Co operation and Working Together

Promoting Mental Health in the CAWT Region:

A Strategic Review

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Acknowledgement

We are grateful for the EU financial support secured by Co-operation and Working Together (CAWT) for this cross border health and social care project. This project, *Mental Health and Young People*, is funded by the EU Programme for Peace and Reconciliation (PEACE II) under Measure 5.2 Improving Cross Border Public Sector Co-operation.
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Promoting Mental Health in the CAWT Region:
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1.0  Background

Co operation and Working Together (CAWT) was established in 1992, when the North Eastern Health Board (NEHB) and North Western Health Board (NWHB)\(^1\) from the Republic and the Western Health and Social Services Board (WHSSB) and Southern Health and Social Services Board (SHSSB) from Northern Ireland signed the Ballyconnell Agreement, committing them to co operation to improve the health and social well-being of residents in the border areas. (CAWT 2002) The work of CAWT has been given new impetus since the signing of the Good Friday Agreement and includes a very wide range of projects, many funded via the EU Interreg 111A and Peace 11 programmes. (www.cawt.com)

The CAWT Young People’s Mental Health Initiative aims to promote mental health and well-being across the CAWT area. The project is funded under Peace 11 and managed by the CAWT Mental Health sub group, together with representatives from the CAWT Health Promotion sub group.

The Mental Health Sub-group has commissioned this strategic review to inform the future direction of the Young People’s Mental Health Initiative, which has a specific focus on:
- young people 16-25 years old
- impacted on by conflict
- living in the CAWT region

More broadly, the review is also intended to be a critical document for action, setting out a framework for the support and development of mental health promotion across the CAWT region.

The Subgroup wishes to ensure that project activities will be influenced by recommendations from existing studies and reports and will align with core health and other relevant strategies North and South. This strategic review therefore includes the following areas:

\(^1\) Now HSE North West and HSE North East

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- what mental health promotion is and how it fits within the policy environment
- existing/emerging policy and strategy related to the promotion of mental health across the island of Ireland, but with specific emphasis on the promotion of young people’s mental health
- an overview of current work and evidence on mental health promotion initiatives for young people (16-25 year olds), with particular reference to the impact of conflict.
- what is required to strengthen existing commitment to and action on mental health promotion in this area

2.0 Aims of CAWT Mental Health Initiative

The goal of the project is to promote positive mental health, with a specific focus on young people aged 16-25. Key objectives of the project include:

- strengthening collaborative working to achieve improved mental health for young people
- recognising and addressing the mental health impact of the civil conflict
- enabling young people to be fully engaged and involved

The aim of the initiative is therefore to have a positive impact on the mental well-being of young people in the CAWT area and also to develop a strong and sustainable basis for supporting cross border mental health promotion in the future. The recommendations of this review therefore address both elements, considering what action is needed to:

- support improved mental well-being among young people
- develop the capacity of young people to promote their own mental well-being and that of others
- develop an infrastructure that will strengthen capacity for mental health promotion, both across the border and between different agencies/ departments/ disciplines e.g. mental health services, health promotion, public health, education and the voluntary and community sector
3.0 Methodology

This review is based on a combination of desk research, semi-structured interviews and a consultation event held in Omagh on 19th May 2005, attended by colleagues with a mental health promotion role from across all four health boards. The review also builds on a series of meetings and seminars held with project staff, members of the Mental Health Promotion and Health Promotion sub-groups and other colleagues held earlier this year as part of the CAWT mental health promotion project’s quality assurance process.

4.0 A question of language: what is mental health promotion?

“Public mental health, (of which mental health promotion is one element), provides a strategic and analytical framework for addressing the wider determinants of mental health, reducing the enduring inequalities in the distribution of mental distress and improving the mental health of the whole population” (Friedli 2004 p.2).

The difficulty of agreeing a common language and shared definitions of mental health promotion is widely acknowledged to be a significant barrier to working across professional and sector boundaries. Mental health, mental well-being, emotional well-being, emotional literacy, well-being and quality of life may be used more or less interchangeably and/or may have very different meaning and significance in different sectors. There are ongoing debates about concepts and definitions of mental health (http://www.wellontheweb.org/well/files/conceptsbriefing-final.doc). Differences in the way in which mental health is defined and measured can also make it difficult to interpret and compare data on prevalence, for example is the mental health of young people declining; is young people’s mental health worse in rural areas?

Some of the difficulties are beginning to be resolved through the development of mental health indicators, which help to make more explicit the difference between:

- measures of mental illness e.g. surveys of psychiatric morbidity
- measures of positive mental health e.g. Affectometer II which identifies cognitive and emotional attributes associated with psychological well-being
- quality of life surveys which assess life satisfaction and access to resources

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2 Meetings were held in Derry and Omagh on 1st/2nd/3rd February 2005 and included project staff, the Chair of the Mental Health Sub-group, members of the Mental Health Sub-group and the Principle Executive Officer of CAWT. In addition, an informal meeting and discussion, followed by dinner, was held with a wider range of colleagues with an interest in mental health promotion, including members of the Health Promotion Sub-group. Findings from the quality assurance review are available in the report CAWT Mental Health Promotion Project: next steps.

3 For a literature review of measures of mental health and well-being see Mauthner and Platt 1998

4 The Scottish Executive is funding a major programme on the development of public mental health indicators, currently in its second year http://www.phis.org.uk/info/mental.asp?p=bg

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Broadly, mental health promotion is an umbrella term that includes action to promote mental well-being, to prevent mental health problems and to improve quality of life for people with a mental illness diagnosis. Definitions of mental health promotion have been influenced by the theory and practice of health promotion:

“Health promotion is the process of enabling people to increase control over, and to improve their health”.

Mental health promotion is essentially concerned with:

- how individuals, families, organisations and communities think and feel
- the factors which influence how we think and feel, individually and collectively
- the impact that this has on overall health and well-being. (Friedli 2000)

Mental health promotion aims to:

- **promote mental health and well-being for all** e.g. health promoting schools, workplace policies, supporting parents
- **prevent mental health problems** through increasing protective factors (e.g. social support, job control, benefit uptake, employment) and reducing risk factors (e.g. racism, violence, bullying, debt, isolation)
- **improve quality of life for people with mental health problems** e.g. reducing discrimination and social exclusion, meaningful occupation

Mental health promotion works at three levels and at each level is relevant to the whole population, to individuals at risk, vulnerable groups and people with mental health problems:

- strengthening individuals or increasing emotional resilience e.g. self-esteem, life and coping skills, communication, parenting skills etc
- strengthening communities e.g. increasing social inclusion, improving neighbourhoods, developing services which support mental health, community safety, mental health strategies in schools and workplaces, 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

(Department of Health 2001)
Public mental health takes a population wide approach to understanding and addressing risk and protective factors for mental health and has been defined as the art, science and politics of creating a mentally healthy society.

“How people feel is not an elusive or abstract concept, but a significant public health indicator; as significant as rates of smoking, obesity and physical activity” (Department of Health 2001)

Improving the mental health of the population may be seen as:
- a valuable goal in itself
- a means to achieving wider goals: improved health behaviour, physical health, educational attainment, productivity, decreased behavioural disorders and criminal activity.

It may involve both:
- reducing the incidence and prevalence of mental illness
- increasing mental well-being (i.e. strengthening emotional and cognitive skills and attributes associated with good mental health, measured for example through SF 36 or Affectometer II)

Historically there has been a tendency to view mental health promotion as of little relevance to mental health services (and vice versa). Increasingly, however, this is changing as mental health services place greater emphasis on recovery, social inclusion and quality of life.

5.0 Policy environment

In Northern Ireland, recent years have seen a commitment to addressing levels of mental distress evident in prevalence figures for mental health problems, which some data suggests are 25% higher than in England (Northern Ireland Statistics and Research Agency 2002; Smyth et al 2003), although the General Household Questionnaire scores (high scores indicating a higher probability of the presence of psychological illness) were similar to those found in UK surveys (Cairns et al., 2003). Civil conflict has cast a long shadow, exacerbated by high levels of deprivation and unemployment (Cairns and Wilson 1984; Curran et al 1990; Fay et al 1999; Kelleher 2003). Suicide trends over the last 10 years show a 27% increase in Northern Ireland, (and a similar increase in the Republic)\(^5\) compared to a 9% decrease in the UK overall (http://www.nisra.gov.uk; Crowley et al 2004).

In Ireland, the Report of the National Task Force on Suicide (Department of Health and Children, 1998) sets the policy context for suicide prevention, although no measurable targets are set. While this policy document is not specific to young people it provides a

\(^5\) Data for the Republic of Ireland refers only to deaths recorded as suicide and is therefore not accurately comparable with data from England, Scotland, Wales and Northern Ireland.
CAWT Mental health promotion: strategic review


Promoting social inclusion (PSI) is a key element of *New Targeting Social Need*, (Northern Ireland Office 2003) which has a special focus on mental health, and promoting mental health and well-being is one of the objectives of *Investing for Health*, the regional health strategy for Northern Ireland launched in 2002 (DHSSPS 2002; DHSSPS 2003). *Investing for Health* has a clear objective around improving mental health and emotional well-being, as does 'A Healthier Future', the 20 year strategy for DHSSPS, which puts a very strong emphasis on health improvement and promotion, including mental and emotional well-being.

The strategy and action plan, *Promoting Mental Health* was published by the Department of Health, Social Services and Public Safety (DHSSPS) in January 2003, following responses to the consultation document *Minding our Health* (DHSSPS 2003; DHSSPS 2000).

*Promoting Mental Health* aims to improve mental and emotional well-being and to prevent or reduce the impact of mental illness. Overall, the Strategy strikes a balance between addressing life circumstances and developing life skills and is based on three principles: a holistic approach, empowerment and respect for personal dignity. The Action Plan addresses four areas: policy development, raising awareness and reducing discrimination, improving knowledge and skills and preventing suicide. *Promoting Mental Health* was well received and provided an impetus for the development of local mental health promotion action plans, for example by the Western and Southern Health and Social Services Boards.

A further key policy development in Northern Ireland is the Bamford Review of policy, practice and legislation relating to mental health and learning disability, commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) in October 2002 (Bamford 2004). While the emphasis of the main Review is on mental health services, Bamford explicitly recognizes the importance of a wider strategy: “a holistic approach to the issues of mental ill-health also requires a robust strategy for prevention and mental health promotion”. Mental health promotion is the subject of a separate report scheduled for publication later this year. The draft report includes a strong vision for mental health promotion:

*The Mental Health Promotion Expert Working Committee wants to see recognition at all levels in Northern Ireland:*

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

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that mental health promotion strategies and practice are in keeping with human rights and equality legislation

We also want to see a society where everyone plays a role in and takes action to create an environment that promotes the mental health and well-being of individuals, families, organisations and communities.

The report also makes a series of recommendations, including the creation of a Regional Mental Health Promotion directorate and identifies the following as crucial to achieving effective delivery of mental health promotion in Northern Ireland:

- prioritisation of key risk groups
- capacity building
- research
- co ordination
- cross sector partnership and working
- compliance with equalities and human rights legislation
- dedicated resources

Recently concerns have been expressed that pressure on public sector funding in Northern Ireland may pose a significant threat to future investment in mental health promotion, which currently stands at around £200,000. Other barriers identified during a consultation exercise on Promoting Mental Health include lack of guidance on delivery, lack of leadership and inadequate commitment to cross sectoral collaboration (Mental Health Promotion Expert Working Committee for Bamford Review, forthcoming).

Making the case for additional investment may be helped by an economic analysis undertaken by the Northern Ireland Association for Mental Health, in collaboration with the Sainsbury Centre for Mental Health (NIAMH 2003). This estimates the total financial cost of mental illness in Northern Ireland at £2,852,000,000.

In the Republic, current policy on mental health promotion is outlined in the National Health Promotion Strategy 2000-2005 (Department of Health and Children 2000; Health Promotion Unit http://www.healthpromotion.ie/). A recent interim review of the Strategy (McKenna, Barry and Friel, 2004) found a high level of activity at national and regional levels, which was bolstered by the recommendations from the Report of the National Task Force on Suicide (1998). Suicide Resource Officers in each of the regional boards have been appointed, many of whom also have a wider mental health promotion role. Substantial funding has been made available for suicide prevention, much of which includes more generic mental health promotion activities in schools and communities.

For the future, much rests on the National Expert Group on Mental Health Policy, which is due to report to the Minister for Health & Children on developing a new national mental health policy for the next ten years in Ireland. If the recommendations of the mental health promotion sub-group are accepted, mental health promotion will be an integral part of the new policy. Considerable impetus is likely to come from the North
West Region, which already has a strategy and action plan for Mental Health Promotion (North Western Health Board 2004).

There is also a wide range of policies which include a focus on the mental health and well-being of young people. North and South, these reflect a number of key themes in relation to approaches to young people that are consistent with the aims of the CAWT project and which provide key opportunities for mainstreaming mental health promotion. These themes include:

- an emphasis on the participation and involvement of young people
- the value of a more holistic or ‘whole person/whole child’ approach
- the importance of cross sector partnerships
- a broad recognition of the importance of emotional well-being to health, social, educational and economic outcomes for young people

The right to participation is also enshrined within the UN Convention on the Rights of the Child.

Most policies also recognize the special needs of at risk and vulnerable groups of young people and the extent to which gender, ethnicity and sexuality, as well as disability, socio-economic status and living in an urban or rural environment influence mental health. In Northern Ireland, the policy environment for young people has been influenced by a growing number of studies concerned with the impact of political conflict and intercommunity divisions on children and young people (Smyth 1998; Cairns 1996; Donnelly 1995; 1999). On both sides of the border, there is concern about:

- increased opportunities to engage in risk taking behaviour
- a greater range of pressures leading to a decline in psychological well-being
- transition to social and economic independence being delayed or protracted

In the Republic, the National Children’s Strategy (Department of Health and Children, 2000b) provides an integrated framework and the policy context for child health initiatives, including the priorities and actions outlined in the health strategy Quality and Fairness – A Health System for You (Department of Health and Children 2001). This recommends the development of an integrated national programme for child health and the expansion of family support services.

Other initiatives include:
- The Health of Our Children Annual Report of the Chief Medical Officer (Department of Health and Children, 2000)
- Get Connected – Developing an Adolescent Friendly Health Service (National Conjoint Child Health Committee, 2000)
Get Connected (National Conjoint Child Health Committee 2000) highlights the need for a greater focus on mental health issues which it describes as having wide ranging implications for other health issues and calls for a “refocus of attention from health related lifestyle behaviour and the concept of risk to the ‘whole child perspective’ endorsed by the National Children’s Strategy”.

Ireland’s National Health Promotion Strategy 2000-2005 (Department of Health and Children 2000) has six objectives for young people, including a strong focus on consulting and involving young people, through for example partnerships with the National Children’s Office and National Youth Council of Ireland, Dail na nOg and the National Youth Health Promotion Training Programme, as well as via activities at health board level, for example peer education.

Promoting mental health (DHSSPS 2003) also includes actions particularly relevant to young people, including suicide awareness for teachers and youth leaders (action 21), working with youth services, the Youth Council for Northern Ireland and the Voluntary and Community Sector (VCS) to develop outreach for young people in areas of need, especially young men. It also includes a specific section on the psychological impact of conflict: segregation, displacement, bereavement and traumatisation and poor mental health.

The Children and Young People’s Strategy for Northern Ireland, currently out for consultation, identifies strategic action under five themes: rights and equality, participation, provision, protection and poverty.
(http://www.allchildrenni.gov.uk/strategy.htm)

A key strategic objective is the development of a culture where children and young people are valued and supported and overall, the strategy highlights a significant number of areas relevant to mental health. Key indicators include reductions in suicide, levels of racial and gender inequality, bullying, vandalism and risk taking behaviour, physical and cultural activity, participation in citizenship studies, as well as a very wide range of indicators concerning opportunities for young people to participate, including peer led programmes. The health and well-being of children and young people in rural areas and action to reduce stress is also highlighted and the impact of the conflict is a cross cutting theme. The strategy currently recommends the development of a Play and Recreation Strategy for Northern Ireland, which also opens opportunities to strengthen awareness of the links between leisure activities and mental well-being.

The Draft Youth Work Strategy for Northern Ireland (Department of Education and Youth Service Liaison Forum 2004), which is being developed in parallel with the Children and Young People’s Strategy, sets out a vision for the role of youth work in addressing the needs, aspirations and rights of young people aged 4 – 25 years. It includes a wide range of themes relevant to mental health promotion, with an explicit focus on well-being, self esteem, building skills and confidence and personal and social development and is also a valuable example of the cross cutting and inter-sectoral
approach that is essential to working with young people. Key needs identified for young people aged 16 – 25 are:

- information
- specialist support during periods of crisis
- citizenship and support to active participation in community life

As the above discussion indicates, in many ways the policy environment for mental health promotion has never been more favourable. In their cross border study, Barry et al (2002) found that mental health promotion is increasingly recognized on the agendas of a range of statutory and voluntary agencies across Ireland, North and South and the Northern Ireland Health Promotion Agency has an extensive database of mental health promotion initiatives. (http://www.healthpromotionagency.org.uk/Resources/mental/pdfs/database.pdf. The past decade has seen a growing recognition of the benefits of action to promote mental health across the UK and Europe (Friedli 2004; WHO 2004; WHO 2005a, WHO 2005b) and internationally (Murray and Lopez 1999; Jane-Llopis et al 2004; Hosman et al 2005), as well as in the trends described in Northern Ireland and the Republic.

### 6.0 Mental health promotion policy and strategy in the CAWT region

Each of the four health boards across the CAWT region has an explicit commitment to promoting mental health.

- HSE North Western and SHSSB have dedicated mental health promotion strategies and action plans (NWHB 2004; SHSSB 2005).
- Following a major mental health promotion conference, *Making it happen in the West*, WHSSB has focussed on building shared ownership and delivery of the regional strategy (Promoting Mental Health), as well as linking the sexual health strategy and mental health promotion strategy in addressing the needs of young people.
- In the North East, mental health is included in *A health strategy for the people of the North East: a framework for change and development* (2003) which prioritises health promotion and prevention and includes a commitment to “continue to contribute to the Co-operation and Working Together (CAWT) partnership to support cross-border working and improve the health and social well-being of families and communities in the border region”. The North East Suicide Prevention Strategy *EROS* (NEHB 2003) also places a strong emphasis on mental health promotion, through enhancing protective factors and reducing risk factors (NEHB undated).

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6 Copies of the WHO declaration and action plan can be found on:
http://www.euro.who.int/document/mnh/edoc06.pdf
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All four Health Boards also have a strong focus on the emotional well-being and mental health needs of young people, with a wide range of initiatives to promote mental health both within the school setting and more broadly. SHSSB has a specific aim to “consult with and involve young people in addressing the factors that influence their mental health and well-being”, which also features centrally in the WHSSB Framework for Mental Health Services for Young People 16-19 years: meeting their needs (WHSSB 2004) which asks:

- what are the outcomes for young people that we are working towards?
- how do we know that young people subscribe to those outcomes?
- what do we really mean by young person centered?

Meeting their needs is concerned with services for children and young people with emotional, behavioural, psychiatric and psychological needs (EBPP) but recognizes the importance of a comprehensive approach, embracing promotion, prevention and care, illustrating the growing interest in including mental health promotion as part of the package of services required to meet young people’s mental health needs. For health services, this requires stronger links with tier one services e.g. substance misuse and sexual health, as well as stronger partnership working with other sectors e.g. youth justice, education, employment.

Broadly then, there is a positive policy environment for mental health promotion within the CAWT region, which provides a supportive context for the CAWT mental health initiative.

6.1 Mental health promotion action in the CAWT region – what’s already happening?

Although a systematic mapping of mental health promotion activity is beyond the scope of this review, it is clear that there is a wide range of initiatives and programmes designed to target the needs of young people. The following table is intended to give an overview, rather than a definitive list. The difficulty of collating activity in this area suggests the need to consider possible mechanisms for recording and updating data on mental health promotion programmes. For example WHSSB is currently creating a database on mental health promotion initiatives in the area, including a mental health promotion website and a ‘map’ of emotional and psychological support services for children and young people in the Western Area.

### Table 1: mental health promotion activity across the CAWT region

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For ease of reference, initiatives have been classified in three categories: promotion, prevention or improving quality of life for people with mental health problems. These categories frequently overlap e.g. a programme to promote mental health and well-being for all may also prevent mental health problems and/or improve quality of life for people with a diagnosis.

<table>
<thead>
<tr>
<th>Promote Mental Health and Well Being for all</th>
<th>Prevent Mental Health Problems</th>
<th>Improve quality of life for people with mental health problems</th>
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<tbody>
<tr>
<td>HSE NW Introduction of Mental Health Days in all schools</td>
<td>SHSSB Workshop to identify Mental Health Promotion needs of Young Carers</td>
<td>HSE NE, NW, WHSSB, SHSSB</td>
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<tr>
<td>HSE NW The School Journal</td>
<td>SHSSB Suicide awareness and support for those bereaved by suicide</td>
<td>ASIST suicide awareness</td>
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<tr>
<td>HSE NW Circle Time training for primary schools</td>
<td>SHSSB Network of bereaved by suicide groups</td>
<td>CAWT and AWARE (tbc)</td>
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<tr>
<td>HSE NW Restorative Justice Initiative</td>
<td>SHSSB Peer Education 18-25</td>
<td>Mental health first aid training</td>
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<td>HSE NE <a href="http://www.youthhealth.ie">www.youthhealth.ie</a> youth health information website with email response</td>
<td>SHSSB Right in UR Head</td>
<td>HSE NW</td>
</tr>
<tr>
<td>HSE NE Mind Yourself – Bringing Services Closer to Adolescents at Risk of Suicide</td>
<td>SHSSB UP! Training manual for youth workers</td>
<td>Create-a-link promoting mental health through arts and creativity</td>
</tr>
<tr>
<td>HSE NE Teenage Health Initiative Project - Foroige To delay the onset of early sexual activity among teenagers, targeting those known to be at greater risk of pregnancy</td>
<td>SHSSB Research on emotional and mental health needs of young people and good practice guidelines</td>
<td>SHSSB/HSE NE</td>
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<tr>
<td>HSE NW <a href="http://www.spunout.ie">www.spunout.ie</a> youth health information website</td>
<td>SHSSB/TASSK Crisis cards for post primary</td>
<td>Young People who self harm conference and working group</td>
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<tr>
<td>HSE NW Finn Valley Alliance for Positive mental health</td>
<td>HSE NW MINDOUT – cross border secondary schools to be extended to all schools and youth settings e.g. Youthreach</td>
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<tr>
<td>HSE NE</td>
<td>HSE NW Daybreak</td>
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<td>HSE NW Senior Help Line</td>
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Based on the information supplied to date, it is not easy to draw any firm conclusions about either duplication or gaps in mental health promotion provision. However, emerging impressions include:

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<td>Cool School anti bullying programme</td>
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<td>HSE NE Local action groups: suicide awareness and mental health promotion</td>
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<td>SHSSB Annual cross border mhp conference: young people and positive mental health</td>
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<tr>
<td>East Cavan Project – MIND Yourself Campaign</td>
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<td>‘Borderwise’ cross border information and advice project developed in partnership between Comhairle and Citizens Advice in Northern Ireland.</td>
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<tr>
<td>WHSSB Survive &amp; Thrive on the Farm – leaflet prepared as result of rural Mental Health Projects</td>
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<td>WHSSB Women in Enterprise Booklet</td>
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<td>Young People Health &amp; Social Well Being Strategy, Limavady</td>
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<td>WHSSB I’Dare – rural drug awareness</td>
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<td>WHSSB Crossroads</td>
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<td>WHSSB Drugwiser</td>
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<td>WHSSB Hope North West</td>
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<td>WHSSB Edge Project – lifeskills for vulnerable young people</td>
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<td>WHSSB E go Project for 13-18 yr olds</td>
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<td>WHSSB Shekinah Centre services</td>
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<td>WHSSB STEPS project</td>
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<td>WHSSB Underage drinking forum</td>
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<td>WHSSB Aisling centre youth counselling</td>
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<tr>
<td>Mood Matters Programme run by AWARE NI targets children and young people in the school setting</td>
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provision tends to be focussed on addressing existing problems, rather than on promotion and prevention
provision is topic focussed e.g. drugs, alcohol, although for young people, the evidence suggests that generic, life skills approaches may be more effective
it is not clear whether counselling services are based on approaches known to be effective i.e. CBT; there is very limited evidence that non directional or generic counselling is effective
there is a very limited number of mental health promotion initiatives which are youth led, i.e. which involve young people in all aspects of planning and delivery

7.0 Assessing the mental health promotion needs of young people in the border regions

There is no single study which provides data on the mental health needs or status of young people in the CAWT region. There is, however, a range of sources of information on national and regional trends which provides a reasonable basis on which to identify priorities, although these will need to be informed by local intelligence, in addition to the views of young people themselves.

7.1 Mental health status and determinants

Broadly, there is robust evidence of low levels of mental health (generally measured through GHQ scores) for a significant proportion of young people. This is consistent with trends across the UK and Europe, with a growing body of research suggesting that the mental health of young people has declined in recent decades. Rates of depression and anxiety among teenagers have increased by 70% in the past 25 years (Collishaw et al 2004), with a rise in prescriptions for anti depressants to children under 18 of 70% between 1992 and 2001 (Murray et al 2004). In the UK overall, 700,000 prescriptions for psychotropic medication are given to children annually, a rise of 68% in just two years and the biggest increase in the world (Wong et al 2004).

There is considerable debate about the extent to which social and economic change has influenced young people’s mental health, debates which have a particular resonance for both Northern Ireland and the Republic in a period of rapid economic growth, a perceived breakdown in communities, changes to traditional patterns of employment, higher rates of parental separation and the emergence of smaller family units and more one parent families (O’Reilly and Stevenson 1998; Bradley 2000; Layte and Jenkinson 2001; Cairns and Lloyd 2005; Crowley et al 2004).

It has also been argued that young people now face increased demands and challenges. They are exposed to more performance measurement within schools and are regularly targeted by the media and advertising (Weare 2000). A theme to emerge from a conference in 2004 in Limavady involving young people (organised by LATCH) was that

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a greater number of opportunities for young people also generated more opportunities to fail.

Levels of inequality and considerable variations in the experiences of young people in different areas make it increasingly difficult to generalize: in particular, national and regional data on mental health cannot be reliably transposed for young people in the border regions. For example, the Northern Ireland Children and Young People’s Strategy makes a number of upbeat observations which may not reflect outcomes in Derry or Omagh:

“Qualifications attained at school are of a higher standard in Northern Ireland than within the UK as a whole and increasing numbers of young people are entering further and higher education. It has also been reported that most children enjoy school and that they are optimistic about their futures. At any one time over a third of children and young people are members of youth service provision, and it has been estimated that four out of every five young people benefit from participation in the youth service of some time during their childhood and/or adolescence.”

The 2004 Young Life and Times Survey (Cairns and Lloyd 2005) identified 24% of sixteen year olds as having ‘high levels of psychological distress’ defined as scoring 4 or more on the GHQ 12 scale. Significantly more young women (30%) than young men (16%) fell into this category. There were no major differences in levels of distress among Catholics and Protestants or between rural and urban areas. Cairns and Lloyd compared the Northern Ireland findings with 16 year olds who took part in the 2002 British Household Panel Survey: prevalence for the latter was 16%, compared with 24% in the Northern Ireland survey. Schoolwork was the most commonly cited cause of stress (Cairns and Lloyd 2005).

Research carried out through the Design for Living Partnership among 16-25 year olds showed that mental health problems such as sleep disorders, stress, anxiety and behavioural problems affect one in five young people in Northern Ireland (Design for Living 2001).

Get connected reported that while the majority of young people perceive their own health to be good, around 25% experience regular psychosomatic symptoms. The Health Promotion Agency survey (HPA 2001) found

“Most of the young people who took part in the survey regard themselves as healthy, but many young people in Northern Ireland (especially girls) have a relatively negative view of their health compared to those in other European countries.”

“Girls are much more concerned with how they look than boys, with a large majority of girls from the age of 15 onwards wanting to ‘change’ their appearance in some way. In general, the changes with increased age are most marked among girls, with the older girls having a much more negative assessment
of themselves and their situation than the younger girls and all boys. A particular change in attitude can be observed in girls between Years 8 and 9.”

7.2 Suicide

Suicide rates have been seen as an indicator of broader mental distress among young people.

‘Suicide may be seen as the extreme result of poor mental and emotional health and wellbeing. The traumatic impact of suicide on individuals, families, communities and society warrants a specific focus by those involved in promoting mental health and emotional wellbeing. It should also be emphasised in policies and practices developed and implemented across many sectors whether government, statutory, community, voluntary or private’

(DHSSPS 2000: 31)

In the early 1980s, the Republic of Ireland’s low rate of reported suicide in young men started to increase, resulting in a fourfold increase in the rate in this age group between 1990 and 1996(6). In Ireland, suicide is now the main cause of death in young people, exceeding both accidents and cancer. In Ireland, suicide and undetermined injury rates for the decade were 12 per 100,000 population in 1991 and 17.5 per 100,000 in 2001. In 2002 and 2003 records show deaths by suicide and undetermined injury in the 15-24 year old age bracket as 96 (91 suicides) and 117 (108 suicides) respectively. Northern Ireland rates ranged from 10.5 per 100,000 in 1991 to 14.2 per 100,000 population in 2001. In 2002 rates of 10 per 100,000 occurred. Overall, suicide trends in the 15-24 year old age group over the last 10 years show a decrease in England and Wales, and an increase in Scotland, Northern Ireland and Ireland (Crowley et al 2004).

In the Republic, figures from the National Parasuicide Registry indicate that at a national level there were 8,304 hospital presentations due to parasuicide by 6,705 individuals (National Suicide Review Group (NSRG), 2003). A study in Southwest Ireland (Corcoran et al 2004) found the Irish rate of parasuicide to be higher than eight of 11 centres in a 1995 World Health Organization Europe study (Corcoran et al. compared the parasuicide rate in Southwest Ireland with 11 European centre results). The rate peaked in the 20-24 year range and rates were significantly higher in women.

7.3 CAWT

There are a number of factors in the border region that increase risk for mental health problems and/or may contribute to poorer outcomes for those experiencing mental illness.
These include areas of relative isolation, levels of unemployment and weak infrastructures. There are considerable variations in some risk factors, for example the national unemployment rate for Ireland is 8.8% but male unemployment in Co Donegal is 17.5%.

In a consultation with young people in Co Donegal carried out in 1999 (Sheridan 1999), key mental health issues identified by 16 year olds included relationships, pressure, bullying, alcohol/drugs and sexuality. This consultation also revealed that:

- initial attitudes to mental health, help seeking and coping skills are negative
- males had fewer positive coping skills than females
- there was a poor knowledge of available services
- myths existed about professional help and counselling

A study of men’s health needs in the North East highlighted the extent to which concepts of health and illness, help-seeking behaviour and risk taking in men are linked to rule of manhood and notions of masculinity which appear to inhibit men’s ability to act on physical and emotional distress signals (NEHB undated). The report identified six groups of men as being particularly vulnerable: travelers, gay men, male victims of domestic violence, farmers, rural bachelors and disabled men.

The Report of National Consultative Committee on Health Promotion highlighted the significance of educational achievement as a protective factor for mental health. In 1996, 31% of young people in the border counties left school without qualifications (30% ceasing education under the aged of 15) compared with 28% nationally,)which means that a significant percentage of the current population aged around 22-25 have very limited education. Although this figure is improving, by 2002, 18.44% or nearly one in five young people ceased education under 15 (Central Statistics Office 2002).

Although mortality rates are not an adequate measure of public mental health, it is worth noting that compared to the rest of the island, the directly standardised mortality rate for homicides and assaults is 57% higher in the CAWT region, the largest excess of all causes of death. Excess mortality in the CAWT region was also statistically significant for ischaemic heart disease. The strength of the evidence for the relationship between mental health and physical health indicates the importance of raising awareness of the potential contribution of mental health promotion to improving physical health outcomes, as well as to influencing health behaviours.

### 7.4 Recognising and addressing mental health impact of the Troubles

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A discussion document submitted to the Western Trauma Advisory Panel (undated, unpublished) noted that a growing body of research highlights the need to recognise and respond to the specific needs of young people affected by the troubles.

Key findings include:

- central importance of identity
- main effects of conflict have not subsided
- impact of the troubles on mental health, quality of social and personal life of young people is deeper than we may care to admit

(see also Smyth and Goldie 2001)

The Northern Ireland Young Life and Times Survey elicited survey data on the opinions, attitudes and lifestyle of young people aged 12-17. This survey found that 79% of young people had contact with pupils from a different community background at school. 60% of these young people had their experience of cross community contact through an inter-schools project although for 31% of these young people it came about through travelling to school. 76% of 12-17 year olds surveyed visit the homes of friends from a different community background either very often or sometimes (21% did so very often). 64% had attended cross community projects of which almost three-quarters saw as a positive experience.

Young people in Northern Ireland have, on average, experienced twice the number of negative life events and reported much higher stress scores than adolescents in other countries (Chief Medical Officer Northern Ireland, 1999). Although the extent of the relationship between neighbourhood environment and mental health status has been questioned, some research suggests that there is a significant association between the degree to which an area is perceived to be dangerous and threatening and reported levels of depressive symptoms, anxiety and conduct disorder (Aneshensel and Sucoff 1996). A survey undertaken in Northern Ireland in 2001 showed that 12% of adults thought of themselves as victims of the troubles, especially in the 34-65 year old age group and those not in the professional classes (Cairns et al 2003). Using objective criteria, however, 16% appeared to be direct victims and 30% indirect victims. Seeing oneself as a victim was associated with lower levels of psychological wellbeing and these levels have not changed as the peace process has progressed.

A number of studies suggest an independent effect on GHQ-12 caseness score of personal and area based exposures to the Troubles, even when these various socio-economic indicators are taken into account, although those living in disadvantaged circumstances are much more likely to rate an impact of the Troubles on their lives (O’Reilly and Stevenson 2003). In their review of the literature, O’Reilly and Stevenson argue that the Troubles are a separate and additional burden and therefore contribute significantly to the higher psychological morbidity in Northern Ireland.

Research undertaken by Design for Living in 2001 suggests that ‘a return to the Troubles’ is a significant worry for young people, rating second only to ‘not having any money’
(see table 2 below). However, job security and school work were higher in unprompted responses.

http://www.healthpromotionagency.org.uk/Resources/mental/pdfs/designforliving.pdf

**Table 2: Most common worries (prompted)**

<table>
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<tbody>
<tr>
<td>Not having any money</td>
<td>68</td>
</tr>
<tr>
<td>A return to the Troubles</td>
<td>52</td>
</tr>
<tr>
<td>The future</td>
<td>50</td>
</tr>
<tr>
<td>My appearance (weight/height/looks)</td>
<td>47</td>
</tr>
<tr>
<td>Crime or violence</td>
<td>43</td>
</tr>
<tr>
<td>Not being able to get a job</td>
<td>35</td>
</tr>
<tr>
<td>Not being able to make a decision about what I'm going to do</td>
<td>35</td>
</tr>
<tr>
<td>The drugs problem in Northern Ireland</td>
<td>33</td>
</tr>
<tr>
<td>Being in a job/course I don’t enjoy</td>
<td>30</td>
</tr>
<tr>
<td>Schoolwork/exams</td>
<td>30</td>
</tr>
<tr>
<td>Problems with my boyfriend/girlfriend</td>
<td>29</td>
</tr>
<tr>
<td>Lack of confidence</td>
<td>27</td>
</tr>
</tbody>
</table>

The lower level of psychological morbidity in the Republic of Ireland (Layte and Jenkinson 2001; South Eastern Health Board 2002) has been related to the feel good factor associated with the booming economy of the “Celtic tiger” (Bradley 2000).

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8.0 Evidence of effectiveness: what works?

There is an increasingly robust evidence base for the effectiveness of interventions to promote mental well-being (Barry et al 2004; National Electronic Library for Health;

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Friedli 2003). It is drawn from a growing body of evidence that mental well-being influences health and social outcomes across a range of domains, including health behaviours, educational achievement, employment, physical health and crime.\(^7\)

The strength of evidence for the effectiveness of promotion and prevention is particularly robust for interventions targeting children and young people. While there is a clear need to improve child and adolescent mental health services and to strengthen mechanisms for the early identification of emotional problems in childhood, all children and young people have mental health needs and will benefit from a greater focus on emotional well-being in families, schools and the wider community (Mental Health Foundation 1999; 2005).

The following summary, drawn primarily from the National Electronic Library for Health and Making it Effective (Friedli 2003) highlights key findings which should be taken into account in the development of CAWT’s mental health promotion programme with young people:

- Working with networks of young people within the community: this is particularly important as children grow older and often spend more time with their friends than with their family (Morrow 2002). Peer group pressure is particularly significant in early adolescence (Heaven 1994).

- The growing gap between the health of young women and young men, and the apparent impact of gender roles on the experience and expression of mental distress, has led to calls for a much greater emphasis on different approaches for young men and young women (Health Development Agency 2001; Meryn and Jadad 2001; NEHB undated). Self esteem, peer pressure, identity and coping styles are all important influences on young people’s mental health and all have significant gender elements.

- Effective programmes are most likely to be those that involve young people in their design and delivery as well as in their evaluation and monitoring (NeLH). A qualitative review (Harden et al 2001) demonstrated that asking young people about mental health was ineffective. They tended to equate mental health with mental illness - and so as a problem belonging to other people and not relevant to their own lives. However young people showed a good understanding of useful mental health coping strategies. Many traditional health promotion materials and approaches are out of step with young people's pragmatic, everyday worries and interests. Harden et al confirm that research and evaluation should involve young people in its design and delivery.

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\(^7\) The most up to date source of evidence on risk and protective factors and effective interventions to promote mental health is the National Electronic Library for Health (Mental Health Promotion) [http://www.nelh.nhs.uk/nsf/mentalhealth/whatworks/intro/risk.htm](http://www.nelh.nhs.uk/nsf/mentalhealth/whatworks/intro/risk.htm). See also recent findings from the World Health Organisation: [http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf](http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf)
• The success of a recent evaluation of a programme in Scotland designed to reduce vandalism suggests the importance of creating opportunities for young people to be involved in activities that are exciting and meaningful for them: engaging socially excluded young people has to be on their terms and in locations where they gather (NHS Health Scotland 2004).

• Oliver et al provide a promising example of using the views of young people in the context of an evidence based approach (Oliver et al 2003; Thomas et al 2004). To address the question: ‘what factors are associated with mental health, healthy eating and physical activity’ among young people, they used surveys, cohort/case controlled studies and qualitative studies. Controlled trials were used to establish which interventions are effective.

Young people’s views were used to assess interventions drawn from the research literature as follows:

- to what extent have interventions addressed the barriers identified by young people?
- to what extent have interventions built on the facilitators identified by young people?

Using ‘constant comparison’ across the results of each synthesis, the review team looked for interventions that diminished identified barriers and that built upon identified facilitators. In other words, the synthesis of evidence was centered on young people’s views and matched their perspective on their spheres of influence.

This approach has several distinguishing features. It provides a systematic account of young people’s views, drawn from the literature and integrates them with findings from experimental studies (controlled trials). It then invites young people to engage in the process of assessing evidence of effectiveness in the light of their own knowledge about barriers and facilitators. As the authors argue, it is based on the understanding that interventions are more likely to be effective if they are multifaceted and target barriers and facilitators operating in three spheres:

- the individual (knowledge, attitudes, self esteem)
- the community (family and social support networks)
- wider society (social class, access to resources and services)

This model suggests the value of involving young people in assessing the likely effectiveness of any mental health promotion initiatives proposed by CAWT.

• Helping children to negotiate stressful transitions (through cognitive behavioural approaches), in combination with modifying the school environment, was effective in reducing psychological and behavioural problems and increasing
competencies (Durlak and Wells 1997 – meta analysis). Problem solving skills are associated with effective outcomes for children and adolescents (Dadds et al 1997 – controlled trial)

- Life skills and social skills training help children to cope positively with the stresses of transition from junior to middle school. In the comparison group, boys had higher rates of alcohol consumption and violent behaviour and girls had higher rates of cigarette consumption and vandalism (Bruene-Butler et al 1997 – controlled trial). Skills based approaches, role play, support and practical information based on needs assessment are more effective than top down, didactic methods (Oakley et al 1994).

- Exercise prevents clinical depression and is as effective in treatment as other psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self esteem (Fox 2000, Mutrie 2000). Although most of the research has focused on adults, there is a robust case for a greater focus on the mental health benefits of exercise and physical activity for young people.

- Interventions to promote positive self-esteem are more likely to be effective if self-esteem is the main focus of the intervention, rather than just one component of a broad mental health initiative. Holistic, multi-dimensional self-esteem based programmes were found to have positive impacts on young people’s mental wellbeing (NeLH). A programme of ten weekly 80 minute sessions at a local voluntary youth project, with a focus on communication, assertiveness, problem solving, decision making, team working and activities to promote friendship bonds had a significant impact on confidence, ability to cope with pressure, bullying and self harm (NHS Health Scotland 2004).

- Systematic review level evidence demonstrated the efficacy of cognitive behavioural therapy (CBT) for moderate, but not severe, depression amongst children and adolescents (Harrington et al 1998). There seemed to be a significant amount of spontaneous remission in moderately severe juvenile depression and so the reviewers make a strong case for using brief supportive interventions as the first line of treatment and keeping CBT for patients who fail to respond.

- Preventing suicide and suicidal behaviour (Crowley et al 2004)
  Two reviews found some evidence that universal interventions to diminish conflict and enhance cohesion between parents and children had persisting benefits in terms of the behaviour and mental health of offspring but no effect on suicide was found.

  Promising interventions that need further development and evaluation:
  - Problem-solving therapy and provision of emergency contact cards as they showed some effectiveness in preventing deliberate self-harm
• ‘Moderate’ studies (i.e., studies that were rated as having used moderately robust methodology) gave encouraging evidence for indicated suicide prevention programmes (these are programmes aimed at those identified as at-risk of suicide) targeting at-risk youths
• Education and general coping skills training as they have beneficial effects on suicidal potential and depression
• Restricting access to paracetamol
• Interventions to improve the material and physical circumstances of people’s lives need to be developed and evaluated
• Promoting responsible reporting by the media.

9.0 Infrastructure

A number of organisations set up to address cross border issues have an interest in public mental health and mental health promotion, including the Institute of Public Health in Ireland, (http://www.publichealth.ie/) which promotes North-South co-operation for public health and the Centre for Cross Border Studies, (http://www.crossborder.ie/) which commissions and publishes research on opportunities for, and obstacles to, cross border co-operation in all fields. Both agencies are a valuable source of data and research on mental health on the island and in the CAWT region (Barry et al 2002; Balanda 2001; Crowley et al 2004).

The Centre for Health Promotion Studies at the National University of Ireland, Galway, includes a mental health promotion module as part of its MA/Higher Diploma Programme in health promotion and the Centre plays an important research role in mental health promotion (Barry 2003; Reynolds et al 2004; Barry et al 2005; Byrne et al 2004a; 2004b; Barry et al 2002). This includes the evaluation of mental health promotion programmes, in collaboration with practitioners and policy makers, but also publishing findings and raising the status and profile of mental health promotion internationally (Jane-Llopis et al 2004; Barry and McQueen 2004).

Within CAWT, there is considerable scope for strengthening awareness of mental health promotion and in the longer term for embedding mental health promotion within other CAWT programmes. Relevant areas from the 2001-2006 work programme include active retirement for older people; projects within Social and Community Care, care of type 11 diabetes; cross border out of hours services; learning disability; public health (health impact assessment); family and child care. The current revisiting of CAWT structures provides a significant opportunity to consider how mental health promotion can become more mainstream within CAWT.

There are also opportunities within each health board area to consider what infrastructures or systems are already in place that support or could more effectively support mental health promotion.
• SHSSB – Southern Area Mental Health Promotion Network – database of good practice and virtual discussion forum www.goodhealthinfo.org.uk
• SHSSB – working groups in each trust to take lead in development of health and well-being policies
• HSE north east – regional mental health promotion advisory committee

It is also important to look beyond the health sector and consider opportunities in other sectors and settings. For example, the County Development Plans in each region have cross cutting themes including social inclusion, well-being, culture, learning and education, all of which are relevant to mental health promotion and provide a context for putting mental health promotion on the agenda. Many of the structures and initiatives in place to support youth work e.g. youth councils, youth participation projects and health promotion youth services are ideal forums for moving mental health promotion forward.

10.0 Recommendations

10.1 Building capacity for mental health promotion

In recent years, there has been a growing recognition of the need to build capacity for mental health promotion, through dissemination, training and opportunities for networking, exchange of information and debate.

In Scotland, for example, a key element of the National Programme for Improving Mental Health and Well-being is capacity building, with considerable resources dedicated to the development of training and resources to support mental health improvement practice. (Hogg 2004; www.wellontheweb.net) In England, the mental health promotion charity mentality, with funding from the Department of Health, has also carried out a range of training to support delivery of Standard One, the mental health promotion element of the National Service Framework for Mental Health (www.mentality.org.uk) Although the extent to which training influences practice is open to question, recent studies suggest that high quality mental health promotion training has a wide range of benefits and can have a significant impact on practice. (Halliday et al 2004; Seymour and Fletcher 2003)

All four health boards currently support training and/or capacity building for mental health promotion, with suicide and depression awareness receiving the strongest focus. The CAWT mental health promotion project has recognized the role of training in raising awareness, building ownership and creating opportunities for working in partnership and is currently proceeding with a programme of Mental Health First Aid training (MHFA). There are therefore two potential gaps in training and capacity building which could be addressed by CAWT:
training that aims to equip and empower young people to promote their own mental health and that of other young people; the focus should be on promoting positive mental health and well-being, and should involve young people in needs assessment, design and delivery.

- training that aims to strengthen expertise and capacity in evaluating mental health promotion, targeting colleagues across the CAWT region in both the statutory and voluntary sectors; the focus should be on evidence into practice and practice into evidence, perhaps drawing on the ongoing NHS Health Scotland/Scottish Executive programme.

### 10.2 Supporting improved mental health among young people

This review has identified a wealth of data on the mental health needs of young people in the Border region, much of it drawn from studies involving young people themselves, as well as a wide range of cross sectional data drawn from surveys. What is less clear, is the extent to which young people themselves are involved in deciding what mental health promotion services and interventions are most likely to meet their needs. To strengthen the capacity of young people to be meaningfully involved in mental health promotion in the CAWT region would require a sustained commitment and possibly a refocusing of attention towards protective factors (e.g. physical activity, social support, peer relationships, life skills, communication, help seeking), rather than risk factors (e.g. drugs and alcohol). An immediate priority might be to assess which organisations/networks/infrastructures are already in place that could be used as a basis for asking:

- how much do young people know about ‘positive steps’ for mental health?
- what do young people themselves believe they can do to promote their own mental health and well-being and that of their peers?
- What kind of training or support would an initial cohort of young people in the CAWT region need to become ‘mental health promoters’?

### 10.3 Mapping mental health promotion activity

The difficulty of compiling an accurate picture of mental health promotion activity across the CAWT region suggests that identifying a workable structure for capturing and updating initiatives is an important medium term goal.
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