# SERVICE FRAMEWORK FOR MENTAL HEALTH

# AND WELLBEING

**Consultation Document**

Working for a Healthier People

INVESTOR IN PEOPLE

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**Foreword**

As Minister of Health I am determined to ensure that services are safe, improve health and wellbeing of individuals and communities and, at the same time, make the best use of available resources. In addition, I believe it is important that services, as far as possible, meet the needs and preferences of people and are accessible to all regardless of where they live or who they are.

To make this happen, my Department has started work on the development of a set of Service Frameworks which set out explicit standards for health and social care to be used by patients, clients, carers and their wider families to help them understand the standard of care they can expect to receive. These Frameworks will also be used by health and social care organisations in planning and delivering services.

The first group of Frameworks focus on the most significant causes of ill health and disability in Northern Ireland – cardiovascular disease, respiratory disease, cancer, mental health and learning disability. Two further Service Frameworks – for children and young people and older people are also being developed.

The Service Framework for Mental Health and Wellbeing sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation and palliative care of individuals and communities who currently have or are at a greater risk of developing mental illness.

Each standard is supported by levels of performance to be achieved over 3 years and the Framework will be subject to regular review and refinement in the light of new evidence. This will ensure that it provides a sound basis for continued improvement in the quality of health and social services.

The development of this Framework has been an inclusive process involving people from all aspects of health and social care, patients, clients and carers, all of whose support has been invaluable.

The application of the standards set out in this Framework has the potential to transform the quality of service provision in relation to mental health for all our people.

Michael McGimpsey MLA
Minister for Health, Social Services and Public Safety

Summary of Standards

**Health Improvement and Mental Health Promotion**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 1**<br><br>Health and social care should work in cooperation with voluntary, education, youth and community organisations to prevent young people from starting to smoke. | Percentage of 12, 14 and 16 year old boys and girls who smoke. | March 2012 – 5% decrease on baseline for boys (rate has been constant)<br><br>March 2012 – Maintain at baseline for girls (rate has been increasing therefore initial target to halt rise) |
| **Standard 2**<br><br>All Health and Social Care professionals should identify those who smoke, make them aware of the dangers of smoking, advise them to stop and provide information and signposting to specialist cessation services. | Smoking cessation services available for Mental Health Users.<br><br><br>Percentage of clients quitting at 4 and 52 weeks. | March 2011 – Establish baseline<br><br>Performance level to be determined once baseline established<br><br>March 2010 – Establish baseline<br><br>March 2011 – 2% increase in number of quitters (4% increase in uptake of service) |

|  |  | March 2012 – 2% increase in number of quitters (4% increase in uptake of service) |
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| **Standard 3**<br><br>People should be provided with healthy eating support and advice, appropriate to their needs, in a range of settings. | Services available for mental health users. | March 2011 – Establish baseline<br>Performance level to be determined once baseline established |
| **Standard 4**<br><br>Health and social care should work with early years settings, schools, workplaces and communities in the promotion and support of breastfeeding, healthy eating and physical activity to prevent obesity and assist in early detection and minimise the development of an eating disorder. | Percentage of people who have a BMI of above 25.<br><br>Percentage of P1 Children who have been identified as being overweight and obese or underweight malnourished.<br>*Note: these PIs will be reviewed in light of the forthcoming obesity strategy.* | March 2011 – 2% increase on 2005/06 baseline<br><br>March 2010 – Establish baseline<br>Performance level to be determined once baseline established |

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| **Standard 5**<br><br>A person accessing or availing of mental health services in any setting that is identified as being inactive* should be provided with advice and support to accumulate a minimum of 30 minutes of moderate activity** on 5 days of the week or more.<br><br><br>*inactive refers to all people who do not meet the recommended level of physical activity.<br><br>**walking briskly, walking downstairs, dancing, biking, swimming, gardening, housework e.g. washing floors.<br>http://www.paho.org/English/HPP/HPN/whn2002-factsheet2.pdf | Percentage of people being asked and advised about their physical activity.<br><br>Percentage of people advised who achieve the recommended level of physical activity. | March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established |

| Standard 6<br><br>Primary care professionals should identify people who consume hazardous/harmful amounts of alcohol or who misuse drugs (illicit or prescribed), make them aware of the associated dangers, advise them to reduce or stop and provide information and signposting to specialist services if appropriate. | Percentage of people who receive Brief Intervention in Primary Care to reduce alcohol related risk.<br><br>Percentage of young people who were assessed using the Regional Initial Assessment Tool (RIAT). | March 2010 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established |
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| **Standard 7**<br><br>Health and social care professionals should identify children across the wider age spectrum and their parents or carers, who require additional services to help promote the child's development and should address the needs of the children, parents and/or carers by commissioning services, where appropriate, to meet their individual needs. | Percentage of parents / carers identified as requiring additional support who are offered evidence based parenting programmes.<br><br>Percentage of referrals to Child and Adolescent Mental Health Services (CAMHS) for attachment / parenting / control problems.<br><br>Review of early intervention, prevention activities formally commissioned in each Trust area (to include perinatal and infant mental health). | March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – All Trusts |
| **Standard 8**<br><br>Health and social care organisations should implement the Health and Safety Executive's Management Standards to reduce work related stress among staff. | Implementation of the Health and Safety Executive Management Standards. | March 2013 – All HSC organisations |

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| **Standard 9**<br><br>Older people (adults aged 65 years and older) living independently with or without support, or in residential care should have opportunity to access individual or group health promotion sessions including healthy eating and physical activity programmes. | Percentage of older people known to health and social services who are in receipt of individual or group health promotion sessions. | March 2013 – Establish baseline Performance level to be determined once baseline established |

**Improving the Experience of the Service Users and Carers**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 10**<br>A person who uses mental health services should be actively and meaningfully involved in planning, delivering and monitoring of health and social care at all levels. | Evidence of Health and Social Care Organisational Strategies for Person and Public Involvement.<br><br>Evidence of systematic involvement and participation of mental health users in service planning, delivery and monitoring across Health and Social Care Trusts. | March 2012 – All HSC Organisations<br><br>March 2012 – All HSC Organisations |

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| **Standard 11**<br><br>Carers of people with a mental health problem should be given the opportunity to be involved in the planning and delivery of services.   All carers, including children and young people, should be offered a carers assessment. | Evidence of health and social care strategies for family and carers involvement.<br><br>Percentage of carers, including children and young people, offered a carers assessment. | March 2012 – All Trusts<br><br><br><br>March 2012 – Establish baseline Performance level to be determined once baseline established |
| **Standard 12**<br><br>A person using specialist mental health services should have access to advocacy services in both community and hospital settings. | Percentage of people in contact with specialist mental health services who avail of timely and age appropriate advocacy services. | March 2012 – Establish baseline Performance level to be determined once baseline established |
| **Standard 13**<br><br>Mental health services should be provided in an environment that ensures the safety, privacy and dignity of those who use the services and their families and carers. | Evidence of arrangements to ensure safety, privacy and dignity. | March 2012 – All Trusts |

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| **Standard 14**<br><br>A person and their carers and members of the public, where appropriate, using or accessing mental health services should be provided with evidence-based, targeted mental health and wellbeing information including information in relation to their detention under the Mental Health Order 1986 if applicable. | Evidence of mental health and wellbeing information available from health and social care services. | March 2012 – All HSC organisations |
| **Standard 15**<br><br>Health and social care organisations and their staff should communicate effectively with those who use or access mental health services, including their carers, as an essential and universal component of the planning and delivery of health and social care. | HSC organisational communication strategies that show evidence of direct user/family carer feedback as part of regular audit of their effectiveness.<br><br>HSC organisational complaints reports should show evidence of action where communication is the primary factor. | March 2012 – All HSC organisations<br><br><br>March 2012 – All HSC organisations |

| Standard 16 | | |
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| Health and social care organisations should ensure that effective and secure patient information systems are in place to record and share relevant information across HSC services and with other agencies in line with agreed protocols. | HSC organisational communication strategies that show evidence of effective communication between mental health services, other organisations and professionals. | March 2012 – All HSC organisations |
| | HSC organisational complaints reports should show evidence of action where communication is the primary factor. | March 2012 – All HSC organisations |
| **Standard 17** | | |
| A person with complex mental health needs should be treated and supported in the community and in their own home, where possible, with due regard to their physical and mental health needs. | Percentage of people with complex mental health needs being treated and supported in community settings including their own home. | March 2012 – Establish baseline Performance level to be determined once baseline established |
| | Percentage of people being treated for complex mental health problems whose physical needs have been assessed. | March 2012 – Establish baseline Performance level to be determined once baseline established |

| Standard 18 | | |
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| A person experiencing a significant mental health crisis should have timely access to age appropriate health and social care services 24 hours a day and 7 days per week. | Establish current level of service provision for mental health crises. | March 2012 – Establish baseline Performance level to be determined once baseline established |
| | Percentage of young people (under the age of 18) admitted to age appropriate inpatient beds. | March 2012 – 98%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |
| Standard 19 | | |
| A person using mental health services should have an integrated care pathway for their assessment, treatment, care and ongoing management where health and social care (including primary care) work in partnership with users and their carers to develop the most appropriate and accessible services. | Establish the range of care pathways in place or being developed regionally or locally. | March 2013 – All Trusts |
| | Evidence of involvement of users, families, carers and advocates in the development of care pathways. | March 2013 – All Trusts |

| Standard 20 | | |
|---|---|---|
| A person receiving treatment and care in primary care and / or mental health services (community and inpatient) should have a care plan prepared in partnership with them that is recovery focused, evidence based and fully recorded. The shared care plan should allow for urgent access to specialist services, if required.  (Where relevant this should identify the needs of their children and family members). | Percentage of people contributing to their care plans. | March 2012 – Establish baseline Performance level to be determined once baseline established |
| | Percentage of people who report that they felt involved and able to contribute to their care planning. | March 2012 – Establish baseline Performance level to be determined once baseline established |
| | Percentage of patients on the schizophrenia, bipolar and other psychoses registers who have a comprehensive care plan documented within their records and which is agreed between individuals, their family and / or carer as appropriate. | March 2012 – 90%<br>March 2013 – 95%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |

| Standard 21

A person with severe mental health needs should have a full occupational assessment, reviewed on at least an annual basis and thereafter, access to a range of adequate occupational services should be arranged. | Percentage of people with severe mental illness offered an occupational assessment.

Percentage of places available for mental health vocational / rehabilitation / day support out of total. | March 2013 – Establish baseline Performance level to be determined once baseline established

March 2013 – Establish baseline Performance level to be determined once baseline established |
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| **Standard 22**<br><br>A person and their carers, where appropriate, should have the opportunity to access sufficient information to enable them to make an informed decision about their medication and other treatments, in partnership with their healthcare professionals. | Percentage of people given a choice of treatments. | March 2012 – Establish baseline<br>Performance levels to be determined once baseline established |
|---|---|---|
| | Where medicines are prescribed, percentage of care plans where medication is documented appropriately. | March 2012 – Establish baseline<br>Performance levels to be determined once baseline established |
| | Percentage of people for whom an assessment of effectiveness and side effects is documented. | March 2012 – Establish baseline<br>Performance levels to be determined once baseline established |
| | Percentage of people who were given the opportunity to discuss their medication. | March 2012 – Establish baseline<br>Performance levels to be determined once baseline established |
| | Level of prescribing concordance with local and national guidelines. | March 2012 – 70%<br>March 2013 – 80%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |

| Standard 23<br><br>A person with severe and/or enduring mental illness should be offered a physical health check at least annually (normally in primary care) according to locally agreed protocols based on National Guidelines. | Percentage of people with schizophrenia or bipolar disorder who have a documented physical health check. | March 2012 – 95%<br>March 2013 – 98%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |
|---|---|---|
| Standard 24<br><br>Health and social care staff should be aware of the signs and symptoms of violence (including domestic violence), abuse and neglect in order to help them identify victims and are trained, where necessary, to offer early help and support. | Percentage of people identified by primary care and health and social care as victims of violence, abuse and neglect. | March 2013 – Establish baseline Performance level to be determined once baseline established |
| Standard 25<br><br>A person with a mental illness and their carers being assessed for supportive and palliative care should have their specific mental health needs taken into account in consultation with them and their carer. | Percentage of people with mental health needs who have had their specific needs taken into account. | March 2013 -  Establish baseline Performance level to be determined once baseline established |

| Standard 26 | | |
|---|---|---|
| A person attending an acute general hospital should, where appropriate, have access to age appropriate psychiatry services and should include follow-up arrangements if required such as the Card Before You Leave scheme. | Review of arrangements in acute general hospitals for accessing age appropriate mental health services. | March 2012 – All HSC Trusts |

**Children and Young People – Conduct Disorders**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 27**<br><br>A young person presenting with features of Conduct Disorder should offered an early assessment by a child and adolescent mental health (CAMH) specialist knowledgeable in the area of conduct disorders and receive appropriate early interventions or onward referral as required.  A standardised outcome measurement tool should be used from first assessment. | Regional review of supported interventions and therapeutic approaches.<br><br>Agree and implement standardised outcome measurement tool.<br><br><br>Percentage of children and young people being treated where outcome measurement shows improvement after 12 months. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2014 – Establish baseline Performance levels to be determined once baseline established |

**Children and Young People – Depression**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 28**<br><br>A young person experiencing mild depression should have a comprehensive assessment in primary care and onward referral, as required, to mental health specialists in order to identify their mental health needs and any co-morbidities to enable early interventions. Information and support for the young person and family should be offered including parent training / education management programme in accordance with NICE guidelines. A standardised outcome measurement tool should be used in treatment and care. | Agree and implement standardised outcome measurement tool.<br><br><br>Percentage of children assessed and diagnosed with anxiety and depression that are involved in primary care and/or school initiatives.<br><br><br>Percentage of children and young people who have received psychological interventions to treat their anxiety or depression and from whom they receive it. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

| Standard 29 | | |
|---|---|---|
| A young person experiencing persistent symptoms of moderate to severe depression should be offered specific psychological therapy which may include Cognitive Behavioural Therapy (CBT), Interpersonal Therapy or shorter term Family Therapy, provided by therapists trained in Child and Adolescent Mental Health.  Anti-depressant medication should not be offered, except in a combination with psychological interventions in accordance with the NICE guidelines for Depression in Children and Young People.  A standardised outcome measurement tool should be used in treatment and care. | Percentage of children and young people in receipt of medication for moderate depression.

Percentage of children and young people receiving a combination of medication and psychological therapies for moderate depression.

Agree and implement standardised outcome measurement tool. | March 2012 – Establish baseline Performance levels to be determined once baseline established

March 2013 – Establish baseline Performance levels to be determined once baseline established

March 2013 - All Trusts |

**Children and Young People – Attention Deficit Hyperactivity Disorder (ADHD)**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 30**<br><br>A young person with suspected ADHD, their families and carers should be offered an early comprehensive assessment of their needs by a CAMHS specialist knowledgeable in the area of ADHD and receive appropriate care and treatment or onward referral as appropriate to age appropriate specialist mental health services for further assessment and care. A standardised outcome measurement tool should be used in treatment and care. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of young people referred for assessment and early intervention of ADHD to Paediatrics or CAMHS.<br><br>Percentage of families offered and in receipt of parent education training programme. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

**Children and Young People – Transition to Adult Services**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 31**<br><br>A young person approaching their 18<sup>th</sup> birthday (between 3–6 months) receiving treatment and care for a significant health problem from CAMHS or a Paediatric service should be assessed, their need for services identified and where appropriate, arrangements should be made for transition to adult services.  These arrangements should be made in partnership with the young person and their family/carers. | Percentage of young people moving to adult services.<br><br><br>Evidence of transitional arrangements in place.<br><br><br>Percentage of young people in CAMHS/Paediatric services who attend adult services after their 18<sup>th</sup> birthday. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br><br>March 2012 - All Trusts<br><br><br>March 2012 - Establish baseline Performance levels to be determined once baseline established |

**Adults - Anxiety Depression**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 32**<br><br>A person experiencing mild to moderate depression and/or anxiety should have an early assessment of their psychological, physical, clinical and social care needs at primary care level using a validated assessment tool in line with NICE Guidelines and, if appropriate, offered low intensity short term interventions. | Percentage of patients with a new diagnosis of depression who have had an assessment of severity at the outset of treatment. | March 2012 – 95%<br>March 2013 – 98%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |
| | Percentage of people referred to low intensity short term interventions (Level 1 & 2 – Stepped Care Model). | March 2012 – Establish baseline Performance levels to be determined once baseline established |
| | Percentage of people referred to low intensity short term interventions who complete them. | March 2012 – Establish baseline Performance levels to be determined once baseline established |

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| **Standard 33**<br><br>A person experiencing moderate to severe depression should have an assessment, early intervention and ongoing care in line with NICE Guidelines.  This should include an assessment of their psychological, physical, clinical and social care needs including a risk assessment undertaken by a mental health specialist(s) using a recognised outcome measurement tool. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcome measurement shows improvement after 12 months. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

**Adults - First Episode Psychosis – Early Interventions in Psychosis**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 34**<br><br>A person experiencing early signs of psychosis should have an assessment of their psychological, physical, clinical and social needs including a risk assessment undertaken by a mental health specialist(s) using an appropriate outcome measurement tool to aid diagnosis and age appropriate onward referral. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcome measurement shows improvement after 12 months.<br><br>Percentage of young people (Under 18 years) receiving early intervention services provided by a psychosis team working jointly with CAMHS. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

**Adults – Schizophrenia and other psychoses**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 35**<br><br>A person with either newly diagnosed or established schizophrenia should, following referral from primary care have assessment (including a risk assessment), early intervention, treatment (including psychotropic medication and psychological therapies as appropriate) and ongoing care (including a yearly physical health check) in line with NICE guidelines.  A standardised outcome measurement tool should be used to aid monitoring of treatment and care. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcome measurement shows improvement after 12 months.<br><br>Percentage of people being offered a choice of medications and psychological interventions.<br><br>Percentage of people receiving psychological and social interventions. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

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| | Percentage of young people who receive education and/or whose inpatient treatment involves the potential (depending on health) for at least 25% of their week (Monday – Friday) in educational activities. | March 2013 – Establish baseline Performance levels to be determined once baseline established |
| | Percentage of patients who continue to be adherent to their medication. | March 2012 – Establish baseline Performance levels to be determined once baseline established |

**Adults - Obsessive Compulsive Disorder**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 36**<br><br>A person who presents with psychological problems should be screened by age appropriate specialist mental health services using a recognised assessment tool to identify the presence of obsessions and compulsions and possibly associated functional impairment.  A standardised outcomes measurement tool should be used to monitor progress following assessment.  Treatment and care should be based on the person's level of functional impairment in line with NICE Guidelines. | Agreement and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcome measurement shows improvement after 12 months. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

**Adults - Bipolar Disorder**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 37**<br><br>A person with suspected, newly diagnosed or established bi-polar disorder should have an assessment, early intervention, treatment and ongoing care in line with NICE guidelines.  If presenting as a risk to themselves or to others they should be referred to and assessed by mental health specialist(s).  The referral should take place immediately. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcomes measurement shows improvement after 12 months.<br><br>Percentage of people being offered a choice of medications and psychological interventions.<br><br>Percentage of people receiving psychological and social interventions.<br><br>Percentage of young people who receive education and/or whose inpatient treatment involves the potential (depending on health) for at least 25% of their week (Monday – Friday) in educational activities. | March 2012 – All Trusts<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

| | Percentage of patients who continue to be adherent to their medication. | March 2013 – Establish baseline Performance levels to be determined once baseline established |
|---|---|---|

**Adults - Addictions and Substance Misuse**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 38**<br><br>A person with difficulties/concerns about their drug or alcohol misuse should have an initial assessment when first presenting to services in primary care or any acute or community setting and should be encouraged to fully participate in their assessment and onward referral, if necessary.   Any person presenting either a risk to themselves or others should be offered and assessed by mental health specialist(s) in a timely manner. | Percentage of people who participated in their assessment and ongoing referral. | March 2011 – Establish baseline Performance levels to be determined once baseline established |

| Standard 39 | | |
|---|---|---|
| A person requiring early intervention, treatment and ongoing care in relation to their substance misuse should have a comprehensive assessment by substance misuse services using a standardised outcome measurement tool, have access to an appropriate range of evidence based treatment and care including residential treatment and specialist medical treatments and services, if required, in line with NICE guidelines. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where outcomes measurement shows improvement after 12 months. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

**Adults - Eating Disorders**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 40**<br><br>A person with eating concerns/difficulties should have an initial assessment of their needs at primary care level and onward referral to age appropriate mental health specialist services if required.  A standardised outcome measurement tool should be used in the assessment in accordance with the Northern Ireland Care Pathway for Eating Disorders and NICE guidelines. | Agree and implement standardised outcome measurement tool.<br><br><br>Percentage of people being treated where outcome measurement shows improvement after 12 months. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2013 – Establish baseline Performance levels to be determined once baseline established |

| Standard 41 | | |
|---|---|---|
| A person with an eating concern/difficulty should have prompt access to therapeutic and medical interventions appropriate to their individual need to include medical monitoring, initial supportive management, psychological therapies, dietetics, occupational therapy and physiotherapy in line with NICE guidelines and the Northern Ireland Eating Disorder Pathway. | Percentage of people (young people and adults) assessed as requiring treatment in:<br>• Special Teams<br>• Co-working with Community Teams<br>• Other services<br>• By length of time from assessment to treatment.<br><br>Percentage of people with eating disorders requiring medical and psychiatric admissions by:<br>• Length of stay<br>• Re-admission. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br><br><br><br>March 2012 – Interim report Performance levels to be determined after interim report |

**Adults – The Mental Health Aspect of Asperger Syndrome**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 42**<br><br>A person showing clinical features of Asperger Syndrome should be referred, following initial assessment in primary care, to specialist services for assessment, diagnosis, intervention, care and support as outlined in the Northern Ireland Care Pathway for Autistic Spectrum Disorder (ASD). | Percentage of people referred to specialist services for assessment, diagnosis, intervention and support. | March 2012 – Establish baseline Performance levels to be determined once baseline established |

**Adults - Dementia**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 43**<br><br>A person who experiences a change in cognitive performance should have access to early diagnostic assessment, investigation, treatment and support. | Review of arrangements for early assessment, diagnosis, treatment and support for people who have change in cognitive performance. | March 2012 – All Trusts |

| Standard 44 | | |
|---|---|---|
| A person with dementia, and their carer, should have access to information, education and support including a regular review of their physical and mental health needs. Alternatives to neuroleptic prescription should be offered in line with regional and national guidelines. | Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months. | March 2012 – 80%<br>March 2013 – 85%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known |

**People with Specific Needs – Women in the perinatal period**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 45**<br><br>All women presenting to maternity service should be asked about past or present mental illness and treatment including at their first contact visit with primary care, the booking visit, the 3<sup>rd</sup> trimester visit, during the post-natal contact period between 6-10 weeks and up to 1 year postnatal.  Where appropriate, they should be referred to specialist mental health services that include access to psychological interventions, additional health visitor support and inpatient care as appropriate and in accordance with NICE guidelines. | Percentage of women assessed for mental health problems during pregnancy in past 12 months.<br><br>Percentage of women who are in receipt of Specialist Mental Health Services including psychological interventions and additional health visitor support, appropriate to their needs.<br><br>Percentage of mothers advised to seek support through Sure Start. | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br><br><br>March 2012 – Establish baseline Performance levels to be determined once baseline established |

**Older Peoples' Mental Health**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 46**<br><br>A person with severe and enduring mental illness who are approaching the age of 65 years should have a review to assess whether their needs are best met in existing adult mental health services or older people mental health services.  This should take into account the views of the individual, their families and carers and should be reviewed on an annual basis thereafter. | Percentage of people in Adult Mental Health services between 64 and 65 years old who have had a review in the previous 12 months. | March 2012 – Establish baseline Performance level to be determined once baseline established |

| Standard 47 | | |
|---|---|---|
| Older people (age 65 years and over) should have access to a comprehensive older people's mental health service including mental health promotion, early detection and diagnosis, assessment and treatment and support for carers. Any older person experiencing mental health problems should have access to appropriate physiological investigation and screening by Primary Care to rule out potential physical conditions and to inform referral decisions. Following any initial diagnosis they should have an early comprehensive assessment using an appropriate assessment tool, followed by appropriate interventions and/or onward referral to specialist mental health services and/or other services as appropriate. | Percentage of older people who have access to the full range of older people's mental health services.<br><br>Percentage of older people in receipt of services who have had a holistic review including mental health assessment. | March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Post Traumatic Stress Disorders**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 48**<br><br>A person with a confirmed diagnosis of post traumatic stress disorder should have access to timely interventions and treatment appropriate to their needs, delivered by suitably qualified and supervised practitioners. A standardised outcome measurement tool should be used in treatment and care. | Agree and implement standardised outcome measurement tool.<br><br>Percentage of people being treated where standardised outcomes measurement is used. | March 2013 – All Trusts<br><br>March 2014 – Establish baseline Performance levels to be determined once baseline established |

**People with Specific Needs – Personality Disorder**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 49**<br><br>A person presenting with clinically problematic personality disorder should have a comprehensive mental health assessment including a risk assessment by mental health specialist using an appropriate assessment tool and be referred for  specialist personality disorder assessment, if required.  They should have access to a range of appropriate treatments and care according to their individual needs and access to education, advice, support and management delivered by a specialist, regional personality disorder service as appropriate. | Quality of Life Indicators.<br>Social Performance Indicators – to be determined. | March 2012 – Establish baseline Performance levels to be determined once baseline established |

**People with Specific Needs – Self Harm and Suicide**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 50**<br><br>A person who is contemplating self harm/has self harmed or has expressed suicidal ideation should have access to a co-ordinated comprehensive range of age appropriate advice, information, counselling and support and other initiatives that can address their needs in relation to self harm and suicide. This should include accessible and appropriate information, for example regarding services and potential sources of help for the person and family, carer or friend. | Availability of information, support and initiatives. | March 2012 – Establish baseline Performance levels to be determined once baseline established |

| **Standard 51**<br><br>A person who has self harmed should have any physical injuries dealt with as a matter of urgency and be offered preliminary psychosocial assessment when first presenting to services.<br>If presenting either a risk to themselves or others they should be referred and assessed by age appropriate specialist mental health services **immediately** in line with NICE guidelines.<br><br>Anyone presenting to A&E who does not immediately require access to specialist services will be provided with a specific follow-up appointment scheduled within 7 days, i.e. Card Before You Leave scheme. | Percentage of people presenting with self harm who have had a preliminary psychosocial assessment.<br><br>Percentage of young people presenting with self harm who have an assessment by CAMHS or other appropriate practitioner.<br><br>Percentage of people who have a comprehensive assessment by an adult specialist practitioner.<br><br>Percentage of people discharged in accordance with Trust A&E based Card Before You Leave scheme | March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2012 – Establish baseline Performance levels to be determined once baseline established<br><br>March 2012 – Establish baseline Performance levels to be determined once baseline established |

**People with Specific Needs – Acquired Brain Injury**

|  | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 52**<br><br>A person with a neurological or brain injury should have access to a full range of age appropriate mental health services for assessment, early intervention and a full range of age appropriate specialist treatment, care and support that include residential options and specialist inpatient mental health services staffed by a team of professionals with a range of skills and competencies offering rehabilitation in order to meet their continuing and changing needs. | Agree and implement referral criteria for mental health services that demonstrate inclusion for people with Mental Health needs post brain injury.<br><br>Percentage of people who have been assessed and are in receipt of community accommodation and care packages. | March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2013 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Deaf People with Mental Health Needs**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 53**<br><br>A deaf person (of any age) with mental health needs and their carers should have access a full range of mental health provision including early assessment, treatment and ongoing care provided by specialist mental health services including access to key worker, inpatient care and out of hours services if required.  Interventions should be focused on the person and the family and include a range of supports that facilitate communication within primary and secondary care. | Percentage of deaf children and young people / adults accessing Mental Health provision.<br><br>Percentage of people being treated where outcomes measurement shows improvement after 12 months.<br><br>Percentage of deaf people using mental health services that have a key worker.<br><br>Evidence of arrangements and facilities for deaf people in mental health services. | March 2013 – Establish baseline Performance level to be determined once baseline established<br><br>March 2013 – Establish baseline Performance level to be determined once baseline established<br><br>March 2013 – Establish baseline Performance level to be determined once baseline established<br><br>March 2013 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Gender Dysphoria**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 54**<br><br>A trans person should have hormone support as part of their care from a multi-disciplinary network using regionally agreed protocols including having access to an endocrinologist, to non-statutory peer support and mentoring, and to services that will, as part of their ongoing treatment and care, help them to improve their self-image. | Percentage of trans people accessing multidisciplinary assessment and screening prior to Hormone Therapy.<br><br>Percentage of trans people who access peer support.<br><br>Percentage of trans gender people within the gender identity service accessing services to improve their self image. | March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established<br><br>March 2012 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Forensic Mental Health**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 55**<br><br>A person who is a mentally disordered offender (young person or adult) should have access to the full range of services and interventions delivered in the appropriate environment by suitably trained staff. | Range of services and interventions available to any person within the criminal justice system. | March 2013 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Learning Disability**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 56**<br><br>A person with a learning disability should have access to appropriate mental health support for their needs. | Percentage of people who are receiving appropriate mental health services. | March 2012 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – Black and Minority Ethnic (BME) Communities**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 57**<br><br>A person from a black or minority ethnic community should have access to a full range of mental health services that are sensitive to their specific cultural needs and have support to enable good communication. | Percentage of BME people who are in receipt of mental health services that are sensitive to their needs. | March 2012 – Establish baseline Performance level to be determined once baseline established |

**People with Specific Needs – The Homeless**

| | Key Performance Indicators | Anticipated Performance Level |
|---|---|---|
| **Standard 58**<br><br>Health and Social Care should work in partnership with statutory and voluntary agencies to ensure the delivery of a high quality, comprehensive service to individuals with mental health problems who are homeless. | Review partnership arrangements and programmes for people with mental health problems who are homeless. | March 2012 – Establish baseline Performance level to be determined once baseline established |

A NOTE ON TERMINOLOGY

Many terms are used to describe mental health difficulties and there are many views on the subject.

The term 'mental health problem' has been used throughout the standards document to describe the full range of mental health difficulties that might be encountered, from the psychological distress experienced by many people to serious mental disorders that affect a smaller number of people.

The term 'mental illness' is used to refer to specific conditions such as schizophrenia, bipolar disorder and depression.

The term 'user' will be used throughout this document to reflect the term 'expert by experience' and those who use mental health services.

The term 'person' will be used to describe someone of any age who accesses mental health services delivered by health and social care in any setting.

The term 'carer' is used to describe a family member including children and young people or informal carer.

A glossary of terms is provided in Appendix 9.

# SECTION 1 – INTRODUCTION TO SERVICE FRAMEWORKS

## Background

The overall aim of the Department of Health, Social Services and Public Safety (DHSSPS) is to improve the health and social wellbeing of the people of Northern Ireland.

In support of this the Department is developing a range of Service Frameworks which set out explicit standards for health and social care that are evidence based and are capable of being measured.

The first round of Service Frameworks focuses on the most significant causes for ill health and disability - cardiovascular health and wellbeing, respiratory health and wellbeing, cancer prevention, treatment and care, mental health and wellbeing and learning disability.   Work has also commenced to develop Service Frameworks for children and young people and older people.

Service Frameworks have been identified as a major strand of the reform of health and social care services and provide an opportunity to:

• Strengthen the integration of health and social care services;
• Enhance health and social wellbeing, to include identification of those at risk, and prevent / protect individuals and local populations from harm and / or disease;
• Promote evidence-informed practice;
• Focus on safe and effective care; and
• Enhance multidisciplinary and intersectoral working.

## Aim of Service Frameworks

Service Frameworks will set out the standards of care that patients, clients, their carers and wider family can expect to receive in order to help people to:

• prevent disease or harm;
• manage their own health and wellbeing including understanding how lifestyle affects health and wellbeing including the causes of ill health and its effective management;
• be aware of what types of treatment and care are available within health and social care;  and

- be clear about the standards of treatment and care they can expect to receive.

Service Frameworks will also be used by a range of stakeholders including commissioners, statutory and non-statutory providers, and the Registration and Quality Improvement Authority (RQIA) to commission services, measure performance and monitor care.

The Frameworks will identify clear and consistent standards informed by expert advice and by national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The auditing and measuring of these standards will be assisted by the newly established Guidelines and Implementation Network (GAIN) which will facilitate regional audit linked to priority areas, including Service Frameworks.

The standards will aim to ensure that health and social care services are:

**i.** Safe – health and social care which minimises risk and harm to service users and staff;

**ii.** Effective – health and social care that is informed by an evidence base, resulting in improved health and wellbeing outcomes for individuals and communities;

**iii.** Efficient – health and social care that is commissioned and delivered in a manner which maximises resource use and avoids waste;

**iv.** Accessible – health and social care that is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to need;

**v.** Person centred – health and social care that gives due regard to the preferences and aspirations of those who use services, their family and carers and respects the culture of their communities. A person of any age should have the opportunity to give account of how they feel and be involved in choices and decisions about their care and treatment dependent on their capacity to make decisions. In absence of the capacity to make decisions they should listen to those who know and care for the person best.

**vi.** Equitable – health and social care which does not vary in quality because of personal characteristics such as age, gender, ethnicity, race, disability (physical disability, sensory impairment and learning disability), geographical location or socioeconomic status.

**Involving and communicating with service users, carers and the public**

The Department has produced guidance, "Strengthening Personal and Public Involvement in Health and Social Services", which sets out values and principles which all health and social care (HSC) organisations and staff should adopt when engaging with the public and service users.   These include the need to involve people at all stages in the planning and development of health and social care services.

It is important that the views of service users and carers are taken into account when planning and delivering health and social care. The integration of the views of service users, carers and local communities into all stages of the planning, development and review of Service Frameworks is an important part of the continuous quality improvement and the open culture which should be promoted in HSC.

The Department is committed to involving those who use mental health services (experts by experience), their carers and wider families.  Through the proactive involvement of the service users and carers in the planning of Service Frameworks, it is hoped that concerns and ideas for improvement can be shared and that the standards developed in partnership with service users, carers and the public will focus on the issues that really matter to them.

It is also important that Service Frameworks provide service users and carers with clear and concise information, which is sensitive to their needs and abilities, so that they can understand their own health and wellbeing needs.  Service users and carers are not interchangeable.

People are ultimately responsible for their own health and wellbeing and that of their dependents, and it is important that patients, clients, their carers and wider family are made aware of the role they have to play in promoting health and wellbeing.

**Involving other agencies in promoting health and wellbeing**

Improving the health and wellbeing of the population requires action right across society and it is acknowledged that health and wellbeing is influenced by many other factors such as poverty, housing, education and employment. While Service Frameworks set standards for providers of health and social care services it is essential that HSC services work in partnership with other government departments and agencies both statutory and non statutory to seek to influence and improve the health and social wellbeing of the public.

People who use health and social care services, including mental health services, may have complex needs which require inputs from a range of health and social care professionals and other agencies.

The benefits of multidisciplinary team working and multiagency working, including voluntary and community organisations, are well recognised and it is a key component of decision making regarding prevention, diagnosis, treatment and ongoing care. This will be a key theme underpinning the development and implementation of Service Frameworks.

**Data Collection**

As Service Frameworks are implemented it is important that timely, accurate information is available to assist decision making and service improvement.

Each specialist service must ensure timely submission of robust data collection to a regionally agreed minimum dataset. Where there are gaps in the availability of data against which to monitor service improvement then work should be undertaken at an early stage to develop these minimum datasets.

**Research and Development**

It is important that Service Frameworks are based on valid, relevant published research, where available, and other evidence.

**Education and Workforce**

Education and workforce development occur at individual, team, organisational, regional and national levels: they are part of the drive to promote quality. The ongoing development and implementation of Service Frameworks will influence the education and training agenda and curricula content for all staff involved in the delivery of health and social care. This will require a commitment to lifelong learning and personal development alongside a focus on specific skill areas to ensure that newly qualified and existing staff are in a position to deliver on quality services.

**Leadership**

Effective leadership is one of the key requirements for the implementation of Service Frameworks and will require health and social care professionals from primary, community and secondary care to work together across organisational boundaries including other government departments and the voluntary and community sectors. It is essential that Service Frameworks are given priority at senior, clinical and managerial level and implemented throughout all health and social care organisations.

**Affordability**

Extensive discussions have been held on the overall affordability of the Service Framework for Mental Health and Wellbeing and several of the standards do not require additional resources and should be delivered within existing funding baselines. Where there are additional costs associated with specific standards, performance indicators have been adjusted, and will be subject to further review. The final phasing of implementation of the Mental Health Service Framework will be determined following the work that will be completed to determine baseline activity and funding and following the outcome of the 2010 Comprehensive Spending Review (CSR).

## SECTION 2 – SERVICE FRAMEWORK FOR MENTAL HEALTH AND WELLBEING

### Introduction

Mental illness is one of the major causes of ill health and disability in Northern Ireland.  The aim of the Service Framework is to improve the mental health and wellbeing of the population of Northern Ireland, reduce inequalities and improve the quality of health and social care in relation to mental health.  It is recognised that achievement of this aim goes beyond traditional health and social care boundaries and is strongly influenced by population and individual attitudes and behaviours and the contribution of other sectors including voluntary and community organisations.

Some facts and figures in relation to mental health and wellbeing are set out in Appendix 1

The Service Framework for Mental Health and Wellbeing sets standards in relation to the prevention, assessment, diagnosis, treatment, care, rehabilitation of individuals and communities who currently have or are at greater risk of developing mental illness.  The standards adopt a lifespan approach that will enable each individual to be seen in their own context at their own point in life.  Standards have been developed in relation to:

- Health improvement and mental health promotion

- Improving the experience of service users and carers

- Specific Conditions – Children and Young People
    - Conduct disorder
    - Depression
    - Attention deficit hyperactivity disorder (ADHD)
    - Transition to adult services

- Specific Conditions
    - Anxiety Depression - Adults
    - First episode psychosis
    - Schizophrenia and other psychoses
    - Obsessive compulsive disorder
    - Bipolar disorder
    - Addictions and substance misuse
    - Eating disorders

- o Mental Health Component of Asperger Syndrome
- o Dementia

- • People with Specific Needs
  - o Perinatal mental health
  - o Older people's mental health
  - o Older people's transition from adult services
  - o Older people's assessment and early intervention
  - o Post traumatic stress disorder
  - o Personality disorders
  - o Self harm and suicide
  - o Acquired brain injury
  - o Deaf people with mental health needs
  - o Gender dysphoria
  - o Forensic mental health
  - o Learning disability
  - o Black and minority ethnic communities
  - o Homeless people

This is a three year Service Framework and was not designed to be fully comprehensive of all mental health conditions. Those involved have highlighted the most important areas for mental health and wellbeing. It will be subject to review as new evidence becomes available.

**Process for developing the Service Framework for mental health and wellbeing**

The development of Service Frameworks is overseen by a multidisciplinary Programme Board, which is jointly chaired by the Chief Medical Officer and Deputy Secretary of the DHSSPS. In addition the Mental Health Service Framework has been developed by a project team and regional reference group with representation from all aspects of the service including service users, carers, advocates, voluntary organisations and community groups. The project team is accountable to the Departmental Service Framework Programme Board. The full membership of the project team and regional reference group are set out in Appendix 3.

A total of 14 working groups were held between February and March 2008. Those attending were representative of the above partnership. Groups were led by people with a knowledge and expertise in the relevant specialist area (Appendix 4).

**Equality Screening**

The Project Team has completed an equality impact screening to take account of Section 75 of the Northern Ireland Act 1998 and any potential impact that the Service Framework might have on human rights.

**Value and Principles**

The values and principles that were developed for the Bamford Review following consultation and direct involvement with users and carers (Appendix 6) have been adopted in full in the development of the Service Framework for Mental Health and Wellbeing.

**Recovery**

The development of the Service Framework for Mental Health and Wellbeing is underpinned by the ethos of 'recovery'.

Recovery focuses on a person's right to build a meaningful life for themselves with or without the continuing presence of mental ill health.  Recovery is about a person's self determination and self management.

The recovery ethos should enable users to understand and cope with their mental health problems, build on their inherent strength and resourcefulness, establish supportive networks and pursue dreams and goals that are important to them and to which they are entitled as citizens (Vision for Change 2006).  It is essential for those who use services to be active participants in their own recovery rather than passive recipients of 'expert' care.

Recovery has become the underlying principle on which mental health services are being delivered in New Zealand, United States of America, Ireland and Scotland.  In England the recovery model is also supported by various Department of Health policies which aim to promote self management of long term conditions and choice.

In Northern Ireland, the Reform and Modernisation of Mental Health and Learning Disability Services Review (Bamford, May

2007) recommended that the recovery approach should be at the centre of all mental health services.

The concept of recovery is at the heart of the mental health Service Framework.

**Family Focus**

Parents with mental health problems need support and recognition of their responsibilities as parents. The Crossing Bridges Family Model (Falkov, 1998) is a useful conceptual framework that can help staff to consider the parent, the child and the family as a whole when assessing the needs of and planning care packages for families with a parent suffering from a mental health problem. The model illustrates how the mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked in at least three ways (see Appendix 7):

- parental mental health problems can adversely affect the development, and in some cases the safety, of children
- growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood
- emotional, behavioural or chronic physical difficulties in children can precipitate or exacerbate mental ill health in their parents/carers.

The Model also identifies that there are risks, stressors and vulnerability factors increasing the likelihood of a poor outcome, as well as strengths, resources and protective factors that enable families to overcome adversity (A diagram of the model can be found in Appendix 7).

The family approach should be taken into consideration when implementing the standards framework.

**Policy and Legislative Context**

- **The Reform and Modernisation of Mental Health and Learning Disability Services Review (Bamford May 2007)**

A review of policy, practice and legislation relating to Mental Health and Learning Disability was commissioned by DHSSPS in October 2002. The Review concluded in August 2007 and produced ten reports (see Appendix 2) that detailed the vision for promoting mental health and wellbeing at all levels of society and for the delivery of specialist health and social care for everyone who needs it.

The DHSSPS response to Bamford, 'Delivering the Bamford Vision' (2008), states "the Northern Ireland Executive accepts the thrust of the recommendations", and sets out proposals to take the recommendations forward over the next 10-15 years.

The standards in this document build on the approaches to mental health service provision proposed in the Bamford Review and subsequent Action Plan published in 2009.

- **Consistency with other documents**

The Mental Health Service Framework has also taken cognisance of reports and documents that have been  or are being developed by DHSSPS and other regional groups, including:

- Regional group for personality disorders
- Improving Dementia Services in NI – A Regional Strategy
- A Strategy for the Development of Psychological Therapy Services
- Think Child, Think Parent, Think Family project

- **Mental Health Order / Proposed Legislation**

The Mental Health Order (NI) 1986 is the legislation which currently applies in Northern Ireland. Whilst some elements are considered to work well it is evident that some aspects of the Order are outdated and may not comply with Human Rights legislation or good practice developments.

The Reform and Modernisation of Mental Health and Learning Disability Services (Bamford May 2007) Review of legislation has suggested a rights-based approach as a guiding principle for the reform of legislation which should respect the decisions of all who are assumed to have capacity to make their own decisions.

The DHSSPS will introduce a single piece of legislation that will bring innovative long term legislative change to Northern Ireland and will make a real difference to people.  The overall principle of the legislative reform will be 'autonomy' – which means individuals with mental capacity to make their own decisions will be allowed to do so.

The new legislation will be ready for consideration by the Assembly in 2011 and thereafter potentially in place by summer 2013.  The Mental Health Service Framework has been developed within the context of the Mental Health Order 1986 and will be reviewed and updated as and when required in order to reflect the new legislation.

- **Human Rights and Social Inclusion**

A key priority for health and social care services and the wider community is to tackle stigma, discrimination and inequality and to empower and support people with mental health problems and their families to be actively engaged in the process.  This is underpinned by legislation from Europe and the United Kingdom. A summary of all the relevant legislation can be found in "Promoting Social Inclusion", The Reform and Modernisation of Mental Health and Learning Disability Services (Bamford May 2007) and "Human Rights and Equality" Report (Bamford October 2006)

- **The Children (Northern Ireland) Order 1995**

The Children (Northern Ireland) Order 1995 is the primary domestic legislation in respect of children and is based upon a number of general principles.

The principles applicable to the standards in this document are:

- The welfare of the child is the paramount consideration

- Whenever possible children should be brought up and cared for within their own families

- Children should be safe and protected by effective intervention but such intervention should be open to challenge

- Children should be informed about and involved in decisions about what happens to them and able to participate in such decisions about their future

- Parents continue to have parental responsibility even when their children are not living with them.  They should be kept informed and able to participate when decisions are made about their future.

- Parents of children in need should be supported to bring up their children and such support provided in partnership with parents/carers

The general principles are in keeping with both UN Convention on the Rights of the Child 1989 and Domestic and Human Rights Legislation.

The responsibilities for the implementation of these principles as outlined within the Children Order rest with the respective organisations and all the professional bodies and individual professional staff who may have contact with children and families.

**How to read the rest of this document**

Each Service Framework follows an individual's journey from prevention though to end of life care taking into account the different health and social care needs of children, adults and older people.

Each standard is presented in the same way. Figure 1 shows the information that is included in each standard.

**Figure 1: Explaining the standards**

| Overarching Standard |
| --- |
| This is a short statement that outlines what will be delivered. |
| **Rationale** |
| This is a short section that outlines why/how the standard will make a difference for people using mental health services. |
| **Evidence** |
| This includes brief references for the research evidence or guidance that the standard is based on. |
| **Responsibility for delivery/implementation** |
| This lists the health and social care organisations tasked with responsibility for delivering the standard. It will include partners in care such as voluntary organisations and community groups that have service level agreements with health and social care organisations. |
| **Quality Dimensions** |
| • Person Centred<br>• Timely<br>• Effective<br>• Efficient<br>• Safe<br>• Equitable |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| This information will be monitored to show if the standard is being delivered. | This identifies where the information will be derived from. | This describes how well the service must perform against this indicator. | This specifies when the anticipated performance level should be reached. |

Each standard sets out the evidence base and rationale for the development of the standard, the impact of the standard on quality improvement as well as the performance indicators that will be used to measure that the standard has been achieved within a specific timeframe.

The standards are colour coded for ease of reference, for example the standards relating to health prevention and mental health promotion are green.

| Health Improvement /<br>Mental Health Promotion |
| :---: |
| Improving the Experience of Service<br>Users and Carers |
| Specific Conditions –<br>Children and Young People |
| Specific Conditions |
| People with Specific Needs |
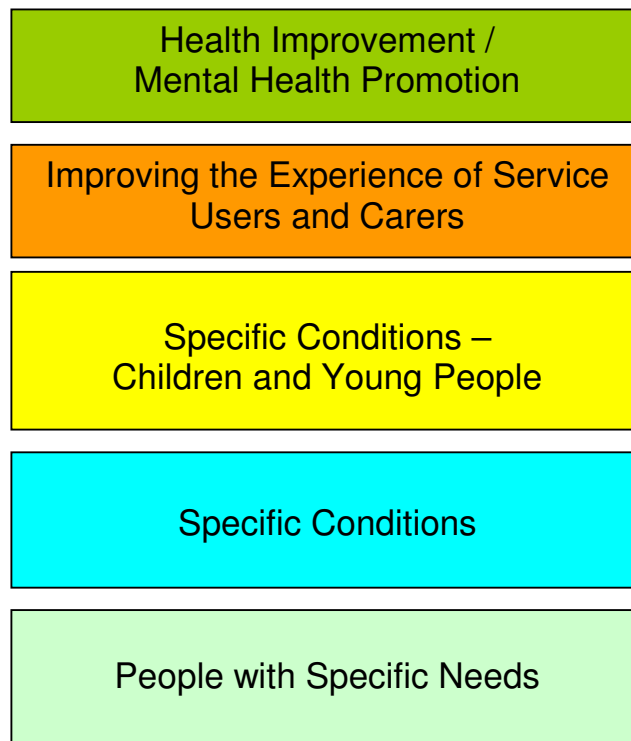
The rest of this document is divided into the following sections:

- **Section 3** sets out standards in relation to health improvement and mental health promotion;
- **Section 4** sets out standards to improve the experience of service users and carers;
- **Section 5** sets out standards for children and young people with specific conditions
- **Section 6** sets out standards for specific conditions;
- **Section 7** sets out standards for people with specific needs.

## SECTION 3 – PROMOTING GOOD MENTAL HEALTH AND WELLBEING

Physical health and mental heath are inextricably linked with each impacting upon the other. The World Health Organisation gives equal value to physical and mental health in the definition of health as "a complete state of physical mental and social wellbeing, not just the absence of disease and infirmity".

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

Many factors influence the health of individuals and communities. Whether people are healthy or not depends a great deal on their circumstances and the environment in which they live.

The determinants of health and wellbeing include:

- social environment
- the physical environment
- the person's individual characteristics and behaviour

Many of these factors of health are not under the direct control of the individual and therefore one person's health may differ from another's depending on their circumstances.

Addressing these factors of health and social wellbeing may potentially have a major impact on the health of the people of Northern Ireland. However, it will require action from all government departments and agencies not just health and social care. Investing for Health (IFH), the Public Health Strategy for Northern Ireland 2002, recognised that 'health improvement is largely about acting before people need medical care and that it requires action across Government and beyond in addressing a broad range of economic, social and environmental policy issues. Health and social services should act as advocates for health in order to influence policy that will impact on the wider determinants of health and wellbeing and work in partnership with all departments and agencies to influence change. Unfortunately this work does not fit easily into the Service Framework template and it is therefore not included as a standard but it is one of the essential actions required in order to improve overall health and wellbeing.

The following standards are important for mental health and wellbeing because, as previously stated, people with poor physical health are at a higher risk of experiencing common mental health problems.  In addition, people with mental health problems, especially those with severe and enduring mental illness, are more likely to have poor physical health.

## Overarching Standard 1: Smoking Prevention
Health and social care should work in cooperation with voluntary, education, youth and community organisations to prevent young people from starting to smoke.

**Rationale**

Smoking is one of the recognised risk factors for many physical illnesses such as cardiovascular disease, respiratory disease and cancer.  Its effects are related to the amount of tobacco smoked daily and the duration of the smoking.

Stopping young people from starting to smoke is crucial to reducing smoking levels, as evidence suggests that 82% of adult smokers started in their early teens (Tobacco Action Plan).  The Young People Behaviour and Attitude Surveys in 2000 and 2003, have shown that the rates of boys smoking every day has remained constant (25.2% and 23.9% of sample) whilst girls who smoke every day has increased (24.9% and 30.6% of sample).
Current interventions have not been shown to stop recruitment to smoking by young people.  There is some evidence that 'The Smoke Busters' programme delays the age of onset.  NICE guidance on smoking and young people is expected in July 2008 and this standard may need revised at that time.

**Evidence**

A 5 year Tobacco Action Plan was produced in 2003, detailing a comprehensive programme of action to reduce the harm cause by tobacco use
http://www.dhsspsni.gov.uk/publications/2003/tobaccoplan.pdf

The prevention of recruitment of young people to smoking was identified as a key area of action in the Tobacco Action Plan.

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

'Preventing the uptake of smoking by children and young people – review of effectiveness', NICE rapid review, June 2008
http://www.nice.org.uk/nicemedia/pdf/PH14reviewofeffectiveness.pdf

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care (including GPs, Pharmacy)
Voluntary Agencies

| Quality Dimensions | | | |
|---|---|---|---|
| **Person Centred –** Should take account of balancing what is important to people with what is important for them in regard to their health and welfare. **Equitable** - Tobacco education should be accessible to all young people in a range of media settings. | | | |
| **Performance Indicator** | **Data Source** | **Anticipated Performance Level** | **Date to be achieved by** |
| Percentage of 12, 14 and 16 year old boys and girls who smoke | Establish baseline data from Young People Behaviour and Attitude Survey (2007) in 12, 14 and 16 year olds<br><br>Survey repeated 3 yearly*<br><br>*subject to available resources | 5% decrease on baseline for boys (rate has been constant)<br><br>Maintain at baseline for girls (rate has been increasing therefore initial target to halt rise) | March 2012<br><br><br><br>March 2012 |

**Overarching Standard 2: Smoking Cessation**
All Health and Social Care professionals should identify those who smoke, make them aware of the dangers of smoking, advise them to stop and provide information and signposting to specialist cessation services.

**Rationale**
Smoking prevalence is significantly higher among those with mental health problems than among the general population.  Daily consumption of cigarettes is higher among smokers with mental health problems.  This increases the risk of developing smoking related illnesses such as heart and respiratory disease.  In addition, there is evidence that smoking is associated with and may intensify some mental disorders such as depression, schizophrenia and psychosis.

More than 50% of those with mental illness who smoke say they want to quit yet evidence shows it is harder for them to access services and they are often not directed to cessation services by healthcare professionals.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) produced guidance on brief interventions and referral for smoking cessation in primary care and other settings in March 2006, which represents best practice
http://guidance.nice.org.uk/PHI1

NICE guidance on 'Smoking Cessation Services, in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, February 2008
http://www.nice.org.uk/Guidance/PH10

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** – Should take account of what is important to the person, their relationships and activities in working with them to address issues around stopping smoking.  Exploring what works best for the person around support.
**Effective/Efficient**
Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on smoking cessation.
**Equitable/Effective**
Specialist smoking cessation services will be delivered to regional quality standards ensuing equitable service provision.

| Performance Indicator | Data source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Smoking cessation services available for Mental Health Users | Trust report | Maintain 2007/08 baseline levels | March 2010 |
| | | 4% increase in uptake | March 2011 |
| | | 4% increase in uptake | March 2012 |
| Percentage of clients quitting at 4 and 52 weeks | | Establish baseline | March 2010 |
| | | 2% increase in number of quitters (4% increase in uptake of services) | March 2011 |
| | | 2% increase in number of quitters (4% increase in uptake of services) | March 2012 |

**Overarching Standard 3: Healthy Eating**
People should be provided with healthy eating support and advice, appropriate to their needs, in a range of settings.

**Rationale**
Eating well and healthy helps to prevent many diseases which are linked to being overweight such as high blood pressure, high blood sugar, heart problems, risk of stroke, cancer, joint problems and sleeping difficulties to name just a few.  Eating well also helps to make people emotionally well and improve mental health and wellbeing.

People with mental health problems are more likely to have a weight problem which can be related to how they feel in general or to the specific mental health problem.  It is important to eat healthily and combine this with physical activity to improve mental health and wellbeing.

**Evidence**
WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

Scientific Advisory Committee on Nutrition recommendations on healthy eating for the general population
http://www.sacn.gov.uk/reports_position_statements/reports/the_nutritional_wellbeing_of_the_british_population.html

The Royal College Psychiatrists Nutrition and Mental Health
http://www.rcpsych.ac.uk/mentalhealthinfo/problems/nutrition.aspx

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts
Primary Care

| Quality Dimensions | | | |
|---|---|---|---|
| **Person Centred** – Should take account of the balance between what is important to the person and what is important for them in regard to healthy eating.  Healthy eating choices should be explored through the knowledge of the person's preferences and tastes.<br>**Equitable** – Support and advice to develop skills for healthy eating in a range of settings should be available.<br>**Effective** – All health and social service staff should promote a consistent nutrition message by using the Eat Well – getting the balance right plate model. Training and education should be available for child carers / group care workers. | | | |
| **Performance Indicator** | **Data Source** | **Anticipated Performance Level** | **Date to be achieved by** |
| Services available for Mental Health users | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2011 |

**Overarching Standard 4: Healthy Eating**
Health and social care should work with early years settings, schools, workplaces and communities to prevent obesity (by encouraging healthy eating and physical activity and through the promotion and support of breastfeeding) and to and to assist in early detection and minimise the development of an eating disorder.

**Rationale**
As body weight increases so does the risk of cardiovascular disease, diabetes, hypertension and low self esteem.
Eating disorders have a high risk of morbidity and mortality and it is the third most common cause of chronic illness in adolescents.
The importance of early detection has been proven to have a better outcome with this client group.  Early understanding of healthy eating can assist in the reduction of eating disorders in children and young people.

**Evidence**
WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

Scientific Advisory Committee on Nutrition recommendations on healthy eating for the general population
http://www.sacn.gov.uk/reports_position_statements/reports/the_nutritional_wellbeing_of_the_british_population.html

The Royal College of Psychiatrists Nutrition and Mental Health
http://www.rcpsych.ac.uk/mentalhealthinfo/problems/nutrition.aspx

National Institute for Health and Clinical Excellence (NICE) (2004) Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders
http://guidance.nice.org.uk/CG9

Scottish Intercollegiate Guidelines Networks (SIGN) (April 2003) Management of Obesity No 115 http://www.sign.ac.uk/guidelines/fulltext/115/index.html

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts
Primary Care

| Quality Dimensions |
| --- |

**Person Centred** – Lifestyle issues including eating and physical activity choices should be explored through knowledge of what is important to the person.  This should also take account of what has worked and what hasn't worked in the past.
**Equitable** – Support and advice to develop skills for healthy eating in a range of settings should be available
**Effective** – All health and social service staff should promote a consistent nutrition message by using the Eat Well – getting the balance right plate model. Training and education should be available for child carers / group care workers

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Percentage of people who have a BMI of above 25 | Health and Social Wellbeing Survey 2005/06<br><br>Survey repeated 5 yearly<br><br>Child Health System | 2% decrease on 2005/06 baseline | March 2011 |
| Percentage of P1 Children who have been identified as being overweight and obese or underweight and malnourished.<br><br>Note: these PIs will be reviewed in light of the forthcoming obesity strategy | | Establish Baseline<br><br>Performance level to be determined once baseline established | March 2010 |

**Overarching Standard 5: Physical Activity**
A person accessing or availing of mental health services in any setting that is identified as being inactive* should be provided with advice and support to accumulate a minimum of 30 minutes of moderate activity** on 5 days of the week or more.

*inactive refers to all people who do not meet the recommended level of physical activity
**walking briskly, walking downstairs, dancing, biking, swimming, gardening, housework e.g. washing floors.
http://www.paho.org/English/HPP/HPN/whn2002-factsheet2.pdf

**Rationale**
National Institute for Health and Clinical Excellence (NICE) has fully endorsed the importance of physical activity as a means of promoting good health and preventing disease.  Lack of physical activity is associated with an increase in the risk of several medical conditions such as coronary heart disease, stroke, osteoporosis, cancer etc.
Physical activity can also be helpful to improve mental health and wellbeing by lifting mood, help deal with negative emotions and improve a sense of mental wellbeing.  People of all ages who have mental health problems – especially severe and enduring mental health diagnoses have poorer health than those who do not have a mental health diagnosis. People of all ages who are inpatients of mental health hospitals may not have the opportunity to be physically active. For a range of reasons those living in the community may find it difficult to participate in physical activity.

**Evidence**
WHO (2004) Global Strategy on Diet, Physical Activity and Health
http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf

National Institute for Health and Clinical Excellence (NICE) Public Health Intervention Guidance No.2 (2006) Four commonly used methods to increase physical activity:  Brief intervention in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling http://www.nice.org.uk/nicemedia/pdf/word/PH002_physical_activity.doc

DHSSPS (2005) Fit Futures http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

Bamford Review: Mental Health Promotion Report (May 2006)
http://www.rmhldni.gov.uk/mentalhealth-promotion-report.pdf

M Jones & C O'Beney (2004) Promoting mental health through physical activity: examples from practice. Journal of Mental Health Promotion March 2004

The Royal College of Psychiatrists – Nutrition and Mental Health
http://www.rcpsych.ac.uk/mentalhealthinfo/problems/nutrition.aspx

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred –** Paying attention to what works best for the person in undertaking physical activity, working with their interests.  What has worked in the past and what doesn't work.
**Effective** / **Efficient** – Appropriate physical activity brief intervention training should be provided for Health and Social Care Staff to ensure clients receive consistent and timely advice.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people being asked and advised about their physical activity | Audit | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |
| Percentage of people advised who achieve the recommended level of physical activity | Audit | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |

**Overarching Standard 6: Addictions / Substance Misuse**
Primary care professionals should identify people who consume hazardous/harmful amounts of alcohol or who misuse drugs (illegal or prescribed), make them aware of the associated dangers, advise them to reduce or stop and provide information and signposting to specialist services if appropriate

**Rationale**
Alcohol and drug misuse has an impact on both physical and mental health. A person with a combination of mental illness and alcohol and/or substance misuse faces many challenges which are complex and have multiple causes. Health and social care organisations should work in partnership with voluntary and community organisations to promote the mental health and wellbeing of this vulnerable group of people.

**Evidence**
Scottish Advisory Committee on Drug Misuse (SACDM), Scottish Advisory Committee on Alcohol Misuse (SACAM) (2003) Mind the Gap – Meeting the needs of people with co-occurring substance misuse and mental health problems http://www.scotland.gov.uk/Publications/2003/11/18567/29477

Bamford Review: Alcohol and Substance Misuse Report (December 2005) http://www.rmhldni.gov.uk/index/published-reports/asm-report.htm

Scottish Intercollegiate Guidelines Network (SIGN) (September 2003) The Management of harmful drinking and alcohol dependence in Primary Care No 74 http://www.sign.ac.uk/pdf/sign74.pdf

DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011) http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009 http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts
Primary Care

| Quality Dimensions |
| --- |

**Person Centred –** Take account of what and who is important to the person now and in the future in relation to lifestyle and where alcohol fits in. Explore how alcohol can be managed in the person's life by taking account of what has worked and what hasn't worked in the past for this person.

**Effective/Efficient** - Brief Intervention Training for Health and Social Care Staff will ensure clients receive consistent and timely advice on alcohol consumption.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Percentage of people who receive Brief Intervention in Primary Care to reduce alcohol related risk | Cardiovascular DES | Establish baseline<br><br>Performance level to be determined once baseline established | March 2010 |
| Percentage of young people who were assessed using the Regional Initial Assessment Tool (RIAT) | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |

**Overarching Standard 7: Mental Health Promotion of Children and Young People**
Health and social care professionals should identify children across the wider age spectrum and their parents or carers, who require additional services to help promote the child's development and should address the needs of the children, parents and/or carers by commissioning services, where appropriate, to meet their individual needs.

**Rationale**
Early years experience and particularly good parent child relationships are vital for promoting strong attachments, developing childhood resilience and promoting good emotional health and wellbeing in childhood and later life. Interventions which strengthen the relationship between infants and carers have a strong impact on both mental and physical health.

**Evidence**
Northern Ireland Association for Mental Health. Mental Health Promotion: Building an Economic Case. Lynne Friedli, Michael Parsonage. November 2007 http://www.niamhwellbeing.org/Information-Centre-4848.html

Bamford Review: A Vision of a Comprehensive Child and Adolescent Mental Health Service (July 2006) http://www.rmhldni.gov.uk/camh-vision-comprehensive-service.pdf

The Sainsbury Centre for Mental Health. Briefing Paper 24 (January 2004). Mental Health Promotion – Implementing Standard One of the National Service Framework for Mental Health
http://www.scmh.org.uk/publications/mh_promotion.aspx?ID=535

Sure Start National Evaluation Summary: Family and Parenting Support in Sure Start Local Programmes. Barlow J et al.
http://www.dcsf.gov.uk/rsgateway/DB/RRP/u015255/index.shtml

DOH (2004) National Service Framework for Children, Young People and Maternity Services – Mental Health and Psychological Well Being of Children and Young People
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114

Every Child Matters http://www.dcsf.gov.uk/everychildmatters/

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

| Responsibility for delivery/implementation |
| --- |
| HSC Board |
| Public Health Agency |
| HSC Trusts |
| Primary Care |
| In partnership with all statutory agencies, voluntary and community groups |

| Quality Dimensions |
| --- |
| **Person Centred**: Ensure that the child is at the centre of assessment and planning regardless of age or ability.  Those working with children and their families should be able to meaningfully engage with them in order to understand and promote their views and choices. |
| **Timely:** Providing services in a timely manner will increase the likelihood of problems being dealt with earlier with the minimum of negative impact on the child |
| **Effective:** Early identification of children and their families who will need additional help, support and stimulation can improve outcomes.  Appropriate services include perinatal and infant mental health services, Primary Care, Tier 2 CAMHS, Sure Start, Parenting Programmes, School Health, and Maternity Services. |
| **Efficient:** The cost of delivering programmes is relatively low. The lifetime cost of caring for children who go on to develop conduct disorder or other mental health problems is high. |
| **Equitable:** Potential barriers to attending parenting programmes should be addressed to ensure parents can avail of the programmes. Most programmes can be delivered by community and voluntary groups. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Percentage of parents / carers identified as requiring additional support who are offered evidence based parenting programmes | Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of referrals to CAMHS for attachment / parenting / control problems | Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

| | | | |
|---|---|---|---|
| Review of early intervention, prevention activities formally commissioned in each Trust area. (To include perinatal and infant mental health) | Trust Report | All Trusts | March 2012 |

**Overarching Standard 8: Workplace**
Health and social care organisations should implement the Health and Safety Executive's Management Standards to reduce work related stress among staff.

**Rationale**
Although working has a positive impact on people's mental health, work related stress and other factors can have a negative impact on mental and physical health. In both men and women, high job demands and low social support at work have been found to be predictive of depression. The Health and Safety Executive report that over half a million people experience work related stress to the point where they believe it is potentially making them ill. Work related stress accounts for over a third of all new incidences of ill health absences from work.

Many of the factors that contribute to work related stress can be addressed through good management practice. The Health and Safety Executive have developed the Management Standards approach which aims to reduce the levels of stress.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (November 2009) Promoting Mental Wellbeing at Work: Guidance for employers on providing mental wellbeing through productive and healthy working conditions
http://guidance.nice.org.uk/PH22

Health and Safety Executive. Management Standards for Work Related Stress.
http://www.hse.gov.uk/stress/standards

British Occupational Health Research Foundation (September 2005): Workplace interventions for people with common mental health problems: Evidence review and recommendations
http://www.bohrf.org.uk/downloads/cmh_rev.pdf

Northern Ireland Association for Mental Health. Mental Health Promotion: Building an Economic Case. Lynne Friedli, Michael Parsonage. November 2007 http://www.niamhwellbeing.org/Information-Centre-4848.html

Making it Effective: A guide to evidence based mental health promotion. Radical mentalities briefing paper 1. London, Mentality, 2003.
http://www.scmh.org.uk/pdfs/makingiteffective.pdf

The Sainsbury Centre for Mental Health. Briefing 24. Mental Health Promotion – Implementing Standard One of the National Service Framework for Mental Health. http://www.scmh.org.uk/publications/mh_promotion.aspx?ID=535

Health and Safety Executive Northern Ireland (HSENI).  Stress management

http://www.hseni.gov.uk/guidance/guidance/topics/stress-3-column.htm

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts

**Quality Dimensions**

**Person Centred:** The needs of the individual worker should be understood in relation to what is important to the individual relative to what is important for the organisation.  When employees are treated as individuals they are likely to be more productive.

**Efficient:** Reduced stress related absence from work will have positive effects on service delivery and efficiency.

**Equitable:** The management standards and similar approaches are applied across the whole organisation.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Implementation of the Health and Safety Executive Management Standards | Reports from all HSC organisations | All HSC organisations | March 2013 |

**Overarching Standard 9: Mental Health Promotion for Older People**
Older people (adults aged 65 years and older) living independently with or without support, or in residential care should have the opportunity to access individual or group health promotion sessions including healthy eating and physical activity programmes.

**Rationale**

It is recognised that physical and mental health are closely inter-related. Reports from the voluntary, public and private sectors state that the mental wellbeing of older people is being unnecessarily compromised. Health and social services providers need to improve their focus upon preventing ill health through promotion of healthy lifestyles (DOH 2006).

**Evidence**

National Institute for Health and Clinical Excellence (NICE) (October 2008) Mental wellbeing and older people: Guidance for Occupational therapy and physical interventions to promote the mental wellbeing of older people in primary care and residential care http://guidance.nice.org.uk/PH16

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007)  http://www.rmhldni.gov.uk/

UK Inquiry into Mental Health and Wellbeing in later life (June 2006) http://www.mhilli.org/index.aspx?page=stage2promotion.htm#Inquiryreport

**Responsibility for delivery/implementation**

HCS Trusts in partnership with voluntary / community organisations

**Quality Dimensions**

**Person Centred –** Older people, what is important to them. Their family and friends are central to the planning and delivery of health promotion activities and materials. Options should be explored regarding to what would work best for them given their unique context and lifestyle.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of older people known to health and social services who are in receipt of individual or group health promotion sessions. | Trust report | Establish baseline

Performance levels to be determined once baseline established | March 2013 |

## SECTION 4 – IMPROVING THE EXPERIENCE OF SERVICE USERS AND CARERS

Standards 10 – 26 apply to anyone who uses mental health services and their carers.  They should be read in conjunction with all other standards relevant to the individual.  Standards in relation to specific conditions and/or specific needs can be built-on as required.

**Overarching Standard 10: User Participation**
A person who uses mental health services should be actively and meaningfully involved in planning, delivering and monitoring of health and social care at all levels.

**Rationale**
Actively involving individuals who use the service, their families and carers and the public in the planning and provision and monitoring of health and social care in general has been noted to bring many advantages to both those who receive and those who provide care.

**Evidence**
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
http://www.dhsspsni.gov.uk/hpss_qi_regulations.pdf

DHSSPS (2005) A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025
http://www.dhsspsni.gov.uk/show_publications?txtid=7282

Healthy Democracy (NHS National Centre for Involvement, 2006)
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?content=90

Living Fuller Lives – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) (June 2007)
http://www.rmhldni.gov.uk/living_fuller_lives.pdf

DOH (2004) National Service Framework for Children, Young People and Maternity Services
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089114

Every Child Matters http://www.dcsf.gov.uk/everychildmatters/

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts in partnership with the independent sector
Primary Care

| Quality Dimensions |
| --- |
| **Person Centred -** Those who avail of services and their friends and family should be respected as partners in planning, developing and evaluating services based on their expert knowledge as service users. <br> **Timely** - Involvement by those who use the service as early as possible is beneficial both for the person using the service and for those who care for them. <br> **Effective/Efficient/Equality** - Improved communication between individuals who use the service and health and social care staff increases satisfaction with positive health effects and better outcomes. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Evidence of Health and Social Care Organisational Strategies for Person and Public Involvement | HSC organisational monitoring reports | All HSC organisations | March 2012 |
| Evidence of systematic involvement and participation of mental health users in service planning, delivery and monitoring across Health and Social Care | Trust Report RQIA <br><br> User feedback Mental Health and Children's services Think family project | All HSC organisations | March 2012 |

**Overarching Standard 11: Carers**
Carers of people with a mental health problem should be given the opportunity to be involved in the planning and delivery of services.   All carers, including children and young people, should be offered a carers assessment.

**Rationale**
Health and social services should recognise the expertise of carers and develop partnerships to ensure more meaningful involvement in the planning, delivery and monitoring of care. Engagement with family and carers helps to improve outcomes for all stakeholders.  Even when the individual using the service removes consent for family and carer involvement, they should be given the opportunity to discuss any difficulties in their caring role.

**Evidence**
DHSSPS (2007) Caring for Carers. Recognising, valuing and supporting the caring role  http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

DHSSPS (2002) Valuing Carers – Proposals for a Strategy for Carers in NI http://www.dhsspsni.gov.uk/valuing_carers-2.pdf

The Royal College of Psychiatrists (2004) Carers and confidentiality in mental health - Issues involved in information sharing http://www.rcpsych.ac.uk/PDF/Carersandconfidentiality.pdf

McCartan Review 2007 (re involvement of parents as carers of young people with mental health problems under 18)

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009 http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Trusts in partnership with non- statutory providers

**Quality Dimensions**

**Person Centred –** Carers have a significant contribution to make to the understanding of what is important to service users and how best to support them.  A person centred approach in understanding and supporting carer's needs should be used.  It is desirable to understand what is important to the carer as it is to understand the individual that they are caring for.
**Timely** – Carer involvement can enhance the person's recovery.
**Effective** – Carer involvement in planning and care delivery can improve outcomes
**Safe** – Involvement by carers helps minimise risk

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Evidence of health and social care strategies for family and carers involvement | Trust Report | All Trusts | March 2012 |
| Percentage of carers, including children and young people, offered a carers' assessment | Trust report<br><br>Carer feedback | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## Overarching Standard 12: Advocacy
A person using specialist mental health services should have access to advocacy services in both community and hospital settings.

**Rationale**

Advocacy promotes personal empowerment and self determination.   Advocacy assists service users to express their views and take a pro-active part in decision making.

**Evidence**

DOH (1995) Building Bridges

DOH (1997) The Mental Health Patient's Charter

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts

**Quality Dimensions**

**Person Centred/Effective** – The role of an advocate in understanding and communicating what is important to the person in regard to their lifestyle and aspirations is vital.  This is especially so where the person is under the age of 18 or they do not have anyone other than health and social care professionals to advocate on their behalf or where there are conflicting views about their needs and how best to meet these.

**Equitable** – access to a range of advocacy services including peer and/or independent advocacy

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people in contact with specialist mental health services who avail of timely and age appropriate advocacy services | Advocacy Services Reports<br><br>RQIA monitoring report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## Overarching Standard 13: Safety
Mental health services should be provided in an environment that ensures the safety, privacy and dignity of those who use the services and their families and carers.

**Rationale**

Mental health treatment and care is provided in a range of settings in the community and in hospitals.  The changes in the way services are being delivered, advances in technology and a more complex health and social care system brings risks.  Evidence and practical experience has shown that things can go wrong.  There is a need for mental health and social care providers to improve safety by tackling the specific issues in mental health care in a collective and systematic way.

**Evidence**

NHS Executive (2000) Safety, Privacy and Dignity in Mental Health Units: Guidance on mixed sex accommodation for mental health services
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_4007095

NPSA (2004) Seven Steps to Patient Safety
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Recommendations of the Independent Reviews – McCartan, McCleary and O'Neill

DHSSPS (2008) Improving the Patient and Client Experience
http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts

**Quality Dimensions**

**Person Centred –**Improves a person's experience of services
**Safe –** Enhances a person's feeling of being secure and supported.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Evidence of arrangements to ensure safety, privacy and dignity | Trust report User and carer feedback Complaints report | All Trusts | March 2012 |

**Overarching Standard 14**: **Information sharing**
A person and their carers and members of the public, where appropriate, using or accessing mental health services should be provided with evidence-based, targeted mental health and wellbeing information including information in relation to their detention under the Mental Health Order 1986 if applicable.

**Rationale**
People need to be aware of and have access to a range of mental health promotion approaches to reduce stigma towards mental health issues and to build capacity, resilience, skills and knowledge to support individuals and communities in need.  This will help to increase self esteem, confidence and self worth.  Information regarding mental health services is also essential

**Evidence**
DHSSPS (2003) Promoting Mental Health: Strategy and Action Plan 2003-2008
http://www.dhsspsni.gov.uk/menhealth.pdf

Independent Reviews, McCartan, O'Neill, McCleary Recommendations

Bamford Review: Mental Health Promotion Report (May 2006)
http://www.rmhldni.gov.uk/mentalhealth-promotion-report.pdf

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts
Primary Care
Voluntary and Community Groups
Other Statutory Groups
Independent Sector (Nursing and Residential Homes etc)

**Quality Dimensions**

**Person Centred** - Information sharing should take into account the culture and understanding of the individual and their family/carers and from this content provide information in a way that meets their needs and is respectful.  This is likely to include various information media including verbal, written, pictorial and audio-visual and potentially also information in a range of languages
**Timely and Safe -** recognition that timely intervention could limit or minimise the effect
**Equitable** - addresses ageism and inequity
**Effective** - Evidence has shown that early recognition and appropriate intervention improves outcomes

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Evidence of mental health and wellbeing information available from health and social care services | Trust Report<br><br>User and carer feedback<br><br>RQIA monitoring report | All HSC Organisations<br><br>Report | March 2012 |

**Overarching Standard 15: Effective communication between mental health services and users / carers**
Health and social care organisations and their staff should communicate effectively with those who use or access mental health services, including their carers, as an essential and universal component of the planning and delivery of health and social care.

**Rationale**
Effective communication may potentially have a significant impact on all aspects of care provisions from prevention, to diagnosis, to self-management of long-term conditions. Poor communication is often a significant contributory factor in complaints against HSC organisations.

**Evidence**
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care  http://www.dhsspsni.gov.uk/hsc__sqsd__29-07.pdf

Good Medical Practice (GMC, 2006)
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 – http://www.dhsspsni.gov.uk/hpss-_qi_regulations.pdf

Recommendations of the Independent Reviews – McCartan, McCleary and O'Neill

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Board
Public Health Agency
HSC Trusts
Primary Care

| Quality Dimensions |
|---|

**Person Centred** – Good communication is a pre-requisite of a person centred approach.

**Timely** – Good communication helps to deliver and sustain appropriate person/carer access to services and a clear understanding of the role and responsibilities of the service user in achieving health and care outcomes.

**Equitable** – Good communication helps to ensure input by all service users across all aspects of the services they receive assisting in the highlighting of gaps in provision and areas for improvement.

**Effective/Efficient** – Health and care outcomes themselves are enhanced through improved patient partnership and dialogue, including, but not limited to – diagnosis, self-referral, health promotion, disease prevention and management of long term conditions.

**Safe** – Good communication with the person and their carers enables adequate understanding of, consent to and compliance with treatment and care and contributes to audit and monitoring.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| HSC organisational communication strategies that show evidence of direct user/family carer feedback as part of regular audit of their effectiveness. | HSC communication strategies<br><br>User and carer feedback | All HSC Organisations | March 2012 |
| HSC organisational complaints reports should show evidence of action where communication is the primary factor. | HSC complaints records | All HSC Organisations | March 2012 |

**Overarching Standard 16: Communication between services, organisations and professionals**
Health and social care organisations should ensure that effective and secure patient information systems are in place to record and share relevant information across HSC services and other agencies in line with agreed protocols.

**Rationale**
Effective communication may potentially have a significant impact on all aspects of care provision. To ensure continuity and quality of care it is vital that relevant information regarding the person is shared between professionals. Effective information sharing is a crucial contributory factor in terms of preventing adverse outcomes including protection from abuse – of both adults and children. Mental health professionals can be in possession of sensitive information. The need to keep such information confidential needs to be balanced with the risks of not passing on crucial information including those relating to potential child protection issues. Clear policies and procedures coupled with robust staff training and support should be present in order to enable professionals to make appropriate decisions when dealing with patient and client information.

**Evidence**
DHSSPS (2007) Guidance on strengthening Personal and Public Involvement in Health and Social Care  http://www.dhsspsni.gov.uk/hsc___sqsd___29-07.pdf

Good Medical Practice (GMC, 2006)
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003  http://www.dhsspsni.gov.uk/hpss-_qi_regulations.pdf

The Children (Northern Ireland) Order 1995
http://www.legislation.gov.uk/nisi/1995/755/contents/made

Recommendations of the Independent Reviews – McCartan, McCleary and O'Neill

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

| Responsibility for delivery/implementation | | | |
|---|---|---|---|
| HSC Board | | | |
| Public Health Agency | | | |
| HSC Trusts | | | |
| Primary Care | | | |

| Quality Dimensions | | | |
|---|---|---|---|

**Person Centred** – Ensure that the service user is always recognised for being a unique individual and that their best interests are represented in all communication between services, organisations and professionals.  The service user/their family and friends should be at the centre of any communications or decision-making processes.

**Safe** – Good communication between professionals ensures relevant risks are known to all those involved in care and treatment.  It also helps to reduce the risk of serious adverse incidents occurring.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| HSC organisational communication strategies that show evidence of effective communication between mental health services, other organisations and professionals | HSC communication strategies

RQIA monitoring report | All HSC organisations | March 2012 |
| HSC organisational complaints reports should show evidence of action where communication is the primary factor | HSC complaints records | All HSC organisations | March 2012 |

**Overarching Standard 17:  Service Delivery**
A person with complex mental health needs should be treated and supported in the community and in their own home, where possible, with due regard to both their physical and mental health needs.

**Rationale**
Specialist mental health treatment and support should be provided in a service which imposes the least personal restriction of rights and choices balanced with the need to provide effective treatment.  People often have physical health and social care needs that benefit from medical and psychiatric assessment, intervention and treatment to alleviate mental ill health – as well as physical conditions – to ensure a better quality of life and prolong independence.  In respect of children and young people this includes assistance in maintaining their education and social networks.

**Evidence**
Living Fuller Lives – The Bamford Review of Mental Health and Learning Disability (Northern Ireland) (June 2007)
http://www.rmhldni.gov.uk/living_fuller_lives.pdf

Bamford Review: A Vision of a Comprehensive Child and Adolescent Mental Health Service (July 2006) http://www.rmhldni.gov.uk/camh-vision-comprehensive-service.pdf

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) Home Treatment and Community Based Care
http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

Malone D, Marriott S, Newton-Howes G, Simmonds S, Tyrer P. Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD000270. DOI: 10.1002/14651858.CD000270.pub2.

Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. Cochrane Database of Systematic Reviews 2006, Issue 4. Art. No.: CD001087. DOI: 10.1002/14651858.CD001087.pub3.

Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 1998, Issue 2. Art. No.: CD001089. DOI: 10.1002/14651858.CD001089

| Responsibility for delivery/implementation |
|---|
| HSC Board |
| Public Health Agency |
| HSC Trusts |
| Primary Care |
| **Quality Dimensions** |
| **Person Centred** – The person and their family and friends should be involved in 'designing' the appropriate service/supports necessary to meet the individual's specific requirements.  Every service offered should take into account the unique aspects of who the person is, what is important to them and what has worked or has not worked before. |

**Effective** – Assessment, treatment and care are more effective when undertaken in partnership with the person
**Efficient** – Integrated care and treatment is more efficient.
**Safe** – Minimises risk for both user and carer.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people with complex mental health needs being treated and supported in community settings including their own home | Trust Report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people being treated for complex mental health problems whose physical needs have been assessed | Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## Overarching Standard 18: Access to services
A person experiencing a significant mental health crisis should have timely access to age appropriate health and social care services 24 hours a day and 7 days per week

**Rationale**

The needs of individuals experiencing a crisis must be met in a timely basis and within an environment which is age appropriate. Where the individual is already known to other services this should take account of their existing crisis response plan.  Protocols should be developed to ensure the prompt referral and assessment of people who are not known to other services.


**Evidence**

Independent Regional Inquiries

DOH (1999) National Service Framework for Mental Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598


*Meeting the Target: providing on call and 24 hour specialist cover in CAMHS*
P Storey and J Statham, March 2007, Thomas Coram Research Unit


Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** – Support and response to people should be based around understanding of who they are and what is important to them including children and family.  This knowledge should feature in any support or crisis intervention plan.
**Equality** – young people under the age of 18 should not be admitted to adult beds
**Timely** – When required
**Safe** – Help to minimise risk

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Establish current level of service provision for mental health crises | Baseline review<br><br>RQIA inspection reports | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of young people (under the age of 18) admitted to age appropriate inpatient beds | Trust monitoring returns<br><br>RQIA inspection reports | 98%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012 |

| **Overarching Standard 19: Care Pathways** |
|---|
| A person using mental health services should have an integrated care pathway for their assessment, treatment, care and ongoing management where health and social care (including primary care) work in partnership with users and their carers to develop the most appropriate and accessible services. |

**Rationale**

Integrated care pathways set out the anticipated process and standards of care and enable people with a similar diagnosis or set of symptoms move progressively through services and achieve positive outcomes.  They improve the care provided to those who use services.


**Evidence**

NHS Quality Improvement Scotland

http://www.nhshealthquality.org/mentalhealth/


Hall J, Howard D. Integrated Care Pathways in Mental Health

(2006) Royal Society of Medicine


Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009

http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**

HSC Board

Public Health Agency

HSC Trusts

Primary Care

**Quality Dimensions**

**Person Centred** – Integrated care pathways should reflect the needs of service users and carers.  Service users and carers should be involved in their development and take into account to what works and what doesn't work from all perspectives including service users, carers, professionals and the community.

**Timely** – Improves the timeliness of services being delivered

**Equitable** – Will assist in highlighting gaps in service

**Effective** – Provides a record of care and allows clarification around who does what and when.

**Efficient** – Helps reduce duplication of work and improves communication.

**Safe** – Minimises risk

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Establish the range of care pathways in place or being developed regionally or locally | Regional review | All Trusts | March 2013 |
| Evidence of involvement of users, families, carers and advocates in the development of care pathways | User, carer and family feedback via Trust user/carer forum Patient Client Council | All Trusts | March 2013 |

| Overarching Standard 20: Care planning |
|---|
| A person receiving treatment and care in primary care and / or mental health services (community and inpatient) should have a care plan prepared in partnership with them that is recovery focused, evidence based and fully recorded. The shared care plan should allow for urgent access to specialist services, if required. (Where relevant this should identify the needs of children and family members) |

**Rationale**

The care plan should reflect integrated planning and coordination and all the elements of the individual's treatment & care.  An assessment will be undertaken to identify and detail all of the individual's needs.  The care plan will then be developed and this should reflect discussion between the individual, their carers and professional staff.  It is important that this includes an assessment of risk given that mental health services must identify and manage risks that some people with mental health problems pose either to themselves or to others.  While understanding the level of risk associated with an individual forms just one part of their overall needs assessment, it is nevertheless an integral part of formulating an appropriate care plan.

**Evidence**

DOH (1999) National Service Framework for Mental Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

DHSSPS (2008) Good Practice Guidance on the Assessment and Management of Risk in Adult Mental Health Services DHSSPS 2008
http://www.dhsspsni.gov.uk/good-practice-guidance-and-risk-assessment.pdf

Independent Inquiries 2006/2007

DHSSPS (2007) Caring for Carers. Recognising, valuing and supporting the caring role  http://www.dhsspsni.gov.uk/ec-dhssps-caring-for-carers.pdf

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** – Care plans should be person centred, uniquely built around each individual reflecting what is important to them as individuals and how they should be best supported.  Care plans should be developed alongside the person, their family and carers, and be available in an accessible format.
**Timely** – Involves people from the beginning and throughout their treatment

and care
**Equitable** – Provides all service users with the opportunity to be involved in their plan of care using an appropriate outcome measurement tool
**Effective**    Involving people in development of their care plan,
**Efficient**    helps engagement and delivery of care
**Safe** – Risk assessment that will be reviewed in line with agreed protocols and guidance.  Minimises risk to self and others

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people contributing to their care plans | Feedback from users and carers via Trust user/carer forum | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people who report that they felt involved and able to contribute to their care planning | PCC monitoring report<br><br>RQIA monitoring report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of patients on the schizophrenia, bipolar and other psychoses registers who have a comprehensive care plan documented in their records and which is agreed between individuals, their family and / or carers as appropriate | QOF | 90%<br>95%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012<br>March 2013 |

| **Overarching Standard 21: Occupational therapy** |
|---|
| A person with severe mental health needs should have a full occupational assessment, reviewed on at least an annual basis and thereafter, access to a range of adequate occupational services should be arranged |

**Rationale**

There is a clear link between occupational activity, quality of life, normalisation and social inclusion.

**Evidence**

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

DOH (2001) Mental Health Policy Implementation Guide http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058960.pdf

DOH (1999) National Service Framework for Mental Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

National Institute for Health and Clinical Excellence (NICE) (2009) Schizophrenia: Core Interventions in the Treatment and Management in Primary and Secondary care (update) http://guidance.nice.org.uk/CG82

Social Care Institute for Excellence (SCIE) (2008) Knowledge Review 21: Supporting people in accessing meaningful work: Recovery approaches in community based adult mental health services http://www.scie.org.uk/publications/knowledgereviews/kr21.pdf

**Responsibility for delivery/implementation**

HSC Trusts

**Quality Dimensions**

**Person Centred –** People should be supported to explore what is important to them in regard to occupational desires/aspirations and how they may wish to achieve this in relation to their lifestyle and the community to which they relate to/live in.

**Equitable –** Occupational opportunities available throughout Northern Ireland.

**Timely & Safe –** Early participation in structural activity and opportunity for social interaction ensures better outcomes,

**Effective & Efficient –** Allows for more detailed knowledge of service users needs and aspirations.

| Performance indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people with severe mental illness offered an occupational assessment | Audit of Care Plans | Establish baseline Performance level to be determined once baseline established | March 2013 |
| Percentage of places available for mental health vocational/ rehabilitation/ day support out of total | Audit of availability | Establish baseline Performance level to be determined once baseline established | March 2013 |

**Overarching Standard 22: Medicines Management**
A person and their carers, where appropriate, should have the opportunity to access sufficient information to enable them to make an informed decision about their medication and other treatments, in partnership with their healthcare professionals.

**Rationale**
Medicines remain one of the main treatments for mental illnesses. When used appropriately they can improve functioning and quality of life. Prescribing decisions should be evidence-based and in accordance with national guidance where available. Good documentation of prescribing decisions, recording of reported side effects and an assessment of whether medication has been effective are necessary to ensure safe and effective care, including those that have an adverse effect on parenting capacity. All health and social care professionals who prescribe medicines should work with the support and advice of appropriately trained pharmacists and, in addition, they can help to inform and support people whilst they are taking their medication.

**Evidence**
DOH (2008) Medicines management: Everybody's Business – A guide for service users, carers and health and social care practitioners.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_082201.pdf

DOH (2007) Mental Health: New ways of working for everyone
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074490

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/ implementation**
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** – The provision of medicines to people should be based on what is important to them as individuals and what has worked in the past and what hasn't worked for them. People should be active partners in decisions about medicine.
**Timely** Access to appropriate treatment promotes recovery

**Efficiency / Effectiveness** – Prescribing decisions should be evidence-based and in accordance with national guidance where available. Individual prescribing decisions must be recorded. Properly managed, prescribed medication can improve quality of life.

**Safe** Appropriate management minimises the risk of adverse side effects. Medicines should be prescribed, administered and monitored in accordance with national guidelines.

| Performance indicator | Data Source | Anticipated Performance level | Date to be achieved by |
|---|---|---|---|
| Percentage of people given a choice of treatments | Survey of users | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Where medicines are prescribed, percentage of care plans where medication is documented appropriately | Care Plan Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people for whom an assessment of effectiveness and side effects is documented | Care Plan Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people who were given the opportunity to discuss their medication | User and carer feedback | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

| Level of prescribing concordance with local and national guidelines | Trusts and Business Services Organisation | 70% 80% **Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012 March 2013 |
|---|---|---|---|

**Overarching Standard 23: Physical Care of People with severe and enduring mental illness**

A person with severe and/or enduring mental illness should be offered a physical health check at least annually (normally in primary care) according to locally agreed protocols based on National Guidelines.

**Rationale**

People with a severe and enduring mental illness have a higher risk of developing physical health problems such as cardiovascular disease and endocrine disorders and increased mortality compared to the general population.

**Evidence**

National Institute for Health and Clinical Excellence (NICE) (2009) Schizophrenia: Core Interventions in the Treatment and Management in Primary and Secondary care (update) http://guidance.nice.org.uk/CG82

National Institute for Health and Clinical Excellence (NICE) (2006) The management of bipolar disorder in adults, children and adolescents, in primary and secondary care http://guidance.nice.org.uk/CG38

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

**Responsibility for delivery/ implementation**

HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** Provides the person with a regular review of their physical health needs and also to review the medication needs of individuals.
**Timely** Helps to ensure that physical health needs are detected earlier
**Efficiency / Effectiveness** To improve overall physical health and wellbeing. To improve concordance with prescribed medication. Also, where physical health is being affected (by prescribed medication) changes can be made to medication or alternative medication prescribed.
**Safe** Improved overall patient wellbeing. Improved patient safety by detecting adverse effect on physical health

| Performance indicator | Data Source | Anticipated Performance level | Date to be achieved by |
|---|---|---|---|
| Percentage of people with schizophrenia or bipolar disorder who have a documented physical health check | QOF | 95%<br>98%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012<br>March 2013 |

**Overarching Standard 24: Domestic Violence and Abuse**
Health and social care staff should be aware of the signs and symptoms in relation to violence (including domestic violence), abuse and neglect in order to help them identify victims and trained, where necessary, to offer early help and support.

**Rationale**
Domestic violence and abuse can have an enormous effect on mental health and wellbeing.  The experiences of the individual, their families (especially children) can affect their emotional, psychological, physical and sexual development and relationships.  These often precipitate or are contributory factors to the development of mental health problems.

**Evidence**
DHSSPS (2005) Tackling Violence at Home – A Strategy for Addressing Domestic Violence and Abuse in Northern Ireland
http://www.dhsspsni.gov.uk/tackling_violence_strategy.pdf

DHSSPS (2008) Tackling Sexual Violence and Abuse.  A Regional Strategy 2008 – 2013
http://www.dhsspsni.gov.uk/sexualviolencestrategy08.pdf

**Responsibility for delivery**

HSC Trusts
Primary care
In partnership with other statutory sector organisations, voluntary and community groups

**Quality Dimensions**

**Person Centred –**  provides targeted help and support for an individual and their family
**Equitable –** a consistent approach across Northern Ireland at all levels of the service.
**Effective –**  Early recognition, help and support improves long term outcomes for the individual and family
**Safe –** Minimises risk to self and others

| Performance Indicators | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people identified by primary care and health and social care as victims of violence, abuse and neglect | Monitoring arrangements for domestic violence and abuse data | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

**Overarching Standard 25: Supportive and Palliative Care**
A person with a mental illness and their carers being assessed for supportive and palliative care should have their specific mental health needs taken into account in consultation with them and their carer

**Rationale**

Early identification of the supportive, palliative and end of life care needs of patients, their care-givers and family, through a holistic assessment, maximises quality of life for all in terms of physical, emotional, social, financial, and spiritual health and wellbeing.

People who experience mental illness are entitled to the same services and respect throughout life as anyone else. Good palliative and end of life care is about enabling the individual to live out their potential when faced with an advanced progressive illness. By addressing the physical, emotional, spiritual and social issues which often make us fearful of death, it ensures that all individuals, regardless of clinical diagnosis, receive appropriate care, at the right time, in the right place, in a way that they can rely on.

A regional model for palliative and end of life care is described in Appendix 8.

**Evidence**

National Institute for Health and Clinical Excellence (NICE) (2004) Improving Supportive and Palliative Care for Adults with Cancer
http://guidance.nice.org.uk/CSGSP

National Institute for Health and Clinical Excellence (2004) Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) http://guidance.nice.org.uk/CG101

Gold Standards Prognostic Framework Programme, NHS End of Life Care Programme. England 2006. Prognostic Indicator Paper vs. 2.25
http://www.healthcareforlondon.nhs.uk/assets/End-of-life-care/Prognostic-Indicator-Guide-2008.pdf

**Responsibility for delivery/implementation**

Primary Care
HSC Trusts
Voluntary Palliative Care Organisations
Private nursing home and care providers

| **Quality Dimensions** |
|---|

**Patient Centred –** People, what is important to them, their family and friends are central to the assessment for support, palliative and end of life needs. Options should be explored in regard to what would work best for them and their family given their unique personal history, context, lifestyle and wishes.

**Equity, timeliness, safety**

All patients identified as requiring supportive and palliative care should have their needs recorded.  This should be available to the patient and all health and social care professionals involved in the holistic assessment of needs.

**Effectiveness**

All health and social care professionals should be able to identify the appropriate level of palliative care required for the individual patient.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people with mental health needs who have had their specific needs taken into account | Audit<br><br>User and carer feedback | Establish baseline<br><br>Performance indicators to be determined once baseline established | March 2013 |

**Overarching Standard 26**
A person attending an acute general hospital should where appropriate have access to age appropriate psychiatry services and should include follow up arrangements if required such as the Card Before You Leave scheme.

**Rationale**

The mental health needs of patients using acute general hospital services are often not detected or considered.  People with a physical illness are three to four times more likely to develop a mental illness that the general population.  People admitted to a acute general hospitals are more likely also to have a diagnosable psychiatric disorder.  The rates of psychiatric illness in older adults in general hospital beds are as follows: up to 40% have dementia; 53% have depression; and, 60% have delirium.

In general, acute and mental health services are provided in very separate and distinct facilities with relatively little cross-over / integration between services.  This means that many patients with co-morbid physical and mental illness have limited access to appropriate mental health services either while in hospital or after discharge.

"Liaison psychiatry" describes the appropriate sub speciality service which endeavours to bring together the diagnosis, treatment and management of patients with co-morbid physical and mental disorders.  The service should also provide training and support for acute general hospital staff caring for these patients.

**Evidence**

Healthy Mind, Healthy Body – How Liaison Psychiatry Services can transform quality and productivity in acute settings.  NHS Confederation; Mental Health Network; Briefing Issue 179 April 2009
https://www.rcpsych.ac.uk/pdf/Healthmindhealthbody.pdf

Quality Standards for Liaison Psychiatry Services, Psychiatric Liaison Accreditation Network Plan, Royal College of Psychiatrists September 2009

Who Cares Wins: Improving the outcome for older people admitted to the general hospital: Guidelines for the development of Liaison Mental Health Services for Older People. Working Group for the Faculty of Old Age Psychiatry, Royal College of Psychiatrists (2005)
http://www.leeds.ac.uk/lpop/documents/WhoCaresWins.pdf

Psychiatric Services to Accident and Emergency Departments.  Royal College of Psychiatrists British Association for  Accident and Emergency Medicine (2004) http://www.rcpsych.ac.uk/files/pdfversion/cr118.pdf

Managing Urgent Mental Health Needs in the Acute Trust: A guide by practitioners, for managers and commissioners in England and Wales. Academy of Royal Colleges (2008)
https://www.rcpsych.ac.uk/pdf/ManagingurgentMHneed.pdf

**Responsibility for delivery/implementation**

Health and Social Care Trusts

**Quality Dimensions**

**Person centred**:  Liaison services improve the holistic assessment, treatment and management of individual needs.

**Timely**:  Evidence suggests that identifying and treating mental health needs in acute hospitals early has a direct impact on the recovery of their physical health.

**Effective** / **Efficient**: Liaison services can improve care and bring cost savings as people can potentially be discharged earlier if their mental health needs are addressed.  Services can also bring savings by reducing re-attendances / readmission.

**Safe**: Minimises risk to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Review of arrangements in acute general hospitals for accessing age appropriate mental health services | Trust report  PCC report (Card before you leave) | All HSC Trusts | March 2012 |

**SECTION 5 – SPECIFIC CONDITIONS – CHILDREN AND YOUNG PEOPLE**

**Introduction**

The challenge for health and social care in partnership with other agencies in Northern Ireland is to provide timely and effective mental health prevention, health promotion, assessment and treatment services in primary care and specialist settings for children and young people with emotional and behavioral challenges and to their families.

## 5.1    Conduct Disorders

"Conduct disorder" refers to a group of behavioural and emotional problems in young people. Children and adolescents with this form of disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than experiencing mental health difficulties and or a mental illness. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences.

Children who exhibit behaviours which constantly cause concern should receive a comprehensive assessment and comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, post traumatic stress disorder, substance abuse, attention deficit hyperactivity disorder, learning difficulties, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are more likely to have ongoing problems if they and their families do not receive early and comprehensive care/treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding down a job. They are more likely to be involved with the judicial system and/or behave in an antisocial manner and find it difficult to make and maintain friendships.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment can be the child's uncooperative attitude, fear or distrust of adults. In developing a comprehensive response to the child, assistance from a CAMHs professional may be required i.e. to assist with acquiring information from the child, family, teachers, and other medical specialties to understand the causes of the disorder. However, not all children with conduct disorder are referred to specialist CAMHs teams.  Many are managed and helped effectively by a coordinated response from a range of professionals.

Behavioural interventions are sometimes necessary to help the child appropriately express and control anger. Special education may be needed for young people with learning difficulties. Parents often need expert assistance in devising and carrying out special

management and educational programs in the home and at school. Treatment may also include medication in some young people, such as those with difficulty paying attention, impulse problems, or those with depression.

Interventions and treatment may need to be repeated over time as the child reaches new stages of development.  However early intervention is rarely brief since establishing new attitudes and behaviour patterns takes time. Providing treatment at an early stage offers a child a better chance for considerable improvement and hope of a more successful future.

**Rationale**
Conduct disorders vary widely in their presentation and may co-exist with other conditions/disorders and have a significant and detrimental impact on the quality of life of both the child/young person and their family.  Therefore, accurate assessment and early intervention is essential

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2006) Parent-training / Education in the management of children with conduct disorders
http://guidance.nice.org.uk/TA102

HNS July 2006

**Responsibility for delivery/implementation**
HSC Trusts

**Quality Dimensions**

**Person Centred** – every effort should be made to fully engage the young person in order to explore options that would work best for them given their unique context and lifestyle.
**Timely** – early intervention can lead to positive outcomes
**Equitable** – primary care and specialist services available across Northern Ireland.
**Effective** - improves outcomes for the young person in the longer term
**Safe** – Minimises risk of exclusion in social, school and employment.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Regional review of supported interventions and therapeutic approaches | Trust report | All Trusts | March 2012 |
| Agree and implement standardised outcome measurement tool | Trust Audit routine measurements of clinical outcomes following intervention | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of children and young people being treated where outcome measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2014 |

## 5.2  Depression – Children and Young People

Children and young people like everyone have to deal with many emotions, sometimes happy, sometimes sadness as a result of good and bad life events.  Depression occurs when the sad emotions are overwhelming, affects the ability to enjoy life and never seems to go away.  It affects children and young people significantly in terms of their life and participation in school, leisure activities and their relationships with others.

Depression is characterised by persistent low mood or sadness and impairments of a range of other bodily functions such as sleep, appetite, concentration, memory and the ability to enjoy normal, agreeable activities and clinical depression is diagnosable when a number of symptoms exist concurrently and have lasted for a number of weeks without remission.

**Overarching Standard 28: Children and young people – mild to moderate depression – assessment and early intervention**
A young person experiencing mild depression should have a comprehensive assessment in primary care and onward referral, as required, to mental health specialists in order to identify their mental health needs and any co-morbidities to enable early interventions.  Information and support for the young person and family should be offered including parent training / education management programme in accordance with NICE guidelines.  A standardised outcome measurement tool should be used in treatment and care.

**Rationale**
When a child or young person becomes anxious or depressed it is essential that those who care for the child where they live or at school and at play recognise early signs and symptoms.  They should respond appropriately to ensure that all aspects of a young person's life are assessed in order to provide appropriate intervention early and to prevent longer term problems developing.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2005) Depression in Children and Young People: Identification and management in primary, community and secondary care
http://guidance.nice.org.uk/CG28

Social Care Institute of Excellence (SCIE) Guide 6 Promoting Resilience in Foster Children and Young People, September 2004
http://www.scie.org.uk/publications/guides/guide06/index.asp

Social Care Institute of Excellence (SCIE) Guide 7 Fostering, November 2004
http://www.scie.org.uk/publications/guides/guide07/index.asp

**Responsibility for delivery/implementation**
Primary care
HSC Trusts
In partnership with Education, Youth Sector and Criminal Justice Service

**Quality Dimensions**
**Person Centred** – Children and young people, what is important to them, their family and friends are central to the assessment and early intervention/treatment process.  Options should be explored in regard to what would work best for them given their unique context and lifestyle.
**Effective** - A young person's health and well being will be  improved by timely and appropriate interventions
**Equitable** – primary care and Specialist services available across Northern Ireland.
**Safe** – Reduces risk to self and others

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool. | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of children assessed and diagnosed with anxiety and depression that are involved in primary care and/or school initiatives | School Health Service Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of children and young people who have received psychological interventions to treat their anxiety or depression and from whom they receive it | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

| **Overarching Standard 29: Children and young people – moderate / severe depression – treatment and ongoing care**<br>A young person experiencing persistent symptoms of moderate to severe depression should be offered specific psychological therapy which may include Cognitive Behavioural Therapy (CBT), Interpersonal Therapy or shorter term Family Therapy, provided by therapists trained in Child and Adolescent Mental Health. Anti-depressant medication should not be offered, except in a combination with psychological interventions in accordance with the NICE guidelines for Depression in Children and Young People. A standardised outcome measurement tool should be used in treatment and care. |
|---|
| **Rationale**<br>Some children and young people with more complex needs, comorbid conditions or more significant levels of depression will require more specific interventions to help with their depression. This should be provided as early as possible in order to help the young person and improve their quality of life<br><br>**Evidence**<br>National Institute for Health and Clinical Excellence (NICE) (2005) Depression in Children and Young People: Identification and management in primary, community and secondary care<br>http://guidance.nice.org.uk/CG28<br><br>Social Care Institute of Excellence (SCIE) Guide 6 Promoting Resilience in Foster Children and Young People, September 2004<br>http://www.scie.org.uk/publications/guides/guide06/index.asp<br><br>Social Care Institute of Excellence (SCIE) Guide 7 Fostering, November 2004<br>http://www.scie.org.uk/publications/guides/guide07/index.asp |
| **Responsibility for delivery/implementation** |
| HSC Board<br>Public Health Agency<br>HSC Trusts<br>Primary Care |
| **Quality Dimensions** |
| **Person centred** - The agreed care plan should be designed, implemented and reviewed in regard to what is working and what is not working from the perspective of the child or young person, their family, carers and other professionals and changes negotiated on the basis of this.<br>**Effective/Efficient -** A young persons health and well being will be improved by timely and appropriate interventions<br>**Equitable** – Specialist services available across Northern Ireland.<br>**Safe** – Reduces risk to self and others |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of children and young people in receipt of medication for moderate depression | Prescribing Data | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of children and young people receiving a combination of medication and psychological therapies for moderate depression. | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2013 |

## 5.3   Attention Deficit Hypertension Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder characterised by poor concentration which includes a combination of additional symptoms including difficulty in controlling behaviour, impulsiveness and over activity.  Sometimes ADHD is called Hyperkinetic Disorder.  ADHD affects 2-5% of UK school age children, with rates being higher in boys than girls

**Overarching Standard 30: ADHD – Assessment and early intervention**
A young person with suspected ADHD, their families and carers should be offered an early comprehensive assessment of their needs by a CAMHS specialist knowledgeable in the area of ADHD and receive appropriate care and treatment or onward referral as appropriate to age appropriate specialist mental health services for further assessment and care.  A standardised outcome measurement tool should be used in treatment and care.

**Rationale**
Symptoms of ADHD can overlap with other disorders and it can be difficult to make a definitive diagnosis.  Therefore children and young people need access to paediatric and/or child and adolescent mental health services who have specific competencies regarding ADHD assessment, diagnosis, treatment and ongoing monitoring of treatment outcomes.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2008) Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults http://guidance.nice.org.uk/CG72

Social Care Institute of Excellence (SCIE) Research Briefing 7 ADHD Background Assessment and Diagnosis, August 2004 (Updated August 2005) http://www.scie.org.uk/publications/briefings/briefing07/index.asp

**Responsibility for delivery/implementation**
HSC Trusts in partnership with education, youth sector and criminal justice system
Primary Care in partnership with specialist children's services

**Quality Dimensions**
**Person Centred** – Every effort should be made to fully engage the person in assessment.  Children and young people, what is important to them, their family and friends are central to the assessment and early intervention/treatment process.  Options should be explored in regard to what would work best for them given their unique context and lifestyle.
**Timely** – Early identification, treatment and advice for children and families can positively impact on the management of the child with ADHD and improve their life chances.
**Effective -** Early assessment and interventions by appropriate staff will improve health and wellbeing of young persons, their families and carers and decreases the need for long term mental health interventions
**Equitable** – primary and specialist services available across Northern Ireland.
**Safe** – Minimises risks to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of young people referred for assessment and early intervention of ADHD to Paediatrics or CAMHS | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of families offered and in receipt of parent education training programme | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

### 5.4 Transition to adult services

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**Overarching Standard 31: Transition to adult services**
A young person approaching their 18th birthday (between 3–6 months) receiving treatment and care for a significant health problem from CAMHS or a Paediatric service should be assessed, their need for services identified and where appropriate, arrangements should be made for transition to adult services.  These arrangements should be made in partnership with the young person and their family/carers.

</div>

**Rationale**
Transition from one service to another can cause anxiety for the young person, family and carer. Thresholds for accessing care and treatment from different agencies are variable.  Early involvement and planning enables inter agency discussion and agreement about managing transition between services. Potential patient/client anxiety can be minimised by good planning and joint working between the young person, their family, carers and professionals.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2008) Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults http://guidance.nice.org.uk/CG72

National Institute for Health and Clinical Excellence (NICE) (2005) Depression in Children and Young People: Identification and management in primary, community and secondary care
http://guidance.nice.org.uk/CG28

British Medical Association (BMA) (2006) Child and Adolescent Mental Health
http://www.bma.org.uk/images/ChildAdolescentMentalHealth_tcm41-20748.pdf

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

DOH (2004) National Service Framework for Children, Young People and Maternity Services – Mental Health and Psychological Well Being of Children and Young People
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_4089114

DOH (2006) Transition: Getting it right for young people: Improving the transition of young people with long term conditions from children's to adult health services
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets
/@dh/@en/documents/digitalasset/dh_4132149.pdf

| Responsibility for delivery/implementation | | | |
|---|---|---|---|
| HSC Trusts | | | |
| **Quality Dimensions** | | | |
| **Person Centred** – Young people, what is important to them, their family and friends are central to the transition process. Options should be explored in regard to what would work best for the person given their unique context and lifestyles as well as their dreams and aspirations. **Equitable** – Primary care and Specialist services available across Northern Ireland. **Effective/Efficient/Timely** - Engagement with new people at an early stage can improve outcomes. Transition planning undertaken at an early stage improves outcomes. **Safe** – Minimises risks to self and others. | | | |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of young people moving to adult services | Care Plans | Establish baseline

Performance levels to be determined once baseline established | March 20112 |
| Evidence of transitional arrangements in place | Trust reports | All Trusts | March 2012 |
| Percentage of young people in CAMHS/Paediatric services who attend adult services after their 18th birthday | Feedback from a percentage of young people, parents and carers involved in discussion and design of treatment and care. (To be determined)

A care plan on file for every young person moving to adult services

Questionnaires | Establish baseline

Performance levels to be determined once baseline established | March 2012 |

## SECTION 6 – SPECIFIC CONDITIONS

Condition specific standards are in addition to the generic standards.  These standards describe specific interaction and interventions provided by mental health services for people with a specific condition.

### 6.1   Anxiety Depression - Adults

Anxiety is a condition characterized by persistent worry or unease and is usually accompanied by fear, panic, irritability, poor sleep, poor concentration and avoidance, as well as physical symptoms such as excessive sweating, a racing heart, palpitations or rapid breathing.

Depression is a condition characterized by persistent low mood and loss of interest which is usually accompanied by changes in appetite, weight or sleep pattern, low energy, poor concentration, feelings of guilt or worthlessness and suicidal ideas.

People may experience different levels of severity of anxiety and depression and may also experience symptoms of both conditions at the same time. The implementation of the 'Stepped Care Model' across Northern Ireland is designed to take account of the different levels of severity so that people may receive the appropriate care and treatment.

**NICE**[1] defines depression as follows;

**Mild depression**: Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

**Moderate depression**: Symptoms or functional impairment are between 'mild' and 'severe'.

**Severe depression**: Most symptoms are evident, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

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[1] *NICE Guidelines Depression: The Treatment and Management of Depression in Adults October 2009 (NOTE: This partially updates and replaces NICE Guidelines Depression: Management of Depression in Primary and Secondary Care December 2004.)*

**Overarching Standard 32: Mild to moderate depression and / or anxiety – assessment, early intervention, treatment and ongoing care**
A person experiencing mild to moderate depression and / or anxiety should have an early assessment of their psychological, physical, clinical and social needs at primary care level using a validated assessment tool in line with NICE Guidelines and, if appropriate, offered low intensity short term interventions.

**Rationale**
Early assessment improves detection of mental health problems and allows timely intervention leading to better outcomes.

Early and appropriate short term interventions are effective in treating anxiety and mild to moderate depression. This may prevent the need for longer term intervention for many people.  Service users prefer to be treated in primary care settings where possible

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2009) Depression: The Treatment and Management of Depression in Adults (update)
http://guidance.nice.org.uk/CG90

A National Standard for Mental Health NHS England

Stepped Care Model in New Ways of Working, Care Services Improvement Partnership http://www.newwaysofworking.org.uk/

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Trusts
Primary Care
In partnership with voluntary and community organisations

**Quality Dimensions**

**Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle.
**Timely/Effective/Efficient** – Early involvement and intervention can improve outcomes and minimise longer term problems
**Safe** – Minimises risk to self and others
**Equitable** – Available across Northern Ireland

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of patients with a new diagnosis of depression who have had an assessment of severity at the outset of treatment | QOF | 95% 98% **Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012 March 2013 |
| Percentage of people referred to low intensity short term interventions (Level 1 & 2 – Stepped Care Model) | Mild to Moderate Depression DES | Establish baseline Performance levels to be determined once baseline established | March 2012 |
| Percentage of people referred to low intensity short term interventions who complete them | Mild to Moderate Depression DES | Establish baseline Performance levels to be determined once baseline established | March 2012 |

**Overarching Standard 33: Depression Moderate to Severe (Adults) – Assessment, Early Intervention, Treatment and Ongoing Care**
A person experiencing moderate to severe depression should have an assessment, early intervention and ongoing care in line with NICE Guidelines. This should include an assessment of their psychological, physical, clinical and social care needs including a risk assessment by a mental health specialist(s) using a recognised outcome measurement tool.

**Rationale**
Early assessment and involving people meaningfully in their care planning at the beginning of their treatment and care will encourage better communication and this has been shown to improve outcomes and aid recovery. Many people with moderate to severe depression do not require routine reviews by specialist mental health services. The shared care plan will help reduce unnecessary review appointments whilst ensuring quick access to specialist services when required. Evidence has shown that psychological interventions used following medication can improve recovery.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2009) Depression: The Treatment and Management of Depression in Adults (update)
http://guidance.nice.org.uk/CG90

A National Standard for Mental Health NHS England

Stepped Care Model in New Ways of Working, Care Services Improvement Partnership http://www.newwaysofworking.org.uk/

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**
HSC Trusts
Primary Care

| Quality Dimensions |
|---|
| **Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle. |
| **Timely –** Receiving appropriate care and treatment or onward referral to age appropriate specialist mental health services improves long term outcomes. |
| **Effective** Treatment and care for a person with treatment-resistant, recurrent, atypical and psychotic depression should be provided by specialist mental health services in partnership with primary care. This reduces duplication and improves communication |
| **Safe** – If presenting either a risk to themselves or others should be referred to and assessed by mental health specialist(s) immediately. This minimises risk to self and others |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of people being treated where outcome measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |

## 6.2　First Episode Psychosis

**Early Interventions in Psychosis**

Early intervention can improve the longer term course of psychosis, prevent mental and social decline and lead to better outcome.  Services which provide early interventions aim to offer appropriate, up to date, evidence-based and individual needs assessed interventions to young people experiencing a first-episode psychosis and their families/carers.

Benefits for the individual include the reduction of the impact of a first psychotic episode through earlier recognition of symptoms and improvement in the course of illness.  It supports the development of appropriate coping skills as well as reducing social disablement, improved vocational prospects, increased understanding of illness and prevention of relapse.

For the family/carer interventions lead to enhanced affinity with professionals and other agencies, decreased stress and enhanced communication within the family.

**Overarching Standard 34: First episode psychosis – assessment and early intervention**
A person experiencing early signs of psychosis should have an assessment of their psychological, physical, clinical and social needs including a risk assessment undertaken by a mental health specialist(s) using an appropriate outcome measurement tool to aid diagnosis and age appropriate onward referral.

**Rationale**
Early assessment, care and treatment improve opportunities for early engagement for the person and their family/carer which has been shown to improve long term outcomes and improved quality of life.

**Evidence**
Canning (2008) Early Intervention in Psychosis

Birchwood et al (1997) Early Intervention in Schizophrenia, BJ Psychiatry 170: 2-5

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

Edwards J, McGarry P (2002) Implementation Early Intervention Psychosis

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009 http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**

HSC Trusts
Primary Care
In partnership with voluntary and community organisations

**Quality Dimensions**

**Person Centred** – people and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle.
**Timely** – the earlier a detailed assessment is completed and appropriate treatment and care is commenced, the better the outcomes.
**Equitable** – primary care and Specialist services available across Northern Ireland.
**Effective/Efficient - a**ppropriate assessment improves the effectiveness of care and treatment choices which provide a better way of managing care.
**Safe** – minimises risks to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of people being treated where outcome measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |
| Percentage of young people (Under 18 years) receiving early intervention services provided by psychosis team work jointly with CAMHS | Case Notes Audit | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |

## 6.3    Schizophrenia and other psychoses

The exact cause of schizophrenia is unknown.  However some experts believe that the condition is caused by a combination of genetic and environmental factors.

Schizophrenia is one of the most common serious mental health conditions.  One in 100 people will experience at least one episode of schizophrenia during their lifetime.  Men and women are equally affected by the condition.

In men who are affected by schizophrenia the condition usually begins between 15 – 30 years of age.  In women schizophrenia usually occurs later beginning between 25 – 30 years of age.
(NHS UK website, accessed March 2010)

**Overarching Standard 35: Schizophrenia and other psychoses – early intervention, treatment and ongoing care**
A person with either newly diagnosed or established schizophrenia should, following referral from primary care have assessment (including risk assessment), early intervention, treatment (including psychotropic medication and psychological therapies as appropriate) and ongoing care (including a yearly physical health check) in line with NICE guidelines.  A standardised outcome measurement tool should be used to aid monitoring of treatment and care.

**Rationale**
Because of the level of distress, anxiety and subjective confusion experienced by people of all ages with schizophrenia and other psychoses it is sometimes difficult for the individual / their families to access services.  Evidence shows that appropriate treatment and care in the early stages of the illness will help minimise the severity and length of the first episode and provide users and their families with the opportunity for building a relationship with professionals.

Antipsychotic drugs are an indispensable treatment option for people with schizophrenia with the aim of reducing psychotic symptoms, preventing relapse and promoting recovery.  Evidence has shown that pharmacological/drug treatments are often necessary in order for the psychological interventions to be effective.

People with schizophrenia have a high risk of developing physical health problems such as cardiovascular disorders, endocrine disorders and increased mortality.  There is a need for long term commitment from professionals to work with the person in order to achieve optimal quality of life and recovery.  This will help reduce the risks of long term physical, mental and social difficulties.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2009) Schizophrenia: Core Interventions in the Treatment and Management in Primary and Secondary care (update) http://guidance.nice.org.uk/CG82

**Responsibility for delivery/implementation**
HSC Trusts in partnership with Primary Care

**Quality Dimensions**

**Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process.  The choice psychotropic drug should be informed by a discussion between the person and the responsible clinician taking into account the relative benefits of each drug and their side effects.  The use of an outcome measurement tool assists both the person and the professional assess recovery.  Options should

be explored in regard to what would work best for the person given their unique context and lifestyle.

**Timely** – Provides access to appropriate help and support and ensures any physical health needs are detected early

**Equitable** – A person is offered the opportunity of choice and involvement in their treatment and care.

**Effective & Efficient** – Early assessment and access to appropriate treatment aids recovery.

**Safe** – A person, if presenting as a risk to themselves or others should immediately be referred and assessed by mental health specialists in order to minimise the risk to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of people being treated where outcome measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of people being offered a choice of medications and psychological interventions | Audit of care plans<br>Trust user and carer forums<br>Patient Client Council | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

| | | | |
|---|---|---|---|
| Percentage of people receiving psychological and social interventions. | Audit of care plans<br>Trust user and carer forums<br>Patient Client Council | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of young people who receive education and/or whose inpatient treatment involves the potential (depending on health) for at least 25% of their week (Monday – Friday) in educational activities | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of patients who continue to be adherent to their medication | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## 6.4   Obsessive Compulsive Disorder

Obsessive-compulsive Disorder is a condition characterised by obsessions or compulsions but commonly both. Obsessions are unwanted and intrusive thoughts which repeatedly enter a person's mind. Compulsions are repetitive behaviours which a person feels driven to perform.

The diagnosis is dependent on whether the obsessions or compulsions are causing marked distress or significantly interfering with a person's ability to function. Over time approximately 25% of the people affected by this condition will experience significant improvement, approximately 50% will experience moderate improvement and approximately 25% will continue to experience problematic symptoms.

**Overarching Standard 36: Obsessive Compulsive Disorder – Assessment Early Intervention, Treatment and Ongoing Care**
A person who presents with psychological problems should be screened by age appropriate specialist mental health services using a recognised assessment tool to identify the presence of obsessions and compulsions and possibly associated functional impairment. A standardised outcomes measurement tool should be used to monitor progress following assessment. Treatment and care should be based on the person's level of functional impairment in line with NICE Guidelines.

**Rationale**
Treatment of obsessive compulsive disorder is dependent on the level of functional impairment whether mild, moderate or severe:
- People with mild functional impairment should be offered low intensity psychological interventions.
- People with moderate functional impairment should be offered a choice of medication or cognitive behavioural therapy.
- People with severe functional impairment, or those with an inadequate treatment response to the above, should be offered a combination of medication and cognitive behavioural therapy.

Many people with Obsessive Compulsive Behaviour do not require routine reviews by specialist mental health services. The shared care plan will help reduce unnecessary review appointments whilst ensuring quick access to specialist services when required.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2005) Obsessive compulsive disorder (OCD) and body dismorphic disorder (BDD): Core interventions in the treatment of obsessive compulsive disorder and body dismorphic disorder http://guidance.nice.org.uk/CG31

**Responsibility for delivery/implementation**
HSC Trusts
Primary care

| **Quality Dimensions** |
|---|
| **Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle. <br> **Timely** – Early assessment and treatment ensures better outcomes.  The shared care plan should allow for urgent re-entry to specialist service when required. <br> **Equitable** – primary care and specialist services available throughout NI <br> **Effective**/**Efficient**   A shared care plan involving both primary and specialist services reduces duplication and improves communication <br> **Safe** – Minimises risk to self and others. |

| **Performance Indicator** | **Data Source** | **Anticipated Performance Level** | **Date to be achieved by** |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of people being treated where outcome measurement shows improvement after 12 months | Trust | Establish baseline <br><br> Performance levels to be determined once baseline established | March 2013 |

## 6.5   Bipolar Disorder

Bipolar disorder is a condition in which a person's mood and activity levels are significantly disturbed. People with this condition experience episodes of feeling very low (depression) and episodes of feeling very high (hypomania, or in more severe cases mania). The pattern of remissions and relapses is extremely variable. Recovery may or may not be complete between episodes. A diagnosis of bipolar disorder is made after two episodes (one of which must be a manic or hypomanic episode) have been identified.

Bipolar disorder is a relatively common condition with around one person in a hundred (1%) being diagnosed with the condition.

Bipolar disorder can occur at any age although it most often develops in people between 18 – 24 years of age.  Both men and women and people from all backgrounds can develop bipolar disorder.

The pattern of mood swings in bipolar disorder varies widely between individuals.  For example some people will only have a couple of bipolar episodes in their lifetime and will be stable in between, while others may experience many episodes.  (NHS UK website, accessed March 2010)

**Overarching Standard 37: Bipolar disorder – assessment, early intervention, treatment and ongoing care**
A person with suspected, newly diagnosed or established bi-polar disorder should have an assessment, early intervention, treatment and ongoing care in line with NICE guidelines.  If presenting as a risk to themselves or to others they should be referred to and assessed by mental health specialist(s).  The referral should take place immediately.

**Rationale**
Bipolar disorder is a lifelong relapsing condition.  A timely assessment and diagnosis is required in order to prepare a shared care plan that will promote recovery and prevent relapse.   Many people with bipolar disorder do not require routine reviews by specialist mental health services.  The shared care plan will help reduce unnecessary review appointments whilst ensuring quick access to specialist services when required.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2006) Bipolar Disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care http://guidance.nice.org.uk/CG38

British Medical Association (BMA) (2006) Child and Adolescent Mental Health http://www.bma.org.uk/images/ChildAdolescentMentalHealth_tcm41-20748.pdf

**Responsibility for delivery/implementation**
HSC Trusts
Primary Care

**Quality Dimensions**
**Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. The agreed care plan should be designed, implemented and reviewed in regard to what is working and what is not working from the perspective of the person, their family, carers and other professionals and changes negotiated on the basis of this.
**Timely** – Early assessment and treatment ensures better outcomes
**Equitable** – Specialist services available throughout NI
**Effective/Efficient**    Appropriate assessment and early intervention or onward referral to specialist mental health services improves recovery
**Safe** – Have any early assessment of their psychological, physical and clinical needs including a risk assessment by mental health specialist(s) using a standardised outcome measurement tool which minimises risk to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | All Trusts | March 2012 |
| Percentage of people being treated where outcomes measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of people being offered a choice of medications and psychological interventions | Audit of care plans<br>Trust user and carer forums<br>Patient Client Council | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of people receiving psychological and social interventions | Audit of care plans<br>Trust user and carer forums<br>Patient Client Council | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |
| Percentage of young people who receive education and/or whose inpatient treatment involves the potential (depending on health) for at least 25% of their week (Monday – Friday) in educational activities | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

| | | | |
|---|---|---|---|
| Percentage of patients who continue to be adherent to their medication | | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

## 6.6 Addictions and Substance Misuse

Alcohol and drug misuse are significant public health and social issues costing Northern Ireland millions of pounds every year. Alcohol misuse continues to have the biggest impact on the health of the population and accounts for approximately 70% of referrals to treatment services. The impact of alcohol and drug misuse not only affects the individuals concerned but affects families and local communities and is not confined to young people but can affect all ages.  Harm associated with alcohol and drug misuse can be addressed by providing a range of preventative, early intervention and treatment services using a tiered model of care approach. The earlier intervention / treatment services are provided to someone who is misusing alcohol or drugs the more likely it becomes that the harm associated with such use can be minimised. These services are provided by a range of Health and Social care Staff and are best addressed within a multi agency service provision framework which takes into account a person's physical, social and psychological wellbeing. The following standards address this broad spectrum of services. They take account of the New Strategic Direction on Alcohol and Drug Misuse and targets in this area set by DHSSPS in this area of policy.

Note - The standards provided within this document reflect only a small proportion of the much wider range of initiatives being developed in the "New Strategic Direction for Alcohol and Drugs" DHSSPS 2006/2011

**Overarching Standard 38: Addictions and substance misuse – assessment and early intervention**
A person with difficulties/concerns about their drug or alcohol misuse should have an initial assessment when first presenting to services in primary care or any acute or community setting and should be encouraged to fully participate in their assessment and onward referral, if necessary.   Any person presenting either a risk to themselves or others should be offered and assessed by mental health specialist(s) in a timely manner

**Rationale**
Given the high levels of alcohol and drug misuse, health and social services can play a key role in assessment and early interventions that can be delivered by a very wide range of agencies and within many different settings.  People of all ages who misuse substances in a problematic way are able to access age appropriate harm reduction interventions to minimise the physical, psychological and social harm brought about by lifestyle choices.

**Evidence**
National Treatment Agency (2006) Models of Care for Alcohol Misusers
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf

National Treatment Agency (2006) Models of Care for Treatment of Adult Drug Misusers (Update)
http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011)
http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

NICE Guidelines

Every Child Matters http://www.dcsf.gov.uk/everychildmatters/

**Responsibility for delivery/implementation**
HSC Trusts
Primary Care
In partnership with voluntary and community organisations

**Quality Dimensions**

**Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle.
**Timely** – Early screening, assessment and brief interventions ensures better outcomes
**Equitable** – Specialist services available throughout NI

**Effective/Efficient -** Appropriate assessment improves the effectiveness and efficiency of care and treatment
**Safe** – Minimises risk to self and others.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people who participated in their assessment and ongoing referral | User and Carer Feedback | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2011 |

**Overarching Standard 39: Addictions and substance misuse – early intervention, treatment and ongoing care**
A person requiring early intervention, treatment and ongoing care in relation to their substance misuse should have a comprehensive assessment by substance misuse services using a standardised outcome measurement tool, have access to an appropriate range of evidence based treatment and care including residential treatment and specialist medical treatments and services, if required, in line with NICE guidelines.

**Rationale**
Substance misuse affects the whole family and the needs of the family especially children need to be considered.  It is essential that a holistic care plan is prepared that will involve specialist medical services if required as substance misusers have a higher incidence of medical problems that are associated with their addictive behaviours.  If residential admission is required this should be brief and goal focused with an effective and robust recovery plan agreed with the service user and all relevant health and social care professionals to ensure continuity of appropriate care.

**Evidence**
National Treatment Agency (2006) Models of Care for Alcohol Misusers
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf

National Treatment Agency (2006) Models of Care for Treatment of Adult Drug Misusers (Update)
http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

DHSSPS (2006) New Strategic Direction for Alcohol and Drugs (2006-2011)
http://www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

DOH (2007) Drug Misuse and Dependence: UK Guidelines on Clinical Management
http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

Drug and Alcohol National Occupational Standards
http://www.skillsforhealth.org.uk/competences/drugs-and-alcohol.aspx

O'Neill Independent Inquiry 2007

Every Child Matters http://www.dcsf.gov.uk/everychildmatters/

| Responsibility for delivery/implementation |
|---|
| HSC Board |
| Public Health Agency |
| HSC Trusts |
| Voluntary and community organisations |
| **Quality Dimensions** |
| **Patient Centred –** The agreed care plan should be designed, implemented and reviewed in regard to what is working and what is not working from the perspective of the person, their family, carers and other professionals and changes negotiated on the basis of this. |
| **Safety** – correct and appropriate information is obtained and allows information flow between services |
| **Equitable –** Assessment available across Northern Ireland.  All service users accessing addiction treatment services receive the same assessment |
| **Efficient/Effective** – Assessment and implementation of care plan promotes recovery. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people being treated where outcomes measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

## 6.7   Eating Disorders

Eating disorders are serious psychological conditions that can lead to severe physical and psychosocial complications. The most commonly recognised eating disorders are anorexia nervosa (characterised by self-starvation and marked weight loss) and bulimia nervosa (recurrent binge-eating accompanied by extreme weight-control measures); presentations that resemble these but do not meet their specific diagnostic criteria come under the category of 'eating disorder not otherwise specified'.

The onset of anorexia nervosa is typically in the mid-teenage years and that of bulimia nervosa in the late-teenage/early adulthood stage.

**Overarching Standard 40: Eating disorders – assessment and early intervention**

A person with eating concerns/difficulties should have an initial assessment of their needs at primary care level and onward referral to age appropriate mental health specialist services if required. A standardised outcome measurement tool should be used in the assessment in accordance with the Northern Ireland Care Pathway for Eating Disorders and NICE guidelines.

**Rationale**

Early detection and intervention has been proven to lead to improved outcomes of this debilitating illness.
A standardised care pathway allows equity and consistency while taking into account best practice.

**Evidence**

Users and carers and voluntary groups testimonials

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

Regional Care Pathways, Professor Lash/Dr R Bryant-Waugh 2007

National Institute for Health and Clinical Excellence (NICE) (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders
http://guidance.nice.org.uk/CG9

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care
In partnership with other statutory and non-statutory agencies

**Quality Dimensions**

**Person centred** – There should be an agreed holistic care plan.
**Timely** - As in accordance with Regional Care Pathways
**Effective** - Time managed to access service quickly
**Safe** - Minimises risk to self
**Efficient** - Questionnaires for GP's/Users/Carers/Voluntary groups
**Equality** - Across the trust/across population

| Performance Indicator | Data Source | Anticipated Performance Level | Date To Be Achieved By |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of people being treated where outcome measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2013 |

**Overarching Standard 41: Eating disorders – treatment and ongoing care**
A person with an eating concern/difficulty should have prompt access to therapeutic and medical interventions appropriate to their individual need to include medical monitoring, initial supportive management, psychological therapies, dietetics, occupational therapy and physiotherapy in line with NICE guidelines and the Northern Ireland Eating Disorder Pathway

**Rationale**
Psychotherapeutic interventions are the mainstay of treatment for these complex psychological conditions that can lead to marked physical and psychosocial complications without such interventions/assistance. Offering a range of interventions promotes a person's engagement with, collaboration in and ownership of therapy. Several structured psychological interventions (e.g. cognitive behavioural therapy for bulimia nervosa and specific family interventions for children and adolescents with anorexia nervosa) are evidence-based treatments for eating disorders. Children and young people with a severe eating disorder can become dangerously unwell in a relatively short space of time. Effective psychological treatment is dependent on achieving initial physical stabilisation and nutritional restoration. Untreated eating disorders can lead to longer-term physical complications (e.g. osteoporosis, infertility) that can have a major negative impact on a patient's quality of life. People with severe and enduring eating disorders have high levels of physical and psychological morbidity and can present with ongoing risk issues. Due to the complexity of need, the necessary input to manage this client group traverses usual mental health boundaries. A planned treatment approach aimed at achieving stability in the community can help avoid repeated crises and recurrent hospitalisation. Even people with severe and longstanding conditions retain the potential to move towards fuller recovery.

**Evidence**

National Institute for Health and Clinical Excellence (NICE) (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders
http://guidance.nice.org.uk/CG9

Northern Ireland Care Pathway for Eating Disorders (2008)

American Psychiatric Association (2006). Practice guideline for treatment of patients with eating disorders, 3rd edn
DOI:10.1176/appi.books.9780890423363.138660
http://www.psychiatryonline.com/pracGuide/PracticePDFs/EatingDisorders3ePG_04-28-06.pdf

NHS Quality Improvement Scotland (2006). Eating disorders in Scotland: Recommendations for management and treatment
http://www.nhsqis.org/nhsqis/files/EATDISORDER_REP_NOV06.pdf

Waller et al (2007) Cognitive Behavioural Therapy for Eating Disorders: A Comprehensive Treatment Guide. Cambridge University Press

Yager J & Powers P, Eds (2007). Clinical manual of eating disorders. American Psychiatric Association

**Responsibility for delivery/implementation**

HSC Board
Public Health Agency
HSC Trusts
Primary Care

**Quality Dimensions**

**Person Centred** – People and what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the person given their unique context and lifestyle.
**Timely:** Appropriate early intervention enhances treatment and eventual outcomes
**Equitable:** Available in a range of settings in a variety of modalities
**Effective:** Treatment should be evidence-based where possible
**Efficient:** Clear referral pathways and treatment protocols
**Safe:** Risk management is a vital aspect of care

| Performance Indicator | Data Source | Anticipated Performance Level | Date To Be Achieved By |
|---|---|---|---|
| Percentage of people (young people and adults) assessed as requiring treatment in:- <br>• Special Teams <br>• Co-working with Community Teams <br>• Other services <br>• By length of time from assessment to treatment | Trusts/Regional Eating Disorders Network baseline audit | Establish baseline <br><br> Performance levels to be determined once baseline established | March 2012 |
| Percentage of people with eating disorders requiring medical and psychiatric admissions by:- <br><br>• Length of stay <br>• Re-admission | Eating Disorder Research by Health Development Officer | Interim Report Performance levels to be determined after interim report | March 2012 |

## 6.8 Mental Health Component of Asperger Syndrome

Asperger syndrome has been described as 'high functioning autism'. People with Asperger Syndrome do not generally have a learning disability and Asperger Syndrome may not become obvious until a child is older. Some people can go through their whole lives having Asperger Syndrome and not receive a diagnosis until they are in the 40's or older.

The main clinical features of Asperger Syndrome are:
- Lack of empathy;
- Naive, inappropriate and one sided interactions;
- Limited ability to form friendships;
- Repetitive speech;
- Poor non-verbal communication;
- Intense absorption in certain subjects;
- Clumsy, ill coordinated movements and odd postures.

Individuals with Asperger Syndrome (in common with all people within the autistic spectrum disorder) will have difficulties in 3 main areas:
- Social communication – knowing what to say to other people and understanding what they are saying to you;
- Social understanding – knowing what to do when you are with others or behaving inappropriately (apparently oblivious to social rules);
- Imagination – pretend play, make believe and fantasy.

Adapted from Autism NI website accessed September 2009 (www.autismni.org).

**Overarching Standard 42: Mental Health Component of Asperger Syndrome**

A person showing clinical features of Asperger Syndrome should be referred, following initial assessment in primary care, to specialist services for assessment, diagnosis, intervention, care and support as outlined in the Northern Ireland Care Pathway for Autistic Spectrum Disorder (ASD).

**Rationale**

Asperger Syndrome, like other autistic spectrum disorders, is not always easy to indentify.  It can present in different ways and in different settings.  ASD poses many challenges and can be difficult to diagnose.  Early recognition, diagnosis and intervention is essential for people with Asperger Syndrome in order to provide specific support for the individuals affected as well as their families and carers.

**Evidence**

Bamford Review: Autism Spectrum Disorder Report (May 2006)
http://www.rmhldni.gov.uk/asd_report_may06.pdf

Maginnis, K (2008) Independent Review of Autism Services

OFMDFM (2006) Our Children and Young People – Our Pledge.  A Ten Year Strategy for Children and Young People in Northern Ireland 2006-2016
http://www.dardni.gov.uk/our-children-and-young-people.pdf

DHSSPS (pending) Review of Health Visiting and School Nursing

DHSSPS (2008) Understanding the Needs of Children in Northern Ireland (UNOCINI) http://www.dhsspsni.gov.uk/unocini_guidance.pdf

**Responsibility for delivery/implementation**

HSC organisations in partnership with DENI, voluntary and community groups
Primary care

| Performance indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people referred to specialist services for assessment, diagnosis, intervention and support | ASD Action Plan monitoring reports | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |

## 6.9    Dementia

Dementia is a term associated with memory loss that is not a part of the normal ageing process.  Old age does not cause dementia but is a factor in developing the condition.  The probability of an individual developing dementia increases with age but not everyone will develop dementia in old age.

Dementia describes a set of symptoms caused by a number of different illnesses or diseases that affect the brain including Alzheimer's disease.

When a person has dementia the nerve cells in the brain are damaged and die faster than normal. When the nerve cells die they cannot be replaced.  Different parts of the brain may be affected or the brain may be affected in different ways.  Dementia is a progressive condition for which there is currently no cure, although in recent years some promising treatments have been developed.

(Draft Strategy for Improving Dementia Services in Northern Ireland February 2010)

**Overarching Standard 43**
A person who experiences a change in cognitive performance should have access to early diagnostic assessment, investigation, treatment and support.

**Rationale**
Early assessment, diagnosis, treatment and support helps a person maintain optimum function, prevent avoidable deterioration and enables social and legal planning.

**Evidence**
DHSSPS (pending) Improving Dementia Services in Northern Ireland

DOH (2009) Living Well with Dementia: A National Dementia Strategy
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf

Bamford Review: Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (June 2007) http://www.rmhldni.gov.uk/living_fuller_lives.pdf

National Institute for Health and Clinical Excellence (NICE) (2006) Dementia: Supporting people with dementia and their carers in health and social care
http://guidance.nice.org.uk/CG42

**Responsibility for delivery/implementation**
Health and Social Care in partnership with voluntary and community organisations

**Quality Dimensions**

**Person Centred** – provides a coordinated approach to meet an individual's agreed needs
**Timely** / **Effective** / **Efficient** – providing services in a timely manner will increase the likelihood of problems being dealt with earlier to minimise negative impact
**Equitable** – available throughout Northern Ireland
**Safe** – minimises risk to self and others

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Review of arrangements for early assessment, diagnosis, treatment and support for people who have change in cognitive performance | Trust Report  User/carer feedback  General Practice / Primary Care feedback | All HSC Trusts | March 2012 |

**Overarching Standard 44**
A person with dementia, and their carer, should have access to information, education and support including a regular review of their physical and mental health needs. Alternatives to neuroleptic prescription should be offered in line with regional and national guidelines.

**Rationale**
A large proportion of people with dementia are within the moderate to severe stage of the illness and while the current focus is on early diagnosis and access to anti-dementia therapies. Improving the quality and range of services and support would enhance the care and wellbeing experienced by the individual with dementia as well as their family and carers.

**Evidence**
DHSSPS (pending) Improving Dementia Services in Northern Ireland

DOH (2009) Living Well with Dementia: A National Dementia Strategy
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf

Bamford Review: Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (June 2007) http://www.rmhldni.gov.uk/living_fuller_lives.pdf

National Institute for Health and Clinical Excellence (NICE) (2006) Dementia: Supporting people with dementia and their carers in health and social care
http://guidance.nice.org.uk/CG42

**Responsibility for delivery/implementation**
Health and Social Care in partnership with other statutory organisations, the independent sector and community groups

**Quality Dimensions**
**Person-centred** – allows for the person to stay at home for al long as possible and helps to ensure that institutional care, when required, is a positive experience
**Timely / Effective / Efficient** – Providing appropriate interventions and care environments when required will improve mental health and wellbeing and minimise stress for the person and their carers
**Equitable** – Addresses ageism and inequality
**Safe** – Minimises risk to self and others

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months | QOF | 80%<br>85%<br><br>**Note** - Performance levels are subject to review once the outcome of the 2010 CSR is known | March 2012<br>March 2013 |

## SECTION 7 – STANDARDS FOR PEOPLE WITH SPECIFIC NEEDS

The overwhelming majority (over 95%) of people who have a mental health problem are cared for exclusively within primary care. Those with more complex and enduring mental health needs are likely to require access to specialist mental health services. There are however some people with specific needs that cannot be fully addressed by either primary care or secondary mental health services, usually because interventions are necessary which require highly specialist skills and services. The following standards relate to those people who need such services.

## 7.1 Perinatal Mental Health

Perinatal mental health refers to the mental health of the mother during pregnancy, delivery and the first 6 months of following childbirth.  Services should include consideration of the mental health and wellbeing of the child and father.

Fears about children being 'removed' can prevent mothers and families from actively seeking help and support.  Often it is not until a crisis occurs that the need within the family is identified.

Mental health problems following childbirth are may be serious and can have an adverse effect on the woman herself, as well as on her relationships, family and, in particular, on the future development of her baby.

*Saving Mothers' Lives: Reviewing Maternal Deaths to make Motherhood Safer",* the report of the 2003-2005 National Confidential Enquiry into Maternal and Child Health, reported that 10% of new mothers are likely to develop a depressive illness in the year following delivery, of whom between a third and a half suffer severe depressive illness.

Women, who have had a previous episode of serious mental illness, either following childbirth or at other times, are at an increased risk of developing a postpartum onset illness, even if they have been well during pregnancy and for many years previously.

Risk factors for illness in the period after childbirth can be identified and the antenatal period offers an opportunity to screen for these and intervene.  Identifying and treating mental illness is not only beneficial for the mother, but also for the future psychological health of their children and the family unit as a whole.

**Overarching Standard 45: Women in the perinatal period – assessment and intervention**

All women presenting to maternity service should be asked about past or present mental illness and treatment including at their first contact visit with primary care, the booking visit, the 3rd trimester visit, during the post-natal contact period between 6-10 weeks and up to 1 year postnatal.  Where appropriate, they should be referred to specialist mental health services that include access to psychological interventions, additional health visitor support and inpatient care as appropriate and in accordance with NICE guidelines.

**Rationale**

Psychiatric disorder and depression are common during pregnancy and following birth.  Ten per cent of new mothers are likely to develop depression in the year following childbirth, of whom between a third and a half will be suffering from a severe depressive illness.  A particularly severe form of mental illness, puerperal psychosis will occur in 2 per thousand births.  Women with a history of serious mental illness have an increased risk of recurrence in the post natal period.  Early identification and treatment is essential to minimise risk and improve short and long term outcomes for mother and baby.  Mental health problems during pregnancy and/or following childbirth can have serious and long term complications for the mother, for her unborn child or newborn baby and for other members of her immediate family.

**Evidence**

Confidential Enquiry into maternal and child health (CEMACH) (2007)

National Institute for Health and Clinical Excellence (NICE) (2005) Ante Natal and Post Natal Mental Health: Clinical management and service guidance
http://guidance.nice.org.uk/CG45

Bamford Review: A Strategic Framework for Adult Mental Health Services (June 2005) http://www.rmhldni.gov.uk/adult_mental_health_report.pdf

Social Care Institute of Excellence (SCIE) Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf

**Responsibility for delivery/implementation**

Primary Care
Maternity Services in partnership with specialist mental health

| Quality Dimensions |
|---|

**Person Centred** – Women, their partners and those in their social network are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for the woman, her infant and involved biological father given her unique context, lifestyle and family situation.

**Equitable** – Accessible services for women in vulnerable groups with additional needs e.g. women with disabilities, homeless or travelling women, substance abusers and those who experience disadvantage or feel excluded from services.

**Safe** – Ensures appropriate risk assessed environment is used for women to store information about their mental health and minimises risk to self and others.

**Timely -** Timely access to treatment is therefore essential to benefit those affected and to minimise the impact on the child and family.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of women assessed for mental health problems during pregnancy in past 12 months | Trust Report/Audit Case Notes Northern Ireland Maternity A T System (NIMATS) | Establish Baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of women who are in receipt of Specialist Mental Health Services including psychological interventions and additional health visitor support, appropriate to their needs | | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of mothers advised to seek support through Sure Start | | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## 7.2  Older Peoples Mental Health

Good mental health in older age is just as important as physical concerns.  Indeed poor mental health in old age will inevitably contribute to physical deterioration.  Therefore mental health problems in old age should be treated as vigorously as physical health problems in that age group and mental health problems in younger people.  It is estimated that between ten and twenty percent of older people (aged 65 years or over) suffer from serious mental heath problems.  Hence there is need to develop standards specific to the mental health of older people.  However, the generic mental health standards for people of all ages within this document apply equally to older people.

Serious mental health problems seen in older people include long term conditions persisting from earlier in life as well as depression occurring for the first time in old age which can both precipitate and exacerbate the condition.  The so called "organic" conditions including Alzheimer's disease and other dementing illnesses predominantly occur in older age groups.  Particular skill is required in their early identification and management.

Early identification, diagnosis and intervention is crucial in the care of people with dementia.  A strategy for dementia is currently (2010-11, DHSSPS) being developed for Northern Ireland and specific standards for dementia will be developed following its completion.

**Overarching Standard 46: Older People's Transition**
A person with severe and enduring mental illness who are approaching the age of 65 years should have a review to assess whether their needs are best met in existing adult mental health services or older people mental health services. This should take into account the views of the individual, their families and carers and should be reviewed on an annual basis thereafter.

**Rationale**
Services should take account of each individual's need rather than their chronological age.

**Evidence**
Bamford Review: Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (June 2007) http://www.rmhldni.gov.uk/living_fuller_lives.pdf

DOH (2001) National Service Framework for Older People
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications
PolicyAndGuidance/DH_4003066

**Responsibility for delivery/implementation**
Trusts – Adult Mental Health Services

**Quality Dimensions**

**Person Centred** – Older people, what is important to them, their family and friends are central to the planning and delivery of health promotion activities and material. Options should be explored in regard to what would work best for them given their unique context and lifestyle.
**Timely –** takes consideration of service boundaries and barriers
**Efficient** – Appropriate resources would be available
**Effective** – Appropriate care being delivered in the correct setting
**Equitable –** Addresses ageism and inequity
**Safe** – Provides an appropriate age related consideration of need

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people in Adult Mental Health services between 64 and 65 years old who have had a review which incorporates transition planning in the previous 12 months. | Trust report/Audit *(No of people age 64-65 and no of reviews undertaken)* | Establish baseline  Performance levels to be determined once baseline established | March 2012 |

**Overarching Standard 47: Older People's Assessment and Early Intervention**

Older people (age 65 years and over) should have access to a comprehensive older people's mental health service including mental health promotion, early detection and diagnosis, assessment and treatment and support for carers. Any older person experiencing mental health problems should have access to appropriate physiological investigation and screening by Primary Care to rule out potential physical conditions and to inform referral decisions. Following any initial diagnosis they should have an early comprehensive assessment using an appropriate assessment tool, followed by appropriate interventions and/or onward referral to specialist mental health services and/or other services as appropriate.

**Rationale**

As longevity increases, there will be an increased proportion of people living in the community who can present with mental illness. Around 15% of older people are affected by mild to moderate depression. Dementia is a progressive neurodegenerative disorder that affects cognitive functioning causing behavioural disturbance and reduced activities of daily living.

It is important that older people are assessed in order to detect any Mental Health problems including Dementia. This will allow early intervention, signposting to appropriate services and information provided from a wide range of community, statutory and voluntary organisations.

Older people may have a possible mental health problem as the result of an underlying medical condition which should be treated in the first instance.

**Evidence**

Bamford Review: Living Fuller Lives: Dementia and Mental Health Issues in Older Age Report (June 2007) http://www.rmhldni.gov.uk/living_fuller_lives.pdf

Royal College of Psychiatrists (2006) Raising the standard – specialist services for older people with mental illness. Report of the Faculty of Old Age Psychiatry. http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf

DOH (2004) Integrating Older Peoples Mental Health Services. Commissioned by the Children, Older People and Social Care Policy Directorate http://www.nmhdu.org.uk/silo/files/integrating-opmh-services.pdf

Social Care Institute of Excellence (SCIE) Guide 3 Assessing the Mental Health needs of Older People, April 2006 http://www.scie.org.uk/publications/guides/guide03/index.asp

| **Responsibility for delivery/implementation** |
|---|
| Trust – Mental Health and Older People Directorates<br>General Practice and Primary Care in partnership with Voluntary / Community Groups |
| **Quality Dimensions** |
| **Person Centred** – Access to mental health services should be accessible for older people.  Options should be explored in regard to what would work best for them given their unique personal history, context and lifestyle.<br>**Efficient** – Pro-active services<br>**Effective** – Good Practice Initiatives (see Living Fuller Lives and Older Docs)<br>**Safe** – A comprehensive service would minimise the risks associated with living with dementia. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of older people who have access to the full range of older people's mental health services | Trust report to indicate services available | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |
| Percentage of older people in receipt of services who have had a holistic review including mental health assessment | Trust report | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## 7.3   Post Traumatic Stress Disorder (PTSD)

People directly or indirectly exposed to traumatic events or conditions such as conflict related events, accidents including road traffic accidents, sexual abuse, serious assaults, sudden or serious illness, child birth and associated trauma are at risk of developing post traumatic stress disorder.

Exposure to traumatic events can result in a range of trauma related symptoms including PTSD and other trauma related mental health disorders such as depression, phobic anxiety, etc. Additionally, those presenting with post traumatic stress disorder may also develop secondary mental health problems (e.g. depression, alcohol abuse and other addictions).
People with post traumatic stress disorder will benefit considerably from early detection of the disorder and the provision of evidence based trauma focused interventions provided by suitably trained and supervised practitioners.

In order to address the issues of prevention, recognition, early intervention and treatment of post traumatic stress disorder and allied conditions, a multi-agency, public health based approach is required.   All health professionals need a greater awareness of the possible adverse psychological consequences of traumatic events. Health and Social Services should work in partnership with other agencies to reduce exposure to traumatic events, where possible. To minimise the onset of trauma related disorders and to promote help seeking, individuals exposed to trauma should be offered psychosocial support as appropriate.

Whilst knowledge about what can prevent the onset of PTSD is at an early stage of development, there are humanitarian and service related benefits in evidence-informed measures aimed at creating the optimum psychological and social conditions for recovery.

**Overarching Standard 48: Post Traumatic Stress Disorder – treatment and ongoing care**
A person with a confirmed diagnosis of post traumatic stress disorder should have access to timely interventions and treatment appropriate to their needs, delivered by suitably qualified and supervised practitioners. A standardised outcome measurement tool should be used in treatment and care.

**Rationale**
People with post traumatic stress disorder (PTSD) should be treated by suitably qualified and supervised practitioners who have the experience and skills to provide evidence based psychological treatments for PTSD. Medication can ameliorate disabling symptoms and may reduce symptomatic distress enabling engagement in evidence based trauma focused psychological therapies. Psychosocial interventions should be offered as adjuncts to psychological and pharmacological therapies throughout the course of PTSD. Family members or carers often contribute to identification of the condition and should then be involved in treatment at all stages.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2005) Post traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care
http://guidance.nice.org.uk/CG26

Clinical Resource Efficiency Support Team (CREST) (2003) The management of post traumatic stress disorder in adults
http://www.gain-ni.org/Library/Guidelines/post_traumatic_stress_disorder.pdf

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

Cochrane (2008)

International Society for Traumatic Stress Studies (2005) Post Traumatic Stress Disorder Treatment Guidelines
http://www.istss.org/Content/NavigationMenu/ISTSSTreatmentGuidelines/PTSDTreatmentGuidelines/default.htm

**Responsibility for delivery/implementation**
HSC Trusts
Primary Care

| Quality Dimensions |
|---|
| **Person Centred** – The agreed care plan should be designed, implemented and reviewed in regard to what is working and what is not working from the perspective of the person, their family, carers and other professionals and changes negotiated on the basis of this. <br> **Timely and Effective** –Early detection and access to appropriate treatment aids recovery. Family involvement may aid quicker identification/diagnosis and promote engagement in the treatment process. <br> **Equitable** – Psychosocial support will assist patients accessing other treatments in a timely manner. <br> **Efficient** – use of suitably qualified practitioners applying evidence based treatments will be an appropriate use of resources. <br> **Safe** – If psychological therapies are not delivered by suitably qualified and supervised practitioners, treatment could potentially be harmful <br> **Safe** - Medical practitioners must educate people about side effects of medication and manage these as necessary. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement standardised outcome measurement tool | Trust Report | All Trusts | March 2013 |
| Percentage of people being treated where standardised outcomes measurement is used | Trust Report | Establish baseline Performance level to be determined once baseline established | March 2014 |

## 7.4 Personality Disorders

Personality disorder is significant in terms of prevalence, morbidity and the extensive use of services by those who sometimes exhibit the most chaotic and disturbed behaviour.

There is established evidence that personality disorders can be effectively managed, increasing the person's quality of life and decreasing use of health and criminal justice services, however to date there have been insufficient services provided in Northern Ireland.

People with a personality disorder and their carers are least likely to be satisfied with traditional provision of care and the Bamford Review of Mental Health services recommended the development of dedicated personality disorder services in both the reports on forensic services and adult mental health services.

People with personality disorders are already heavy users of health, social care and criminal justice services, however in the absence of dedicated provision may not receive optimal management.  Approximately 10 % of people with personality disorder eventually commit suicide and 12% of all people who commit suicide have a diagnosis of personality disorder. Middle aged women with borderline personality disorder commit suicide as commonly as young males.

**Overarching Standard 49: Personality disorder – assessment, early intervention, treatment and ongoing care**
A person presenting with clinically problematic personality disorder should have a comprehensive mental health assessment including a risk assessment by mental health specialist using an appropriate assessment tool and be referred for specialist personality disorder assessment, if required. They should have access to a range of appropriate treatments and care according to their individual needs and access to education, advice, support and management delivered by a specialist, regional personality disorder service as appropriate.

**Rationale**
Early assessment and engagement with appropriate services will reduce an inappropriate use of other services.
To ensure quality, consistency, co-ordination and accountability of care.
Supports treatment models and addresses a gap in current services.
Appropriate treatment and care delivered to meet individual need can help to manage interpersonal functioning, cognition, mood and impulsivity.

**Evidence**

DOH (2003) Personality Disorder – No Longer a Diagnosis of Exclusion
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/
@dh/@en/documents/digitalasset/dh_4054230.pdf

National Coordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) report (2007) Learning the Lessons: A multi-method evaluation of dedicated community-based services for people with personality disorder
http://www.sdo.nihr.ac.uk/files/project/83-final-report.pdf

Home Office and Department of Health England (2006) Personality Disorder Capacity Plans 2005
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets
/@dh/@en/documents/digitalasset/dh_4139095.pdf

National Institute for Health and Clinical Excellence (NICE) (2009)
Antisocial Personality Disorder: treatment, management and prevention
http://guidance.nice.org.uk/CG77

National Institute for Health and Clinical Excellence (NICE) (2009)
Borderline Personality Disorder: treatment and management
http://guidance.nice.org.uk/CG78

NI Personality Disorder Group

| Responsibility for Delivery |
| --- |
| Commissioners |
| Trusts |
| Specialist Personality Disorder Service |
| Criminal Justice System |
| Primary, Secondary and Recovery Mental Health Services |
| Other Statutory, Voluntary and Community Groups. |

| Quality Dimension |
| --- |
| **Person Centred -** People, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle. |
| **Effective** – Evidence has shown that appropriate and timely interventions can improve outcomes and reduce adversity. |
| **User and Carer** – Centred.  Considers the needs of the individual and his/her carer/family. |
| **Equitable** – Promotes social inclusion regardless of age and inequity. |
| Safe – any person presenting either as a risk to themselves or others should be referred and assessed by specialist mental health specialists immediately |

| Performance Indicators | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Quality of Life Indicators. Social Performance Indicators – to be determined | Evaluation of treatment and service delivery model. Health economics evaluation. | Establish baseline  Performance levels to be determined once baseline established | March 2012 |

## 7.5  Self Harm and Suicide

Self harm is an act of self poisoning or self injury irrespective of the purpose of the act.  Self harm is always a sign that something is seriously wrong.

Suicide is the act of deliberately taking ones own life (Protect Life 2006) and we have already seen in Chapter 4 Facts and Figures that the number of people taking their own life in Northern Ireland has increased over recent decades.

Preventing suicide and self harm is a shared responsibility between statutory, voluntary, community groups, communities and individuals.

Within Northern Ireland partnerships such as Investing for Health launched in 2002 continue to provide a framework for improving mental health and wellbeing.  More specifically the Northern Ireland Suicide Prevention Strategy - Protect Life (2006) Implementation Group continue to engage a wide range of statutory and non-statutory groups in taking forward the recommendations of the strategy.

The following 2 standards focus specifically on things that are the responsibility of Health and Social Services and contribute to the overall initiatives for the prevention of suicide and the prevention and management of self harm.

**Overarching Standard 50: Self Harm – Information and support**
A person who is contemplating self harm/has self harmed or has expressed suicidal ideation should have access to a co-ordinated comprehensive range of age appropriate advice, information, counselling and support and other initiatives that can address their needs in relation to self harm and suicide. This should include accessible and appropriate information, for example regarding services and potential sources of help for the person and family, carer or friend.

**Rationale**
The general population would benefit from increased awareness of and access to a range of approaches to reduce stigma towards mental health issues and build capacity to support individuals and communities in need. The promotion of positive mental health and wellbeing through awareness, knowledge and information, the involvement of individuals, families, communities and all agencies can improve an individual's resilience, capacity, skills, self esteem, confidence and self worth.

**Evidence**
DHSSPS (2006) Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011
http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf

Choose Life: The national strategy and action plan to prevent suicide in Scotland
http://www.chooselife.net

Health Service Executive, the National Suicide Review Group and Department of Health and Children (Ireland) (2005) Reach Out: National Strategy for Action on Suicide Prevention 2005-2014
http://www.dohc.ie/publications/pdf/reach_out.pdf?direct=1

DHSSPS (2003) Promoting Mental Health: Strategy and Action Plan 2003-2008
http://www.dhsspsni.gov.uk/menhealth.pdf

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

McCartan Independent Review

Social Care Institute for Excellence (SCIE) (2005) Research Briefing 16: Deliberate self harm (DSH) among children and adolescents: who is at risk and how is it recognised?
http://www.scie.org.uk/publications/briefings/briefing16/index.asp

| Responsibility for delivery/implementation |
|---|
| DHSSPS |
| Commissioners |
| Trusts |
| Voluntary and Community Groups |
| Other Statutory Groups |

| Quality Dimensions |
|---|

**Person Centred** – People, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle. Information and support should be tailored to their age, understanding and accessibility.

**Timely** – Information available when needed, sensitive to individual circumstances

**Equitable** – Available to all throughout NI

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Availability of information, support and initiatives | Trust report – Protect Life evaluation | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |

**Overarching Standard 51: Self Harm – Assessment and early intervention**
A person who has self harmed should have any physical injuries dealt with as a matter of urgency and be offered preliminary psychosocial assessment when first presenting to services.  If presenting either a risk to themselves or others they should be referred and assessed by age appropriate specialist mental health services **immediately** in line with NICE guidelines.

Anyone presenting to A&E who does not immediately require access to specialist services will be provided with a specific follow-up appointment scheduled within 7 days, i.e. Card Before You Leave scheme.

**Rationale**
Self harm is a significant problem that requires a co-ordinated input from a number of agencies including Primary Care, Ambulance, acute medical and psychiatric care.  Preliminary psychosocial assessment to establish physical risk and mental state assessment in a respectful and understanding way, taking account of emotional distress as well as the physical distress will help to identify motives for the act and associated problems that might be amenable to intervention at a later stage.
A full assessment will assist the person and the practitioner to identify factors associated with the self harm, to identify potentially treatable mental disorders and assess continuing risk.  This will assist in making the most appropriate referral for help and support.
Not everyone who self harms is willing to discuss their thoughts and feelings and this will make psychosocial assessment difficult. A person should be dissuaded from leaving if possible until appropriate arrangements in place to receive appropriate care and treatment or onward referral.   It will be necessary for capacity/mental illness assessment to minimise risk and to try and provide ongoing support and care.

**Evidence**
National Institute for Health and Clinical Excellence (NICE) (2004)
Self Harm: The short term physical and psychological management and secondary prevention of self harm in primary and secondary care
http://guidance.nice.org.uk/CG16

Royal College of Psychiatrists Council Report CR122 (2004) - Assessment following self harm in adults http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf

DHSSPS (2006) Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011
http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf

| Responsibility for delivery/implementation |
|---|
| Primary Care |
| HSC Trusts, including NIAS |
| Acute General Hospitals |
| Mental Health Services |
| In partnership with voluntary and community groups |

| Quality Dimensions |
|---|
| **Person Centred** – People, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle.<br>**Timely** – An early assessment helps inform ongoing care<br>**Equitable** – Ensures assessment is completed regardless of where the person presents following self harm<br>**Safe** – Minimises risk |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people presenting with self harm who have had a preliminary psychosocial assessment | Case Notes<br><br>Audit – Primary and Secondary Care | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |
| Percentage of young people presenting with self harm who have an assessment by CAMHS or other appropriate practitioner | Case notes | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |
| Percentage of people who have a comprehensive assessment by an adult specialist practitioner | Case notes | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |

| | | | |
|---|---|---|---|
| Percentage of people discharged in accordance with Trust A&E based Card Before You Leave Scheme | Trust Report PCC Report | Performance level to be determined once baseline established | March 2012 |

## 7.6   Acquired Brain Injury

Acquired Brain Injury is a common condition which can lead to long-term illness and disability. Often the most difficult problems for patients and their families to address are the neuropsychological and neuropsychiatric sequalae, including cognitive impairment, organic personality change and challenging behaviour. The incidence of serious mental illness is also high in this population. Those who have suffered a brain haemorrhage, brain tumour, or hypoxic brain injury and those affected by some neurological conditions including Huntington's disease may experience similar problems. There are also a significant number of people whose difficulties are compounded by having sustained damage to their brain as a result of the effects of alcohol.

The difficulties which many face following a brain injury are complex. Often, the brain injury leads to major changes in life, perhaps moving from independence, and from being a partner, provider or carer, to being dependant and greatly in need of support. The difficulty in adjustment to disability is compounded by the fact that the very part of the body which is central to the understanding and adaptation to change is affected by the injury. It is often the neuropsychological and neuropsychiatric effects of the brain injury that give rise to the greatest difficulty for those who have been injured and those around them.

The needs of those who have suffered significant brain injury can be complex and long term and can emerge at various points in the course of recovery. They cross traditional service boundaries. There are often social, medical and psychological needs to be met. An important principle is that the provision of services should be tailored to meet the needs of the individuals affected by brain injury rather than expecting that they will fit into structures and systems. The standards which follow reflect this.

**Standard 52: Acquired Brain Injury Assessment, Early Intervention, Treatment and Ongoing Care**
A person with a neurological or brain injury should have access to a full range of age appropriate mental health services for assessment, early intervention and a full range of age appropriate specialist treatment, care and support that include residential options and specialist inpatient mental health services staffed by a team of professionals with a range of skills and competencies offering rehabilitation in order to meet their continuing and changing needs.

**Rationale**
The needs of those who have sustained a brain injury can be complex. There may be co-existing developmental physical, emotional and social problems. The incidence of psychiatric problems, particularly mood disorder, is high. Situations can arise where there is lack of clarity regarding responsibility for service provision. This can occur where there is co-morbidity or where the individual needs cut across programmes of care.
People are very different in terms of need and therefore no single service solution will meet their needs.
For a number of people these needs will be life long.
Management in an appropriate setting optimises function and reduces the need of sedative medication which can have adverse effects.
Specialist neurobehavioral rehabilitation is effective and can improve long term outcomes and reduce the cost of long term care. It is essential for safe management of people whose behaviour is significantly challenging. Currently there is no dedicated in-patient unit for females, children and adolescents.

**Evidence**
British Society Rehabilitation Medicine/Royal College of Physicians (2003) Rehabilitation following acquired brain injury: National Clinical Guidelines. http://www.rcplondon.ac.uk/pubs/contents/43986815-4109-4d28-8ce5-ad647dbdbd38.pdf

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

DOH (2005) National Service Framework for Long-term Conditions http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4105361

| Responsibility for delivery/implementation |
|---|
| Trusts |

**Quality Dimensions**

**Person Centred** – People, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle.

**Timely, Effective, Efficient** - Reduce demand across services, people will be seen by the appropriate services. Treatment of mental health needs has a significant impact on rehabilitation and long term outcomes

Variability in practice currently

**Safe** – appropriate assessment and treatment will minimise vulnerability, risk of suicide and risk to self and others arising from behaviours that challenge

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Agree and implement referral criteria for mental health services that demonstrates inclusion for people with Mental Health needs post brain injury | Regional review of referral criteria – adult and CAMHS<br><br>Trust Report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2012 |
| Percentage of people who have been assessed and are in receipt of community accommodation and care packages | Trust Report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |

## 7.7 Deaf People with Mental Health Needs

**Definition of deafness** - By "deaf" we mean anyone with a permanent or temporary hearing loss. This could be a mild, moderate, severe or profound hearing loss, and includes people who communicate orally or through sign language.

People are Deaf for many reasons - through illness, trauma or a congenital condition. However, the most common type of hearing loss is age-related, which may also be associated with tinnitus (ringing, buzzing, whistling, hissing or other noise, heard in the ear in the absence of environmental noise).

For the purposes of these Standards, we have included deafblind people (i.e. those with dual sensory loss) who are referred to the service because of their hearing loss.

There are approximately 1700 people in Northern Ireland who have experienced severe or profound hearing loss. Of these, 300 are aged between 16 and 60 years.

People who are Deaf are at high risk of social exclusion. Social exclusion amongst the Deaf community affects both their mental health and their access to appropriate mental health services.

**Overarching Standard 53: Deaf people with mental health needs – assessment, early intervention, ongoing treatment and care**
A deaf person (of any age) with mental health needs and their carers should have access a full range of mental health provision including early assessment, treatment and ongoing care provided by specialist mental health services including access to key worker, inpatient care and out of hours services if required. Interventions should be focused on the person and the family and include a range of supports that facilitate communication within primary and secondary care

**Rationale**
Deaf adults face twice the degree of psychological problems faced by the hearing community, and high levels of severe and enduring mental health problems. Deaf people are more likely to experience social exclusion and isolation than the hearing population. Deaf people report higher levels of low self-confidence and self-esteem than the hearing population.

Deaf people are more likely;
- To experience a delay in diagnosis of their mental health problem than the hearing population
- To experience some level of co-morbidity e.g. physical illness, neurological conditions, learning disability etc.
- To experience delay in accessing specialist care and treatment than the hearing population;
- Deaf people can have very complex needs and a wide range of services involved; or they can have complex needs few of which are adequately addressed or assessed.

Current inequalities in accessing mental health care, particularly in relation to communication needs and information availability. Deaf users are often unaware of what help is available and how to access it. There is a lack of deaf awareness across most generic mental health professionals and a lack of understanding of the complexity of need in the deaf population. Many young deaf people will not have their mental health difficulties identified when they first occur, leading to an increased risk of their problems deteriorating. Current acute/inpatient provision is mainly through referral to the specialist John Denmark Unit in Birmingham, leading to isolation of our deaf service users from their families and locale. Financial costs are high. Access to crisis care/risk assessment is particularly difficult in light of communication issues and lack of information available in deaf friendly form.

**Evidence**

The National Deaf Children's Society (NDCS) (2005) report: Developing mental health services for deaf children and young people in Northern Ireland
http://www.ndcs.org.uk/document.rm?id=1306

DOH (2002) A Sign of the Times: Modernising Mental Health Services for people who are Deaf
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets /@dh/@en/documents/digitalasset/dh_4018723.pdf

DOH (2005) Mental Health and Deafness: Towards Equity and Access
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets /@dh/@en/documents/digitalasset/dh_4104005.pdf

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

Royal National Institute for the Deaf (RNID) (2004) A Simple Cure: A national report into deaf and hard of hearing people's experiences of the National Health Service http://www.rnid.org.uk/VirtualContent/84923/asimplecure.pdf

Disability Discrimination Act
http://www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/ DisabilityRights/DG_4001068

**Responsibility for delivery/implementation**

DHSSPS
Boards
Trusts
Primary Care
Commissioners in partnership with voluntary and community groups

| Quality Dimensions |
| --- |
| **Person Centred** - Deaf people, what is important to them, their family and friends are central to the assessment and early intervention/treatment process. Options should be explored in regard to what would work best for them given their unique context and lifestyle. |
| **Timely** - Formal assessment of mental health and other needs as early as possible i.e. at primary care level will ensure that identified needs can be addressed in a timely manner |
| **Equitable** - Deaf children, adolescents and adults should be able to access all primary care services |
| **Effective** - Appropriate management of needs at primary care level should improve expected outcomes leading to reduced morbidity and improved quality of life |
| **Safe** – All deaf children, young people and adults should have ongoing assessment of their needs, with particular emphasis on secondary prevention, information, education and support |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of deaf children and young /adults accessing Mental Health provision | Trust report | All Trusts | March 2013 |
| Percentage of people being treated where outcomes measurement shows improvement after 12 months | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |
| Percentage of deaf people using mental health services that have a key worker | Trust user and carer feedback | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |
| Evidence of arrangements and facilities for deaf people in mental health services | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |

## 7.8   Gender Dysphoria

Gender dysphoria is a state that is often misunderstood and as a consequence those who experience it are frequently marginalised and isolated.

The exact cause of gender dysphoria is unknown, and there is much debate over its possible causes, however it is no longer regarded as a form of mental illness.  There are recent persuasive studies indicating biological causes for the condition resulting from hormonal influences on brain systems involved in the regulation of gender and sexuality, during pregnancy.  Whether these represent potentialities requiring other subsequent environmental influences or not are yet to be determined and certainly much more research in the area is required.

The aim of treatment is to help the individual come to the best solution for them in regard to their sense of disharmony between sex and gender.  Often the conflicts of having to live with this distressing condition have resulted in significant emotional and mental health difficulties, which require psychiatric and psychotherapeutic treatment.  Trans people have high incidences of mental illness, self-harming behaviour and addiction problems, prior to specialist treatment.  After an appropriate period of assessment and counselling to establish the diagnosis and the preferred clinical pathway the patient wishes to take, there is a spectrum of possibilities for the treatment of gender dysphoria. Although ultimately this may involve radical hormonal and surgical treatments to achieve a complete transition, patients frequently reach a position of satisfaction with themselves at some stage short of this.  However, most transsexuals pursue transition and eventually enter into a Real Life Experience or RLE (living fully in the chosen gender role) for a minimum of one year before they are considered for surgery.  During this process they undergo sex hormone reassignment, and a variety of gender role therapies (speech therapy, cosmetic/deportment, hair removal), which are crucial in assisting their adjustment.  During this period their progress is closely assessed and they may continue to receive a range of psychiatric and psychotherapeutic treatments.  It is also recognised that peer support independent of their Gender Identity Service is extremely import in facilitating this process.

**Overarching Standard 54: Gender Dysphoria – treatment and ongoing care**

A trans person should have hormone support as part of their care from a multi-disciplinary network using regionally agreed protocols including having access to an endocrinologist, to non-statutory peer support and mentoring, and to services that will as part of their ongoing treatment and care, help them to improve their self-image.

**Rationale**

Hormone Treatment is becoming increasingly complex requiring a much more multi-disciplinary approach to care involving psychiatry and endocrinology services.

Trans people suffer enormous social isolation as one of the most marginalised groups in society; these services reduce that extreme social isolation.

Accessing peer groups who have a communal experience of the transitional process involved in sex re-assignment has a significant positive impact in optimising adjustment to the treatment process.

Most trans people feel more comfortable talking to those who have been through similar experiences and are much more likely to trust their help and accept their advice.  Consequently it is vital that these opportunities are offered external to statutory services thus maintaining a clear demarcation line between peer support and the therapeutic relationships within statutory services.

To enable people who are marginalised to have access to the factors that promote good mental health and well being and take responsibility for developing their emotional resilience and wellbeing

**Evidence**

Royal College of Psychiatrists (2008) Good practice guidelines for assessment and treatment of gender dysphoria

Michel, A. Mormont, C. Legros, JJ. 2001. A psycho-endocrinological overview of transsexualism.  European Journal of Endrocrinology, 145 ; 365-376

**Responsibility for delivery/implementation**

Trusts; Gender Identity Clinic
Endocrinology Departments

| Quality Dimensions |
|---|
| **Person Centred** - The agreed care plan should be designed, implemented and reviewed in regard to what is working and what is not working from the perspective of the trans person, their family, carers and other professionals and changes negotiated on the basis of this. <br> **Timely –** Timely intervention of the above have been shown to have positive outcomes. <br> **Efficient** – All of the above standards will facilitate trans people to have improved mental health and wellbeing. <br> **Effective –** non-statutory peer support and mentoring will help to support and maintain psychological wellbeing <br> **Safe** – All of the above will reduce the risk of harassment and protect personal safety. |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of trans people accessing multidisciplinary assessment and screening prior to Hormone Therapy. | Baseline Audit of Gender Identity Disorders 2007 Follow-up Audit 2009 children and young people and adults | Establish baseline <br><br> Performance level to be determined once baseline established | March 2012 |
| Percentage of trans people who access peer support | Trust Report in partnership with peer support services | Establish baseline <br><br> Performance level to be determined once baseline established | March 2012 |
| Percentage of trans gender people within the gender identity service accessing services to improve their self image | Trust Report | Establish baseline <br><br> Performance level to be determined once baseline established | March 2012 |

## 7.9   Forensic Mental Health

Forensic Mental Health Services provide assessment, treatment, and rehabilitation for mentally disordered people who pose a significant risk of serious harm to others. There is a tiered protocol of service delivery with assessment available to all suitable referrals.

Regional Forensic Mental Health in-patient services are provided by the 34-bedded Shannon Clinic facility on the Knockbracken Health Care Park site. Inpatients are required to be detainable under the Mental Health Order so the inpatient service is orientated towards severe mental illness.   Community forensic multi-disciplinary teams in each Board area work collaboratively with both Shannon Clinic and general mental health services as well as the various agencies of the Criminal Justice System, i.e. Police, Probation, Courts and Prison. The community service will deal with a wide range of mental disorder.

The mentally disordered offender, regardless of setting (e.g. whether in police custody, in prison or in the community) can access mental health services in the same way as a non-offender patient i.e. through crisis teams and sector mental health teams. If these teams identify serious risk they will refer to forensic mental health services for additional input. This integrative approach makes most efficient use of resources.

**Overarching Standard 55: Forensic Mental Health Services**
A person who is a mentally disordered offender (MDO) (young person or adult) should have access to the full range of services and interventions delivered in the appropriate environment by suitably trained staff.

**Rationale**
Mentally disordered offenders are entitled to equal access to the full range of services and interventions, and should not be denied access solely on the principle of risk or lack of available resources.

**Evidence**
Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

Reed Principles (1994)

Human Rights Act (1998)
http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

Revolving Doors (2005)
http://www.revolving-doors.org.uk

NACRO (2005)
http://www.nacro.org.uk

Responsibility for Prison Health Care transferred to NHS

**Responsibility for delivery/implementation**
There are a wide range of services and agencies required to work collaboratively to make this standard a reality. These agencies include, but are not exclusive to:
DHSSPS and their associate HSC Trusts in partnership with
Northern Ireland Prison Service
Police Service of Northern Ireland
Northern Ireland Probation Board
Northern Ireland Housing Executive
Voluntary/Independent Sector

| Quality Dimensions |
| --- |

**Person Centred -** People accessing forensic mental health services, what is important to them, their family and friends are central to the assessment and early intervention/treatment process.  Options should be explored in regard to what would work best for them given their unique history, context and lifestyle.

**Timely -** Complies with Human Rights legislation.  Drives agenda for step-down resources.

**Equitable -** Decisions based on needs assessment.  Reflective of generic service provision.  Mental health issues are given serious consideration when dealing with the individual supports the principles of 'equivalence' and 'reciprocity'

**Effective -** Treatment and interventions are delivered in the most appropriate environment.  Mental health needs are speedily identified and interventions put in place early to address need.  Promotes effective communication between agencies.  Early intervention promotes better outcomes.  Service delivery is needs driven.

**Efficient -** Promotes better use of resources.  Treatment delivered in the most appropriate environment.  Supports collaborative working and sharing of resources.

**Safe -** Care and treatment are delivered in the most appropriate environment based on assessed need.  Promotes proactive positive risk management.

**Equitable** - MDOs regardless of their location have access to services and resources appropriate to their need.

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Range of services and interventions available to any person within the criminal justice system | Trust report | Establish baseline<br><br>Performance level to be determined once baseline established | March 2013 |

### 7.10  Learning Disability

**Overarching Standard 56: Learning Disability**
A person with a learning disability should have access to appropriate mental health support for their needs.

**Rationale**
A person with learning disabilities experiences four times the incidence of mental health disorders compared to their non-disabled peers, and yet have limited access to mental health services.  It is essential that individuals and families who require support have access to these services in order to maintain the person's emotional, physical and mental wellbeing.

People with a dual diagnosis of learning disability and mental ill health require a coordinated multidisciplinary approach to having their needs met through integrated services that respond flexibly to the demands of their conditions with clear pathways of care identified so that the most appropriate supports are available to the person their family and carers when required.

**Evidence**
Raising our sights: services for adults with profound intellectual and multiple disabilities – A report by Professor Jim Mansell (2010)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/ @dh/@en/@ps/documents/digitalasset/dh_117961.pdf

NHS Quality Improvement Scotland – Learning Disability Framework
http://www.nhshealthquality.org

Black LA et al (2008) Lifelines Report An Evaluation Report of the Impact of the Families Services delivered by Positive Futures in Rural and Urban Areas of Northern Ireland

MENCAP (2003) Breaking point: A report on the continuing problem of caring without a break for children and adults with severe and profound learning disabilities http://www.mencap.org.uk/displaypagedoc.asp?id=297

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

**Responsibility for delivery/implementation**
HSC Organisations in partnership with Education, Voluntary and Community Groups

| Quality Dimensions |
|---|

**Person Centred** – People with a learning disability and a combined mental illness have individual plans in place with clear pathways of care identified and planned that enable the person to lead as normal a life as possible. To involve the person, their family and carers in the process in a way that supports them to be empowered and be able to make informed choices

**Equitable** – The mental health needs of people with learning disabilities are met in the most appropriate setting

**Effective/Efficient** – Services surrounding the person with a mental illness should be coordinated and a lead person identified to effectively manage and promote the mental health and wellbeing of the person. Effective coordination will avoid duplication of services.

**Safe** – Addressing the mental health needs of people with a learning disability requires a combination of services that are consistently available for the person's own safety and others to enable the person's full participation within the structures of society

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Percentage of people who are receiving appropriate mental health services | Audit | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

## 7.11  Black and Minority Ethnic Communities

**Overarching Standard 57: Black and Ethnic Minority Communities**
A person from a black or minority ethnic (BME) community should have access to a full range of mental health services that are sensitive to their specific cultural needs and have support to enable good communication

**Rationale**
Many people from black and minority ethnic communities experience greater social adversity than the rest of the population.  Many experience urban poverty, discrimination, racism, housing difficulties and poor employment prospects all of which can affect their mental health and wellbeing.  Language and cultural insensitivities are often found to be a problem by a person using services.

People from BME communities also find it difficult to access and engage with mental health services for several reasons.  Communication is essential when using mental health services as the diagnostic process relies largely on talking to a person.  If English is not the person's first language, the mental health professionals may not get enough accurate information to make an accurate diagnosis.  Different cultural attitudes to mental illness are also an important factor which may impact on an individual's willingness to seek professional help.

It is often difficult for people from BME communities to access psychological therapies (talking therapies) which can limit the effectiveness of treatments and medication.

**Evidence**
Race Relation (NI) Order 1997
http://www.ofmdfmni.gov.uk/index/equality/race/race_relations_order.htm

Race Relations Order (Amendment) (NI) 2003
http://www.ofmdfmni.gov.uk/index/equality/race/race_relations_order.htm

Human Rights Act (1998)
http://www.direct.gov.uk/en/Governmentcitizensandrights/Yourrightsandresponsibilities/DG_4002951

Section 75 of the Northern Ireland Act 1998
http://www.ofmdfmni.gov.uk/index/equality/statutory-duty.htm

Exploring Mental Health Needs of the Chinese Community in South and East Belfast HSC Trust (2005)

DHSSPS and Equality Commission (2003) Racial Equality in Health and Social Care – Good Practice Guide
http://www.dhsspsni.gov.uk/raceeqhealth_cover.pdf

OFMDFM (2005) A Racial Equality Strategy for Northern Ireland 2005-2010
http://www.ofmdfmni.gov.uk/race-equality-strategy.pdf

OFMDFM (2007) A Shared Future and Racial Equality Strategy – Good Relations Indicators Baseline Report http://www.ofmdfmni.gov.uk/good-relations-report.pdf

Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/

Inside Out Report (2003)

| **Responsibility for delivery/implementation** |
| --- |
| HSC Trusts <br> Primary Care <br> In partnership with voluntary and community groups |
| **Quality Dimensions** |
| **Person Centred –** Being sensitive to individual needs taking into account cultural, religious and language barriers will help empower  the person to be involved in their care <br> **Effective -**  Being able to overcome barriers may improve outcomes <br> **Efficient –** Early assessment, intervention, treatment and care will assist people and their families to actively participate in their care <br> **Safe -**  Improved communication will minimise risk to self and others <br> **Equitable -**  enables equal access to a range of mental health services for everyone |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
| --- | --- | --- | --- |
| Percentage of BME people who are in receipt of mental health services that are sensitive to their needs | HSC Trust Report to include user and carer feedback | Establish baseline <br><br> Performance levels to be determined once baseline established | March 2012 |

### 7.12  Homeless People

| Overarching Standard 58: Homeless people |
|---|
| **Overarching Standard 58: Homeless people**<br>Health and Social Sare will work in partnership with statutory and voluntary agencies to ensure the delivery of a high quality, comprehensive service to individuals with mental health problems who are homeless |
| **Rationale**<br><br>It is essential that health and social care organisations work with all relevant agencies to ensure the needs of individuals with mental health problems who are homeless are met through a co-ordinated responsive approach.  This will maximise the individual's recovery<br><br>**Evidence**<br>Bamford Review: The Reform and Modernisation of Mental Health and Learning Disability Services (May 2007) http://www.rmhldni.gov.uk/<br><br>Homeless Legislation**:** Housing Northern Ireland Order 1988<br><br>McGilloway and Donnelly (1996) Don't Look Away: Homelessness and Mental Health<br><br>The Mental Health (NI) Order 1986<br>http://www.nidirect.gov.uk/index/information-and-services/people-with-disabilities/health-and-support/your-rights-in-health/the-mental-health-act.htm<br><br>Crisis and Brent Homeless User Groups (2009) No one's priority: the treatment of single homeless people by local authority homelessness services<br>http://www.crisis.org.uk/publications-search.php?fullitem=254<br><br>Crisis and Brent Homeless User Groups (2009) Crisis' submission to St Mungo's call for evidence on mental health and street homelessness<br>http://www.crisis.org.uk/publications-search.php?fullitem=246<br><br>Crisis and Brent Homeless User Groups (2009) Crisis' submission to the Cabinet Office and Department of Health's call for evidence on access to primary healthcare for socially excluded groups<br>http://www.crisis.org.uk/publications-search.php?fullitem=251 |
| **Responsibility for delivery/implementation** |
| Health and Social Care Trusts in partnership with other statutory agencies an voluntary and community groups |

| Quality Dimensions |
|---|
| **Person centred** - provides a co-ordinated approach to the agreed need of individuals. |
| **Timely** - providing services in a timely manner will increase the likelihood of a positive outcome for individuals. |
| **Effective/ Efficient** - Partnership working will improve communication, reduce the likelihood of duplicating work and enable the identification of most appropriate services to meet assessed need. |
| **Equitable** - Available throughout Northern Ireland |
| **Safe** - Minimising risk to self and others |

| Performance Indicator | Data Source | Anticipated Performance Level | Date to be achieved by |
|---|---|---|---|
| Review partnership arrangements and programmes for people with mental health problems who are homeless | Board/Trust Reports<br><br>Reports from other agencies if available | Establish baseline<br><br>Performance levels to be determined once baseline established | March 2012 |

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

**1.    Mental Health and Wellbeing**

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

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

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

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

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

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

In October 2008 the government launched the Foresight Project on Mental Health Capital and Well-Being. The project drew on 80 commissioned scientific reviews and received input from over 400 experts in fields ranging from economics to neurosciences. Including input from people who use services, families and carers. The report has taken a life span approach to develop a vision that

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

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

The study found:-

- Early intervention is crucial: from noticing and treating learning difficulties in the young to using biomarkers to spot the early signs of dementia in older people.

- A small increase in mental wellbeing leads to a large decrease in mental health problems for all age groups.

- There are a lot of ways to tackle and reduce the huge burden of mental ill health in the UK.

The Foresight report recommends five steps to help people protect their own mental health and make them feel better about themselves.
- CONNECT: With people around you
- BE ACTIVE: Exercise makes you feel good
- TAKE NOTICE: of your surroundings and savour the moment
- KEEP LEARNING: Try something new or rediscover an old interest

- GIVE: Do something nice for a friend or a stranger

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

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

The full report can be accessed on www.foresight.gov.uk.

## 2.    Mental Health Problems

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

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

| Internal Factors | External Factor |
|---|---|
| • Poor quality of relationships; | • Poverty and unemployment; |
| • Feelings of isolation; | • Social exclusion and discriminating; |
| • Experience of disharmony, conflict or alienation; | • Poor physical environment; |
| • Physical illness, infirmity or disability; | • Negative peer pressures; |
| • A lack of self esteem. | • Family or community conflict or tensions |

(Ref. Chief Medical Officer Report DHSSPS 2004)

Statistics in relation to mental health problems should be treated with caution as a large number of people do not report their problems and manage without any help from General Practitioners and/or Mental Health Services.  It is also sometimes difficult for General Practitioners to diagnose a mental health issue as people

are reluctant to talk about their feelings and talk about physical problems instead. It is therefore very likely that any figures relating to mental ill health are underestimated. It is important also, to remember that the factors which predispose, perpetuate or precipitate mental health problems are generally the same for children and young people as they are for adults, and that if parents or close family members have mental health problems this is likely to affect a child or a young person.

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


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

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

For example

•      It is estimated that approximately 450 million people worldwide have a mental health problem. (The World Health Report 2001)

•      1 in 4 families worldwide are likely to have at least one member with a behavioural problem or mental disorder. (The World Health Report 2001)

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

- 1 in 4 British adults experience at least one mental disorder in their lifetime  (Singleton N, Bumpstead R, et al 2001)

- 280,000 people (1 in 6) in Northern Ireland experience a mental health problem at any one time.
(Chief Medical Officers Annual Report  DHSSPS 2004)

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

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

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

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

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


## 4.    The Main Types of Mental Health Problems

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

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

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

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

## 5.    Common Mental Health Problems

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

- Depression will be the second leading contributor of disease in the world by 2020  (The World Health Report 2001)

- Worldwide 5.8% of men and 9.5% of women will experience a depressive episode in a 12 month period, a total of about 121 million people (National Suicide Prevention Strategy DOH 2006)

- 33 million people in Europe suffer from Depression (WHO 2005).

- In the United Kingdom (UK) it is estimated 4 million people experience mental health problems the majority of them depression and anxiety.  (Layard R 2005).

- Mixed anxiety and depression is the most common mental health disorder in Britain with almost 9% of people meeting the diagnostic criteria (Singleton N, Bumpstead R, et al 2001)

- 17% of men and 24% women aged 35-44 show signs of depression (Northern Ireland Health and Social Wellbeing Survey 2001).

- The rates of people with depression in Northern Ireland are higher in more deprived areas, those who are unemployed and those with low education attainment.  As a result use of

sedatives, tranquillisers or antidepressants is also high (Chief Medical Officer Annual Report 2006).

- Half of people with common mental health problems are no longer affected after 18 months, but poorer people, long term sick and unemployed people are more likely to be still affected than the general population. (Singleton N, Lewis G, et al 2003)

- Overall, common mental health problems peak in middle age, 20-25% of people in 45-54 age group have a 'neurotic disorder'. As people age, neurotic disorders become less common, with the lowest level recorded in the 70-74 year age group. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H 2001)

- Only 2% of the population experience a depressive episode without anxiety occurring at the same time. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H 2001)

- Depression tends to recur in most people. More than half of people who have one episode of depression will have another, while those who have a second episode have a further relapse risk of 70%. After a third episode the relapse risk is 90%. For about 1 in 5 people the condition is chronic.

- According to the 2001 Census there are 7,159,694 16 to 25 year olds in the United Kingdom. This equates to 12% of the UK population. About 5% of the total population are between 16-19 years old. 1.7% of the 16-19 year olds and 2.2% of 20-24 year olds have suffered from a depressive episode.

## 6.    Self Harm and Suicide

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

## 6.1    Suicide

- Suicide is now recognised as one of the biggest cause of 'years of life lost' after cardiovascular disease and cancer. (Chief Medical Officers Report 2006).

- Suicide is an emotive and sensitive issue, and there is currently little evidence as to why people take their own lives. Risk factors include depression, alcohol and drug misuse, personality disorder, hopelessness, low self esteem, bereavement, break-up of a relationship and social isolation. (Protect Life DHSSPS 2006).

- In 2004 more than 5,500 people in UK died by suicide. (Samaritans Suicide Statistics August 2006)

- Prior to 2005 the average number of suicides per year was 150 in Northern Ireland. In 2005 this was around 50% higher at 213. (Chief Medical Officers Report DHSSPS 2006)

- Of these 4 out of every 5 were men and ½ were under 35 years of age. (Chief Medical Officers Report DHSSPS 2006)

- Although the rate of suicides among young men has reduced in the UK from 1998 – 2005 suicide remains the most common cause of death in men under the age 35. (The National Service Framework for Mental Health – Five Years On 2005)

- In the UK younger people who had taken their own life more often had a history of schizophrenia, personality disorder, drug or alcohol misuse or violence than older people who had taken their own life. (Safety First 2001)

- In the UK 4% of people who took their own lives were the lone carers of children. (Safety First 2001)

- In the 5 years prior to 2001 6% of the people who took their own lives in England and Wales were from an ethnic minority group. In Scotland this was 2% and in Northern Ireland 1%. (Safety First 2001)

- The 2001 Census found that 9% of the population in England were from ethnic minorities. In Wales 2%, in Scotland 2% and in Northern Ireland 0.75%. (Census 2001)

- People from ethnic minorities who died by suicide usually had a severe mental illness. (Safety First 2001)

- In the UK a quarter of all people who died by suicide in the 5 years prior to 2001 had been in contact with Mental Health Services.  (Safety First 2001)

- A quarter of suicide inquiries in the UK showed the person died within 3 months of discharge from in-patient care.  In England and Wales 40% died before the first review appointment.  This was 35% in Scotland and 66% in Northern Ireland.  (Safety First 2001)

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

## 6.2   Self Harm

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

- Self harm involves differing degrees of risk to life and suicidal intent, and it is often considered to be a coping mechanism or means of helping someone deal with their life.  (Protect Life 2006)

- The UK has one of the highest rates of self harm in Europe, at 400 per 100,000 population.  (Horrocks J, 2002)

- There is a high correlation between self harming behaviour and mental health problems.  Most people attending accident and emergency after self harming would meet the criteria for one or more psychiatric diagnosis.  More than 2/3rd would meet the criteria for depression.  (The British Psychological Society 2004)

- People with current mental health problems are 20 times more likely than others to report having harmed themselves in the past.  (The British Psychological Society 2004)

- People who have self harmed are at significant risk of suicide.  (Owens D, Horrocks J 2002) (Hawton K, et al 2003)

- Self harming and suicide may be influenced by the depiction of similar behaviour in the media or taking place in peer groups. Major public events may lead to amplification of existing distress such as in the month following the death of Diana, Princess of Wales when the number of women dying by suicide increased by a third.  (Hawton K, et al 2003)

- The young life and times survey reported that 15% of respondents had seriously thought about self harm.  10% had self injured – 5% once and 5% more than once. Females (13%) were much more likely to have self-injured than males (5%).  Respondents from less well off backgrounds were twice as likely to have self injured as those from better off backgrounds (16% and 8% respectively).  The main reason for self harm given by those who had injured themselves was that they wanted to punish themselves.  Those who self injured had more negative coping mechanism for emotional health problems than those who had not.  The attitudes to self injury collected from the young life and times survey respondents show that the majority of young people recognise that young people who self harm suffer from serious emotional health problems and do not self harm for attention seeking.  64% of respondents agree that self injury can be prevented.  (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the young life and times survey)

## 7.    Severe Mental Health Illness (SMI)

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

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

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

## 7.1 Psychosis

- About 1 in every 200 adults experience a 'probable psychotic disorder' in the course of a year.  (Singleton N, Bumpstead R 2001)

- Less than a quarter of people who have a distressing psychotic experience at some time in their lives remain permanently affected by them.  (The British Psychological Society Division of Mental Health June 2000)

- The average age of onset of psychotic symptoms is 22 but it can be much younger than that.  (Mental Health Implementation Guide 2001)

- According to the 2001 Census there are 7,159,694 16 to 25 year olds in the UK.  This amounts to 12% of the UK population.  About 0.2% of these have a probable psychotic disorder and 0.9% of 16-19 year olds and 1.9% of 20-24 year olds suffer from obsessive compulsive disorder. (Singleton N et al (2001).

- 4.4% of people in the general population say they have experienced at least one symptom of psychosis such as delusions or hallucinations.  Risk factors include smoking, excessive drug and alcohol use, little social support, adverse life events and neurosis.  (Wiles N J, Zammit S, et al 2006)

## 7.2  Bi Polar Disorder

- Between 0.9% and 2.1% of the adult population experience a bi-polar disorder at some point in their lives and there is very little difference in relation to gender.  (National Institute for Health and Clinical Excellence, NICE 2004)

- Symptoms usually begin between ages 15 and 24.  (National Institute for Health and Clinical Excellence, NICE 2004)

- The onset of mania is earlier in men than in women, although women have a higher incidence throughout the rest of adult life. However the first episode may occur at any age from childhood to old age.  (Kennedy N, et al Feb 2005)

### 7.3  Schizophrenia

• Schizophrenia is the most common form of psychotic disorder affecting between 1.1% and 2.4% of people at any one time.  (National Collaborating Centre for Mental Health p31, (2002)

• The most frequent age of onset for schizophrenia is between 20 and 30 years however the symptoms may have been there much earlier.  (The British Psychological Society 2004)

• On average men have an earlier age of onset than women by about 5 years.  (Kennedy N, et al 2005)

• After a first episode approximately 25% of people with schizophrenia make a full recovery and experience no further episodes.  Between 10 and 15% will experience severe long term difficulties and the remainder will experience recurrent acute episodes with periods of remission or with only residual symptoms in between.  (Wing J, Marshall P, 1994)

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

### 8.1    Gender Differences

• Women are more likely to be treated for a mental health problem than men.  (29% compared to 17%)  (National Statistics 2003)

• More than half the contacts with the Samaritans are made by men – 53% compared with 43% by women.  (4% were unidentified)

• Depression is more common in women than men.  1 in 4 women will require treatment for depression at some time compared to 1 in 10 men.  (National Institute for Health and Clinical Excellence Depression 2003)

• Doctors are more likely to treat depression in women than in men even when they present with identical symptoms.  (World Health Organisation Fact Sheet No 248 (2000)

- Women are twice as likely to experience anxiety as men. (Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H, 2001)

- Young men aged 15-34 years are more likely than young women to take their own life (NISRA 2009).

- Survey of young people between the ages of 5 and 15 found that the proportion of children and adolescents with any mental disorder is greater among boys than girls (Mental Health Foundation 1999)

## 8.2  Ethnic Groups

- In general rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population; but they are less likely to have their mental health problems detected by General Practitioners.  (National Institute for Mental Health, Inside Outside 2003)

- Depression in Ethnic Groups has been found to be up to 60% higher than in the white population.  (National Health Service Mental Health 1999)

- Young Asian women are three times as likely to take their own lives as young white women.

- A higher prevalence of diagnosed mental illness particularly schizophrenia has been found among Black Caribbean people in the UK.  (Mind 2004)

- Black people are twice as likely as white people to be diagnosed as having a psychotic disorder.  (Spranston K, Nazroo J, 2002)

- A substantial body of research indicates that, for people from Black and Asian ethnic minorities, access to, utilisation of and treatments prescribed by mental health services differ from those for White people (Lloyd & Moodley, 1992);

- These examples infer that we must consider the cultural competence of our services: i.e. does our workforce reflect the cultural diversity in our populations, are our staff trained

and supported to recognize and respond to the different cultural representations and presentations of mental illness and distress and are our organizations sufficiently culturally competent to support staff in providing services which are sensitive and appropriate to our populations

## 8.3 Children and Young People

• Estimates for children and young people with mental health problems vary but research suggests that 20% of children have a mental problem in any given year, and about 10% at any one time in the UK. (Mental Health Foundation Lifetime Impacts 2005)

• The British Medical Association estimates that at any point in time up to 45,000 young people in UK under the age of 16 are experiencing a severe mental health disorder and approximately 1.1 million children under the age of 18 would benefit from specialist mental health services. (British Medical Association 2006)

• The attitudes towards mental health differed significantly between those who have experienced serious emotional and mental health problems and those who hadn't. Groups of Young Life and Times survey respondents who hadn't experienced serious emotional and mental health problems reported overall significantly more positive views than the young people affected by mental health issues. Females held more negative views than males and same sex attracted respondents held more negative views than those who were only sexually attracted to people of the opposite sex. (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

• In Northern Ireland it is estimated that 10-12% of children and teenagers have mental health problems severe enough to need help to overcome them (Young Minds).

• In 2008, in Northern Ireland, 29% of young life and times respondents were potential sufferers of a psychiatric disorder measured by General Health Questionnaire (G4Q12) (Schubotz, 2010, The Mental and Emotional Health of 16

year olds in Northern Ireland – Evidence from the Young Life and Times survey)

- Research has shown that young people in substitute care have higher levels of mental health difficulties than children in the general population (Philips 1997, McCann J B, James A & Wilsons 1996).

- Almost half of children in care have a mental health problem. Children in care are 4-5 times more likely to have a mental health problem as other children.  (Every Child Matters 2003).

- Children of single parent families are twice as likely to have a mental health problem as children of two parent families. Also at higher risk are children in large families, children of poor and poorly educated parents and those living in social sector housing.  (Mental Health Foundation Lifetime Impacts 2005)

- Children in poor households are three times as likely to have mental health problems as children in well off households. (National Health Service Frameworks 1999)

- 41% of British 11-15 year olds who smoke regularly have a mental disorder, as well as 24% of those who drink alcohol at least once a week and 49% of those who use cannabis at least once a month.  (National Statistics 2004)

- A high proportion of 16 year olds in Northern Ireland experienced social pressures to engage in health-adverse behaviours.  76% felt pressurised to drink alcohol, 39% felt pressurised to smoke, 32% felt pressure to lose weight, 22% experienced the pressure to have sexual intercourse and 15% felt pressurised to take illegal drugs.  Apart from the pressure to take illegal drugs, females felt more pressure to engage in another activity.  The pressure among females to lose weight was almost five times higher than among males (46% and 10% respectively).  Social pressures were also much more experienced by same-sex attracted and not well off respondents (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

- Behavioural problems have been found to be higher among homeless children living in temporary accommodation. (Shelter 2006)

- Over one third of all UK adults with mental health problems are parents. Most parents with mental health problems parent their children effectively.

- Two million children are estimated to live in households where at least one parent has a mental health problem but less than one quarter of these adults is in work.

- Children's resilience is enhanced by a secure and reliable family base in which relationships promote self-esteem, self-efficacy and a sense of control.

- A parent's resilience is enhanced by family (particularly children's) understanding, satisfying employment, good physical health and professional, community and personal support.

- Potential stressors leading to parental mental health problems include a lack of money; breakdowns in valued relationships, bereavement, loss of control at work and long working hours.

- For children, stress factors include loss through bereavement, marital breakdown or illness, acting as a carer, being bullied at school, homelessness and poverty. (Parrott L, et al 2008)

## 8.4   Older People

- Older people are less likely to have a neurotic disorder (or common mental health problem) other than depression than any other section of the British population. (Singleton N, Bumpstead R, et al 2001)

- Depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes. (Baldwin R, 2002)

- However it is likely that only a small proportion of older people with depression are in contact with their GP or Mental Health Services.(The Health Survey England 2000)

- An estimated 70% of new cases of depression in older people are related to poor physical health. (Social Exclusion Unit Report 2004), Dennis M, et al 2005)

## 8.5   Homeless People

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

- In 1996 McGilloway showed that 37% of the homeless in Northern Ireland had mental health problems rising to 41% among single residents in accommodation for homeless people, half of whom had moderate to severe levels of mental health impairment, as well as high levels of unmet need for most services. (McGilloway S, Donnelly M, 1996)

- The percentage of homeless people in the UK judged to be homeless and vulnerable to mental illness or disability rose from 3.25% in 1991 to 7.8% in 2006. (Hansard October 2006)

- Less than a third of homeless people with mental health problems receive treatment. (National Health Service Frameworks 1999)

- In Northern Ireland for the year 2006-07, 21,600 households presented as homeless, 7000 of whom have dependent children. Two thirds do not have dependent children and are mostly single, half of whom are aged 25 or over. (Northern Ireland Housing Executive 2007)

- 1 in 4 homeless people will take their own lives. (Social Exclusion Unit Report 2004)

- 30-50% of homeless rough sleepers experience mental health problems. About 70% misuse drugs. (Shelter 2006)

- Mental health problems are significantly higher among mothers and children who are homeless. (Shelter 2006)

## 8.6   The Prison Population

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

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

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


## 8.7   Other Groups

- People who provide a large amount of care to the family are twice as likely to have a mental problem as in the general population.  (Mental Health and Social Exclusion 2004, Quoting Singleton 2002)

- Female carers in England are 23% more likely to suffer from anxiety or depression than the general population.  (Office of National Statistics Mental Health of Carers 2002)

- Two thirds of refugees have experienced anxiety and depression which may be linked to war, imprisonment, torture or oppression in their home countries and/or social isolation, language difficulties and discrimination in their new country.  (Burnett A, Peel M, 2001).

- 30% of deaf people using British Sign Language have mental health problems primarily anxiety and depression.  (Mental Health and Social Exclusion Unit 2004)

- 25% - 40% of people with learning difficulties are estimated to have a mental health problem.  (Foundation for People with Learning Difficulties August 2006)

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

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

### 9.1 Mental Health and Material Deprivation

- Low income, unemployment, living in poor housing, low levels of education and being in social class (iv) (partly skilled people) and (v) (people with no skills) are all associated with a greater risk of experiencing a mental health problem.  (Meltzer H, Singleton N, et al 2002)

- A study of British adults completing the psychological wellbeing questionnaire (GHQ) showed that high scores (indicative of a psychiatric problem) increased as household income decreased.  (Department of Health Survey for England 2003)

- Financial difficulties can be a cause and a consequence of mental health problems.  People with mental health problems are three times as likely to be in debt as the general population and more than twice as likely to have problems managing money.  (Mental Health Exclusion Unit p88 2004)

- People without a degree are almost twice as likely to experience depression as those with a degree.  (Singleton N, Bumpstead R, et al 2001)

### 9.2 Family Related and Social Factors

- Social isolation is a factor in mental health problems.  Twenty percent of people with common mental health problems live alone compared to 16% of the overall population.  (Singleton N, Bumpstead R, et al 2001)

- A person with a severe mental health problem is four times more likely than average to have no close friends.  (Huxley P, Thornicroft G, 2003)

- One in four people who use Mental Health Services has no contact with their family and one in three has no contact with friends.  (National Health Service Frameworks p46 1999)

- Low levels of social support can reduce the likelihood of recovery.  (Singleton N, Lewis G, 2003)

- People with common mental health problems are twice as likely to be separated or divorced as their mentally healthy counterparts.  (Singleton N, Bumpstead R, et al 2001)

- Children of depressed parents have a 50% risk of developing depression themselves before the age of 20.  (World Health Organisation p29 2004)

- The Young Life and Times Survey NI noted that friends and parents were identified as the main sources of support if young people suffer from emotional or mental health problems.  Apart from friends, females were less likely than males to think that any other source was helpful for them when they were experiencing an emotional health problem.  The highest proportion of respondents (50%) preferred support from only one professional.  The least popular option was medication as a way to helping young people (20%).  Friends and parents were the most likely source of support by those who self injured.  The findings suggest that support from parents was much stronger after the episode of self harm than before, which indicates that parents may not be able to identify early signs of serious mental and emotional distress among their children (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

- Taking part in social activities, sport and exercise is associated with higher levels of life satisfaction.  (Donovan N, Halpem D 2002)

- Other social and economic risk factors for mental health problems include poor transport, neighbourhood disorganisation and racial discrimination.  Social and economic protective factors for mental health include: community empowerment and integration, provision of social services, tolerance and strong community networks.(World Health Organisation pp22-24 2004)

- Bullied children are known to be more likely to have anxiety, depression and thoughts of suicide, as well as to experience social isolation. (Arseneault L, et al)

- Over one third (37%) of 16 year old respondents in Northern Ireland had experienced school bullying. Experience of bullying among same sex attracted respondents is much more common with seven out of ten same sex attracted young men and over six out of ten (62%) same sex attracted young women reporting school bullying. Respondents from minority ethnic backgrounds had significant experiences of xenophobic name calling, bullying and harassment (Schubotz, 2010, The Mental and Emotional Health of 16 year olds in Northern Ireland – Evidence from the Young Life and Times survey)

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

## 9.3  Physical Health

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

- A person with schizophrenia will on average, live for 10 years less than someone without a mental health problem. (Health Body and Mind NIMHE 2004)

- Depression affects 27% of people with diabetes, 29% of people with hypertension, 31% of people who have had a stroke, 33% of cancer patients and 44% of people with HIV/AIDS. (Investing in Mental Health WHO 2003)

- People who experience persistent pain are four times as likely to have an anxiety or depressive episode as the general population. (New Understanding, New Hope WHO 2001)

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- 61% of people with schizophrenia presenting at GP surgeries and 46% of those with manic depression smoke, compared to 33% of the remaining population. (Equal Treatment, Disability Rights Commission 2006)

## 9.4  Spirituality

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

- Research literature has reported for many years that aspects of religious and spiritual involvement, is associated with good mental health and wellbeing. (Swinton J 2001, Mentality – Adulthood 2004)

- The Royal College of Psychiatrists state that people who use mental health service identify the benefits of good quality spiritual care as being:-improved self control, self esteem and confidence; speedier and easier recovery; and improved relationships. (Culliford L, Powell A 2006)

- Sixty per cent of people with severe mental health problems across a range of diagnosis reported that religion/spirituality had a 'great deal' of helpful impact on their illness through the feelings it fostered of being cared for and of not being alone. (Foskett J et al 2006)

## 9.5  Other Facts

- People who live in towns and cities are more likely to have a common mental health problem than those who live in the country. However among rural areas the most remote and deprived areas have the highest overall levels of any mental health problems and suicides. (Meltzer D 2002)

- Workplace stress can frequently contribute to mental health problems. Long hours, unrealistic workload or bad

management is seen as having caused or exacerbated the problem.  (Out at Work 2002)

- Mental Health is adversely affected by war, conflict, extreme poverty, displacement and natural disasters.  Worldwide it is estimated that between a third and a half of those affected by such events suffer from diagnosable mental distress, especially post traumatic stress disorder, depression and anxiety.  (World Health Report WHO p43 2001)

- The impact of 30 years of civil conflict on the Northern Ireland population has been assessed in several community based studies.  In a random sample of 1000 adults it was found that 16% of people were direct victims of the conflict and 30% indirect victims.  Perception of being a victim was consistently associated with poorer psychological wellbeing. (Cairns E, Mallet J et al 2003)

- Women who have been abused in childhood are four times more likely to develop major depression in adulthood. (World Health Report p10 WHO 2001)

- People who experienced childhood sexual abuse are almost three and a half times as likely to be treated for psychiatric disorders in adulthood as the general population.  They are five times as likely to have a diagnosis of personality disorder.  (Spotaro J et al 2004)

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

## 10  The Costs of Mental Health Problems

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

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

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

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

(Taken from 'Counting the Cost' NIAMH 2004)

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

In 2002/03 the Sainsbury Centre for Mental Health estimated that the cost of Mental Illness in England was over £77 billion, taking into account the cost of care, lost work and poor quality of life.  The high estimate takes into account the 'hidden' costs linked to 'quality of life' not normally calculated (Sainsbury Centre 2003).

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

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

• The Fundamental Facts – Mental Health Foundation (2007)

• Counting the Cost – Northern Ireland Association of Mental Health/Sainsbury Centre for Mental Health (2004)

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

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

Further detailed information can be found in "Building an Economic Case". NIAMH 2007
Specific mental health promotion initiatives are identified in the Mental Health Promotion Section of this document.

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

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

## Appendix 3 – Membership of the Reference Group

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

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

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

**Appendix 4 – Working Groups and Leaders**

**Child and Adolescent** - Moira Davren, Belfast HSC Trust
**Adults** - John Simpson**,** Southern HSC Trust
**Elderly** - Gerry Waldron, Northern Health and Social Service Board
**Mental Health and Deafness** – Joyce McKee, EHSSB
**Post Traumatic Stress Disorder** – Oscar Daly, South Eastern HSCT
**Suicide and Self Harm** – Jo Murphy and Philip McTaggart, PIPS
**Gender Dysphoria –** Richard Ingram, Belfast HSC Trust
**Anxiety and Mild to Moderate Depression –** Moira Davren, Belfast HSC Trust, John Simpson, Southern HSC Trust, Gerry Waldron, NHSSB
**Mental Health Needs of People with Acquired Brain Injury –** Marie Goss, Belfast HSC Trust
**Severe and Enduring Mental Illness –** Moira Davren, Belfast HSC Trust, John Simpson, Southern HSC Trust, Gerry Waldron, NHSSB
**Perinatal Psychiatry -** Janine Lynch, Belfast HSC Trust
**Eating Disorders –** Ken Yeow, Belfast HSC Trust and Jackie Nelson, Northern HSC Trust
**Forensic Psychiatry –** Hugo Kelly, Belfast HSC Trust
**Addictions and Dual Diagnosis –** Owen O'Neill, EHSSB and Kevin Morton, Southern HSC Trust

## Appendix 5 – Membership of Working Groups

## Generic Workshop

Oscar Daly (Lead), Consultant Psychiatrist, South Eastern HSC Trust
Kevin Morton, Service Manager, Southern HSC Trust,
Moira Davren (CAMHS Lead), Co-Director Nursing Education and Learning, Belfast Trust
Joyce McKee, Principal Social Worker, Adult Services, ESSHB
Gerry Waldron (Older Peoples Lead), Consultant in Public Health Medicine, NHSSB,
John Simpson (Adults Lead), Associate Medical Director/Consultant Psychiatrist, Southern HSC Trust
Bill Halliday, Chief Executive, Rethink
Anne McDonald, Newry & Mourne Mental Health Forum
Maria Callan, Newry & Mourne Mental Health Forum
Veronica Cleland, SE Trust
Brenda O'Donoghue, WHSCT
Paul Fee
Hugo Kelly, Belfast Trust
Michelle Teggart, SE Trust, Mental Health Services Older People, Ards Hospital
Mark Finnerty, Downshire Hospital SEHSCT
Katie Campbell, Belfast HSC Trust
Oscar Donnelly, Director of Mental Health, Northern HSC Trust
Artie O'Hara, Western HSC Trust
Elaine O'Doherty, Advocate for Health and Wellbeing Improvement (Investing for Health Manager) NHSS
Michael Lenaghan, Southern HSC Trust
Ian McMaster, Medical Officer, DHSS&PS
Roy McClelland, Mental Health Review, DHSS&PS
Siobhan Murphy, Community Mental Health Team (Older People) BHSCT
Barbara Burns
Jacqui Wilson, Child & Family Centre, Minnowburn House, Milltown
Moira Young
Tony McCusker, SE HSC Trust
Karen McAlister, VOYPIC
Tanya Kane, Specialist Registrar, Southern HSC Trust,
Ashling O'Hare
Molly Kane, Senior Nurse Advisor, NHSSB,

Rodney Morton, Belfast HSC Trust,
Dana Devlin, Northern HSC Trust,
Evelyn McGettigan, Mind Yourself / Foyle Advocates
Brendan Mullen, Director of Mental Health
Philip McGarry, Belfast HSC Trust
Bernie Smith, Project Worker, Newry & Mourne Mental Health
Forum
Francis McConnell, Southern HSC Trust
Seamus Logan, Assistant Director Social Services, NHSSB,
Stephen Guy, Senior Clinical Pharmacist, Mental Health, Belfast
HSC Trust
Anne Cunningham, CAUSE
Elizabeth Williamson, Trasna House
Deirdre McManus, Service User, Newry & Mourne Mental Health
Forum
John McGeown, Belfast HSCT
Angela Meyler, Carer Advocate, CAUSE
Lara Foley, SHSCT
Ruth Brown, Deputy Team Leader, Crisis Response Team, Antrim
Ian Sutherland, Assistant Director Mental Health Services,
Southern HSC Trust
Patricia Casey, Social Worker, Dementia Services, Cookstown
Amanda McFadden, Senior Nurse Advisor, Western HSC Trust
Bernard McAnaney, Assistant Director Mental Health, Western
HSC Trust
Tom O'Leary, General Practitioner, Newtownhamilton
Angela Corr, SHSCT
Kathleen Dobbin, SEHSCT

## GENDER DYSPHORIA WORKING GROUP

Richard Ingram (Lead), Consultant Psychiatrist, Belfast HSC Trust,
Angela Sayers, Cognitive Psychotherapist, Belfast HSC Trust,
Etain O'Kane, Development Officer, The Shout Project,
Mary Charlton, Cognitive Psychotherapist, Belfast HSC Trust

# MENTAL HEALTH AND DEAFNESS

Joyce McKee (Lead), Principal Social Worker, Adult Services, EHSSB,

Seamus Logan, Assistant Director, NHSSB

Noel Quigley, Service Planner for Older People and Physical and Sensory Disability, WHSSB

Margaret du Feu, Consultant Psychiatrist, Northern Ireland Mental Health and Deafness Service, Belfast HSC Trust

Martin Creed, Clinical Nurse Specialist, Northern Ireland Mental Health and Deafness Service, Belfast HSC Trust

Mrs Deborah Boyle, Clinical Nurse Specialist, Northern Ireland Mental Health and Deafness Service, Belfast HSC Trust

Carol Carton, Clinical Psychologist, Northern Ireland Mental Health and Deafness Service, Belfast HSC Trust,

Alan Sheeran, Northern Ireland Director, National Deaf Children's Society

Majella McAteer, DANI

Brian Syminton, Director, RNID BDA

Brian Fleming, Consultant Psychiatrist, SE HSC Trust,

Brian Nugent, Pre-reg Mental Health Practitioner, Southern HSC Trust

Pauline Walker, Dep Director UK Services, Family Progs, NDCS

Caroline Doherty, Healthy Minds Officer, NDCS

# POST TRAUMATIC STRESS DISORDER

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Dr Michael Paterson, Director, TMR Health Professionals,
David Bolton, Director, Northern Ireland Centre for Trauma & Transformation (NICTT)
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Sheena Funston, TAP Co-ordinator, WHSSB
Iris Matthews, TAP Co-ordinator, SHSSB
Sharon Campbell, TAP Co-ordinator, EHSSB
Paul Quinn, Senior Cognitive Psychotherapist, Belfast HSC Trust
Mr Alistair Black, Head of Psychologist Therapies, Police Rehabilitation and Retraining Trust (PRRT)
Sharon Lonergan, Deputy Manager, Women's Aid
Clare Quigley, Principal Social Worker, SHSSB
Geraldine Hamilton, Clinical Specialist, Occupational Therapist, Belfast HSC Trust
Bill Halliday, Chief Executive, Rethink

## SUICIDE AND SELF HARM

Jo Murphy (Lead), Co-ordinator, PIPS Project
Philip McTaggart, Chair, PIPS Project
Yvonne Herbert, Consultant Clinical Psychologist, Belfast HSC Trust
Anne-Marie Logue, Coronary Care Unit, Southern HSC Trust,
Madeline Heaney, Commissioner for Health Promotion, NHSSB,
Melanie McClements, Assistant Director of Promoting Wellbeing, Southern HSC Trust,
Kiera Duddy, VOYPIC REP, Mental Health Solicitor, Children's Law Centre
Brenda Devine, Programme Manager, Clinical and Social Care Governance Support Team, DHSS&PS,
Elaine Roub – VOYPIC REP, Regional Co-ordinator of Children's and Young People's Services, Cruse Bereavement Care (NI)
Martin Creed, Clinical Nurse Specialist, NI Mental Health and Deafness Service, Belfast HSC Trust,
Chris Totten, Investing for Health Manager, EHSSB
Damien Carbery, Senior Practitioner, Southern HSC Trust

# ANXIETY AND MILD TO MODERATE DEPRESSION

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John Simpson (Adults Lead), Associate Medical Director/Consultant Psychiatrist, Southern HSC Trust
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## Appendix 6 – Bamford Mental Health and Learning Disability Review Values and Principles

**Values**

- Valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self determination

- Respect them as individuals – through openness in providing of information, respect and courtesy in individual interactions with service users, true partnership and empowerment in service planning and provision – with government, providers and the wider society each accepting their respective responsibilities

- Addressing the challenges facing people with mental health needs

- Demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent and demonstrate equity

- A process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with mental health problems, to their carers and families

**Principles**

- Partnership with users and carers in the planning, development, education and monitoring of services

- Partnership with users in the individual assessment process and all therapeutic interventions of care and support

- Delivery of high quality effective therapeutic interventions, care and support

- Equality of access and provision of services including the needs of people from minority cultures, people with disabilities, people subject to the criminal justice system

- Provision of services which are readily accessible

- Delivery of continuity of care and support for as long as needed

- Taking into account the needs and views of carer, where appropriate, in relation to assessment, therapeutic interventions, care and support

- Provision of comprehensive and equitable professional and peer advocacy where required or requested

- Promotion of independence, self esteem, social interaction and social inclusion through choice of services, facilitation of self management opportunities for employment and social activities

- Promotion of safety for service users, carers, providers and members of the public

- Provision of the necessary education, training and support for staff and provision of services subject to quality control informed by evidence based practice.

These values and principles are integral to the Mental Health and Wellbeing Standards Framework.
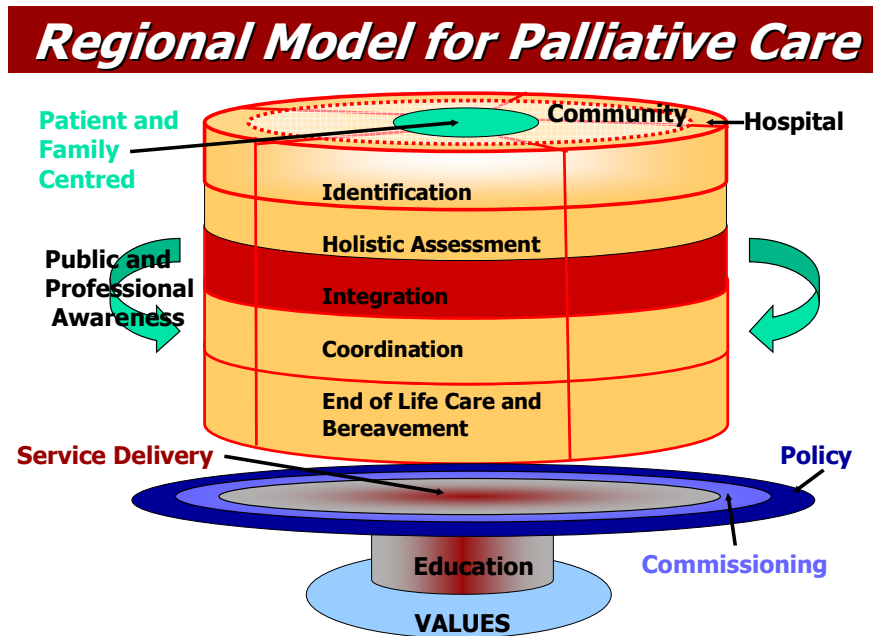
# Appendix 7 - The Family Model

**The Family Model**
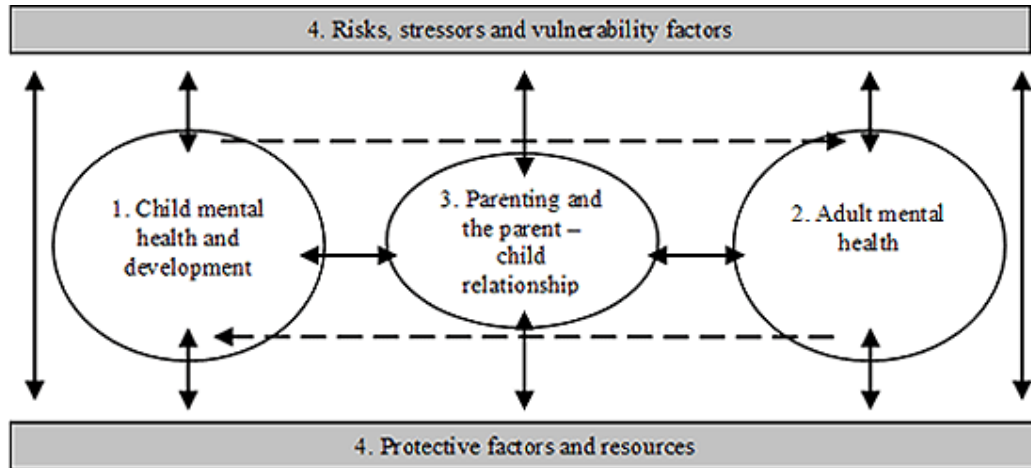


Ref: Think child, think parent, think family: a guide to parental mental health and child welfare, p16.

# Appendix 8 - Regional Model For Palliative Care



## Regional Model for Palliative Care

The model is underpinned by the core values of equity, respect, empowerment and choice. These principles, embedded within robust education, support the quality of service delivery and influence policy and commissioning.
The model recognises that quality of palliative care is shaped by professionals having a competent knowledge base and the ability to ensure effective and empathic face to face communication.

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

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

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

## Appendix 9 – Glossary

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

**Assistive technology**
Equipment that helps people with a disability to be more independent

**Capacity (mental)**
Being able to understand and use information to make a decision

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

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

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

**Community based services**
Services that are delivered in the community, not in a hospital

**Cross-sectoral**
Links between organisations managed by Government and voluntary and community organisations and private businesses

**Domiciliary support/care**
Support or care provided to a person in their own home

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

**Evidence-based Practice**
Doing things that have been shown to work

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

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

**Inter-agency**
Links between different organisations

**Inter- Departmental**
Links between different Government Departments

**Legislation**
The law

**Legislative**
To do with the law

**Mainstream services**
Services that anyone can use

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

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

**Multi-agency**
Staff from different organisations, for example, health and social care, education and employment, working together

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

**NI Executive**
The Ministers and Departments in NI that form the local Government

**Partnership working**
Different organisations working together to achieve something

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

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

**Post-primary school**
School for children and young people above age 11

**Prevalence**
How many people in the population have a particular problem

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

**Primary school**
School for children up to about age 11

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

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

**Public sector**
Organisations that are managed by Government

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

**Review of Public Administration (RPA)**
A review of the organisations that Government uses to deliver services to people across NI.

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

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

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

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

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

**Statutory sector**
Organisations that are managed by Government

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

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

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

## Appendix 10 – Abbreviations

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

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

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## Appendix 12 – NICE Guidelines

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

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