Northern Ireland
Assembly

JOINT COMMITTEE FOR EDUCATION AND HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

‘A Flourishing Society’

21 October 2009

NORTHERN IRELAND ASSEMBLY

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JOINT COMMITTEE FOR EDUCATION AND HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mr Mervyn Storey (Deputy Chairperson)
Mr Dominic Bradley
Mrs Mary Bradley
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mr Trevor Lunn
Mr John McCallister
Mr Basil McCrea
Mrs Claire McGill
Miss Michelle McIlveen
Mr John O'Dowd
Mrs Michelle O'Neill
Mr Alistair Ross

Witnesses:
Dr Gerry Leavey) Northern Ireland Association for Mental Health
Mr Graham Logan)

The Chairperson (Mr Wells):

We now move on to the presentation from the Northern Ireland Association for Mental Health (NIAMH). Members will find in their information packs briefing papers from the association, a copy of the report and correspondence on the issue of mental health that was sent by the

Department of Education to the Committee for Education. Those papers should be read in conjunction with the evidence session.

As this is a Joint Committee, we must be careful with the meeting's protocol. After the witnesses' presentation, I intend to ask some questions, and I will then hand over to the Chairperson of the Committee for Education, the Deputy Chairperson of the Committee for Health, Social Services and Public Safety, and the Deputy Chairperson of the Education Committee in that order. I will then open the floor to allow members of both Committees to ask questions.

I welcome Mr Graham Logan, the policy development manager in NIAMH and Dr Gerry Leavey, the research director of that association. I invite the witnesses to make a presentation to the Committee, and I will allow members to ask questions. I hope to have the session completed by 2.00 pm, and I will try and control the flow of questions and answers to keep to that time frame.

Dr Gerry Leavey (Northern Ireland Association for Mental Health):
I must apologise for the absence of Professor Ferguson, the chief executive of NIAMH. He intended to be here today, but he is unavailable. I thank the Chairpersons of both Committees for inviting us here today to present our report, 'A Flourishing Society: Aspirations for Emotional Health and Wellbeing in Northern Ireland'.

Over the next 10 minutes, I intend to give the Committee an overview of the remit of the report and the process that has been undertaken to complete it, and I will highlight some of its key findings.

The report's remit was to consider the progress that had been made against three strategies: the Bamford review of Mental Health and Learning Disability (Northern Ireland); the 'Promoting Mental Health: Strategy and Action Plan 2003-2008'; and the 'Protect Life: A Shared Vision — The Northern Ireland Suicide Prevention Strategy & Action Plan 2006-2011.' Specifically, the review's purpose was to consider the progress made against, gaps in and successes of the promoting mental health strategy. However, it also sought to examine new opportunities for promoting resilience in individuals and communities in Northern Ireland; to formulate alternative metrics for the measurement of well-being; and to provide advice and strategic guidance to the

Department of Health, Social Services and Public Safety to assist it its development of a new strategy for mental health and emotional well-being.

To achieve that, we initially established a strategic development group in NIAMH, which brought together people from various constituency groups from health, education, business and other relevant sectors. We also established an independent expert group, which comprised Professor Phil Hanlon from Glasgow University, Professor Margaret Barry from The National University of Ireland in Galway and Professor Paul Fleming from the University of Ulster. Also in that group was Gregor Henderson, who has a long record of involvement in well-being in other jurisdictions. Indeed, he led the Scottish well-being strategy, which has become internationally recognised.

In addition to the establishment of those groups, NIAMH also consulted with a wider reference group, which included representatives from various groups such as: The Public Initiative for the Prevention of Suicide and Self-harm (PIPS) project; Cruse Bereavement Care; the Samaritans; school teachers; members of the Pupil Emotional Health and Wellbeing group (PEHAW); the Prison Service; Age Concern; the Health Promotion Agency; the Civil Service; and health boards and trusts. In fact, it involved a wide range of people.

Altogether, we held around 60 face-to-face interviews and another 75 interviews via e-mail. We also contacted people through the local press and invited them to participate in, and comment on, the development of the strategy. Therefore, in the time frame that we had, we met considerably more people than was required by the original brief.

Additionally, we undertook a literature review that comprised all the evidence that has been gathered during the past 25 years in English-speaking countries, such as America, the UK, Australia and New Zealand, and in other European countries. We also examined the best evidence on interventions for mental health and well-being. Where we could, we looked at it from a health-economics perspective. Therefore, we were looking for not only anecdotal evidence, but good solid evidence on what works and is efficient.

Throughout the review, we applied a number of cross-cutting considerations. We had to take a health-and-social-inequalities perspective on it. Although it was a mental-health-promotion exercise that looked at population, we also realised that there are individuals and communities in

society who face harsh determinants of mental health and well-being. Those people would be specifically targeted.

We needed to consider the strategy in the light of the harsh economic climate. Therefore, it was not a consideration of bringing in additional funding: we had to look at it in the context of the credit crunch and try to enhance our existing resources.

We felt that there was a need for transparency with regard to mental health and well-being and the strategies and the outcomes that they achieved. We were also clear that community groups were essential to any mental-health promotion strategy and that the promotion and development of a well-being strategy had to be seen in the context of everyone's responsibilities: it needed cross-departmental consideration and collective responsibility between government, individuals and communities.

One key finding was that all the strategies were, in fact, good in their own right. Specifically, Protect Life was a robust and exemplary well-being strategy in itself. It has everyone's respect and admiration. At the time, agencies still awaited the Department's response to the Bamford review, and that was published on 8 October 2009. From the review and consultation group, we found considerable overlap between the two strategies. Therefore, although one looked at suicide prevention, there was a great deal of mental-health promotion in it. In fact, the two strategies ran in parallel, with separate commissioning streams.

Many people and groups were concerned that the suicide agenda had somewhat overshadowed the mental-health promotion agenda. We also found that although there were many innovative strategies and activities at regional level, there was little evidence to suggest what those particular activities did, how far they extended, or what good they had achieved. There was no database that we could examine to see their achievements.

We found considerable support throughout all agencies for work in schools and parenting and early-years interventions.

We make three key recommendations. There are others, which we can also talk about during the time that we have been allocated. First, we recommend that consideration be given to merging the Protect Life and the promoting mental health strategies. Secondly, the best evidence

suggests that in order to get a high yield for investment in mental health and well-being, money must be put into early-years interventions and parenting strategies, and also into supporting schools to promote resilience and well-being.

We also felt it important to push further towards establishing extended schools in the community, so that the extended schools would be seen as hubs of the community and would, therefore, use existing resources. Another important aspect was the improvement of teachers' recognition of mental-health problems in the class. The PEHAW group is currently engaged in a lot of that work.

Thirdly, there is an urgent need to examine research and evaluation. We examined an enormous range of activities but could find very little evidence about what works and what is good. We recommended the setting up of a database to collect that data to ensure that, when community groups come to commissioning strategies, they have very clear aims, objectives and determined outcomes listed, and that the information is collected on a central database.

Ultimately, those are the recommendations that we have made, but the Northern Ireland Association for Mental Health is a voluntary sector organisation; it is entirely up to the Department of Health, Social Services and Public Safety to push those recommendations through. Graham will speak about their implementation.

Mr Graham Logan (Northern Ireland Association for Mental Health):
Members have a copy of the report and its synopsis. We concluded the report with the issue of strategy implementation. We could have the best strategy in the world, but if the right mechanisms for its implementation are not in place, it will be lost.

The Health, Social Services and Public Safety Committee's 'Report on the Inquiry into the Prevention of Suicide and Self Harm' questioned whether the structures already in place lend themselves to fully implementing the various strategies. The issue of implementation raises a number of questions that we will leave with the Committee, as one of the wheels of government, to work through.

We were very encouraged that, last week, the Minister of Health, Social Services and Public Safety, in his footnote to the Northern Ireland Executive's response to the Bamford review, said

that the Executive are committed to mental-health promotion and building mental-health resilience in the population. The action plan indicates that the new strategy will be with us by December 2009.

The first issue around how the strategy will be implemented was emphasised by Professor Margaret Barry from Galway at her expert symposium: is there a proper framework within government for interdepartmental co-operation? There is a joint ministerial group on suicide prevention, but what is the buy-in for other Departments? Mental-health promotion needs to be a factor across all Departments; there needs to be a cross-sectoral approach. It needs to include non-health sectors as well. We need to know whether the framework is there and whether the necessary structures for implementation exist.

As Gerry mentioned, as the new strategy is rolled out, there must be constant monitoring. Your roles, as Committees, will be to scrutinise it to see whether it is working. Is the monitoring process up to the task? Another issue is that of review and constant evaluation to ask what is being done in the communities; is it working; and what are the outcomes of what is being implemented.

Policy coherence is a big issue. The Ottawa Charter for Health Promotion from the World Health Organization specifies the need for top-down and bottom-up working. The top-down element would be the Government policies, with policy coherence throughout all Government Departments in mental-health promotion. There also has to be a bottom-up approach, with communities very much involved in promoting mental well-being. The two need to go together.

As individuals, we can take steps to improve our mental well-being — we can take exercise, talk to family and show kindness to others. However, government has an awesome responsibility to look after the process of implementation and deal with the structural and social determinants of mental well-being and resilience in our community.

How does mental-health promotion sit with the public service agreements? The Protect Life strategy has taught us a lot about implementation, and the suicide strategy implementation board, on which I sit, does an excellent job in overseeing developments. The position of mental-health promotion in public service agreements must be considered, as must issues of accountability throughout government.

The Chairperson:

I will open with a couple of questions. As you know, the Minister and the Chief Medical Officer, Dr McBride, welcomed your report. Are you content that they are taking adequate steps to implement it?

Dr Leavey:

I understand that they have commissioned a writing group. I have been assured that most, if not all, of our recommendations will be taken on board. However, those recommendations could not be costed in the available time frame. That must be an important part of understanding implementation. To date, feedback has been very positive.

The Chairperson:

As you know, legislation is imminent and will, hopefully, be introduced within the next few months. That has been announced; however, one can never depend on such announcements. The Minister will introduce the legislation in two stages; are you happy with that arrangement?

Dr Leavey:

Yes.

The Chairperson:

Are you happy enough with the arrangement that immediate provisions must be implemented for European legislation and that, further down the line, the bulkier document, which is the full legislation, will be implemented?

Dr Leavey:

That is absolutely fine. In fact, much of the document links into European legislation. Many of the policy documents that we have covered in our literature review related to European policy.

Mr Storey:

You are very welcome this afternoon. I am not sure whether you have seen a copy of the Department of Education's correspondence, which the Committee for Education received on 28 July. To all intents and purposes, that document was a way to acknowledge that 'A flourishing Society' was a good piece of work but to show the areas in which the Department was already

working. A document that is currently being produced by the Department puts a lot of stock on a pupils' emotional health and well-being programme. When you brought together all the elements of your report, did the Department, at any stage, brief you as to how that programme would help to deal with the issues that your report aims to address?

During the Committee for Education's discussions on the Education Bill, members unanimously agreed that schools should have a role to protect children's mental well-being and that the word "mental" should be included therein. However, the Department's response raised a concern. That indicates that although the Department says that it aspires to collaboration, that seems to be, unfortunately, only an aspiration. In many cases — not in all cases — it does not work in practice.

Dr Leavey:

We are aware of PEHAW. In fact, I chair one of the PEHAW work streams. The problem is that PEHAW has progressed considerably more slowly than we had hoped. The two groups are doing much good work, and I suspect that a little bit of bureaucracy is getting in the way. Business plans were submitted last Christmas, but working them out is taking time. Given that we had to wait, there was no time to integrate them with our report. We put our report together at a time when the Department of Education's PEHAW programme had not yet arrived at any conclusions. That was part of the difficulty.

Mr Storey's second point was about terminology?

Mr Storey:

Yes. In the Committee's discussion of the Education Bill, which will establish the functions of the education and skills authority (ESA), it was proposed that ESA's responsibilities would include not just spiritual and emotional well-being, but mental health. The Department's view is that the inclusion of any additional duty relating to mental health ought to be carefully thought through in order to avoid an overlap with the duties and functions of the Department of Health, Social Services and Public Safety.

Dr Leavey:

That is true; it is a useful point. The problem with using the word "mental" is that it turns people away because it has an instant stigma attached to it. Therefore, when we think about well-being

in schools, it is about the promotion of well-being and not necessarily about dealing with mental-health issues. The problem is that mental-health issues in schools do not go away just because we do not like the word. They are there, and, if teachers do not deal with them, they become an educational problem, not just a mental-health issue, and must be dealt with. We often have to fudge our way around that. Having done some related research on the subject in England, it is clear to me that teachers find it difficult to grapple with the recognition and management of mental-health problems in schools. It is important that that issue is dealt with in the training curriculum for teachers.

Mr Storey:

The PEHAW programme came into being as a result of a number of high-profile pupil suicides in 2006. What relationship was there between the exercise that was conducted by the Department of Education and the suicide strategy that was established by the Department of Health, Social Services and Public Safety? Has there been any overlap between those initiatives, given the serious nature of the problem that we are trying to address? It is regrettable that the PEHAW programme came into existence in 2006 because of such a sad situation, but we are almost into 2010, and we are still talking about business cases.

Dr Leavey:

It is hard for me to address that completely, because I was not here in 2006; I was working in London. Having said that, the Protect Life suicide prevention strategy and much of the work that is being done in the health action zones emphasise the importance of putting a lot of effort into schools and education centres in recognition of the need for resilience and early intervention when things have gone too far.

Mr Logan:

Everyone in the policy environment across the UK and the Republic of Ireland is saying the same thing: we must invest in early years. I read a Save the Children report last night entitled 'A Child's Portion', which shows that expenditure on children and child poverty in Northern Ireland is pretty dire compared with that in the rest of the UK. I wrote the figures down: £230 is spent on each preschool child under the age of five in Northern Ireland, compared with £1,300 in England and Wales and £1,000 in Scotland; spending on Sure Start in 2007-08 stood at £80 a child in Northern Ireland, compared with £600 a child in England.

The Committee for Health, Social Services and Public Safety got things absolutely right, if I may say so, in its 'Report on the Inquiry into the Prevention of Suicide and Self Harm'. Recommendation 9 of the report welcomed the Minister of Education's investment in counselling in post-primary education. The Minister of Education invested £2·8 million in such counselling, and that is great. However, the Committee also called on the Minister to extend that service to primary schools as well. The Committee said:

"we believe that developing coping skills and building young peoples self esteem should begin at an early age and we call on this programme to be extended to all schools."

We can debate the semantics of words and phrases such as "mental" and "well-being". The important thing is that we have some kind of comprehensive competence-enhancement approach by which we can build young people's well-being at an early age.

The Chief Medical Officer talked about the upstream focus in his annual report. Aaron Antonovsky talked about the salutogenic approach to well-being. Governments across Europe have been focusing on the pathogenic approach, where it is about —

The Chairperson:

I do not understand the first phrase that you used. Will you explain it?

Mr Logan:

It is simply about dealing with health rather than illness. The pathogenic approach is where we wait until people break down before we try to fix them — to use the terminology of the man in the street. The salutogenic approach builds well-being: it focuses on keeping people well and on building resilience and coping strategies. It incorporates emotional well-being, psychological well-being and social well-being, and it starts, as the Chairperson of the Education Committee said, early on.

Mrs O'Neill:

I welcome the report's recommendations. I commend your good work in involving the stakeholders. It is all well and good to have high-level policies, but it is the way in which those policies are implemented in practice that counts. The report mentioned concerns about cross-departmental working when the time comes to deliver the strategy. We must all be mindful of that, and we all need to address those challenges.

You mentioned an overarching, single coherent well-being strategy, and the Investing for Health strategy builds into that because it promotes a preventative, as opposed to a curative, approach to health promotion and prevention. Those two cannot be divorced; they must be looked at side by side.

Two aspects of the report that stood out involve research and measurement. The report refers to the current measures for mental illness as useful but not sufficient. Could a pilot scheme be run to see how information could be gathered and how it would feed into the overarching strategy? You said that there was a significant evidence gap, and I know that part of your inquiry looked at the issues from an international perspective. Are there examples of good practice that we could draw on? Could the universities have a role in running such a programme?

Dr Leavey:

If one looks at the Bamford review, which was the foundation for all those strategies around mental health, and the evidence and references at the back of its report, one will see that there is very little home-grown research in Northern Ireland. We import the information from elsewhere. Some of it may be appropriate and relevant, but one can never be absolutely sure. However, we must take into account the fact that Northern Ireland is quite a different place in some ways: socio-demographically it is different; it is different in its rurality; and it must be different if we take into account its 30 to 40 years of civil violence and the impact that that has had on the population and the legacy of problems that that provokes in the younger generations. That is one issue.

With regard to the metrics and the way in which we measure things, if you want to move away from looking at illness, then you have to start looking at wellness. The general health questionnaire (GHQ), which is the measure currently used and which looks at common mental disorders, is a crude measure. It gives an indication of illness. We have suggested that there are measures of well-being that could be used in a population-based approach, and one would be the Warwick-Edinburgh Mental Well-being Scale. Again, however, that is being developed in other jurisdictions. As you said, we might need to run a pilot to see whether it would be appropriate to Northern Ireland, and then roll it out from there.

We looked at another important aspect. There are around 5,000 community and voluntary sector groups in Northern Ireland, and they may all be doing exceedingly good work. However,

we do not know that, because we do not have any evidence that shows what they are doing. Some of them are not funded and do not have the capacity to undertake research and evaluation, and we think that there is a role for the universities or other sector organisations to go in and help to provide evaluation and support around research and to bring people up to scratch.

Lastly, we need to have a database to collect all that information so that we can see where there is duplication. Indeed, eradicating duplication would be as useful as anything else, so that we do not waste money on it.

Mr Logan:

Gerry referred to the Warwick-Edinburgh Mental Well-being Scale, and work was done in Scotland, which, as the Committee may be aware, was published in the report, 'Towards a Mentally Flourishing Scotland: The Future of Mental Health Improvement in Scotland 2008-11'. The researchers found that 14% of the population had flourishing mental health, almost 73% of people had moderate mental health, and 14% did not have a mental illness but had languishing, not flourishing, mental health. The issue is that 72% of people with moderate mental health are twice as likely to develop a mental illness. Therefore, one thing that we could do in this part of the world is measure well-being and how well we are, and establish a baseline. Then, with the interventions and the mental-health promotion strategy, we can see how our flourishing society is developing. However, I agree that a pilot scheme or something should be carried out in community groups.

Mr D Bradley:

I welcome the witnesses and thank them for their report. I want to return to a point that was raised by the Chairperson of the Committee for Education, Mr Storey. During the Committee Stage of the Education Bill, we considered clauses that had relevance to the development of young people. Clause 2 of the Bill places a duty on the new Education and Skills Authority:

"to contribute towards the spiritual, moral, cultural, social, intellectual and physical development of children and young persons".

As Mervyn Storey said, the Committee proposed that the word "mental" be included in that clause so that there would be a duty on the ESA to contribute towards the mental development of children and young people. During discussions, departmental officials argued that "intellectual" covered "mental", whereas some Committee members argued that "mental" was a more holistic

term, which included the development of good emotional intelligence, which led to good mental health, which, in turn, facilitated intellectual development. Does the inclusion of the words "mental development" in the duties placed on the new education and skills authority lend weight to your recommendation that schools should adopt a whole-school approach to the fostering of mental health rather than take a single-issue approach?

Dr Leavey:

It is hard to say, because it is hard to say how people will react to the inclusion of the word "mental" in the Bill and whether they back away from it. In some sense, "well-being" encapsulates the mental and intellectual development of children, and all those other facets of humanity, including the spiritual. In that sense, I would prefer "emotional well-being" so that it does not alienate people, but you have to bring people along.

Mr D Bradley:

Surely, if a duty is placed on the ESA, and thereby on schools, to foster the mental development of young people and children, the onus will be on schools to acquaint themselves with what is meant by "mental health", which would, obviously, include the terminology that you mentioned.

Dr Leavey:

Yes, I see what you mean.

Mr D Bradley:

In reaction to that amendment, Department of Education officials said that it would not be appropriate to place overlapping duties on the two Departments. Would you agree that, although it might not be desirable to have overlapping duties placed on Departments, surely there should be interlinkage between Departments, particularly on that issue?

Dr Leavey:

I would be very happy if there were interlinkage. It would be interesting to see how that would be managed.

Mr Logan:

The mental-health trajectory of children is set very early on. Key domains for promoting their mental well-being are preschool and primary school. The Foresight report on 'Mental Capital

and Wellbeing' in England — a massive piece of work that was done for the Cabinet Office — refers to "mental capital" and emotional well-being. I do not know whether that helps or not, but I think that it is an interesting phrase.

Mr McCallister:

A strategy such as this takes mental health to a new level. It goes beyond fire-fighting to actually promoting flourishing mental health. I welcome the report; it is excellent to see that something is being done in that area. I entirely agree with your comments in reply to Mr Dominic Bradley about the investment in early years. Will you elaborate a bit more on the report that showed that we are so far behind in our spend? I noted some of the figures: £230 is spent on each child in Northern Ireland, as opposed to £1,300 in England and Wales. That is a massive difference — five or six times the amount. I would like to see us doing much more. There are so many failings in the education system and in mental-health services that we need much more early intervention. Can you speak a bit more about that report and where it came from?

Mr Logan:

Do you mean the report that I mentioned earlier?

Mr McCallister:

Yes.

Mr Logan:

I read it very briefly last night. Save the Children provided figures for Northern Ireland in comparison with the rest of the UK. The big issue is the need for investment in the early years; that needs to looked at thoroughly. I know that the Department of Education is investing money in counselling in the post-primary education sector. As a psychotherapist, I think that talking therapies and counselling are wonderful and useful for people, but they often only occur when people are having problems.

The view expressed in "A Flourishing Society" is that we need to invest. We are not talking about vast amounts of money. It is not about spending more money, but about using the limited resources we have. If you asked what would be the best thing we could do for our society, it would be to invest in the early years. I am not a health economist, so I cannot comment on the amounts of money required; perhaps Gerry has some thoughts on that. The report states that we

should be investing in the early years.

The Minister of Health said, in his forward to the Executive's response to the Bamford review, that it would take 10 to 15 years to implement the recommendations of that review. In a recent report on suicide in north and west Belfast, John McGeown, the author, said that it would take 30 years. One of the big issues for us is that we need champions who will recognise that it is a generational issue. There are no quick fixes. There must be investment in the early years, and it is up to the experts in Government to think about how to spend more on the young generation and get more back later on.

Mr B McCrea:

I will return to the issue of the Education Bill and the phrase "mental well-being" that others have raised. It was certainly an issue that I raised in the initial stages. There is a significant amount of resistance to the phrase. We have had a couple of discussions about it in the Committee; in fact we went as far as deciding to put that phrase in anyway. Some say that the concern is about some degree of overlapping, but it appears to be more about giving somebody a responsibility without giving them the resources to tackle the issue. For example, there are not enough educational psychologists. How should that issue be addressed? How do we get the educational establishment to not simply — as someone said earlier — work around it?

There have been a number of suicides in my constituency, and they are very distressing. It seems to me that we must put the issue to the forefront, but there is institutional objection to that.

Mr Logan:

Education and training is a big issue for us all, including ESA. It is a matter of looking again at the whole issue of a generational approach. Our association has an education reference group. Teachers from Holy Family Primary School in north Belfast are doing excellent work. They are looking at preschool children and identifying problems very early on.

A paradigm shift in thinking is needed. For the educational establishment, education is about results and academic achievement. One of the things that we have called for in 'A Flourishing Society' is that there should be well-being indicators, though some head teachers might baulk at the idea of more statistics being required. The research shows that there is a correlation: a happy child is a learning child. There needs to be a major shift in thinking about what education is

about. The language talks about giving children what they need to reach their full potential. If a child's well-being or mental health is ignored, that child may well not reach his or her potential.

Dr Leavey:

May I ask the member whether the argument is that, if we include the word "mental" in the clause, teachers will not take on board mental literacy as part of their brief?

Mr B McCrea:

No, the argument is that we wanted to address mental-health issues directly, in exactly the way in which you are describing. We agree that mental-health issues first present at a very early age. There are delays in getting experts in to help children. The teachers say that the problem is that people keep adding to their responsibilities without giving them the resources to tackle the issues. Therefore, my suggestion was that we should clearly identify that we think that mental-health issues are part and parcel of education because of the points that you have just made. We put that point forward, and the response that came back from the Department and others was a sharp intake of breath and the view that that would be a very brave decision for the Minister and that we should not go there. I am not convinced by that. We want to tackle the issue at school level.

Dr Leavey:

I would probably support your endeavour to include the word "mental health" in the Bill. Over the years, teachers have used phrases such as "emotional well-being"; they speak a very different language from that of clinicians. Teachers and clinicians are talking about the same thing, but talking about it in very different ways. That language issue needs to be addressed very clearly. If you do not have "mental health" in there somewhere, teachers will not engage with the child and adolescent mental-health services (CAMHS) as they need to do.

Mr B McCrea:

I want to ask you one follow-up question. The information may be covered in documentation elsewhere. A higher proportion of people in Northern Ireland receive disability living allowance (DLA) than is the case in many other parts of the United Kingdom, and there is an argument that the discrepancy is largely due to mental health and it stems from the traumatic events that we have had in the past, particularly in some of the more deprived areas. Has the connection been made that our mental-health issues are so serious that they are endemic in our society and that we have to start dealing with them? Does that come across in your report?

Dr Leavey:

It is alluded to; we could not go into it in any great detail. We had a short space of time in which to cram a lot of stuff into the report. You are right. The epidemiology on mental health in Northern Ireland does not really exist. A World Health Organization study, which is being run by Professor Brendan Bunting at the University of Ulster, is looking at prevalence. It is hard to say how good that report will be in terms of understanding the level of disorder in our society.

A number of attempts have been made to look at psychological well-being in Northern Ireland as a consequence of the Troubles. However, the results have been pretty contradictory, which I find surprising. To me, there is very clear evidence around that. Perhaps it has had something to do with the methodology of the studies.

Mr Logan:

I have some practical points to make about the Education Bill. From talking to people in the field of education, I have learned that they often find that they are being given material from a health specialist. One of the recommendations from people in the education sector is that they should write the material themselves, using language that is used in education; for example, "emotional well-being". There should be collaboration between health and education, and the issue around the Education Bill may be an example of that.

Mrs Hanna:

I welcome the report, and the conversation has been helpful too.

We all spent so much time on the Bamford review and its recommendations that it was almost difficult to know where to start. However, it is useful if we are focusing in on early intervention. You talked about the cross-departmental element, which I totally agree with. There is an overarching responsibility for everybody, whether that is in the workplace, in training or in primary schools. We have to find a mechanism that ensures that everybody buys into it.

We have had a lot of presentations on early intervention. I remember that one witness talked about a child and a family not coping with the death of a granny. Everyone mourns at some point, but, in some cases, a child might not know how to mourn and, because they do not have the coping strategies and self-esteem to deal with their loss, they go to pieces. I remember thinking

that that was a good and simple example of how early intervention could be useful, and I totally agree that that is what we should be doing.

You talked about measuring well-being and said that that has been done in Scotland. If that was done here, we could, to some extent, measure the challenge, because we could tick the percentage of people who are all right and identify the middle group who may need help.

You also mentioned costing, and the fact that there is not much money in the system. Therefore, it has to be about how we can move the money around. I am not sure what your views are on how we could do that.

The report mentions training, and states that the Health Promotion Agency is doing some work on that. We can all agree that training is needed at different levels, whether for GPs, teachers, or voluntary and community workers. Training is important, and when that piece of work is completed there will be a clearer view of exactly what the training needs are, so that we can create good, targeted parenting programmes. As a midwife, I never heard the term "early intervention", but one realised very quickly —

The Chairperson:

Mrs Hanna, is there a question?

Mrs Hanna:

I asked a question about costing and training.

The Chairperson:

It was a question followed by quite a long statement.

Mrs Hanna:

I did not time myself.

Dr Leavey:

What was your first question?

Mrs Hanna:

My first question was about costing. You said that perhaps the budget could be moved around to some extent.

Dr Leavey:

This must be looked at over a long period of time. Some of the parenting and early intervention schemes, such as the Triple P — positive parenting programme — and the nurse-family partnership programme, provide quite a good yield in the short term. However, such programmes have long-term effects too, not only for children, but also for parents. There are big benefits in that.

We talked about making adequate use of the resources that we already have, which, for the most part, are overlooked. There is a very strong, although slightly declining, faith-based community in Northern Ireland with tremendous resources. That community does a lot of good, but it is an untapped resource. We do not think about how much more or in what ways we could use that resource.

I also suggest using extended schools as a hub within the community. After 4.00 pm, most of the schools in our communities have their lights turned off, yet they could be of tremendous use in bringing people together for all kinds of health and education programmes outside the curriculum.

Training is an interesting issue, because a huge amount of it is going on. The problem is that the uptake is not great, particularly in general practice. We need to understand why uptake is not great: is it due a shortage of time or some other factor? I agree that training is an issue, but we do not know enough about it.

Mrs McGill:

Further to Michelle O'Neill's point about the role of universities, have you had any contact with the Magee campus of the University of Ulster, which plans to create an institute of health and well-being? We received a briefing this morning from Professor Deidre Heenan, who said that the university is trying to develop the Magee campus. Committee members, especially those from the north-west, were trying to explore the possibility of a medical school being developed at the Magee campus.

In the submission that we received this morning, there was a reference to a dedicated research building. If I remember correctly, Deirdre Heenan said that the university does a lot of outreach work in the community. Michelle O'Neill mentioned a pilot project in universities, and that would be great idea for the Magee institute to take forward. Perhaps contact could be made with the university.

Mr Leavey:

We are aware of the institute of health and well-being at Magee and know that the University of Ulster intends to set up a centre for mental health and well-being within that. Over the past couple of months, NIAMH has been in discussion with the University of Ulster on that issue; we support such a centre and are keen to be involved with it. That is partly because Queen's University has quit the mental-health field and has closed down its research into mental health, as it did not fit with its research assessment exercise. Therefore, it is very heartening to know that a lot of resources, interest and money are being put into an institute of well-being at the Magee campus. I agree with your point about the pilot project.

Mrs M Bradley:

A lot of the work on extended schools is being done by local community workers. How can we be sure that those people are receiving proper training to provide counselling? Those people need to be able to give proper advice so that the young people benefit, and I have concerns about that.

Mr Leavey:

I do not understand how counselling in schools is evaluated, who receives it or why they receive it. I do not understand the lack of uptake of counselling and question whether counselling in schools is a good idea.

When I worked in an inner-city area of London, I found that if I mentioned to young people, particularly teenagers, a scheme involving contact with schools, they would not touch it with a barge pole. They fear and mistrust adults hugely, and schools represent authority. I am not making a case for my own work, but sometimes I wonder whether it would worthwhile to do some research on where counselling is best provided.

Mrs M Bradley:

The issue is important, because people could be counselling others and not giving proper guidance. Although common sense, their guidance may not be mental-health orientated.

Dr Leavey:

I am not sure about that. I would like to see the evaluation on it; it would be very useful.

The Chairperson:

We have managed to finish within seven seconds of our deadline. I thank Mr Logan and Dr Leavey for their presentation. I also thank the members from both Committees who attended; there was a good turnout and some good questions were asked. The Health Committee will return to the subject of mental health on 12 November, when it shall consider mental-health legislation. The issue of mental health will run for many more months. I thank everyone, and I hope that we have finished in time to allow members to attend their next Committee.