex offender populations.

PROPOSED PRIORITY AREAS

- Suicide (with a focus on risk groups e.g. middle aged men)
- Mental health needs of older persons with dementia
- Building resilience in children and young people
- Mental health and wellbeing strategy
- Health intelligence
- Inequalities in mental health

1. INTRODUCTION

The purpose of this document is to identify the specific contribution Specialists in Public Health Medicine (SPHM) can make to Public Mental Health and Wellbeing in Ireland.

This will be achieved by

- An analysis of the current WHO policy; Mental Health Action Plan 2013-2020 and targets that Ireland, as a member state, should meet.
- Examination of the relevant skills SPHMs have and the contribution and role envisioned by Consultants in Public Health in the UK.
- Identification of the priorities for the population through an examination of the epidemiology of mental health disorders and relevant health service data in Ireland.

2. BACKGROUND

Mental health is vital to public health; mental wellbeing is profoundly important to quality of life and the capacity to cope with life's ups and downs. It is protective against physical illness, social inequalities and unhealthy lifestyles. There are now a large number of evidence-based approaches to promoting mental wellbeing and preventing mental illness, and these are growing daily.

Mental and physical health are inextricably linked. Mental health problems have increasingly been shown to precede, and be important in the recovery from, physical health problems. Mental illness is associated with an increased risk of heart disease, cancer and psychosomatic problems like irritable bowel. In the reverse direction of causation, people with physical health problems, especially chronic diseases, are at increased risk of poor mental health, particularly depression and anxiety – around 30% of people with a long-term physical health condition also have a mental health problem. The unhealthy lifestyles and behaviours which plague the public's health – smoking, excess alcohol consumption, misuse of illicit drugs, consumption of, sugary foods and over-eating in general – are used because they are seen to be effective in managing stress.

Watson and Maitre found that 87% of people in Ireland with emotional, psychological, or mental health (EPMH) disability also have at least one other type of disability (Watson and Maitre 2014).

Mental health disorders are undertreated, internationally between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high income countries is also high: between 35% and 50%.

Mental wellbeing is a relatively new concept in public health. Public mental health is the art and science of improving mental health and wellbeing and preventing mental illness through the organised efforts and informed choices of society, organisations, public and private, communities and individuals (FPH 2014). It is more than the absence of mental illness, and it seems likely that it is also more than the opposite end of a single continuum from mental illness or disorder as defined by psychiatric diagnosis.

According to the WHO: "mental health and mental illness by and large are viewed as residing outside the public health tradition with its fundamental concepts of health and illness as multi-factorial in origin and of there being a continuum between health and illness. The consequences are twofold. First, the opportunities for improving mental health in a community are not fully exploited. Second, organized efforts in countries to reduce the social and economic burden of mental illnesses tend to depend mostly on the treatment of ill individuals" (WHO 2004a)

Because mental wellbeing is a relatively new concept, the evidence-base with regard to determinants, risk factors and solutions lags behind that related to mental illness. According to the WHO, the personal, social, and

environmental factors that determine mental health and mental illness may be clustered conceptually around three themes (WHO 2004a):

- The development and maintenance of healthy communities: This then provides a safe and secure environment, good housing, positive educational experiences, employment, good working conditions, and a supportive political infrastructure; minimises conflict and violence; allows self-determination and control of one's life; and provides community validation, social support, positive role models, and the basic needs of food, warmth, and shelter.
- Each person's ability to deal with the social world through skills like participating, tolerating diversity, and mutual responsibility: This is associated with positive experiences of early bonding, attachment, relationships, communication, and feelings of acceptance.
- Each person's ability to deal with thoughts and feelings, the management of life, and emotional resilience: This is associated with physical health, self-esteem, ability to manage conflict, and the ability to learn.

Table 1 depicts a range of evidence-based social, environmental and economic determinants of mental health that are discussed further in Prevention of Mental Disorders: Effective Interventions and Policy Options (WHO 2004b). Table 2 depicts a list of risk and protective factors for mental disorders from the same document.

Table 1 Social, environmental and economic determinants of mental health

Social, environmental and economic determinants of mental health	
Risk factors	**Protective factors**
• Access to drugs and alcohol • Displacement • Isolation and alienation • Lack of education, transport, housing • Neighbourhood disorganisation • Peer rejection • Poor social circumstances • Poor nutrition • Poverty • Racial injustice and discrimination • Social disadvantage • Urbanisation • Violence and delinquency • War • Work stress • Unemployment	• Empowerment • Ethnic minorities integration • Positive interpersonal interactions • Social participation • Social responsibility and tolerance • Social services • Social support and community networks

Table 2 Risk and protective factors for mental disorders

Risk and protective factors for mental disorders	
Risk factors	**Protective factors**
• Academic failure and scholastic demoralization Attention deficits • Caring for chronically ill or dementia patients • Child abuse and neglect • Chronic insomnia • Chronic pain • Communication deviance • Early pregnancies • Elder abuse • Emotional immaturity and dyscontrol • Excessive substance use • Exposure to aggression, violence and trauma • Family conflict or family disorganization • Loneliness • Low birth weight • Low social class • Medical illness • Neurochemical imbalance • Parental mental illness • Parental substance abuse • Perinatal complications • Personal loss – bereavement • Poor work skills and habits • Reading disabilities • Sensory disabilities or organic handicaps • Social incompetence • Stressful life events • Substance use during pregnancy	• Ability to cope with stress • Ability to face adversity • Adaptability • Autonomy • Early cognitive stimulation • Exercise • Feelings of security • Feelings of mastery and control • Good parenting • Literacy • Positive attachment and early bonding • Positive parent–child interaction • Problem-solving skills • Pro-social behaviour • Self-esteem • Skills for life • Social and conflict management skills • Socio emotional growth • Stress management • Social support of family and friends

Positive psychology is a new approach to mental health which focuses on the character strengths that increase a person's mental and emotional resilience (Peterson and Seligman). The 'social cohesion' hypothesis argues that inequality damages individual health by creating status hierarchies which impact on psycho-social health at the individual level and social cohesion at the societal level (Wilkinson 1996).

Although there is a growing body of literature on the theory of the determinants of mental health, there is a lack of data for Ireland.

3. GLOBAL MENTAL HEALTH ACTION PLAN

In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

In 2013 the WHO published a mental health action plan which was developed through consultation with member states, civil society and international partners. Fundamentally this strategy is based on a life-course approach, aims to achieve equity through universal health coverage and stresses the importance of prevention and has a human rights perspective (World Health Organization 2013) .

The action plan is linked conceptually and strategically to other global action plans and strategies endorsed by the Health Assembly, including the global strategy to reduce the harmful use of alcohol, the global plan of action for workers' health (2008-2017), the action plan for the global strategy for the prevention and control of noncommunicable diseases (2008-2013) and the global action plan for the prevention and control of noncommunicable diseases (2013-2020). It also draws on WHO's regional action plans and strategies for mental health and substance abuse that have been adopted or are being developed.

It should be clarified that the action plan builds upon the work of WHO's mental health gap action programme (mhGAP), whose main focus is to expand services for mental health in low resource settings . The action plan is designed to provide guidance for national action plans for **all** resource settings.

The vision of the action plan is “a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination”.

The action plan relies on six cross-cutting principles and approaches:

1. Universal health coverage: Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

2. Human rights: Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

3. Evidence-based practice: Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

4. Life course approach: Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

5. Multisectoral approach: A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

6. Empowerment of persons with mental disorders and psychosocial disabilities: Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

It's main objectives are;

1. To strengthen effective leadership and governance for mental health;
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. To implement strategies for promotion and prevention in mental health;
4. To strengthen information systems, evidence and research for mental health.

In the policy document, actions to be undertaken by international, regional and national partners are described, as well as global targets for these objectives. It should be noted at this point that the strategy document explicitly suggests that actions for member states be considered and adapted, as appropriate, to national priorities and specific national circumstances in order to accomplish the objectives.

Actions for member states are as follows, to see the actions for all partners please refer to the source policy document.

1. TO STRENGTHEN EFFECTIVE LEADERSHIP AND GOVERNANCE FOR MENTAL HEALTH

PROPOSED ACTIONS FOR MEMBER STATES

- Policy and law: Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

- Resource planning: Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.

- Stakeholder collaboration: Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.

- Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:

- Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.

Global target 1.1: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments (by the year 2020).

Global target 1.2: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by the year 2020).

2. TO PROVIDE COMPREHENSIVE, INTEGRATED AND RESPONSIVE MENTAL HEALTH AND SOCIAL CARE SERVICES IN COMMUNITY-BASED SETTINGS

PROPOSED ACTIONS FOR MEMBER STATES

- Service reorganization and expanded coverage: Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles, as appropriate] for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

- Integrated and responsive care: Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing, and education] through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.

- Mental health in humanitarian emergencies {including isolated, repeated or continuing conflict, violence and disasters]: Work with national emergency committees and mental health providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with mental disorders (pre-existing as well as emergency-induced] or psychosocial problems, including services for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.

- Human resource development: Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents, inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.

- Address disparities: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.

Global target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020).

3. TO IMPLEMENT STRATEGIES FOR PROMOTION AND PREVENTION IN MENTAL HEALTH

PROPOSED ACTIONS FOR MEMBER STATES

- Mental health promotion and prevention: Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.
- Suicide prevention: Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health {by the year 2020].

Global target 3.2: The rate of suicide in countries will be reduced by 10% {by the year 2020].

4. TO STRENGTHEN INFORMATION SYSTEMS, EVIDENCE AND RESEARCH FOR MENTAL HEALTH

PROPOSED ACTIONS FOR MEMBER STATES

- Information systems: Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).
- Evidence and research: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020].

Actions
1. To strengthen effective leadership and governance for mental health Resource planning: Plan according to measured need and allocate a budget across all relevant sectors that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings Mental health in humanitarian emergencies {including isolated, repeated or continuing conflict, violence and disasters]: Work with national emergency committees and mental health providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with mental disorders (pre-existing as well as emergency-induced] or psychosocial problems, including services for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency. Address disparities: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.
3. To implement strategies for promotion and prevention in mental health Mental health promotion and prevention: Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies. Suicide prevention: Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.
4. To strengthen information systems, evidence and research for mental health Information systems: Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory). Evidence and research: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders

and psychosocial disabilities.

Also note the following commentary from action 4:

Crucial information and indicators that are needed for the mental health system include: the extent of the problem [the prevalence of mental disorders and identification of major risk factors and protective factors for mental health and well-being);coverage of policies and legislation, interventions and services [including the gap between the number of people who have a mental disorder and those who receive treatment and a range of appropriate services, such as social services); health outcome data (including suicide and premature mortality rates at the population level as well as individual- or group-level improvements related to clinical symptoms, levels of disability, overall functioning and quality of life) and social and economic outcome data (including relative levels of educational achievement, housing, employment and income among persons with mental disorders). These data need to be disaggregated by sex and age and reflect the diverse needs of subpopulations, including individuals from geographically diverse communities (for instance, urban versus rural), and vulnerable populations. Data will need to be collected through ad hoc periodic surveys in addition to the data collected through the routine health information system. Valuable opportunities also exist to draw on existing data, for example, gathering information from the reports submitted to treaty-monitoring bodies by governments and nongovernmental and other bodies as part of the periodic reporting mechanisms.

4. THE ROLE OF SPECIALIST IN PUBLIC HEALTH MEDICINE

RELEVANT PUBLIC HEALTH EXPERTISE IN THE SPHM WORKFORCE

- Advocacy- take a proactive role in influencing other professionals, politicians and the public to ensure maximum population health gain
- Epidemiology and Health Intelligence- Apply epidemiological principles to exploit health-related data and provide useful health intelligence
- Health Needs Assessments
- Evidence Based Healthcare -Process of accessing, interpreting and applying information on best practice, including critically appraise primary and secondary research.
- Research -Bring an understanding of quantitative and qualitative research methods
- Health Promotion and Health Education -Public Health has a history of working closely with other disciplines including Health Promotion; particularly in providing expertise in the epidemiology of particular conditions, examining the evidence base for effective interventions, contributing to strategy development and evaluation.
- Strategic Planning and Management (Health Services Organisation, Health Economics and Strategic Policy)- Knowledge of the process of strategy development, including project management and organisational change.
- Effective Governance, Quality of Care and Risk Management- Elements of effective governance in healthcare, including factors that contribute to patient safety in health care settings, internal health service monitoring, external regulatory interventions, methods used to measure, risk management, quality assurance and quality improvement.
- Effectiveness and Outcome Assessment - PH can provide knowledge of outcome theory, outcome measures, types of evaluation and their methodological limitations.

THE ROLE OF SPECIALISTS/CONSULTANTS IN PUBLIC HEALTH IN THE UK

In the UK, a small group of public health professionals have concerned themselves with mental health issues for many years, working in particular on improving services, suicide prevention and stigma (FPH 2014). Public mental health will be a relatively new idea to many of those practicing public health, especially the idea that mental health and mental wellbeing should be at the heart of all we do in public health, and that there can be 'no health without mental health.'

More recently Public Health England produced a Public Mental Health leadership and workforce development framework which aims to inform and influence the development of public health leadership and the workforce in relation to mental health (Public Health England 2015). This is in response to the lack of widespread coverage with regards to staff training in mental health and the increasing demand for it. In addition to this strengthening effective leadership for mental health is one of the four priorities in the World Health Organisation's Mental Health Action Plan 2013-2020.

They describe six main “ambitions” for workforce development;

- Our leaders advocate for the mental health of citizens as a valuable resource for thriving communities and economies.
- A public health specialist workforce that has expertise to lead mental health as a public health priority.
- A local workforce working with communities to build healthy and resilient places.
- Frontline staff are confident and competent in communicating with people about mental health and supporting them to improve it.
- Frontline staff are confident and competent in recognising signs of mental distress and supporting children, young people, parents and adults appropriately.
- The health and social care workforce has the knowledge and skills to improve the health and wellbeing of people with a mental illness and reduce mental health inequalities.

The core principles which underlie the ambitions are as follows;

Know	Believe	Act
1. Know the nature and dimensions of mental health and mental illness. 2. Know the determinants at a structural, community and individual level. 3. Know how mental health is a positive asset and resource to society 4. Know what works to improve mental health and prevent mental illness within own area of work.	5.Understand your own mental health, what influences it, its impact on others and how you can improve it. 6. Appreciate that there is no health without mental health and the mind and body work as one system. 7. Commitment to a lifecourse approach and investment in healthy early environments. 8. Recognise and act to reduce discrimination against people experiencing mental illness.	9. Communicate effectively with children, young people and adults about mental health. 10. Integrate mental health into your own area of work and address mental and physical health holistically. 11. Consider social inequalities in your work and act to reduce them and empower others to. 12. Support people who disclose lived experience of mental illness.

For each part of the workforce key competencies and key priorities have been identified under each “ambition”. The complete set is in appendix 1, but the sections which apply to Directors of Public Health and Consultants in Public Health are below.

Ambition 1. Our leaders advocate for the mental health of citizens as a valuable resource for thriving communities and economies.

Key competencies:

1. Integrate mental health within all policy and take action to mitigate any negative impacts of policy on mental health
2. Promote the value of mental health and the reduction of inequalities across settings and agencies
3. Advocate for mental health and addressing mental illness as central to reducing inequalities and creating thriving communities and economies
4. Create organisations that nurture and sustain the mental health of employees

Key priorities:

1. For public health bodies and organisations to demonstrate leadership in the above competencies.

2. To support the development of the above competencies in current and future leaders, to lead for wellbeing, mental health and community assets as part of a 21st century public health system.

3. To develop a shared understanding across organisations on mental health within the public health (and wider) system.

4. To build capability in embedding mental health in all policy and programmes and taking action to mitigate potential negative impacts of policy on the public’s mental health.

5. For local authorities to adopt the local authority mental health challenge and appoint an elected member champion for mental health. (See box below)

6. For leaders in organisations to understand the mental health of employees and to lead organisational development in a way that sustains good mental health.

7. To increase organisational commitment to the Workplace Wellbeing Charter and support businesses to gain achievement and excellence.

Ambition 2. A public health specialist workforce that has expertise to lead mental health as a public health priority.

Key competencies:

1. Assess and describe the mental health and illness needs of specific populations and the inequities experienced by populations, communities and groups

2. Translate findings about mental health and illness, and needs and assets, into appropriate recommendations for action, policy decisions and service commissioning/ delivery/ provision

3.Influence political/ partnership decision making to maximize the application and use of evidence in achieving change

4. Set strategic direction and vision for mental health and communicate it effectively to improve population health and wellbeing

5.Advise strategic partners to determine priorities and outcomes to achieve improvements in quality and cost-effectiveness of treatments for mental illness and associated co-morbidities

Key priorities:

1. To have a senior lead within every local authority public health team with the necessary capacity and capability in mental health, including the above key competencies.

2. Local public health teams to build workforce capacity and capability in public health practitioners and providers to deliver sustainable improvements in mental health promotion, mental illness and suicide prevention and improving the life expectancy of people living with and recovering from mental illness.

3. To build commitment and capability across the whole public health system, nationally and locally, to: a. address mental health as a key determinant of morbidity and mortality b. increase life expectancy of people with mental illness as a priority for reducing health inequalities and achieving parity of esteem

4. To build capability in mental health intelligence, specifically to:

a. increase knowledge of mental illness and mental health amongst public health analysts and capability in producing joint strategic needs assessments based on mental health and illness needs and assets. b. improve the use of mental health outcome measurement and analysis by public health specialists, practitioners and the wider workforce in assessing local interventions c. develop coherent and comprehensive systems of surveillance and assessment of mental health outcomes within services and across the population

5. To ensure the public health competence framework adequately reflects the knowledge and competence to address mental health and mental illness as public health priorities.

6. To ensure the curricula and formal academic training of the public health workforce adequately addresses mental health and mental illness as public health priorities.

7. Local public health professionals responsible for mental health should have their continuing professional development needs met in relation to their roles as experts and leaders of change in mental health. This includes through: a. leadership development – to strengthen political awareness, influencing and advocacy roles of public mental health leads b. networking, peer support and coaching, sharing of best practice and collaboration across localities

HEALTH INTELLIGENCE AND EPIDEMIOLOGY, HEALTH NEEDS ASSESSMENT

Epidemiology is the study of the distribution and determinants of disease. Public health professionals use epidemiology to describe the occurrence of disease and what the causes may be. The underpinning rationale for public health activities is that the more that is understood about the cause of diseases, the more the public health system can do to prevent them, detect them at an early stage or provide the most appropriate health services (DOH 2014). Mental health information includes information on both mental illness and mental health and wellbeing. Note that mental wellbeing is not a diagnosis – it represents one end of a continuum. Mental health information includes information on determinants, health status (including mortality and morbidity), health service utilization, health service performance and quality, and health economic data.

HEALTH SERVICE INFORMATION

According to Vision for Change, good health intelligence relies upon good sources of data. Some of the types of information that is needed in the Irish setting includes information to support the planning, monitoring and evaluation of mental health services, specifically Information on the outcomes for mental health service users (DOHC 2006), e.g.

- How has a particular service input helped a service user/carer?
- Have their symptoms lessened?
- Is their quality of life improved?
- Are they able to do more in social or occupational terms?

Other information in this category includes human resource management and planning, resource allocation and information that demonstrates service quality and value for money.

STRATEGIC PLANNING AND MANAGEMENT (HEALTH SERVICES ORGANISATION, HEALTH ECONOMICS AND STRATEGIC POLICY)

There is a lack of population-based survey data to guide mental health policy and health service planning (Tedstone Doherty and Moran, Mental health and associated health service use on the island of Ireland. HRB Research Series 7 2009). The Health Research Board National Psychological Wellbeing and Distress Survey provides information on the mental health of the population (Tedstone Doherty, Moran, et al., HRB National Psychological Wellbeing and Distress survey: Baseline Results 2007).

Watson and Maitre compared the circumstances and experiences of people with an emotional, psychological and mental health (EPMH) disability to those of people with mobility & dexterity disability in Ireland (Watson and Maitre 2014). A number of themes emerged including the overlap between populations with each type of disability and the need for an integrated approach to service delivery; the impact of EPMH disability on labour market participation; and the significant barrier that stigma plays in increasing their difficulties in performing daily activities.

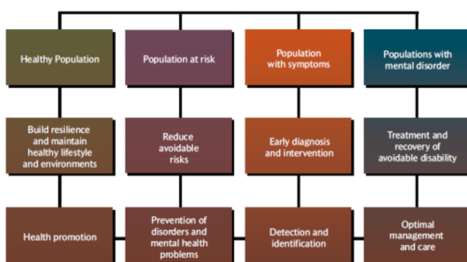
The priority areas identified within the 2015 Mental Health Division include suicide prevention, the development of the Forensic Mental Health Service, development of services for those with eating disorders, and coping with the ageing of the population (increased numbers with dementia), as well as providing services to vulnerable populations e.g. the homeless.

EVIDENCE BASED HEALTHCARE, HEALTH TECHNOLOGY ASSESSMENT, RESEARCH

Public Health Specialists have expertise in the process of accessing, interpreting and applying information on best practice, including critical appraisal of primary and secondary research. This includes an understanding of quantitative and qualitative research methods. Many different types of research are needed to tell whether interventions, programmes or approaches make a difference for whom, and in what circumstances. For instance, much of the evidence of the effectiveness of health promotion interventions to improve mental health and wellbeing must be derived from community-based research (WHO 2004a). There cannot be total reliance on traditional, quantitative measures. Including qualitative methods gives a better understanding of what works and what does not.

PREVENTION

The Public Health approach has an emphasis on prevention of ill health. Prevention can be divided into primary (health promotion and disease prevention), secondary (early detection), and tertiary (optimal treatment to prevent avoidable disability). Vision for Change has adopted an Australian model for mental health promotion that focuses on primary, secondary and tertiary prevention, see figure 5.1.



Source: Vision for change pg 47

PRIMARY PREVENTION

SPHMs can provide a valuable support role in the area of mental health promotion in addressing the factors that act against good mental health. Public Health and Health Promotion can collaborate closely on the development of health promotion initiatives. These initiatives tend to involve recurrent cycles of programme planning, implementation, and evaluation (WHO 2004a). According to WHO, virtually all health promotion practice models include:

- A careful study of a community’s needs, resources, priorities, history, and structure in collaboration with the community: “doing with” rather than “doing to”;
- Agreement on a plan of action, gathering of resources, implementation, and monitoring of action and change processes. Fluidity is needed in planning and acting to meet the demands of new or changing conditions, as well as constant surveillance of and reflection over practice; and
- An emphasis on evaluation and dissemination of best practices, with attention to maintaining and improving quality as dissemination unfolds.

Public Health can offer expertise in these domains (qualitative and quantitative research, strategy development, evaluation and evidence-based practice).

The World Health Organisation consider that mental health promotion works at three levels: strengthening individuals, strengthening communities, and reducing structural barriers to mental health (WHO 2004a). Vision for Change discusses these three levels (DOHC 2006):

- Strengthening individuals – increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills, e.g. communicating, negotiating, relationship and parenting skills.
- Strengthening communities – increasing social inclusion and participation, improving neighbourhood environments, developing health and social services that support mental health, such as anti-bullying strategies at school, workplace health, community safety, and childcare and self-help networks.
- Reducing structural barriers to mental health – through initiatives to reduce discrimination and inequalities and to promote access to education, meaningful employment, housing, services and support for those who are vulnerable.

There is mounting evidence that it is possible to intervene at several levels, from local to national, to improve mental health (WHO 2004a). The factors over which individuals have little or no control require the collective attention of a society as encapsulated by the Ottawa Charter of Health Promotion (WHO 1986). The five action strategies identified by the Charter remain today the basic blueprint for health promotion in many parts of the world: Action strategies;

- Build healthy public policy;
- Develop personal skills;
- Create supportive environments;
- Reorient health services;
- Strengthen community action

Robust evidence of effectiveness exists for public mental health interventions aimed to give children a good start in life. This is also an opportune time to intervene as 75% of mental illness starts before the age of 25 years and many health risk behaviours such as smoking and substance misuse start in childhood, having a long-lasting adverse effect (FPH 2014). Childhood programmes represent by far the largest group of evidence-based approaches to promote mental health. A wide range of programmes has been developed and evaluated, and a very large evidence base has accumulated over the course of the last 60 years. These cover universal, targeted and indicated approaches, and relate to interventions to support parenting and interventions to improve mental health in schools. The key way to reduce risk in very early childhood is to promote healthy parenting by focusing on the quality of parent-infant/child relationships, parenting styles including behaviour management, and infant and child nutrition (including breast-feeding and healthy eating).

The “Five Ways to Wellbeing” is an initiative that identified a set of evidence-based actions which can promote people’s wellbeing (Aked, et al. 2008). These Five Ways to Wellbeing were developed by the New Economics Foundation (NEF) from evidence gathered in the UK government’s Foresight Project on Mental Capital and Wellbeing (NEF 2015). They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives.

SECONDARY PREVENTION

One of the most tragic outcomes of mental distress is suicide. If signs that someone is at risk of suicide can be detected and identified early, then this can allow timely intervention to take place. The vision of the Irish National Strategy for Action on Suicide Prevention is of a society where life is valued across all age groups, where the young

learn from and are strengthened by the experiences of others and where the needs of those who are going through a hard time are met in a caring way so that mental illness is more widely recognised and understood and those experiencing difficulties are offered the most effective and timely support possible (NOSP 2005). By effectively developing an anti-stigma campaign (general population) and by promoting awareness of positive mental health, the likelihood of vulnerable individuals with signs of mental health problems (more high risk) seeking help through the health services will increase. In this regard, three key areas of action were outlined in a recent survey commissioned by the National Office for Suicide Prevention (NOSP) looked at how we view mental health in Ireland today (NOSP 2007):

- Education around mental health and mental health problems
- Awareness and understanding of personal mental health
- Recognising the importance of social and professional support

TERTIARY PREVENTION

A person who is at risk of suicide may present to the mental health service prior to a suicide attempt. The key tasks to be carried out by the National Office of Suicide Prevention that were identified by Reach Out included (NOSP 2005):

- The development of 'fast-track' priority referral systems from primary care to community-based mental health services
- The development of an effective service response for people who have engaged in deliberate self-harm or who are acutely suicidal

5. OVERVIEW OF IRISH FIGURES

It is estimated that mental health disorders account for 14% of the global burden of disease (Davies 2014). One in every four Irish people will experience a mental health problem during his or her lifetime, with depression in particular being a very common condition affecting 450,000 Irish people or one in ten persons at any one time (DOH 2013).

Experience of mental ill-health during adolescence in particular is a risk factor for future mental ill-health in young adulthood and beyond. Irish young adults currently have higher rates of mental health problems than similarly aged young people in other countries and, in addition (Cannon, et al. 2013).

This chapter aims to describe the prevalence of mental ill-health among Irish persons, across the lifespan from young persons to older persons. Information is also provided on suicide and self-harm; there has been an increase in both suicide and self-harm rates since the onset of the recession in 2007 (NSRF 2013) (NOSP 2013). Finally, this chapter looks at current utilisation of some health services in Ireland by persons with mental ill-health, and profiles the persons using them.

WHAT IS MENTAL HEALTH AND WHAT ARE MENTAL DISORDERS?

The World Health Organization (WHO) defines mental health as 'a state of well-being in which every individual recognises his or her own potential, 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'. Therefore, mental health is not just the absence of a mental disorder. It is about having a positive sense of self, being involved in meaningful activities and being able to get through difficult times (WHO 2014).

The PERL Group of the RCSI use the following definition of a mental disorder. 'There are strict criteria that a person must meet to be considered to have a mental disorder. They must be experiencing a clinically significant behavioural or psychological pattern that is either causing them distress, disabling them in some way or puts them at increased risk of suffering, death, disability or a loss of freedom. The person's psychological, behavioural or biological difficulties must be an expression of some level of dysfunction within the person. That means that emotional and behavioural experiences that are culturally accepted or expected (e.g. distress following a death) or behaviour that is simply deviant in nature (e.g. anti-social behaviour) are not mental disorders' (Cannon, et al. 2013).

Many mental disorders are both chronic and disabling. It is estimated that they account for 14% of the global burden of disease (Davies 2014). In 2011, the UK Department of Health estimated that mental health disorders represented 23% of the UK's national burden of disease. It was the single largest cause of disability and it is estimated that treatment costs will double in the next 20 years (Davies 2014).

There are two main types of serious mental health disorders, affective disorders and psychotic disorders.

Affective disorders are mental disorders characterised by dramatic changes or extremes of mood. Affective disorders may include manic (elevated, expansive, or irritable mood with hyperactivity, pressured speech, and inflated self-esteem) or depressive (dejected mood with disinterest in life, sleep disturbance, agitation, and feelings of worthlessness or guilt) episodes, and often combinations of the two. Persons with an affective disorder may or may not have psychotic symptoms such as delusions, hallucinations, or other loss of contact with reality.

Psychotic disorders refer to a range of disorders for which the presence of psychotic symptoms is a primary feature. There are a number of diagnosable psychotic disorders including a brief psychotic episode, delusional disorder, schizoaffective disorder and schizophrenia.

MENTAL HEALTH PROBLEMS IN IRELAND

Key points:

- One in every four people will experience a mental health problem during his or her lifetime (DOH 2013).
- In Ireland, estimates suggest that the overall economic cost of mental health problems is €3 billion per annum; only cardiovascular disease is likely to contribute more to the overall burden of illness (O'Shea and Kennelly 2008).
- Irish young people have higher rates of mental disorders than similarly aged young people in other countries (Cannon, et al. 2013).
- Depression is a very common condition which affects more than 450,000 people in Ireland (one in ten) at any one time (Aware 2014).
- The death rate for suicide amongst young people in Ireland has been higher than other countries (O'Shea and Kennelly 2008)**.** This rate has been falling in recent years.
- One in 20 persons aged over 50 years reported a doctor's diagnosis of depression, with a similar number reporting a diagnosis of anxiety (Barratt, et al. 2011).

The following section provides further information from recently published reports on the prevalence of mental health problems in Ireland.

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

In October 2013, a report entitled 'The Mental Health of Young People in Ireland' was published by the PERL (Psychiatric Research across the Lifespan) Group (Cannon, et al. 2013). This report detailed the mental health of children and young persons in Ireland aged 10-24 years. This report contains research findings from two epidemiological studies on mental disorders and psychopathology among young people in Ireland: the Adolescent Brain Development Study and the Challenging Times Two study. Some of the main findings are detailed below.

- International evidence has suggests that by the age of 13, 1-in-3 young people in Ireland are likely to have had some type of mental disorder; by the age of 24, this rate has increased to 1-in-2.
- Over 1-in-5 young adults (aged 19-24 years) meet criteria for a diagnosable substance use disorder over the course of their lives.
- Significant numbers of young people are deliberating harming themselves and many have experienced suicidal ideation. Over 1-in-15 young people in both studies had engaged in deliberate self-harm and, by the age of 24 years, 1-in-5 young people had experienced suicidal ideation.
- Findings suggest that Irish young people may have higher rates of mental disorder than similarly aged young people in other countries.

Table 3Rates of mental disorders among children and young adults, 2013

Rates of mental disorders	11-13 year olds	19-24 year olds
Current mental disorder	15.4%	19.5%
Lifetime mental disorder	31.2%	56%
Current anxiety disorder	8.1%	11%
Lifetime anxiety disorder	13.6%	26.7%
Current mood disorder	1.7%	4.8%
Lifetime mood disorder	14.9%	28.5%
Lifetime psychotic disorder	None reported	None reported
Lifetime psychotic symptoms	22.6%	10.1%

- A number of risk factors identified are associated with the experience of mental ill-health in young people: experience of health; work and relationship stress; family difficulties; the experience of being in an abusive intimate relationship and having a bisexual or homosexual orientation.
- Gender was not associated with young adults' overall experiences of mental ill-health. However, females were more likely than males to experience a mood disorder in the 19-24 years age range.

The authors concluded that the experience of mental ill-health during adolescence is a risk factor for future mental ill-health and substance misuse in young adulthood. Progressive early prevention and intervention initiatives in the field of youth mental health have the potential to reduce the economic burden associated with mental ill-health among Irish people. More importantly they also have the potential to minimise the personal, relational, social and vocational impact of mental ill-health on young people, their families and the wider society.

ADULTS' MENTAL HEALTH

In 2007, the Health Research Board conducted a study entitled 'The National Psychological Wellbeing & Distress Survey' (NPWDS) (Tedstone Doherty, Moran and Kartalova-O'Doherty, Psychological distress, mental health problems and use of health services in Ireland. HRB Research Series 5 2008). This was a telephone survey of a nationally representative random sample of 2,711 adults aged 18+ years and over living in private households.

Baseline results showed that:

- The majority of respondents reported 'good' or 'very good' mental health in the past year, with 15% reporting 'less than good' mental health. Those aged 50-64 years were more likely to report less than good mental health.
- One-in-seven respondents reported experiencing mental health problems in the previous year, with females more likely to report problems.
- One-in-eight reported experiencing current mental health problems.
- Almost 10% had spoken to a GP about their mental health problems in the previous 12 months, with an average of 4.4 visits per patient recorded.
- Regarding prescribed medications, 6% of respondents had been prescribed medications in the previous year, and this increased for females across the age-groups. Few males aged 65+ years reported using prescribed medications. Antidepressants were more frequently used than tranquillisers.
- 93% were willing to seek help for mental health problems if required, with the GP the preferred source.

The authors estimate that 389,258 people in the Republic of Ireland are experiencing minor or major psychiatric problems at any given point in time; this equates to a rate of 12 in every 100 people aged 18 years and over who are experiencing mild to severe mental health problems.

OLDER ADULTS' MENTAL HEALTH

The Irish Longitudinal Study on Ageing (TILDA) is a large-scale, nationally representative, longitudinal study on ageing in Ireland, the overarching aim of which is to make Ireland the best place in the world to grow old. One chapter reports on the prevalence of common mental health disorders in older adults in Ireland (Barratt, et al. 2011). The main findings are outlined below:

- Depression is common among older persons in Ireland, with 10% reporting clinically significant depressive symptoms and a further 18% reporting 'sub-threshold' levels of depression.
- Overall, 13% of women reported case-level depression, compared with 7% of men. Similarly, 20% of women reported sub-threshold depression, compared with 15% of men.
- The prevalence of case-level depression was highest in the 50-64 year age group (11%) and decreases with advancing years, yet the prevalence of sub-threshold depression was highest in the oldest age group (21%).
- In all age groups utilisation of GP services is far greater among depressed adults. Respondents aged 75 and over with case level depression had an average of 7 visits to their GP in the past year. This compares to an average of 5 visits among the non-depressed older population.
- Anxiety is more common than depression among older adults; 13% report clinically significant anxiety symptoms while 29% report sub-threshold levels of anxiety.

- Overall, 15% of women reported case-level anxiety, compared with 11% of men. Similarly, 30% of women reported sub-threshold anxiety, compared with 27% of men.

- The prevalence of case-level and sub-threshold anxiety was highest in the 50-64 year age group and decreases with advancing years.

- There is under-diagnosis and hence under-treatment of depression and anxiety; 78% of older adults with objective evidence of depression do not report a doctor's diagnosis of depression. Similarly, 85% of older adults with objective evidence of anxiety do not report a doctor's diagnosis of anxiety.

- Co-morbidity of anxiety and depression is highly prevalent in the older Irish population. Of older adults with case level depression, 48% have co-occurring case-level anxiety while 36% of people with case level anxiety have co-occurring case-level depression.

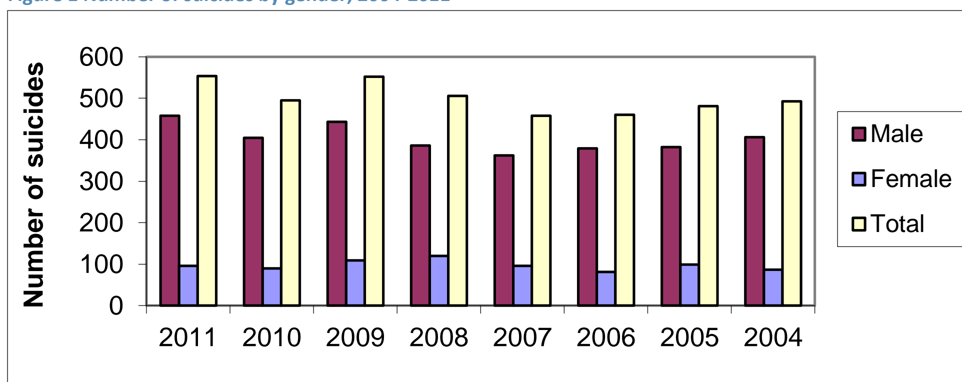
- Of people with both depression and anxiety, 66% have a longstanding illness or disability. This compared to 60% of people with depression only and 44% of people with anxiety only. The association is even more marked for suicide ideation. Of older adults with both depression and anxiety, 30% reported suicidal feelings, compared to 16% with depression and 5% with anxiety.

The authors concluded that 'Given the rapid ageing of the Irish population, the potential public health burden of late-life mental health disorders will also grow, emphasising the importance of continued epidemiologic monitoring of the mental health status of older adults. There is a high prevalence of undiagnosed and, therefore, untreated depression and anxiety in the older Irish population. This represents a serious public health concern as older adults with depressive symptoms are at increased risk for subsequent functional and cognitive impairment, psychological distress and suicide. The need to manage these conditions is emphasised by the overwhelming effect of depression on employment status, disability and health service utilisation'.

SUICIDE IN IRELAND

- The Central Statistics Office publishes national mortality data including data on deaths by suicide. This data on suicide is included in the National Office for Suicide Preventions' Annual Report with all data provided by year of occurrence (NOSP 2013). The National Suicide Registry has provided provisional data for 2012 and 2013.
- There were 475 deaths by suicide in Ireland in 2013, representing a rate of 10.3 per 100,000 population; 396 (83%) of these were among men.
- Over the past number of years, particularly since the onset of the economic recession in Ireland, there was an increase in the suicide rate in Ireland. The increase observed between 2007 and 2011 can be attributed to an increase in the male rate of suicide. Since 2012 the suicide death rate has been decreasing.

Figure 1 Number of suicides by gender, 2004-2011



Source: NOSP - ANNUAL REPORT 2013

- Kennelly estimated the total cost of suicide at over €906 million in 2001 and €835 million in 2002; this is equivalent to a little under 1% of the gross national product in Ireland for those years (Kennelly 2007).

- The following table details the years of potential life lost for all causes of mortality, for external causes of injury and poisoning, and for suicide for the year 2010, by gender for Ireland as taken from PHIS (PHIS 2012). For males, suicide accounts for 14.6% of YPLL up to age 65, compared to 6% for females, and 13% of YPLL up to age 75, compared to 5.3% for females.

Table 4 YPLL for various causes of death by gender, Ireland, 2010

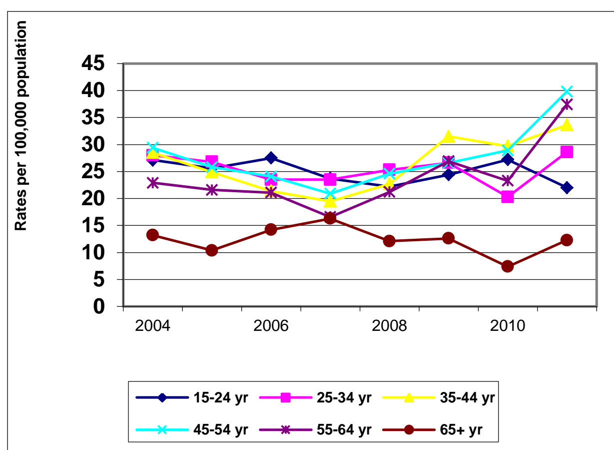
	Cause of Death	YPLL up to age 65	YPLL up to age 70
Male & Female	All causes	103,402	139,222
	External causes of injury & poisoning	30,974	37,282
	Suicide & intentional self-harm	11,907	14,219
Male	All causes	66,090	88,335
	External causes of injury & poisoning	24,036	28,743
	Suicide & intentional self-harm	9,680	11,528
Female	All causes	37,312	50,887
	External causes of injury & poisoning	6,938	8,539
	Suicide & intentional self-harm	2,227	2,691

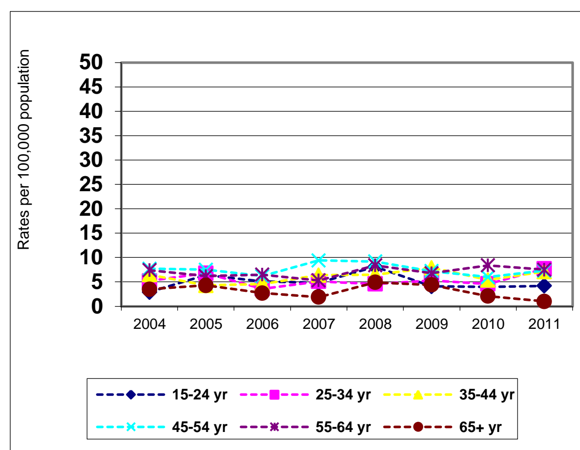
Source: PHIS 12, Department of Health, 2012.

- By age-group, the highest rate is among 45-54 year old males at 29.0 per 100,000 population. The lowest rate for male suicide in 2011 was in the 65+ age-group.

- Similarly, the lowest rate for female suicide in 2011 was in the 65+ age-group. The highest rate for female suicide in 2011 was 7.4 per 100,000 population in the 45-54 year age-group.

(a) Male suicide rates per 100,000 population **(b) Female suicide rates per 100,000 population**





Source: NOSP - ANNUAL REPORT 2013

European Suicide Rates:

- Eurostat data for 2010 reports that Ireland ranked 11th lowest in the EU (31 countries) for total rate of suicide for men and women of all ages, with a rate of 10.9 per 100,000 population. The highest rate was found in Lithuania at 32.9 per 100,000 and the lowest rate in Greece at 3.3 per 100,000.
- The Irish suicide rate among young males and females are relatively high in comparison to international rates for young people (aged 15-19 years), at 10.5 per 100,000. This is the 4th highest in this age group on the EU. The highest rate was found in Lithuania (13.9 per 100,000) and the lowest in Greece (1 per 100,000).

Suicide rates in Ireland by County:

- Table 5 below displays the suicide rates by county over the period 2004-2013*. The rates displayed are three year moving averages. The table is displayed in two parts, those with a rate higher than the national average for Ireland 2011-2013, and those with a rate lower than the national average for Ireland 2011-2013.

Table 5 : Suicide rate by county, 3-year moving average, 2004-2013*

3 year moving average	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010 – 2012*	2011-2013*
Limerick City	16.4	13.7	12.1	10.6	12.2	15.5	21.2	21
Wexford	13.6	16	13.8	14.4	12.7	14.9	17.4	18.9
Kerry	11.3	9.9	9.5	12.7	15.5	18	17.6	18.5
Cork City	17.9	18	18.7	18.9	18.9	16.4	18.7	16.7
Mayo	11.1	13.7	12.8	12.8	11.6	12.8	15.8	15.2

3 year moving average	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010 – 2012*	2011-2013*
Tipperary South	10.5	11	12	14.1	14.3	14.6	15.3	15
Carlow	17	20	17.6	14.7	11.8	11.7	11	13.3
Cavan	19.3	18.9	17.1	15.3	12.4	11	9.8	13.3
Laois	8.8	10.7	12	11.3	14.4	18.6	17.3	13.1
Galway County	11.3	12.2	10.7	11.1	12.8	12.6	13.3	13.1
Leitrim	23.4	13.2	9.1	11.1	15.3	16.1	19.1	12.6
Louth	9.3	8.7	11.2	11.8	13.1	13.7	12.7	12.6
Kilkenny	10.1	11.5	11.6	11	9.7	11	10.8	12.5
Cork County	12.8	12.6	13.3	13.6	13.8	12.9	12.6	12.2
Monaghan	10.9	10	9.8	11.4	12.4	10.1	11.7	12.2
Clare	12.6	12.2	12.9	14.4	11.8	9.7	10.6	12.2
Offaly	12.8	12	13.9	15	17.7	19.7	15.1	12
Galway City	8.7	5.6	7.6	8.9	8.8	8.8	11.5	12
Westmeath	12.7	13.7	12.3	14.6	15.1	15.6	12.7	11.9
Tipperary North	19.1	14.7	14.9	15	15	13.4	11.9	11.9
Limerick County	10.7	10.2	8.7	11	11.4	14.2	13	11.4
Waterford City	11.5	9	9	13.1	11	12.5	13.3	11.4
Kildare	10.6	11.7	11.7	11.7	10.4	9.4	10.7	11.4
Ireland	**11.6**	**11**	**10.9**	**11.5**	**11.6**	**11.6**	**11.4**	**11.2**

3 year moving average	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010 – 2012*	2011-2013*
Roscommon	12.7	17.7	15.7	12.1	11.4	12.3	9.7	10.5
Waterford County	16.6	11.9	13.1	13.4	15.2	14	10.9	10.4
Sligo	13.2	8.6	6.9	7.3	10.4	12.8	12.8	10.3
Dublin City	11.3	10.8	10.2	10.3	10.5	10.2	10.2	9.9
South Dublin	10.2	8.3	8.6	8.2	8.4	7.6	10.3	9.9
Wicklow	13.4	11.8	10.4	9.4	10.6	11.4	11.3	8.9
Donegal	10.4	9.7	10.1	11.1	9.7	7.4	6	7.9
Longford	15.2	12.7	10.6	9.5	8.2	11.5	7	7.6
Meath	11.1	7.8	9.6	11.2	11	9	6.3	6.4
Dun Laoghaire	5.6	5.7	6.4	7.3	8.1	8.2	5.8	4.9
Fingal	6.1	5	5.5	6.7	7.1	6.8	4.4	3.9

** Figures for 2012 and 2013 are provisional and subject to change.*

- In total, 23 counties/geographic areas had a rate higher than the Irish rate for the period 2011-2013, while 11 counties/geographic areas had a rate that was lower.
- For the period 2011-2013, the highest suicide rate was reported for Limerick city at 21 per 100,000 populations, while the lowest reported was for Fingal County at 3.9 per 100,000.

UTILISATION OF HEALTH SERVICES

Irish Psychiatric Units & Hospitals Census 2013

The Irish Psychiatric Units & Hospital Census 2013 is a census of all patients resident in units and hospitals operating within the provision of the Mental Health Act 2001 as on 31 March 2013 (Daly, Walsh and Moran 2013). The main findings were:

- There were 2,401 patients resident in Irish psychiatric units and hospitals on 31 March 2013, representing a hospitalisation rate of 52.3 per 100,000 populations.
- There were 64 children resident, 63 of whom were resident in child and adolescent units.

- Males accounted for 55% of all inpatients on census night.
- One-third of patients were aged 65+ years; 17% were aged 55-64 years; 17% were aged 45-54 years; 15% were aged 35-44 years; 12% were aged 25-34 years; 3.5% were aged 20-24 years and 1.6% were aged 18-19 years.
- Almost 31% of all inpatients had a diagnosis of schizophrenia, 16.5% had a diagnosis of depressive disorders, 11% had a diagnosis of organic mental disorders and 8% had a diagnosis of mania.
- 15% of patients on census night were involuntary; males accounted for 71% of such cases.
- 37% of all inpatients on census night were long-stay, that is had been in hospital for one year or more on census night. 22.5% were old long-stay; that is had been in hospital for five years or more.

County of Residence

- Patients resident in county Dublin had the highest rate of hospitalisation on census night at 70.9 per 100,000 population followed by residents of Westmeath (66.2), Mayo (63.5) and Laois (59.6). Carlow had the lowest rate of hospitalisation at 22.0, followed by Cavan (27.3) and Leitrim (28.3).

Table 6 Irish psychiatric Units and Hospitals Census 2013. County and gender. Numbers with rates per 100,000 total population

County of residence	Male	Female	Total	Male	Female	Total
	Numbers			Rates per 100,000		
Dublin	482	421	903	77.8	64.5	70.9
Kildare	33	28	61	31.5	26.5	29.0
Wicklow	34	29	63	50.3	42.0	46.1
Carlow	8	4	12	29.2	14.7	22.0
Wexford	50	24	74	69.5	32.7	50.9
Kilkenny	23	23	46	48.1	48.3	48.2
Tipperary South	23	24	47	52.0	54.3	53.1
Waterford	26	19	45	46.0	33.1	39.5
Cork	148	141	289	57.5	53.9	55.7
Kerry	43	39	82	59.2	53.5	56.4

County of residence	Male	Female	Total	Male	Female	Total
Limerick	43	26	69	44.9	27.1	36.0
Clare	39	29	68	66.9	49.2	58.0
Tipperary North	14	13	27	39.6	37.2	38.4
Galway	53	36	89	42.5	28.6	35.5
Roscommon	13	15	28	40.2	47.3	43.7
Mayo	57	26	83	87.1	39.9	63.5
Longford	9	14	23	45.8	72.3	59.0
Westmeath	36	21	57	84.1	48.4	66.2
Offaly	19	12	31	49.4	31.4	40.4
Laois	28	20	48	69.0	50.0	59.6
Leitrim	2	7	9	12.4	44.7	28.3
Sligo	24	9	33	74.0	27.3	50.5
Donegal	27	25	52	33.5	31.0	32.3
Cavan	7	13	20	18.9	35.9	27.3
Monaghan	13	12	25	42.7	39.9	41.3
Louth	27	25	52	44.4	40.2	42.3
Meath	38	19	57	41.3	20.6	31.0
Non-resident	6	2	8	-	-	-

County of residence	Male	Female	Total	Male	Female	Total
TOTAL	**1,325**	**1,076**	**2,407**	**58.3**	**46.5**	**52.3**

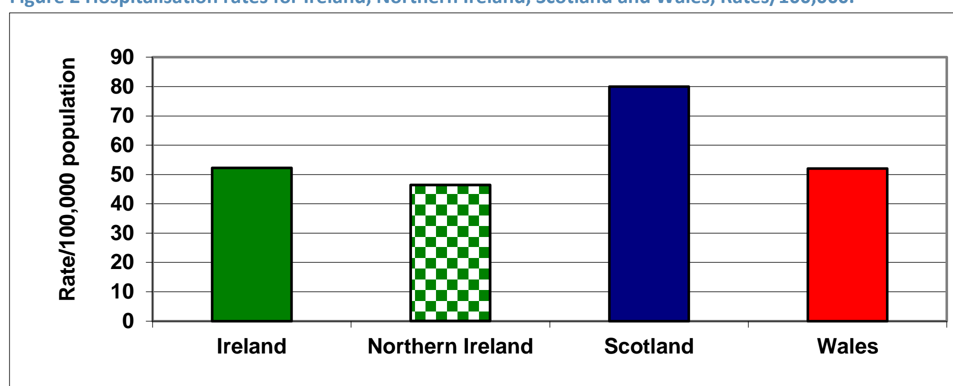
Hospital Type

- There were 65 psychiatric units and hospitals/continuing care units included in the census.
- 35% of patients were resident in psychiatric units/continuing care units, 30% were resident in general hospital psychiatric units, 24% were resident in independent/private/private charitable centres, 5% resident in St Joseph's Intellectual Disability Service, 4% resident in the Central Mental Hospital Dundrum and 2% resident in Carraig Mor, Cork.

International Comparisons

- The figure below presents comparative resident inpatient data for Scotland, Wales and Northern Ireland. Hospitalisation rates for Ireland, Wales and Northern Ireland were broadly similar, with rates of 52.3, 52.1 and 46.4 per 100,000 populations.

Figure 2 Hospitalisation rates for Ireland, Northern Ireland, Scotland and Wales, Rates/100,000.



Source: HRB Statistics Series 22. Irish Psychiatric Units & Hospitals Census 2013

- The proportion of elderly (65+ years) psychiatric inpatients in Ireland was 33%, similar to that in Northern Ireland (32%). Wales had the highest proportion at 49.6%, while 43% of patients in Scotland were aged 65+ years.
- Ireland had the highest proportion of old-long-stay psychiatric inpatients (5+ years) at 22.5% of all inpatients on Census night. This compares with 12.5% in Northern Ireland, 10% in Scotland and 2% in Wales.

DELIBERATE SELF-HARM

In 2013, the National Registry of Deliberate Self Harm recorded 11,061 presentations to hospital due to deliberate self harm nationally, involving 8,772 individuals, corresponding to an age-standardised rate of 199 per 100,000

population; a decrease of 6% on the rate in 2012 (NSRF 2013). However, this rate was still 6% higher than the pre-recession rate of 188 per 100,000 in 2007. Some of the main findings of the report are detailed below:

- In 2013, the national male rate of self-harm was 182 per 100,000 while the female rate was 217 per 100,000. Both rates had decreased from 2012. However, the male rate had increased by 12% since 2007, whereas the female rate was just 1% higher than in 2007.
- As in previous years, the female rate was higher than the male rate but the gender difference had narrowed from 37% in 2004-2005 to 19% in 2013. The peak rate for women was in the 15-19 year age-group, while for men it was in the 20-24 year age-group.

Area of residence:

- There was widespread variation in the male and female rate of self-harm when examined by area of residence. The male rate varied from 93 per 100,000 in Roscommon to 406 per 100,000 in Limerick city. The female rate varied from 130 per 100,000 in counties Sligo and Offaly to 570 per 100,000 in Limerick city.
- Compared to the national rate, a high rate of self harm was recorded for male and female city residents, for men living in Louth, Carlow, South Dublin and Kerry, and for women living in South Dublin, Carlow, Longford and Tipperary North.
- In 2013, the highest rate of self-harm for both men and women was seen in Limerick city, where both rates were more than twice the national average.

Number of attendances:

- The proportion of acts of self harm accounted for by repetition in 2013 was 21.0%.
- The rate of repetition was broadly similar in men (14.5%) and women (13.3%).
- Approximately 14% of self-harm patients aged less than 15 years re-presented with self-harm in 2013.
- At least 5 self-harm presentations were made by 127 individuals in 2013, accounting for 1% of all patients, but representing 9% of all presentations.
- Self-cutting was associated with an increased level of repetition.

Follow-up Care:

1. 61% of patients were assessed by a member of the mental health team in hospital.
2. Assessment was most common following attempted hanging and attempted drowning.
3. 70% of those not admitted to the presenting hospital received a psychiatric assessment prior to discharge.
4. Next care varied significantly by HSE hospital group; the proportion of self harm patients that left before a recommendation was made varied from 10% in Dublin/Midlands to 19% in Dublin North East and North Eastern Hospital Groups.
5. Inpatient care varied from 19% of the patients treated in the Mid-Western Hospital Groups to 45% in the Dublin/Midlands Hospital Group.

6. 70% of patients discharged from the ED were provided with a referral. In 29% of cases, an outpatient appointment was recommended as a next care step for the patient, 17% of patients were discharged with a recommendation to attend their GP for a follow-up appointment.

There are some useful sources of information on mental health in Ireland, including the National Psychiatric In-patient Reporting System (NPIRS) run by the Health Research Board (HRB), and the annual reports of the Inspector of Mental Hospitals.

Data collected in the third National Survey of Lifestyle, Attitudes and Nutrition (i.e. SLÁN 2007) provides measures of positive mental health and non-specific psychological distress from the SF-36 questionnaire, together with measures of social well-being, subjective health, and selected health behaviours (Morgan, et al. 2008). Van Lente et al. used data from SLAN 2007 and found that positive mental health is predicted by lower levels of loneliness and higher levels of social support (Van Lente, et al. 2012). Also, better self-rated health, positive health behaviours and lower GP consultation rates are associated with higher levels of positive mental health. Lower levels of social well-being, were found to be the strongest predictors of negative mental health.

There are some fundamental gaps in our information on mental health in Ireland, some of which are specific to Ireland and some of which are challenges other countries also face. The number of people with depression in the country is not known, although it can be estimated, based on information from other countries. Nor is it known what type of mental health care these individuals receive (DOHC 2006).

There are a number of challenges in the measurement of mental health and wellbeing, including (FPH 2014):

- Mortality data, a mainstay of measurement, does not adequately capture the prevalence or incidence of mental illness, nor the disability it causes. Mortality data is useful for exploring excess deaths due to suicide.
- Prevalence data relies on diagnosis, which is dependent on access to health services. It is estimated that only 32% of those with clinical levels of mental illness receive treatment. Unmet need remains a challenge to public health. Self-report of symptoms of mental illness is influenced by the stigma associated with it.
- The concept of mental wellbeing is not a diagnosis; it represents one end of a continuum and is therefore difficult to measure. It has only recently been measureable with valid and reliable measures. The most popular scales of mental wellbeing in the UK are the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) and the short version (SWEMWBS). Also, recent work in the UK has established population mean scores for mental wellbeing at a national level and in some local areas.

One of the main shortcomings of mental health information in Ireland is the lack of a mental health information technology and telecoms (IT&T) system to support the provision of information (DOHC 2006). In the UK, Public Health England's knowledge and intelligence function has established a wellbeing and mental health stream, including a new Mental Health Information Network.

PUBLIC HEALTH PRIORITIES FROM THE EPIDEMIOLOGY

- Suicide prevention: Current policies focus on suicide in young people, however the highest rates in Ireland are in middle aged men
- A life course approach with a strong focus on prevention e.g. A focus on behavioural disorders and learning disability and autism in children, Deliberate self-harm, eating disorders, substance misuse, suicide and affective and psychotic disorders in young people, substance misuse, affective disorders and suicide in adults and affective disorders and dementia in older people.

- Improvement of health intelligence in relation to mental health e.g. Locality specific data for mental health to enable local prioritisation and increased public health research, development of core indicators for mental health and wellbeing (including risk factor/protective factor data), investigation of outlier areas with regards to suicide, DSH etc.
- Inequalities: Minority groups who may have more mental ill health and perhaps unable to access services e.g. travellers, LGBT groups, prisoner and ex offender populations.

6. PROPOSED CONTRIBUTIONS BY PUBLIC HEALTH

From a rapid review of the epidemiology of mental health in Ireland and a review of the relevant guidance and policy the following priorities have been identified. Note that the possible contributions listed are not an exhaustive list and projects would have to be agreed with the Public Mental Health Working group.

Priority No.	Priorities	Potential Partners	Possible Contribution
1.	Suicide (With a focus on highest risk groups e.g. 45-54 year old men)	NOSP etc.	Any and all areas of PH expertise.
2.	Adopt a life course approach across projects e.g. Building mental resilience in children and young people MH needs of older persons with dementia	Mental Health Division etc.	Any and all areas of PH expertise as needed.
3.	Support activities of the Mental Health division	Mental Health Division etc.	Any and all areas of PH expertise as needed.
4.	Mental health and wellbeing strategy	Health promotion, Mental Health Division, NOSP, Primary Care etc.	Could support development of a cross-sectoral mental health and wellbeing strategy with a focus on prevention
5.	Health intelligence	Public Health Profiles working group, Health intelligence, Institute of Public Health etc.	Could support development of core indicators for mental health and wellbeing (including risk factor/protective factor data), investigation of outlier areas with regards to suicide, DSH etc.
6.	Inequalities in mental health including cultural competence in Mental Health	Any	Could support development of profiles of these groups. Incorporate inequalities and cultural competence throughout other projects. Could support projects which could be identified by potential partners.

REFERENCES

Aked, J, N Marks, C Cordon, and S Thompson. "Five Ways to Wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being." 2008. http://www.neweconomics.org/projects/entry/five-ways-to-well-being (accessed July 21, 2014).

Aware. *Information on Depression.* 2014. http://www.aware.ie/help/information/information-on-depression/ (accessed Novemeber 11, 2014).

Barratt, Alan, George Savva, Virpi Timonen, and Rose Ann Kenny. *Fifty Plus in Ireland 2011: First results from the Irish Longitudinal Study on Ageing (TILDA).* Dublin: Trinity College Dublin, 2011.

Cannon, M, H Coughlan, M Clarke, M Harley, and I Kelleher. *The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group.* Dublin: Royal College of Surgeons in Ireland, 2013.

Daly, A, D Walsh, and R Moran. *Irish Psychiatric Units and Hospitals Census. HRB Statistics Series 22.* Dublin: Health Research Board, 2013.

Davies, S C. *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence.* London: Department of Health, 2014.

DOH. *Healthy Ireland. A framework for improved health & wellbeing 2013-2025.* Dublin: Department of Health, 2013.

DOH. *Strategic Review Of Medical Training And Career Structure – "The McCraith Report".* Dublin: Department of Health, 2014.

DOHC. *A Vision for Change.* Dublin: Department of Health and Children, 2006.

FPH. *Faculty of Public Health UK.* 2014. http://www.fph.org.uk/better_mental_health_for_all (accessed July 21st, 2014).

HRB National Psychological Wellbeing and Distress Survey. Dublin: Health Research Board, 2007.

Kennelly, B. "The economic cost of suicide in Ireland." *Crisis* 28, no. 2 (2007): 89-94.

Layte, R, and B Maitre. *The Association Between Income Inequality and Mental Health: Social Cohesion or Social Infrastructure? Working Paper No. 328.* Dublin: ESRI, 2009.

Morgan, K, et al. *SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland.* Dublin: Department of Health and Children, 2008.

NEF. *Five Ways to Wellbeing.* 2015. http://www.neweconomics.org/projects/entry/five-ways-to-well-being (accessed February 3, 2015).

NOSP. *Mental Health in Ireland: Awareness and Attitudes.* Dublin: National Office for Suicide Prevention, Health Service Executive, 2007.

NOSP. *National Office for Suicide Prevention Annual Report 2013.* Dublin: HSE, 2013.

NOSP. *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014.* Dublin: National Office for Suicide Prevention, Health Service Executive, 2005.

NSRF. *National Registry of Deliberate Self Harm Annual Report.* Cork: National Suicide Research Foundation, 2013.

NSRF. *National Registry of Deliberate Self Harm Annual Report.* Cork: National Suicide Research Foundation, 2013.

O'Shea, E, and B Kennelly. *The economics of mental health care in Ireland: Irish Centre for Social Gerontology and Department of Economics.* Galway: NUIG, 2008.

Peterson, C, and M Seligman. *Character Strengths and Virtues: A Handbook and Classification.* New York: Oxford University Press, 2004.

PHIS. *Public Health Information System 12.* Dublin: Department of Health, 2012.

Tedstone Doherty, D, and R Moran. *Mental health and associated health service use on the island of Ireland. HRB Research Series 7.* Dublin: Health Research Board, 2009.

Tedstone Doherty, D, R Moran, and Y Kartalova-O'Doherty. *Psychological distress, mental health problems and use of health services in Ireland. HRB Research Series 5.* Dublin: Health Research Board, 2008.

Tedstone Doherty, D, R Moran, Y Kartalova-O'Doherty, and D Walsh. *HRB National Psychological Wellbeing and Distress survey: Baseline Results.* Dublin: Health Research Board, 2007.

Van Lente, E, et al. "Measuring population mental health and social well-being.." *International Journal of Public Health* 57, no. 2 (2012): 421-30.

Watson, D, and B Maitre. *Understanding Emotional, Psychological and Mental Health (EPMH) disability in Ireland: Factors Facilitating Social Inclusion.* Dublin: ERSI and National Disability Council, 2014.

WHO and Calouste Gulbenkian Foundation. *Social determinants of mental health.* Geneva: World Health Organization, 2014.

WHO. *Preventing Mental Illness Prevention of mental disorders : effective interventions and policy options.* Geneva: World Health Organisation, 2004b.

WHO. *Promoting mental health : concepts, emerging evidence, practice.* Geneva: World Health Organisation, 2004a.

WHO. *The Ottawa Charter for Health Promotion.* Geneva: World Health Organization, 1986.

—. *World Health Organisation Mental Health: a state of wellbeing.* 2014. http://www.who.int/features/factfiles/mental_health/en/ (accessed November 8, 2014).

Wilkinson, Richard. *Wilkinson, Richard. 1996. Unhealthy Societies: The Afflictions of Inequality. London: .* London: Routledge, 1996.

APPENDIX 1

Ambition 1. Our leaders advocate for the mental health of citizens as a valuable resource for thriving communities and economies.

Target workforce:

• directors of public health

• directors of children's, adult and neighbourhood services

• chief executive and senior officers in local government • PHE – national, regional, centre directors

• political leaders – in local and national government, elected representatives

• local mental health service system leaders – clinical commissioning group commissioners, CEOs, GPs, lay members, mental health service CEOs, senior staff and clinicians

• public health academics and professional bodies

• third sector, independent experts and advocates, including public champions and community leaders

Key competencies:

1. Integrate mental health within all policy and take action to mitigate any negative impacts of policy on mental health
2. Promote the value of mental health and the reduction of inequalities across settings and agencies
3. Advocate for mental health and addressing mental illness as central to reducing inequalities and creating thriving communities and economies
4. Create organisations that nurture and sustain the mental health of employees

Key priorities:

1. For public health bodies and organisations to demonstrate leadership in the above competencies.

2. To support the development of the above competencies in current and future leaders, to lead for wellbeing, mental health and community assets as part of a 21st century public health system.

3. To develop a shared understanding across organisations on mental health within the public health (and wider) system.

4. To build capability in embedding mental health in all policy and programmes and taking action to mitigate potential negative impacts of policy on the public's mental health.

5. For local authorities to adopt the local authority mental health challenge and appoint an elected member champion for mental health. (See box below)

6. For leaders in organisations to understand the mental health of employees and to lead organisational development in a way that sustains good mental health.

7. To increase organisational commitment to the Workplace Wellbeing Charter and support businesses to gain

achievement and excellence.

Ambition 2. A public health specialist workforce that has expertise to lead mental health as a public health priority.

Target workforce:

Public health senior staff: managers, commissioners, specialists, consultants, directors

Key competencies:

1. Assess and describe the mental health and illness needs of specific populations and the inequities experienced by populations, communities and groups

2. Translate findings about mental health and illness, and needs and assets, into appropriate recommendations for action, policy decisions and service commissioning/ delivery/ provision

3.Influence political/ partnership decision making to maximize the application and use of evidence in achieving change

4. Set strategic direction and vision for mental health and communicate it effectively to improve population health and wellbeing

5.Advise strategic partners to determine priorities and outcomes to achieve improvements in quality and cost-effectiveness of treatments for mental illness and associated co-morbidities

Key priorities:

1. To have a senior lead within every local authority public health team with the necessary capacity and capability in mental health, including the above key competencies.

2. Local public health teams to build workforce capacity and capability in public health practitioners and providers to deliver sustainable improvements in mental health promotion, mental illness and suicide prevention and improving the life expectancy of people living with and recovering from mental illness.

3. To build commitment and capability across the whole public health system, nationally and locally, to: a. address mental health as a key determinant of morbidity and mortality b. increase life expectancy of people with mental illness as a priority for reducing health inequalities and achieving parity of esteem

4. To build capability in mental health intelligence, specifically to:

a. increase knowledge of mental illness and mental health amongst public health analysts and capability in producing joint strategic needs assessments based on mental health and illness needs and assets. b. improve the use of mental health outcome measurement and analysis by public health specialists, practitioners and the wider workforce in assessing local interventions c. develop coherent and comprehensive systems of surveillance and assessment of mental health outcomes within services and across the population

5. To ensure the public health competence framework adequately reflects the knowledge and competence to address mental health and mental illness as public health priorities.

6. To ensure the curricula and formal academic training of the public health workforce adequately addresses mental

health and mental illness as public health priorities.

7. Local public health professionals responsible for mental health should have their continuing professional development needs met in relation to their roles as experts and leaders of change in mental health. This includes through: a. leadership development – to strengthen political awareness, influencing and advocacy roles of public mental health leads b. networking, peer support and coaching, sharing of best practice and collaboration across localities

Ambition 3. A local workforce working with communities to build healthy and resilient places

Target workforce:

community health workers, public health/health promotion/health improvement practitioners, health visitors, health trainers, health champions • eople working with communities in a range of sectors including social care, police and crime prevention, housing, neighbourhood development, education and learning

Key competencies:

1. Identify the existing resources and strengths within a community and the expertise within the voluntary and community sector 2. Offer appropriate support to change, development and capacity building in the community, based on asset approaches (PHS17)42 3. Enable communities to develop their capacity to advocate for mental health (PHS18)43 4. Engage, empower and work alongside volunteers, lay workers, community leaders and community members, especially the most marginalised and excluded.

Key priorities:

1. To improve access to evidence and knowledge of practice in working with communities.

2. To have local community development infrastructures, especially in the most disadvantaged communities, co-ordinated between different workforces and agencies and with local citizens.

3. To develop best practice and workforce competence in asset-based approaches to working with communities and community development.

4. To strengthen the role of health trainers, health champions and lay workers as a key workforce to working with communities and reducing health inequalities.

5. To strengthen the role of health visitors and other community public health nurses in working with communities through the building community capacity (BCC) professional development programme (see box below).

6. For the health and social care services to value the role of people with lived experience and work with community groups as valuable assets to support health promotion, self care, recovery and condition management, eg, recovery capital and understanding of mutual aid groups for addiction

7. To develop the evidence and evidence-based practice on ways the workforce can contribute to building social connections, resilient relationships and reduce isolation within communities.

8. To strengthen the role and competence of housing and neighbourhood workers to improve community wellbeing and social capital. 9. For the public health knowledge and intelligence workforce to strengthen the voice of communities and citizens in public health evidence and intelligence.

Ambition 4. Frontline staff are confident and competent in communicating with people about mental health and supporting them to improve it

Target workforce:

health and social sector: primary, community and secondary care staff (eg, GPs, health visitors, midwives), social workers, family workers, parenting practitioners, health trainers, health improvement, pharmacists, alcohol and drugs workers • education sector: teachers, pastoral and welfare, school nurses • community services: probation, police, youth workers, faith, leisure, community and third sector

employment and welfare sector: job centres, work programme providers, occupational health, line managers, benefit and welfare advisors, and housing support staff

Key competencies:

1. Encourage and enable individuals and families to identify the things that are affecting their mental health, now and in the future, and the things they can do to improve it

2. Use appropriate tools and approaches that support people to build their skills and confidence in staying mentally healthy

3. Help people to develop and implement* a personal or family action plan to improve their mental health

4. Enable people to get hold of up to date appropriate information and advice when they need it and access opportunities in their community

Key priorities:

1. Develop appropriate skill-based mental health promotion training, including the above competencies, and roll-out to frontline staff to improve mental health within their day to day practice.

2. Develop and test out appropriate mental health brief intervention models and approaches: a. establish mental health within 'making every contact count' b. integrate with existing brief intervention programmes, eg, AUDIT c. support adoption and uptake within local programmes and care pathways

3. Produce guidance for commissioning and evaluating mental health workforce development for the wider public health workforce.

4. Support the inclusion of the above competencies and up-to-date evidence-based mental health practice within core frontline worker curricula, continuing professional development and professional guidance, eg, nursing, social care, allied health professionals, teaching, youth and community work, alcohol and drug workers.

5. Support adoption of the Skills for Care core principles on mental health and wellbeing by the social care workforce.

6. Include mental health as a core component of the specialist community public health nurse training.

7. Establish infant and parental mental health and wellbeing and parenting support as an integral part of antenatal and postnatal care professional training, eg, midwifery, health visiting.

8. Increase school nursing capacity to deliver emotional health and wellbeing support, build resilience and engage

more children and young people through appropriate services and use of new technologies.

9. Encourage employers to improve workplace wellbeing by adopting existing good practice guidance and frameworks, such as the Public Health Responsibility Deal Health at Work pledge, Health and Safety Executive management standards, Faculty of Occupational Medicine standards, NICE workplace guidance, Workplace Wellbeing Charter, Business in the Community workwell campaign.

10.Embed workplace wellbeing in the work of relevant professional bodies, eg, Chartered Institute of Personnel and Development (CiPD), Association of Occupational Nurse Practitioners, and business schools providing management and leadership training.

Ambition 5. Frontline staff are confident and competent in recognising signs of mental distress and supporting children, young people, parents and adults appropriately.

Target workforce:

• health and social sector: health improvement practitioners, pharmacists, primary, community and secondary care staff, eg, health visitors, midwives, school nurses, alcohol and drugs workers, social care, parenting support and family workers, and health trainers • education sector: early years staff, teachers, pastoral and welfare • community services: police, probation, youth workers, faith, leisure, community and third sector • employment and welfare sector: job centres, work programme providers, occupational health, line managers, benefit, finance and welfare advisors, and housing support staff

Key competencies:

1. Recognise when someone may be experiencing mental distress, including selfharm and suicidal thoughts and intentions

2. Judge risks and follow appropriate procedures and guidelines

3. Apply an early intervention or suicide intervention model

4. Link people to appropriate sources of support, to address psychological need and social causal factors

Key priorities:

1. Gain widespread coverage of prevention training for priority frontline staff working with people at risk of distress and mental illness including vulnerable groups.

2. Gain widespread coverage throughout the regions of suicide prevention training for priority frontline staff working with people at risk of suicide, in line with the suicide prevention strategy.

3. Support the inclusion of the above competencies and up-to-date evidence-based practice within priority frontline worker curricula, continuing professional development and professional guidance.

4. Build capability in the children and young people's workforce through uptake of the MindEd e-programme within localities.

5. Encourage employers to adopt line mangers guidance to support people in the workplace experiencing distress, eg, Mindful Employers, Time to Change.

6. Ensure adequate local professional support and liaison services for front-line workers providing early intervention

and support to people experiencing mental distress.

7. Build capability and practice in addressing the social and causal factors of distress among those at risk, including referring to social and practical support, eg, people experiencing domestic violence, unemployment, debt, homelessness and loneliness.

Ambition 6. The health and social care workforce has the knowledge and skills to improve the health and wellbeing of people with a mental illness and reduce mental health inequalities

Target workforce:

• primary care: practice nurses, GPs, primary mental health care providers, allied health professions • public health practitioners: health improvement/lifestyle behaviour change staff, screening staff, alcohol and drug treatment workforce, sexual health service staff

secondary care: multi-disciplinary mental health service staff, eg, child, adult and later life – psychiatrists, social workers, nurses, allied health professions, prison in reach • community and third-sector providers of services and support to people with mental illness

Key competencies:

1. Support people experiencing mental illness to make and maintain informed choices about improving their health and wellbeing as part of recovery including: – health behaviour and physical health – mental health and resilience – control and participation – welfare support, eg, financial management, benefits uptake, employment, housing

2. Deliver care holistically; through integrating physical, psychological, spiritual and social factors within all care pathways

3. Support individuals and communities in the articulation of their priorities and advocating for health and wellbeing

Key priorities:

1. To include public health competence within the curricula and competency frameworks of mental health service professionals, eg, psychiatrists, nurses, social workers, clinical commissioners, managerial leaders.

2. To increase access to and uptake of professional guidance and continuing professional development by the mental health service workforce to meet the physical health needs of people with mental illness, to address needs holistically and adopt a broader population health care approach.

3. To increase the roll-out and use of 'making every contact count' brief intervention training within the mental health service sector.

4. To develop the knowledge and skills of health improvement, public health and primary care practitioners to address the impact of mental illness on physical health, and provide accessible and effective prevention services for people with a mental illness, eg, screening, NHS Health Check, smoking cessation, drug and alcohol, weight management, physical activity.

5. To build competence amongst statutory providers and commissioners in working with the voluntary and community sector in their locality and understanding the contribution they make to health and wellbeing.