
Department of Health
An Roinn Sláinte
Männystrie O Poustie
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# Mental Health 2021-2031 Strategy

CONSULTATION DRAFT

## Contents

## Ministerial foreword

Mental ill health is a huge challenge for our society. Too many people struggle with being mentally unwell and too many people find it difficult to find the help and support they need when they need it. Mental illness and suicide are severely impacting our communities, limiting the life chances of our young people and constraining our potential across society.

I am determined to reduce the number of people across all sections of our society who wake up every morning and struggle with their own mental health challenges. As such I want to ensure that they have the mental capacity and support to enjoy richer, more fulfilled lives.

Since becoming Health Minister I have repeatedly noted that mental health is one of my top priorities. I have taken action by publishing a Mental Health Action Plan, including a Covid-19 Mental Health Response Plan, on 19 May 2020, by appointing Northern Ireland's first ever Mental Health Champion with cross-Departmental support, and by making new financial resources available. I am therefore very pleased to build on this by publishing this consultation version of a 10 year Mental Health Strategy. The draft Strategy intends to provide a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, and to provide the right response when a person needs specialist help and support.

To drive the strategic change needed, this draft Strategy sets out 29 key, high-level actions under three overarching themes. The first, Promoting Wellbeing and Resilience through Prevention and Early Intervention, is key to ensuring we put the right conditions in place to support our communities to stay mentally well throughout their lives. The second, Providing the Right Support at the Right Time, covers a range of service improvements that ensure better access to support when it is needed, putting the person's needs right at the centre. And the third theme, New Ways of Working, sets out the key changes that will support these improvements across the system, with the ultimate aim of improving outcomes for people.

Of the 29 actions, four stand out. Firstly, I am creating a year on year action plan for mental health promotion. This will entail ongoing work to identify and agree actions that can help to support positive mental health across our community, and prevent mental illness developing. Secondly, I am committing to significant improvements in primary care mental health services, with greater responsibility for our GPs, working through their GP Federations. This will involve completing the roll out of psychological therapies hubs and additional investment to increase availability and accessibility of talking therapies at a local level. This will help to ensure that the system focusses on people and their needs, rather than expecting individuals to conform to a rigid system.

Thirdly, I am proposing better integration between statutory and community and voluntary sectors; this is key to harnessing the huge experience, skills and expertise within the community and voluntary sector to complement and supplement statutory support. Fourthly, I will take forward the creation of a single mental health service. I will do this, not by changing organisational boundaries to create new silos, but by ensuring we have structures in place to deliver regional consistency, quality and access across Northern Ireland. Implementing these four core actions, together with the other 25 outlined in the draft Strategy, will fundamentally reform our approach to mental health in Northern Ireland and will create the foundation for a population with better mental health.

This Strategy is particularly important during these difficult times. I am well aware of the challenges faced by the population as result of the Covid-19 pandemic and the restrictions on everyday life. It is therefore more important than ever that we consider what we want our mental health services of the future to look like. We have an excellent opportunity to build our response to the mental health impact of the pandemic into a strategic vision and foundation for the future, building on our own specific context to drive significant change and improvement for the next decade, and beyond.

As I have previously noted, excellent work has been done in recent years to improve mental health services, to support positive mental health and to help those suffering from mental ill health. It is important to recognise we are not starting from zero; without the dedicated work and effort of those working in this field we would undoubtedly be in an even more difficult position than we are now. It is therefore important that we provide the right tools and support to allow those dedicated to supporting people with their mental health to continue to do so.

The publication of the consultation draft of the Strategy is an important step in this process. However, there remains important work to be done; we then have to work collaboratively to implement the Strategy over the next 10 years.

I would like to thank all those who have been involved in developing this draft Strategy. Your voice, your experience, your expertise and your input have been instrumental in getting us to this point, and this work could not have been done without you.

**Robin Swann MLA**
**Health Minister**

## Summary of actions

### Theme 1 – Promoting wellbeing and resilience through prevention and early intervention

*Promotion, early intervention and prevention*

ACTION 1. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach. The action plan must consider groups disproportionally affected by mental ill health which often struggle to access early intervention services.

ACTION 2. Expand talking therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team. This will expand the delivery of psychological therapies across Northern Ireland to improve the mental wellbeing of the population and prevent the establishment of mental disorders.

*Promoting children and their families' positive mental health*

ACTION 3. Further promote positive social and emotional development throughout the period of childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

ACTION 4. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for the disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

### Theme 2: Providing the right support at the right time

*Child and adolescent mental health*

ACTION 5. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people.

ACTION 6. We will meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

ACTION 7. Create clear and regionally consistent urgent, emergency and crisis services to children and young people.

*Mental health and older adults*

ACTION 8. Ensure adult mental health services cater for older adults with mental ill health, provide adequate support and structures and are mindful of the particular challenges older people face. The artificial cut off in adult services at the age of 65 will stop and people will be supported by the right service based on their individual needs.

*Community mental health*

ACTION 9. Refocus and reorganise primary and secondary care mental health services around the GP Federations to ensure a person centred approach, working with statutory and community and voluntary partners to create local pathways within a regional system.

ACTION 10. Further develop recovery services, including Recovery Colleges, to ensure that a recovery focus and approach is embedded in the whole mental health system.

ACTION 11. Fully integrate community and voluntary sector in mental health service delivery across the lifespan including the development of a protocol to make maximum use of the sector's expertise.

*Psychological therapies*

ACTION 12. Embed psychological services into mainstream mental health services. Psychological therapies will be available across all steps of care.

ACTION 13. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

*Physical healthcare and mental illness*

ACTION 14. Ensure that monitoring of the physical health of mental health patients becomes everyday practice in primary care.

ACTION 15. Ensure that all mental health patients are screened for physical health issues on admission. Across all mental health services, help and support should be provided to encourage positive physical health and healthy living.

*In-patient mental health services*

ACTION 16. Continue the capital works programme to ensure an up to date in-patient infrastructure. Also consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and to ensure that those who need in-patient care can receive the best care available.

ACTION 17. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

ACTION 18. Develop regional low secure in-patient care for the patients who need it.

*Crisis services*

ACTION 19. Create a regional crisis service to provide help and support for persons in mental health or suicidal crisis. The crisis service must be fully integrated in mental health services and be regional in nature.

*Co-current mental health issues and substance use (dual diagnosis)*

ACTION 20. Create a managed care network, with experts in dual diagnosis supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

*Specialist interventions*

ACTION 21. Continue the rollout of specialist perinatal mental health services.

ACTION 22. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a psychosis network.

ACTION 23. Create a personality disorder service and enhance the specialist interventions available for the treatment of personality disorder in Northern Ireland.

ACTION 24. Create a regional eating disorder service.

**Theme 3: New ways of working**

*A regional mental health service*

ACTION 25. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership, responsible for consistency in service delivery and development.

*Workforce for the future*

ACTION 26. Undertake a review of the mental health workforce, including consideration of increasing training places and training of the existing workforce.

ACTION 27. Create a peer support and advocacy model across mental health services.

*Data and outcomes*

ACTION 28. Develop a regional outcomes framework in collaboration with service users and professionals, to use as a method to underpin service development and delivery.

*Innovation and research*

ACTION 29. Create a centre of excellence for mental health research with dedicated funding.

## The current state of mental health in Northern Ireland

*Mental health problems*

1. Northern Ireland has the highest prevalence of mental health problems in the UK, with a 25% higher overall prevalence of mental health problems than England.

2. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. Low-income groups have higher rates of mental health conditions, particularly severe and enduring problems, than high-income groups.[1] People with mental ill health have a higher risk of economic hardship.

3. The legacy of the Troubles is also recognised as having a significant impact on mental health in Northern Ireland; in 2008, 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles. Deprivation and high rates of mental and physical illness co-occur in the areas most impacted by the violence.[2]

**39% OF THE POPULATION IN NORTHERN IRELAND HAS REPORTED EXPERIENCING A TRAUMATIC EVENT RELATING TO THE TROUBLES**

4. According to the *Youth Wellbeing Child and Adolescent Prevalence Study*, among children and young people, one in ten (11.9%) experienced emotional problems, with significantly higher rates in deprived areas. One in six have a pattern of eating disorder, and almost one in ten of 11-19 year olds reported self-injurious behaviours. The prevalence study found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.[3]

**1 IN 10 CHILDREN AND YOUNG PERSONS EXPERIENCED EMOTIONAL PROBLEMS AND 1 IN 6 HAVE A PATTERN OF EATING DISORDER**

[1] Boardman et al, 2010, *Social exclusion and mental health - How people with mental health problems are disadvantaged: An overview.*

[2] Ulster University, 2019, *Review of Mental Health Policies in Northern Ireland: Making Parity a Reality.*

[3] Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*

5. The advent of the global Covid-19 pandemic has also significantly impacted mental health in Northern Ireland. Lockdown, shielding and social distancing, the closure of schools, working from home, increased deaths, reduction in face to face services, as well as the restrictions on funeral rites during the pandemic have had an impact on the emotional wellbeing of many, including those with existing mental health conditions. In addition, evidence has shown increased levels of acuity presenting to acute mental health services. It is highly likely that we will see increased levels of need for a number of years due to the ongoing impact of the pandemic on our society's mental health.

### *Strategic context*

6. There has been a transformation in mental health services over the last 20 years. The *Bamford Review* was established by the Minister of Health, Social Services and Public Safety in October 2002. The Review provided a forward plan for mental health and learning disability policy and services and also focused on the existing provisions of the Mental Health (Northern Ireland) Order 1986, and directed that in future particular account be taken of issues relating to incapacity, human rights, discrimination and equality of opportunity.

7. The *Bamford Review* led to important improvements in care for people with mental health problems, including a significant reduction in long stays in mental health hospitals – meaning more people living well in our communities. We have also made significant improvements in the involvement of people with lived experience in the commissioning and delivery of services, and the establishment of Recovery Colleges has embedded a recovery-oriented practice in mental health services and ensured a greater number of peer support workers.

8. The *You in Mind – Regional Mental Health Care Pathway* launched in 2014 provides a care pathway for people who require mental health care and support. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated. The *Working Together: A Pathway for Children and Young People through CAMHS* launched in 2018 and provides a similar pathway for children and young people who require mental health care and support.

9. Other recent drivers, including Lord Crisp's report on acute psychiatric care and the Bengoa review *Systems not Structures,* have driven further improvement and additional investment. The Department of Health's 2016 response to the Bengoa review, *Health and Wellbeing 2026: Delivering Together*, set out a ten year plan to transform health and social care in Northern Ireland. Delivering Together promotes a model of person centred care focused on early intervention, prevention and supporting independence and wellbeing. It identified mental health as a priority area and committed to building capacity in communities,

developing services to deal with trauma, and achieving parity of esteem with physical health.

10. In recent years, public attitudes towards mental health have improved, an ethos of co-production and co-design has been promoted, and a greater focus on human rights has improved the lives of many suffering from mental ill health. The cross-Departmental policies Making Life Better and Protect Life 2 have driven extensive work on health promotion and suicide prevention by addressing health inequalities and risk factors for suicide and self-harm. We have also seen additional investment in mental health through the establishment of, for example, Multi-Disciplinary Teams and mental health primary care workers in some areas, as well as mental health liaison services in Emergency Departments. The mental health response to the Covid-19 pandemic has also helped to promote and encourage the use of digital resources to support mental wellbeing and mental health.

11. However, gaps in provision remain, services are coming under increasing pressure due to increasing demand and staffing issues, and there remains a stigma attached to mental health. Mental health is still not viewed or treated in the same way as physical health, and despite the injection of additional resources is still underfunded when compared with other UK jurisdictions: in 2018/19 approximately £300m was allocated to mental health, representing around £160 per person in Northern Ireland. During the same period spend in England was £12.2bn, representing around £220 per person, and in Ireland investment equated to over £200 person.[4]

**MENTAL HEALTH SPEND IN NORTHERN IRELAND IS 27% LESS THAN ENGLAND AND 20% LESS THAN IRELAND**

12. In addition, barriers to access mental health services remain, particularly for some marginalised groups who are considered to be at higher risk of mental ill health. This may be due to social exclusion or isolation, communication barriers, or they may be in some way stigmatised by society.

13. To tackle some of these issues in the short to medium term, and set the foundations in place for longer term strategic change, in May 2020 the Department of Health published a new Mental Health Action Plan. The 38 actions in the Action Plan fall into three broad categories: immediate service developments; longer term strategic objectives; and preparatory work for future

[4] There are differences in how mental health spend is calculated. However, even considering such factors there is a significant under investment in Northern Ireland.

strategic decisions. Work is continuing to implement the Action Plan, and improvements are already being realised that will directly benefit people using mental health services. Other actions being taken forward will directly influence, complement and contribute to strategic decision making in the years to come.

### *What needs to change*

14. Despite the improvements we have seen in mental health services in recent years and the positive experiences of many people accessing support, there remains much to be done to achieve real, meaningful and lasting change for all.

15. We consistently hear the same messages from people using mental health services: waiting lists are too long for psychological therapies, crisis support is not available when it is needed, those with specific needs often find themselves outside of service criteria and therefore unable to access the right type of help and support, and that earlier intervention is needed to prevent or delay the onset of more serious mental health problems.

16. Across Northern Ireland targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 240 children and young people waiting more than 9 weeks for core CAMHS services and more than 900 people waiting more than 13 weeks for psychological therapies.[5]

17. We know that if we can provide effective mental health interventions early, the outcomes for individuals and their families are much better. Care and treatment must therefore be available when and where they are needed. We must create systems that work together to reduce waiting lists, that support people at their time of crisis so people do not end up in Emergency Departments, that help people in their recovery to and promote full participation in society. Our mental health system needs to be family focused in its practice to ensure that individual recovery also supports family recovery.

18. It is clear, therefore, that in the same way as there must be a continued strategic focus on parity of esteem between mental and physical health. Attention must also be given to parity within it to ensure equality and equity of access to mental health services for all, with a focus on recognising and meeting the individual's specific needs.

[5] Correct as of 31 October 2020.

19. It is vital that we use the learning from the impact of Covid-19 to ensure we have a system that works to prevent or delay the onset of mental health problems, and that truly meets the needs of its users.

20. Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, and improve outcomes**.** This requires a culture change with better outcomes as the core focus and accountable leadership embedded in our workforce. This will mean regionality of services to ensure consistency of delivery. This will avoid unwarranted variation for patients and ensure better treatment outcomes.

21. And we need to focus on putting the right foundations in place to support our workforce to meet the needs of the people using services, by increasing training numbers, having well trained staff and ensuring we are using the workforce in the best way possible.

22. By learning from our experience to date, by listening to the views and suggestions of people with lived experience, carers and other experts across organisations and sectors, we can ensure that the future for mental health in Northern Ireland is brighter, more positive and reflective of the needs of our population.

23. The changes proposed in this Strategy are the result of co-design and co-production with people with lived experience, carers, professionals, managers and academics. The work started in 2018 through 2019 with the development of the Mental Health Action Plan, and has continued throughout 2020 during the Strategy development process. A large number of people with wide experience have told us that much good has been done over the last decade, but that much more needs to be done.

24. During the process people have told us we need to focus on promotion, early intervention, prevention and family focussed recovery. We have been told that this should include ensuring a good start in life, providing effective support early through primary care and accessible treatment and ensuring that people who are usually difficult to reach are targeted.

25. We have also been told that we need to focus on putting the person and the family at the centre and model services around their needs; that we need to ensure that the same services are available across Northern Ireland; and that services and interventions need to be evidence based.

## Vision for the future

26. We have listened to stakeholders through the process of co-producing this draft Strategy, and we recognise the key issues that matter to them: consistency and equity of access to services, support across the lifespan, choice, a focus on quality of life, and the need to put the person right at the centre of every decision. We have also heard how co-production and co-design must become the standard at every stage of policy and service design, and individual care planning.

27. We have translated the views shared with us into a vision and 7 founding principles, which set out what we want to achieve for mental health in Northern Ireland over the next decade. The 7 principles must be the foundations upon which each of the actions set out in this Strategy are based – they are core threads which must feature in all work to take forward the implementation of the Strategy.

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*Our vision for Northern Ireland is a society which promotes emotional wellbeing and positive mental health for everyone across the lifespan, which supports recovery, and seeks to reduce stigma. We want a system that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice.*

*We want a mental health system that breaks down barriers to put the individual and their needs right at the centre, respecting diversity, equality and human rights, to ensure people have access to the right help and treatment at the right time, and in the right place.*

*And we aspire to have mental health services that are compassionate and able to recognise and address the effect of trauma, that are built on real evidence of what works, and which focus on improving quality of life and enabling people to achieve their potential.*

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28. To achieve this vision, we need to invigorate and energise our communities and organisations, to promote a culture change that will bring about real improvements for the population in Northern Ireland. We need to focus on

learning from our experiences and supporting each other. We need to stop people falling through gaps in services by putting the foundations in place for true collaboration and integration, working together with and supporting our partners in the voluntary and community sector to provide high quality support and services on the ground.

29. The work to implement this vision and the actions made in this draft Strategy must be based on the same core, founding principles:

    I. *Meaningful and effective co-production and co-design at every stage.*

    II. *Person centred care and a whole life approach – a system that meets the needs of the person, rather than expecting the person to fit into a rigid system.*

    III. *Care that considers and acknowledges the impact of trauma – where staff have the appropriate knowledge and skills and are aware of the impact of trauma, particularly in the context of Northern Ireland.*

    IV. *Choice – meaning choice in treatment to fit the needs and preferences of the person.*

    V. *Early intervention, prevention and recovery as a key focus – all decisions should be made with this in mind.*

    VI. *Evidence informed decisions - services and interventions built upon sound evidence of what works.*

    VII. *The specific needs of particularly at risk groups of people, and the barriers they face in accessing mental health services, should be recognised and addressed.*

30. This draft Strategy builds upon this vision and founding principles to set out 29 key actions to bring about change to mental health in Northern Ireland. The actions are set out under 3 overarching themes:

    - **Promoting wellbeing and resilience through prevention and early intervention**
    - **Providing the right support at the right time**
    - **New ways of working**

## Theme 1 – Promoting wellbeing and resilience through prevention and early intervention

31. Health is closely linked to the conditions in which people are born, grow, live, work and age, and inequities in power, money and resources – the social determinants of health.[6] The mental health and wellbeing of the population in Northern Ireland is therefore not just a health and social care issue, it is societal. The Northern Ireland Executive has recognised that promoting and maintaining good mental health cuts across all Departments and all aspects of life. The establishment of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention, and the appointment of the NI Mental Health Champion, demonstrates the clear commitment across the Northern Ireland Executive to joint working to improve society's mental health and wellbeing.

> *Mental Health Champion*
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> In April 2020, cross-Departmental support was secured, through the Northern Ireland Executive, to formally establish a Northern Ireland Mental Health Champion role. The creation of such a role was in response to wide ranging calls from across the mental health sector for the creation of a strong, effective and independent voice to advocate on their behalf. The Mental Health Champion is therefore a joint initiative across the NI Executive and fully supported by all Executive Ministers. As a signal of the collaborative will for the role to succeed, funding for the role is shared across Departments.
>
> The purpose of the Mental Health Champion is to integrate a mental health friendly ethos into all policies and services developed and delivered by the NI Executive and to enhance the level of collaborative working on, and awareness of, psychological wellbeing, mental health, suicide and recovery in Government Departments. The role is also to be a voice for people with lived experience, who are often not heard in the public debate.

32. When considering what impacts on our population's mental health, and how to improve it, we must consider this wider context. If we want to achieve our vision of a system that promotes positive mental health and seeks to enable people to achieve their potential, it is hugely important to invest in measures to promote and support emotional wellbeing and resilience, to raise awareness of mental health and reduce the stigma associated with it, and prevent and delay the onset of mental health problems as far as possible.

[6] World Health Organization *Social determinants of health* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

### *Promotion, early intervention and prevention*

33. Outcomes:

- Better mental health among the wider population, evidenced by a reduction of % of population with GHQ12 scores ≥4 (signifying possible mental health problem).
- Better interagency cooperation to promote wellbeing and resilience.
- Wider awareness of mental health within the health and social care sector outside the mental health profession.
- Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

34. Good mental health is linked to good physical health and positive relations with families, friends, and colleagues. It enables us to fulfil our potential, engage in community life, and lead full and rewarding lives. The natural and built environments in which we live, work, visit and play can impact profoundly on our wellbeing. Surroundings that are well-planned, designed and maintained may help prevent, and support recovery from, mental illness.

35. Prevention of mental health problems and early intervention when they occur is both possible and cost-effective. People's mental health is shaped by a number of social, economic, cultural and environmental factors, which can make people more or less likely to develop a mental health problem. Evidence shows that poverty and mental ill-health are closely associated, and disadvantage can have long-term consequences.[7] We also know that the Troubles has had a lasting impact on both social deprivation and levels of mental ill health. In Northern Ireland we need to continue to work together across government, sectors and the whole of society to implement existing policies designed to address deprivation, poverty and social cohesion issues, and other social determinants of mental ill health. The four new social inclusion strategies (Disability; Anti-Poverty; Gender; and Sexual Orientation) currently being developed are also likely to include interventions from across government Departments that will contribute to improving our population's mental health and wellbeing.

*Case Study: Urban Villages*

This headline action of the Executive's Together: Building a United Community strategy is a good relations programme in places with a history of deprivation and social tension. Mental Health has been prioritised by local communities in Strategic Framework documents covering five Urban Village areas across

[7] *Mental health and poverty in the UK – time for change? (Jed Boardman et al, May 2015)*

Belfast and Derry/Londonderry, and is the focus of many community-led projects supported by the Urban Villages Initiative.

The strategic focus on this issue by local communities demonstrates that poor mental health is a barrier preventing communities from thriving in a post-conflict society. This also reflects intergenerational trauma arising from a legacy of division. To support local efforts, a €6.1m EU PEACE IV funded project called 'Our Generation' was launched in September 2020. This three year programme will work in Urban Village areas and border counties and co-design local approaches to build emotional resilience and improve the mental health of young people.

36. As part of this, as a society we need to continue to provide opportunities for individuals and communities to look after their own emotional wellbeing and mental health, for example, by providing access to green and blue spaces, opportunities for exercise, leisure activity and social interaction, including volunteering opportunities, as well as access to housing and employment, all of which are proven to have an impact on emotional and mental wellbeing.

*Case Study: Connswater Community Greenway*

This £40 million project in East Belfast was developed by EastSide Partnership and delivered by Belfast City Council. Funded by the Big Lottery Fund, Belfast City Council, the Department for Communities and the Department for Infrastructure, the Connswater Community Greenway opened in September 2017. It provides vibrant, attractive, safe and accessible green and blue spaces for leisure, recreation, community events and activities.

Among the wide range of facilities it has created are a 9km linear park making provision for walking, wheeling and cycling along the course of three rivers; 16km of foot and cycle paths, hubs for education, interpretation points and tourism and heritage trails, a wildlife corridor from Belfast Lough to the Castlereagh Hills, and C.S. Lewis Square – an events and activities space.

The route links with the Comber Greenway which is also is improving the quality of life for the people of east Belfast, including the 40,000 residents and pupils and students attending 23 local schools and colleges. A whole new greener environment has emerged to link local residents to parks, leisure facilities, businesses, shopping centres, schools and colleges.

Greenways promote active travel, connect people and communities, create green safe spaces, and encourage community members to volunteer to keep them clear and looking great for everyone to enjoy. In all of these ways, they help to enhance both our physical and mental health.

37. We also need to address public and individual knowledge, awareness and understanding of mental health. By doing this we can make mental health part of everyday conversation, and reduce the stigma still associated with mental ill health. We can raise awareness of the steps individuals, families, friends and carers can take to look after their own mental health, and support others. And we can also seek to ensure there is a clear message around when and how to seek help and support. This could be achieved through public awareness campaigns that increase people's mental health literacy, and may also include targeting specific groups of people who may be vulnerable to mental ill health, for example, peer support programmes for LGBT+ young people, debt advice for people on low incomes, or outreach programmes for ethnic minorities, refugees and asylum-seekers.

*Case Study: Sport Wellbeing Hub*

The Sport Wellbeing Hub is an online resource which Sport NI launched in April 2020. It offers the sports sector and communities wellbeing support during the Covid-19 pandemic. The Hub was developed in partnership with the PHA and Inspire to help sports users to create their own wellbeing care-plan, as well as giving guidance on support through a guided self-assessment. The hub is for everyone across the sporting community, those who are involved in sport, at all levels and all abilities. The Sport Wellbeing Hub provides a range of innovative tools and resources including a guided self-assessment via 'chatbot'; self-help programmes and digital intervention tools; a searchable '5 ways to wellbeing' map; a wellbeing information library; and video content featuring some of our sporting heroes talking about mental health.

38. It is important to focus on the promotion of wellbeing, prevention and early intervention throughout the whole life of the person, incorporating initiatives from perinatal and early years through childhood and early adulthood, working life and into later life.

39. As adverse childhood experiences (ACEs) have been found to account for 29.8% of mental disorders,[8] prevention of ACEs is key to preventing mental ill health among children and in later life. For children, a key focal point for prevention is in connection with schools. Evidence shows that school-based programmes for children and adolescents have achieved a reduction in depressive symptom levels of 50% or more a year after the intervention; and anxiety disorders can

[8] Kessler et al, 2010, *Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys,* British Journal of Psychiatry 197(5).

successfully be prevented by strengthening emotional resilience, self-confidence and cognitive problem-solving skills in schools.[9]

*Case study: mental health in schools*

The Department for Education recognises the importance of embedding mental health and wellbeing into all educational settings, and has been working collaboratively with other agencies to develop a Framework for Children & Young People's Emotional Health and Wellbeing in Education.

The main emphasis of this work is to support schools to promote emotional health and wellbeing at a universal level, through a holistic, multi-disciplinary approach, providing early and enhanced support for those children and young people who may be at risk or showing signs of needing further help. £5m has been made available by Department for Education to enable the implementation of this Framework in 2020/21 and subsequent years, and Department of Health has agreed to provide an additional £1.5m from 2021/22 onward. A range of proposals are currently being considered – all of which have a focus on promotion, prevention and early intervention, through which Education, Health and Community services can work together in an integrated way.

40. Prevention of mental health problems in the workplace is of particular importance, both in terms of its impact on economic productivity, but also given the impact of the Covid-19 pandemic on working practices. Increased isolation due to home working coupled with increased stress, particularly for those working on the front line or in public facing roles, means that it is more important than ever to invest in strategies and measures to support the wider workforce in staying mentally well. This involves demonstrating commitment at the highest levels of the organisation to mental wellbeing, reducing stigmatising attitudes and discrimination, tackling the causes of workplace stress, providing training and support to managers, and providing early intervention supports for employees.

*Case Study: Buy Social – mental health in procurement*

Buy Social works to maximise the social benefits delivered through public investment. This includes social considerations on public contracts, which require Public Sector Contractors to deliver certain initiatives as part of the contract. Work is ongoing by the Department of Finance to consider the possibility of including Buy Social on relevant public sector contracts to benefit the mental health of employees working on these contracts, through for example,

[9] Scott, S. (2005). *Do parenting programmes for severe child antisocial behaviour work over the longer term, and for whom? 1 year follow up of a multicenter controlled trial*. Behavioural and Cognitive Psychotherapy, 33(4), 403–421. https://doi.org/10.1017/S135246580500233X

employment opportunities for those that are disadvantaged from the labour market, work experience and business in education opportunities, digital skills training for people at risk of digital exclusion and a requirement that contractors have a health and well-being policy in place in for staff.

41. The mental health impact of unemployment is also widely recognised. Again, action across government to provide financial and emotional support to those who have become unemployed, and to help people back into work where possible, plays an essential role in preventing the occurrence of mental health problems.

*Case Study: Employment Support*

Through Work Coaches the Department for Communities (DfC) works in collaboration with contracted and specialist local providers to support people with physical and mental health conditions. Support is provided through the Workable (NI), Access to Work (NI), European Social Fund projects and the Condition Management Programme (CMP) to help people realise the ambition to work and achieve mental health improvement and stability. DfC delivers CMP in collaboration with the Department of Health. It is a work-focused, rehabilitation programme, aimed at improving the employability of our people by supporting them to understand and manage their health condition(s), including mental health, to enable them to progress towards, move into and stay in employment.

DfC is in the process of standing up a suite of new programmes to improve the employment prospects of those impacted by the Covid-19 pandemic. This will include a specific focus on our youth and those with health and disability support needs who are particularly vulnerable in the labour market and subsequently at risk for longer term health and wellbeing issues. The Department also has a team of Work Psychologists who are responsible for leading on the work and health agenda and developing the capacity of our front line teams to support people with mental ill-health.

42. For certain sectors, for example, the rural and farming community, mental health is a particular concern. This can be due to physical isolation from communities, worries about livelihood, or anxiety regarding personal and family safety. Research by the Farm Safety Foundation revealed that 84 per cent of farmers under the age of 40 believe that mental health is the biggest hidden problem facing farmers (up from 81 per cent in 2018).[10] It is important to reach out to harder to reach groups to intervene early and prevent the onset of mental health problems.

[10] Farm Safety Foundation *Mental Health in Agriculture*, https://www.yellowwellies.org/mind-your-head/.

*Case Study: Tackling Rural Poverty and Social Isolation Framework*

The Tackling Rural Poverty and Social Isolation (TRPSI) Framework supports the development and delivery of initiatives to address the Framework's three priority areas of financial poverty, access poverty and social isolation. Through this Framework, DAERA supports a range of initiatives to promote better mental health and wellbeing amongst farmers.

The Rural Support charity operates a telephone Helpline and signposting service for farmers and rural dwellers in stress. Their volunteers support clients with a range of issues pertaining to farming matters and stress. Rural Support are currently delivering mental health awareness training workshops entitled 'Coping With The Pressures of Farming', covering mental wellbeing and suicide awareness and prevention funded by Farm Family Key Skills Programme.

Through the Farm Families Health Checks Programme, on an annual basis, 2,600 rural dwellers avail of a comprehensive physical and mental health screening service.

43. Mental health among students is also an area that has come into increasing focus, particularly in the context of the Covid-19 pandemic. Anxiety and stress about exams, money worries, housing and social interactions can all contribute to poor mental health among students. It is important that we continue to work across government and sectors to intervene early to provide support to help students stay emotionally well and build resilience to support them in their learning journeys and lives beyond.

*Case Study: Mood Matters for Students*

The Mood Matters for Students programme is a free online Student Mental Health Programme which has been designed especially for students to deal with the impact on mental health arising from the Covid-19 pandemic. The programme, which is delivered by Aware NI, is based on the Mood Matters for Adults programme commissioned by PHA and gives participants knowledge and skills which can be used to maintain or regain good mental health and build resilience to deal with life's challenges.

The programme is based on cognitive behavioural concepts and introduces the 'Five Areas Approach' which participants use to challenge and change unhelpful thinking and behaviour in order to make a positive difference to their lives. It also features the 'Take5 for Your Emotional Wellbeing' which focuses on the five most evidenced ways of looking after our mental health i.e. Connect, Be Active, Take

Notice, Keep Learning and Give and teaches us how we can build these into our everyday lives.

44. Prevention actions in later life should focus on promoting active and healthy ageing as well as addressing the living conditions and environments that support wellbeing and allow people to lead a healthy life.[11] For many older adults, social contact is key to building emotional resilience and staying mentally well. For others, staying active, both physically and mentally, contributes to their mental wellbeing. As a society we must continue to value the contribution older adults make to our communities, and continue to provide opportunities and support for them to look after their mental health whether through social groups or befriending schemes, access to physical activity, or other advice and support. The Executive's Active Ageing Strategy, which has been extended to May 2022, includes a number of actions which contribute to positive mental health among our older population.

*Case Study: Arts Council and NI Screen*

There has been much research into the powerful contribution that engaging with arts and creativity can make to mental health. The Arts Council plan to reopen its Arts and Older People programme in 2021, which funds projects addressing social and mental health issues in older people. This is particularly welcome given the impact that lockdown and other aspects of the Covid-19 pandemic may have had on older people.

Northern Ireland Screen's Digital Film Archive outreach programme delivers free themed presentations based on the content of the archive to audiences across NI including community groups, charities and care homes. Recent collaborative projects include PLACE EE, a transnational inter-generational project, which works with older people in sparsely populated rural areas to improve wellbeing.

45. In Northern Ireland, for those with a recognised mental disorder mental health promotion, prevention and early intervention is often secondary to the delivery of specific mental health services. Often, this is not in the patient's best interests. To improve this we need to ensure that promotion, prevention and early intervention is mainstreamed in service delivery and across different sectors. This will require a renewed focus to ensure that mental health promotion meets the needs of those who need early intervention. This can include targeted approaches to groups more likely to be adversely affected by mental ill health, such as BAME groups, refugees and asylum seekers, people with a specific

[11] Policy direction for aging and older people can be found in the Department for Communities' *Active Ageing Strategy*. https://www.communities-ni.gov.uk/publications/active-ageing-strategy-2016-2022

trauma exposure, LGBT+ people, people with a physical or sensory disability and persons with an intellectual disability.

**ACTION 1. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach. The action plan must consider groups disproportionally affected by mental ill health which often struggle to access early intervention services.**

46. Early intervention can prevent the escalation of mental health problems. This can, for example, be through providing therapy in primary care to prevent depression and ensuring fast access to psychological therapies. This means providing primary care with the tools to provide mental health early intervention services. In Northern Ireland, the roll out of primary care multi-disciplinary teams, including mental health workers, provides better access to mental health support in an easily accessible format where people need it. This support is now available for an increasing part of the population.

47. The then Department of Health, Social Services and Public Safety's 2010 *Psychological Therapies Strategy* recommended integration of psychological therapies across all steps of mental health services. In practice this has led to the establishment of talking therapy hubs, managed by Trusts. Effective talking therapy hubs can provide early intervention and prevent a worsening of mental ill health of the population. However, the availability of talking therapy hubs varies across Northern Ireland, with services unavailable to significant parts of the population.

48. By expanding the availability of talking therapy through local hubs to ensure complete coverage across Northern Ireland, we can ensure early intervention services are available to the whole population. This needs to happen together with primary care. The hubs should therefore become part of primary care services and be developed in conjunction with the development of mental health in primary care multi-disciplinary teams.

49. In practice that means ownership of the talking therapy hubs will be transferred to primary care, with further integration with the multi-disciplinary teams and with the community and voluntary sector. This will ensure greater and easier access to early intervention in the form of psychological therapies.

50. Expansion of talking therapy hubs with involvement from the community and voluntary sector will increase the availability of psychological intervention which means waiting times will be reduced and people will have easier access to talking therapies when they need it.

**ACTION 2. Expand talking therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team. This will expand the delivery of psychological therapies across Northern Ireland to improve the mental wellbeing of the population and prevent the establishment of mental disorders.**

*Promoting children and their families' positive mental health*

51. We have already noted the importance of focusing on the promotion of prevention, early intervention and wellbeing throughout a person's whole life. However, if we can give every child born a good start in life, and support them and their families throughout their childhood, we can significantly reduce the likelihood of future mental health problems occurring.

52. Outcomes:

- Improved mental health among children and young people using key indicators from the 2020 Youth Wellbeing Child and Adolescent Prevalence Study.

53. Positive social and emotional development in infancy helps children feel safe and better able to develop cognitively and prepares them more fully for transitions into education. Children and young people who have strong attachments with parents and caregivers have an increased likelihood of experiencing good mental health throughout their lifetime.

54. Children's mental health and emotional wellbeing is nurtured primarily in the family. Therefore a key priority for all services is to support parents and carers. A secure parent/child relationship is a key building block for the development of positive attachment and helps to build emotional resilience in children. This support needs to continue into childhood and adolescence. Like cognitive capabilities, resilience, social and emotional skills are malleable. They can be taught and developed throughout childhood, adolescence and beyond.

55. Work needs to continue across sectors to promote positive social and emotional development throughout the period of childhood and adolescence. In practice this means building on existing good practice and areas of collaboration, such as between the health and education sectors, and seek out new, innovative ways of working to ensure children have the best start to improve their chances of a happy, healthy life.

**ACTION 3. Further promote positive social and emotional development throughout the period of childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.**

56. Children with global developmental delay or neurodevelopmental disorders can present with particular behavioural challenges which require specialist support for the child and their parents. Seven out of ten people with autism also have a condition such as anxiety, depression, Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder. The best way to support children and young people with an intellectual disability is to provide specialised parenting education and support programmes.

57. In Northern Ireland the approach to children with developmental delays or neurodevelopmental disorders is often characterised by approaches where the education and support needed is not always provided. In addition, mental health services are not always accessible due the setting of thresholds which often don't allow services to be based around the individual.

58. We need to ensure that the needs of these children and young people are considered as part of a whole system approach, where their needs come first. This means working across service boundaries.

59. It also means providing dedicated programmes to help parents understand the function of their child's behaviours of concern and teach the child new skills that can be used to replace behaviours of concern, as well as teaching the parents strategies to promote positive behaviour and positive mental health. It is vital that specialist mental health and well-being services are available for families caring for children and young people with neurodevelopmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD), intellectual disability or Autism Spectrum Disorder (ASD) and for the young people themselves. These services should work in partnership with other child health services including paediatrics and health visiting.

**ACTION 4. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for the disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.**

## Theme 2: Providing the right support at the right time

60. In Theme 1 we have set out the importance of promoting positive mental health and resilience, and of intervening early to prevent the onset of mental health problems. However, for some individuals more targeted mental health support may be required.

61. Our vision for mental health services is about putting the person and their needs at the centre and ensuring people have access to the support that they need, at the right time and in the right place.

62. This theme therefore focuses on ensuring access to a broad range of services across the lifespan and covering the spectrum of need, from Children and Adolescent Mental Health Services through to support for older people with mental ill health, and covering the range of services provided from community to inpatient and specialist services. Providing services at the right time means that support has to be available when people need it. That might be through appropriate crisis support, but it also means ensuring quicker access to appropriate services without multiple onward referral processes – a "no wrong door" approach. We also need to consider support for individuals with mental health needs holistically, to ensure that they do not fall between gaps in services if they have a dual diagnosis of mental ill health and an addiction, and to ensure they receive support for their physical health as well as mental health.

### *Child and adolescent mental health*

63. Outcomes:

- Children and young people should receive the care and treatment they need, when they need it, without barriers or limitations. This should be evident through shorter waiting lists.
- Reduction in difficult transitions for children and young people, by improved outcomes in 10,000 more voices and similar user surveys.
- A regional approach to the delivery of child and adolescent mental health services.

64. The 2020 *Youth Wellbeing Child and Adolescent Prevalence Study*[12] provides estimates of common mental health problems in children and young people in Northern Ireland. At any time one in ten children and young people are experiencing anxiety or depression, which is roughly 25% higher in the child and youth population in comparison to other UK nations. One in twenty young people aged 11-19 years display symptoms of post-traumatic stress disorder. One in six

[12] Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*

children and young people in Northern Ireland engaged in a pattern of disordered eating and associated behaviours. About one in ten of 11-19 year olds reported self-injurious behaviour with nearly one in eight reporting thinking about or attempting suicide.

**1 IN 20 – POST-TRAUMATIC STRESS DISORDER**

**1 IN 10 – ANXIETY OR DEPRESSION**

**1 IN 6 – PATTERNS OF EATING DISORDER**

**1 IN 10 – SELF-INJUROUS BEHAVIOUR**

65. Child and Adolescent Mental Health Services (CAMHS) provide services to children and young people and are organised according to a stepped care model. This is aimed at delivering the appropriate level of care, at the earliest point, that best meets the assessed needs of the child or young person. This is delivered through the CAMHS Integrated Care Pathway which sets out quality service standards across the different steps of care.

66. The stepped care model with its recovery ethos has provided a foundation which has facilitated improvements to the delivery of CAMHS. However, our model has become a system which tends to define itself in terms of services, meaning that young people with complex needs, or who do not meet narrow criteria for a particular service, may have difficulty accessing treatment. Combined with resource limitations this has led to long waiting times with 240 children and young people waiting longer than 9 weeks for core step 3 CAMHS, with over 120 waiting longer than 26 weeks.[13]

**OVER 120 CHILDREN AND YOUNG PEOPLE WAIT MORE THAN 6 MONTHS FOR STEP 3 CAMHS**

67. To help overcome this we need to focus on the needs of the young person and see them as individuals with a unique set of needs. This must involve improving our system so that service users and families can navigate it easily and it is adaptable to the way that symptoms and needs fluctuate. In practice this means improving the flexibility in the system.

68. Currently CAMHS funding is approximately £20-25m per year, which is between 6.5% and 8.5% of the total mental health budget. This must increase to 10% of

[13] Correct as of October 2020.

the overall mental health budget. This will allow meaningful investment to ensure the stepped care model can be flexible and meet the needs of young people.

69. The structures of CAMHS will change to ensure that the needs of young people are met. CAMHS will need to move away from working focussed solely on the steps of the stepped care model, towards a model where the steps provide indication of level of care modelled on the individual child or young person's needs.

**ACTION 5. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people.**

70. Improved delivery of the stepped care model in CAMHS should incorporate an inclusion health approach. This acknowledges that some groups are disadvantaged when it comes to access to services, or more likely to experience mental ill health. These groups include looked after children, children in immigrant or ethnic minority populations, substance use populations, children with physical health problems and physical and sensory disabilities, children of parents with mental health problems or with parents in prison, young people in the LGBT+ population, travellers, those at the transition juncture to adult services and children and young people with intellectual disabilities.

Case study: co-located mental health services for young people in contact with the justice system

As part of the review of CAMHS and the introduction of the new Stepped Care Model in the Southern Health and Social Care Trust it was identified that young people within the justice system, although they appeared to have considerable levels of mental health needs, struggled to engage with CAMHS. From this, the concept of a pilot mental health worker co-located within CAMHS and the Youth Justice Agency (YJA) was developed.

Commencing in March 2019, a Senior Mental Health Practitioner worked collaboratively across the CAMHS and the YJA teams in Banbridge and Portadown respectively. The service was established and sought to determine more clearly the level of mental health need within the youth justice population.

The service has enabled children coming into contact with the YJA to be assessed and supported directly, with referrals made to CAMHS where appropriate, including the promotion of services available within their multi-disciplinary team. Mental health assessment tools have also been developed for use by YJA to support early intervention with children and their families. The co-location of these services is delivering improved outcomes for children involved

with the youth justice system and has been positively received from the children involved, their families, CAMHS and YJA alike. The pilot has resulted in more children having better access to mental health services, which in turn, contributes to their desistance from offending. This pilot has been co-funded by SHSCT and YJA in 2020 and, such has been its success to date, consideration is now being given to rolling it out across Northern Ireland.

71. Whilst policy direction in Northern Ireland has been set towards equality of access, CAMHS services vary from Trust to Trust in terms of their organisation and remit and there is potential, particularly for vulnerable children, to be 'bounced around' or to 'fall through gaps' and to face barriers to accessing CAMHS.

*Case Study: Equal Access to services*

In 2014 the Southern Health and Social Care Trust reorganised their services to ensure children and young people with an intellectual disability had equal access specialist CAMHS. A 'no wrong front door' approach, with timely access to specialist assessment and therapeutic intervention, has led to improved outcomes for children and young people. The Trust have fewer children and young people with an intellectual disability prescribed psychotropic medication and have reduced the need for, and duration of, inpatient assessment and treatment. This service has been recognised for its innovation, child-centred approaches and clinical excellence across the UK and Ireland.

72. Going forward, particular consideration of these vulnerable groups must be had when developing and improving services for children and young people. This will incorporate a 'no wrong front door' approach meaning that children and young people from vulnerable groups will no longer be passed from service to service and should mean fewer hospitalisations and less use of medication.

**ACTION 6. We will meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.**

73. The regional care pathway and stepped care model has brought improvement and more consistency in acute and crisis care for children and young people across Trust services in recent years. There are, however, still significant variations across Trusts with reports of some young people waiting too long in Emergency Departments.

74. A quarter of CAMHS referrals in Northern Ireland are emergency or urgent compared to the average for the UK of just over one in ten. On average 40% of

children assessed in crisis do not need CAMHS treatment, so having highly skilled staff at crisis points is essential to ensure that children and families get the best and most appropriate care including within the community and voluntary sector.

## 1 IN 4 CAMHS REFERRALS ARE EMERGENCY OR URGENT EVEN THOUGH 4 IN 10 OF THE REFFERED ARE NOT IN NEED OF CAMHS TREATMENT

75. The recently established CAMHS managed care network and partnership board provides a platform for improving urgent, emergency and crisis CAMHS services in Northern Ireland. We will, through this network, develop regionally consistent urgent, emergency and crisis services to children and young people.

76. This means we will have a better response to children and young people in crisis, with the right provisions at the right time to prevent further escalation and provide timely interventions.

**ACTION 7. Create clear and regionally consistent urgent, emergency and crisis services to children and young people.**

77. Currently young people who continue to need mental health treatment and care transition from CAMHS to adult mental health services with the aim for the transition to be completed around their 18th birthday. There is no regional protocol in Northern Ireland for the transition of young people from CAMHS to adult mental health services and transition pathways vary across the five health and social care trusts.

78. Whilst Trusts have worked to establish and improve transition pathways there is a persistent reality of poor service user experience. The IMPACT study on transitions in Northern Ireland, found that none of the young people transitioning experienced an "optimum transition". The study also identified inequities with those prescribed medication and those with psychotic disorders most likely to transfer, whereas service users with autism/ASD are generally transferred back to primary care.

79. We need to improve transitions. An expert review is currently ongoing and will inform the policy direction and a way forward.

*Mental health and older adults*

80. Outcomes:

- All older adults who need mental health services will receive the care and treatment they need.
- Old age psychiatry services are no longer based on an age threshold but on the needs of the person.

81. The world's population has been growing exponentially in the past century and correspondingly, the proportion of older adults is increasing rapidly. Mental ill health is common among older adults and in Northern Ireland it is estimated that a mental health problem is present in 40% of older adults seeing their GP, 50% of older adults in general hospitals and 60% of care home residents. Under-diagnosis is reported as a chronic problem. Older adults with mental illness are more likely to require domiciliary or institutional care. They are more prone to physical co-morbidity and have higher rates of frailty and vulnerability.

**40% OF OLDER ADULTS ATTENDING GP**
**50% OF OLDER ADULTS IN GENERAL HOSPTAL**
**60% OF CARE HOME RESIDENTS**
**HAVE MENTAL HEALTH PROBLEMS**

82. Older adults are vulnerable to the full spectrum of mental illness seen in younger adults, with anxiety disorders particularly prevalent. In addition they have predictably higher rates of mental illness associated with physical illness, frailty and dementia. Social challenges include isolation, bereavement and economic poverty. Even so, evidence suggests older adults receive proportionally less help than other age groups. Depression affects around 22% of men and 28% of women aged 65 years and over, yet it is estimated that 85% of older adults with depression receive no help at all from statutory services.

**22% OF MEN AND 28% WOMEN OVER 65**
**SUFFER FROM DEPRESSION**

83. The legacy of trauma related to the Troubles poses a particular challenge in Northern Ireland. A person who was 18 at the beginning of the conflict will be 68 years old in 2020 and may present to older adults' services where there is an under provision of psychologically informed, recovery strengths focused interventions.

84. Mental health services for older adults in Northern Ireland have not kept up with the changing demand. Old age psychiatry still largely operates on an outmoded concept of health and aging with a cut-off at the age of 65. The increasing number of relatively physically well over 65s may have their needs met by working-age services. However the physically frail older adult (including those under the age of 65 with chronic illness and the elderly older adult) may have needs that result from the physical effects of ageing, needs which are better addressed in specialist old age services.

85. Safeguarding the rights of the frail and older adults will require identification of needs and planning of systems that deliver the right service, in the right way at the right time. Going forward we will recognise that chronological age alone is not sufficient to determine what services are needed and how they are best delivered.

86. In Northern Ireland that means we need to plan services based on the needs of the person, rather than their age.

**ACTION 8. Ensure adult mental health services cater for older adults with mental ill health, provide adequate support and structures and are mindful of the particular challenges older people face. The artificial cut off in adult services at the age of 65 will stop and people will be supported by the right service based on their individual needs.**

*Community mental health*

87. Outcomes:

- A mental health system that is person centred, where the system adapts to the need of the person.
- Reduction in waiting lists.
- Increase in service user satisfaction through methods such as 10,000 voices.

88. According to the Mental Health Foundation it is estimated that just 40% of those with mental health problems in Northern Ireland were able to access effective mental healthcare. 79% of those with a mental disorder who sought treatment felt they had not received the service they need.

## ONLY 40% OF THOSE WITH MENTAL ILL HEALTH WERE ABLE TO ACCESS MENTAL HEALTHCARE

89. Community based services will be evidence based, organised on a stepped care model, the core principle of which is that people are matched to interventions that are appropriate to their level of needs and preferences. However, at all times the services must be adaptable to people and their needs. This includes understanding the underlying factors for the needs, such as social factors, trauma and addictions, including gaming and gambling addiction.

90. In Northern Ireland that will see secondary and community mental health services in a population area focused and integrated around GPs with primary care as the hub for mental health care. This will involve a fundamental change in the operation of secondary mental health, moving away from current service structures which can seem fragmented towards joined-up locality based approaches centred upon populations in GP Federation areas. Services will be organised to work collectively in responding to the spectrum of need of the population, including those with more severe mental health problems, through collaborative and consultative models of care across primary, secondary and community care. This will put professionals where the people are to ensure the system fits the needs of the people.

## GOING FORWARD MENTAL HEALTH SERVICES WILL BE FOCUSSED AROUND THE GP TO ENABLE EASY ACCESS FOR THOSE WHO NEED HELP

91. In practice this means co-design of local pathways of care across primary and secondary care and across the range of available community resources in each Federation area. It will mean involvement of all actors in the delivery of mental health; GPs, Health and Social Care Trusts and the community and voluntary sector. It will also mean including people with lived experience, their family and carers in the co-design process.

92. At the heart of this is the primary care multi-disciplinary team which will include mental health workers. We already have 44 mental health practitioners in primary care covering five GP Federation areas. Over the next few years we will spend over £1m per year to improve access to mental health in the primary care multi-disciplinary team.

93. The GP with the primary care multi-disciplinary team will be the first port of call in the newly structured mental health system. In combination with an increase in

the accessibility of talking therapies through new talking therapy hubs overseen by GPs (see action 2) many people will have their needs met without needing further escalation. This will lead to quicker access to services, less referrals and better outcomes for people.

94. The effect of this will be noticeable for all. It is expected that this will reduce waiting times, that it will ensure timely access to services from primary and secondary care and the community and voluntary sector and that it will improve the user satisfaction with access to services.

**ACTION 9. Refocus and reorganise primary and secondary care mental health services around the GP Federations to ensure a person centred approach, working with statutory and community and voluntary partners to create local pathways within a regional system.**

95. The new models of service delivery across mental health will be founded on an ethos of recovery based care. This will ensure that all those with mental ill health receive the support they need.

96. The Recovery College model represents a valuable resource that could be better used and valued – however a more comprehensive roll out of the recovery and wellness agenda will require time and resources. Currently staff engagement in co-production activities through Recovery Colleges has largely been optional. A truly recovery-focused service will view involvement with Recovery Colleges as integral to practitioners' professional development. Existing expertise in the region within the voluntary and community sector will be part of this, in particular their valuable experience in training and pathways to employment.

97. In practice that means cementing the role of Recovery Colleges and ensuring accessibility of Recovery Colleges to those who need it wherever they are in Northern Ireland.

**ACTION 10. Further develop recovery services, including Recovery Colleges, to ensure that a recovery focus and approach is embedded in the whole mental health system.**

98. The effective delivery of a community based model of mental health is not possible without the full integration of the community and voluntary sector.

99. Historically, work with the community and voluntary sector has developed incrementally and whilst essential their availability, focus and configuration is uneven across Northern Ireland. It is important that these supports are available to those who need them, wherever they are. We must harness the skills and

experience that exist in the community and voluntary sector to ensure that this is used to benefit people with mental ill health.

100. In practice this means seeing the community and voluntary sector as partners who are fully integrated in ensuring improved outcomes for the population. This means fully including the sector in the planning, development and delivery of mental health services. Going forward all service delivery mechanisms must include consideration of the role of the community and voluntary sector.

101. This will mean the development of protocols for formal involvement and integration of the sector in the development of mental health services, in order to harness their expertise.

**ACTION 11. Fully integrate community and voluntary sector in mental health service delivery across the lifespan including the development of a protocol to make maximum use of the sector's expertise.**

### *Psychological therapies*

102. Outcomes:

- Availability of psychological services at the time when people need it.
- Reduction in waiting times to access psychological services.
- Integrated psychological therapies in mainstream mental health services.
- Use of all available methods and technology to meet the needs of the people.

103. An important part of community mental health services is the use of psychological therapies. However, across Northern Ireland there are inequalities in provision of and access to these services. Waiting lists for psychological therapies are long with over 2,400 adults and 269 children and young people waiting longer than 13 weeks and over 750 adults and 81 children and young people waiting longer than a year.[14]

**750 ADULTS AND 80 CHILDREN AND YOUNG PEOPLE HAVE WAITED OVER A YEAR FOR PSYCHOLOGICAL THERAPIES**

104. Improving access to effective psychological therapies is therefore a fundamental component to improving the mental health of the population.

[14] Correct as of October 2020.

105. In practice, to ensure improved access to effective psychological interventions, it is essential to match the right level of intervention to the individual seeking support, at the right time. This will require having a sufficient workforce with the right knowledge, skills and competencies to meet demand and deliver psychologically informed interventions to a high quality.

106. Improving access must encompass a whole life approach, be evidence based and trauma informed, placing the service user at the centre such that they are equal partners in their own self defined and self-directed care. Beyond increasing access to high quality interventions, there is also a need to fully integrate psychological therapies pathways within mental health services. Existing regional variations in service delivery means that in some areas people have to wait excessively long for psychological therapies.

107. This means embedding psychological services into mainstream mental health services, both in primary and secondary care. In primary care this means further rollout of talking therapy hubs (see action 2). In secondary care this mean integrated community mental health teams where psychology is one of the tools for the successful outcomes for the patients. This will ensure that psychological therapies are available across all steps in the stepped care model.

108. This will reduce the time people have to wait for psychological therapies and no one should ever wait longer than a year to access these services.

**ACTION 12. Embed psychological services into mainstream mental health services. Psychological therapies will be available across all steps of care.**

109. Since the Covid-19 outbreak, individuals attending mental health services have received support in innovative, alternative ways using digital technology (e.g. tele-therapy sessions). While these supports should not be viewed as replacements or proxy versions of traditional psychological therapies modalities, they represent an important new avenue of support by providing additional stand-alone treatment models.

110. In Northern Ireland new initiatives have been developed rapidly throughout 2020, including an Apps Library, on-line Stress Control classes and the usage of virtual platforms to deliver group and individual psychological interventions.

## THE PANDEMIC HAS HELPED US FIND NEW WAYS OF DELIVERING SERVICES

111. Going forward we must build on the experiences from the pandemic and bring in the good new practices into the delivery of services. This means developing and

providing digital delivery of mental health services. This will help people to self-help, meaning less people need to access traditional methods and that those who are in traditional methods can have positive outcomes quicker.

**ACTION 13. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.**

### *Physical healthcare and mental illness*

112. Outcomes:

- People with mental health difficulties will enjoy the same quality of life as the general population and have the same life expectancy.
- People with Serious Mental Illness will be offered, and encouraged to participate in, an annual health check.
- Reduction in % of patients who are smoking.

113. In Northern Ireland people with severe and enduring mental illness have a reduced life expectancy of 15 to 20 years because of poor physical health. Addressing this requires a cultural change and systematic approach across our communities, primary care, secondary care and specialist acute services. Every part of the mental health system, at every opportunity, should be asking about smoking, weight, alcohol intake and exercise and supporting change – the physical healthcare of mental health patients is everybody's responsibility.

**LIFE EXPECTANCY OF PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS IS 15 – 20 YEARS LESS THAN THE GENERAL POPULATION**

114. The main responsibility for the physical monitoring of mental health patients receiving treatment in secondary care rests with secondary care. However, often patients with severe and enduring mental health issues see their GP more frequently than secondary care teams. Given the poor physical health outcomes of those with a long term mental illness, we believe there is a need to increase the focus on monitoring the physical health of those with a mental illness. That will mean using every interaction with patients to monitor and seek to improve their physical health.

115. The physical health of mental health patients must become every day practice during routine interactions with mental health patients in primary care, whether

or not the main responsibility for their treatment rests with secondary care services.

116. People with mental ill health will see the effects of this by being asked questions about their physical health when seeing their GP. This will lead to a quicker identification of physical healthcare needs which will improve outcomes for people.

**ACTION 14. Ensure that monitoring of the physical health of mental health patients becomes everyday practice in primary care.**

117. The physical wellbeing of mental health patients continues in secondary care mental health services, and in particular of those who are cared for in acute settings.

118. In practice this means that all mental health patients should be subject to physical health screening. All patients should also have a combined healthy eating and physical activity programme as part of medication initiation and as part of their recovery plan.

**ACTION 15. Ensure that all mental health patients are screened for physical health issues on admission. Across all mental health services, help and support should be provided to encourage positive physical health and healthy living.**

### *In-patient mental health services*

119. Outcomes:

- Acute in-patient bed occupancy levels in line with the Royal College of Psychiatrists recommendations.
- Regional consistency in length of stay.
- Better life outcomes for patients with a long term intensive mental health need.

120. Whilst community mental health services provide the best outcomes for most people who are mentally ill, inpatient services are required for those where an effective community intervention is not possible.

121. In Northern Ireland the acute inpatient care system has for many years been under extreme pressures. Bed occupancy has consistently been around 100%, even though the Royal College of Psychiatrist's recommended occupancy level is 85%.

## AVERAGE ADULT ACUTE MENTAL HEALTH IN-PATIENT BED OCCUPANCY BETWEEN 1 JUNE AND 30 NOVEMBER 2020 WAS 101.2%

122. This has led to an in-patient system that operates in crisis mode, where it is not possible to provide therapeutic intervention as required and due to the pressures the focus is often on patient maintenance rather than recovery.

123. The difficulties of providing therapeutic improvements in in-patient settings is further hampered by the old in-patient infrastructure. About half the acute in-patient beds are in facilities which do not routinely have single bed bedrooms, that have not seen significant upgrades for decades and that do not meet recognised best practice standards.

124. Over the last decade we have invested £57m on building new mental health units across Northern Ireland. This has provided state of the art, single bed bedroom units where the physical infrastructure is helping in the recovery journey of the patient.

## WE HAVE SPENT £57M ON NEW MENTAL HEALTH UNITS AND WILL SPEND A FURTHER £170M

125. The capital works programme to replace the existing in-patient units will continue over the next decade, with a further £170m to invest in a further three new units. When continuing this programme, it is important that new inpatient developments meet the changing needs of the population. This means including consideration of integrated learning disability wards in mental health units, consideration of a specialist perinatal mother and baby unit and a specialist eating disorder unit.

126. Across Northern Ireland there are also significant variations in average patient length of stay (varying from 12 days in one Trust to 42 days in another). Whilst there are demographic and geographic differences between the Trusts, we must get a better understanding of the regional variations to ensure consistent quality services will be provided.

127. Mental health patients will notice that the new units have single bed bedrooms, where the units will be built to help deliver state of the art therapeutic options. We expect this to lead to a reduction in in-patient stay length with less incidents and problems on the wards.

128. For the small cohort of detained patients, the recent first phase commencement of the Mental Capacity Act provides for a framework for deprivation of liberty in

the community. This allows us to consider new ways of dealing with patients who require detention. Going forward we will use this change in legislation to consider if these patients can be cared for safely in the community. This will allow for greater community integration and a more normal life for patients.

**ACTION 16. Continue the capital works programme to ensure an up to date in-patient infrastructure. Also consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and to ensure that those who need in-patient care can receive the best care available.**

129. Across the in-patient units in Northern Ireland there are a number of patients who have a high level of needs who require a longer period of time to respond to treatment. This patient group are often detained under the Mental Health Order and are often in hospital for a very long time, measured in months and years.

130. This patient group, usually consisting of people with complex psychosis who are at risk of being unable to achieve or sustain successful community living, are not in need of acute mental health inpatient beds, but still form up to 20% of the acute in-patient population.

131. Acute in-patient services do not provide the best outcomes for this patient group and are often less effective. A better approach to meet their needs would be a dedicated rehabilitation service based on a recovery model. Rehabilitation services form part of a pathway to recovery for people with schizophrenia and related psychoses. Rehabilitation can be provided in a variety of settings, accepting referrals from acute wards and delivered through inpatient rehabilitation, community based rehabilitation services and various levels of care and support in the community, including supported living, nursing and residential care home options.

132. In Northern Ireland we will create a sustainable rehabilitation service that meets the needs of the patients. In practice that means creating a regional structure for mental health rehabilitation, with specialist community teams and a recovery ethos.

133. This will lead to better outcomes with fewer readmissions and fewer hospital stays for this patient group. This will give them the opportunity to enjoy better lives fully integrated in society.

**ACTION 17. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.**

134. A number of mental health patients in hospital have needs which are higher than what can ordinarily be provided in mental health in-patient units across Northern Ireland. Low secure services are for people detained within a legislative framework that cannot be treated in other settings because of the level of risk or challenge they present. They do not require the provisions of medium secure care as provided by the Shannon Clinic. Such patients may have been in contact with the criminal justice system but others may present other risks.

135. The mixing of patients who have low secure needs with the general mental health population, including those detained under the Mental Health Order but not deemed low secure risk, increases the risk of conflict and reduces recovery times for both patients groups. Specialist low secure services will help in the provision of the accurate assessment and management of risk.

## WE WILL PROVIDE LOW SECURE SERVICES

136. We will therefore provide regional specialist in-patient services for patients with a higher need in dedicated low secure settings. This will support patients with severe presentations that are gravitating towards the criminal justice system resulting in loss of the potential for recovery and potentially family breakdown. This will also lead to less conflict on existing mental health wards and overall shorter patient stay in hospital.

**ACTION 18. Develop regional low secure in-patient care for the patients who need it.**

### *Crisis services*

137. Outcome:

- A regional mental health crisis service.
- Effective help and support for people in crisis, through a regional crisis service, with a resultant reduction in Emergency Department attendance for mental health patients.

138. A recent report by the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services and one in ten people in distress end up in Emergency Departments. People in crisis require help and support and no-one should have to wait for that help.

139. Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage

Team), community crisis intervention service in Derry/Londonderry and others. Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments.

*Case study: Multi Agency Triage Team*

The Multi Agency Triage Team (MATT) pilot commenced its service in July 2018, as a collaborative project which involved two Police Officers, a Community Mental Health Practitioner and a paramedic working together to respond to people experiencing a mental health crisis, aged 18 and over, who have accessed the 999 or 101 system. The pilot was initially established as a 2 year initiative, in the South Eastern Health and Social Care Trust, however following positive feedback from service users and MATT staff the service was extended to cover Belfast Health and Social Care Trust in August 2019.

MATT has successfully assisted in the de-escalation of crisis with signposting to appropriate services and through reducing presentations at Emergency Departments.

140. While the pilots have been providing good results, it is important that the development of crisis response services are an integrated part of the wider mental health system.

141. Effective crisis services will mean fewer people with mental health problems attending Emergency Departments. It will also mean that people with existing mental illness who find themselves in crisis have clear contact pathways and access to the right service when they need it.

142. We need to improve the mental health crisis response. An expert review is currently ongoing and will inform the policy direction and a way forward.

**ACTION 19. Create a regional crisis service to provide help and support for persons in mental health or suicidal crisis. The crisis service must be fully integrated in mental health services and be regional in nature.**

### *Co-current mental health issues and substance use (dual diagnosis)*

143. Outcomes:

- A reduction of patients with a co-current mental health and substance use issue that are non-compliant with mental health treatment
- A person centred approach to care that focusses on the person, rather than expecting the person to fit the system.

- Better health and social outcomes for those with co-current mental health and substance use issues.

144. Access to services for people who have a co-occurring mental health and substance use problem, often called “dual diagnosis”, has been an ongoing concern. For some individuals, their drug use and mental health is inter-related. Both general mental health difficulties and symptoms associated with psychological trauma can lead people to “self-medicate” with alcohol and drugs to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues.

145. Guidelines are clear; no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, clinicians and services users must work collectively together to address the issues and people should not be referred back and forward between different services unnecessarily.

## DUAL DIAGNOSIS GUIDELINES ARE CLEAR – SERVICES SHOULD WORK COLLECTIVELY TO ADDRESS THE NEEDS OF THE PERSON

146. However, service users often report difficulties in accessing services and unclear lines of referral. The response must ensure that mental health services and substance use services consider the patient first, and adjust the systems to fit the patient, rather than expect the patient to fit the system.

147. The creation of a dedicated dual diagnosis service is not the answer. Such a service would be at risk of receiving “difficult” referrals that mental health and substance use services do not feel able to treat. Instead, the most effective approach is likely to be mental health and substance use services that work together.

148. In practice, to achieve this vision support will be provided to ensure services work collaboratively and that existing pathways are followed. This will take the form of a managed care network with experts in dual diagnosis to ensure capacity building and appropriate pathways.

**ACTION 20. Create a managed care network, with experts in dual diagnosis supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.**

*Specialist interventions*

149. Mental health services in Northern Ireland are normally provided in generalist services. Such a system allows a wide angle approach to mental health to capture a large group of people without unnecessary referrals. However, generalist services do not always cater for the needs of specific groups.

150. The evidence from other countries is clear. Specialist interventions set up correctly within a wider generalist mental health system works and provides better outcomes for patients and shorter recovery times. Going forward we will address the shortfall in Northern Ireland and will provide specialist interventions where they are needed.

151. When developing specialist interventions we must remember that we have a relatively small population. Some specialist interventions will not be available in Northern Ireland as they cannot be provided safely.

152. Currently we send approximately 12 to 15 patients detained under the Mental Health Order per year to specialist treatment in England and Scotland. These patients often stay away from family and friends for a very long time. We will, where possible, develop specialist in-patient provisions to avoid sending these people to England and Scotland.

153. Outcome:

- Effective specialist interventions that meet the needs of the people, when they need it.
- A person centred service that avoids silos and where persons are treated as individuals.
- The right specialist interventions when needed, with quicker outcomes thus reducing the time people require mental health interventions.

154. Perinatal mental health is a priority for prevention and early intervention with poor perinatal mental health affecting not only mothers but also increasing the risk of poorer outcomes in health, educational and social outcomes for children. This potentially creates a cycle of poorer mental health in subsequent generations.

155. Northern Ireland is behind the rest of the UK with regards to specialist perinatal mental health care, with only a specialist consultant-led perinatal mental health service within the Belfast Trust. For mothers requiring inpatient mental health care there is no mother and baby unit in Northern Ireland, and mothers requiring admission are cared for on general adult mental health wards with no opportunity for their child to be accommodated alongside them.

156. We have started the work to develop a regional specialist perinatal community mental health service. This will help expectant and new mothers experiencing mental ill health, reduce in-patient care and promote strong, secure, attachments with their children. We will continue to roll out specialist perinatal mental health services, including in-patient services.

**ACTION 21. Continue the rollout of specialist perinatal mental health services.**

157. An early intervention in psychosis approach has been shown to reduce the severity of symptoms, improve relapse rates and significantly decrease the use of inpatient care, in comparison to standard care. A recent meta- analysis of outcomes at 6 to 24 months concluded an early intervention in psychosis approach was associated with superior outcomes compared with treatment as usual regarding all outcomes, including hospitalisation risk, bed-days, symptoms, and global functioning.

158. In Northern Ireland psychosis interventions are provided within community mental health teams, home treatment and throughout in-patient services. They are not as integrated as they could be and do not always help patient recovery. To overcome this we will create a psychosis network to ensure early intervention psychosis care, access to evidence based treatments and interventions for people with psychosis.

**ACTION 22. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a psychosis network.**

159. It is estimated that up to 50% of those attending psychiatric outpatient clinics, 50% of those in psychiatric inpatient services and 80% of the prison population meet the criteria for a personality disorder. 45% of those presenting to Emergency Departments with self-harm have a personality disorder, with 9-10% of those with a personality disorder dying by suicide and with 45-77% of those who die by suicide potentially having a personality disorder. It is estimated that the total cost to the UK economy is £35bn.

160. Specialist interventions are often needed for people with personality disorder. We will therefore create a personality disorder service, with a tiered approach. This will provide a clear model across mental health services where personality disorder specialists can provide services across regionally agreed pathways which will ensure that people get the care they need when they need it.

161. This will reduce the number of detained patients with emotionally unstable personality disorder that have to be transferred to England and Scotland for specialist treatment. It will also reduce the number of in-patients with personality

disorders. It is also expected that it will further the life satisfaction of those with personality disorder through getting effective specialist care and treatment when they need it.

**ACTION 23. Create a personality disorder service and enhance the specialist interventions available for the treatment of personality disorder in Northern Ireland.**

162. Northern Ireland has a regional network for the provision of services for people with an eating disorder. However, the outcomes for patients with eating disorders in Northern Ireland are lower than in other close jurisdictions and some of our service provisions do not currently meet National Institute for Health and Care Excellence (NICE) guidelines.

163. To improve the outcomes for patients with an eating disorder, we will provide further investment so that eating disorder services can achieve optimum staffing levels and skill mix to deliver effective care across the pathways. In practice this includes additional nursing and dietetic staff to support the treatment and safe supervision of patients with an eating disorder in local mental health in-patient units, including the regional CAMHS unit and paediatric wards.

164. Additional support will allow all eating disorder presentations to be subject to immediate referrals and such referrals to be considered without delay. Treatment support should include normal day activities and intensive day treatment should be further developed in line with NICE guidance.

165. We will also decide the future of eating disorder in-patient services. Currently a number of patients travel to England and Scotland for specialist treatment, keeping them away from family and friends who can often help recovery.

**ACTION 24. Create a regional eating disorder service.**

## Theme 3: New ways of working

166. We have set out in this Strategy the strategic changes to mental health services to support individuals throughout their lives. But we need to ensure we have the right framework, structures and support in place to make these changes happen and improve outcomes for individuals.

167. Our vision sets out our desire to ensure consistency and equity of access across Northern Ireland, and to provide a choice of services that are based on evidence of what works. And we need to find a way of measuring how these changes are positively impacting people on an individual level.

168. Having a skilled, compassionate and trauma informed workforce is key to achieving the change required. Our mental health workforce is dedicated and committed to supporting the people they work with, but the system too often hampers their best efforts. It is important to provide the right environment to support staff to do their utmost to recognise and meet the needs of the people they work with.

169. We also need to build on existing and new evidence to allow us to be ambitious and innovative as we seek to bring about lasting change.

### *A regional mental health service*

170. Outcomes:

- A regional approach to mental health with regional consistency in service delivery.
- Less confusion for patients using services across Trusts measured through service user satisfaction surveys.
- Improved experience for those transitioning between Trusts.

171. In Northern Ireland mental health services are delivered through integrated health and social care trusts. This is different than in other close jurisdictions. The integrated structures have significant advantages. Our approach creates an integrated system with a single employer and budgets, integrated management (which fosters inter-professional working) and integrated approaches to hospital discharges.

172. However, the Lord Crisp report into mental health services in Northern Ireland noted that whilst there are significant strengths in the Northern Irish system, there are also weaknesses around commissioning arrangements and that the organisational boundaries get in the way of improving quality and efficiency. Mental health does not always get the same attention as physical health in HSC

Board and Trust decision making. This negates the positive impacts an integrated health and social care system across physical and mental health can have.

173. To overcome the current challenges, we will create regional structures where there is regional oversight of service development and delivery. This will ensure greater consistency, overcoming the sometimes confusing range of different types of service provision in different Trust areas. The regionality that is needed will extend to service models, service delivery and service structures, including service names and language.

174. In practice that means we will create a regional mental health service network which will include professional leadership responsible for regionality in service models and development. This includes ensuring consistency in the services offered across Northern Ireland. The Encompass programme offers us a significant opportunity to start to build this regional consistency. As we roll out new, digitally enabled ways of working this will drive regional discussions on consistent care pathways, data collection, nomenclature and standards.

## A REGIONAL MENTAL HEALTH SERVICE WILL ENSURE REGIONALITY IN SERVICE PROVISIONS

175. Trusts will still be responsible for service delivery and patients will interact with the Trusts. Even so, a regional mental health service will directly benefit patients by removing variations in service availability. It will improve the movement of patients across Trust boundaries and will aid understanding of the system among users.

**ACTION 25. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership, responsible for consistency in service delivery and development.**

### *Workforce for the future*

176. Outcomes:

- A well supported workforce that is fit for the future and meets the needs of those who are mentally ill.
- An increase in the number of training places for mental health professionals.
- An increase in the number of staff employed in mental health services.
- A workforce who have training in meeting the needs of particular high risk groups, suicide prevention skills and trauma informed practice.

177. The significant and enduring mental health needs of Northern Ireland's population have been repeatedly demonstrated and have clear links to well-established socioeconomic determinants of health and the legacy of the troubles. For staff in mental health services, there appears to be an ever increasing demand, more complexity in presentation, and recruitment and retention challenges.

178. Across Northern Ireland mental health services are struggling with high vacancy rates, with some Trusts reporting mental health nurse vacancy rates of over 20%. Over the last few years we have increased training places at local universities for mental health nurses by 85%. Going forward we will continue to train more mental health nurses.

**OVER 20% OF MENTAL HEALTH NURSING POSTS IN HSC TRUSTS ARE VACANT**

179. Whilst the number of vacant psychiatry posts are not higher than the rest of the UK, the use of locums to fill vacant posts is very high with a combined locum and vacant posts rates at 22%. Whilst locums can fulfil the duties of a permanent psychiatrist, the effectiveness is often reduced due to lack of stability and lack of patient knowledge. We will work with the relevant bodies to ensure that the psychiatry workforce is sufficient to meet the demand.

**22% OF PSYCHIATRIST POSTS ARE EITHER VACANT OR FILLED BY LOCUM STAFF**

180. The number of approved social workers in Northern Ireland has increased over the last few years. However, there is still an estimated gap in the number of approved social workers required and it is estimated that at least a further 25% are required.

181. We have significantly increased the training places in clinical psychology, but there is still a shortfall in the availability of clinical psychologists and fewer training places per head than other parts of the UK.

182. Going forward, multidisciplinary working – with a skilled, supported workforce that is equipped to meet the demands – is central to the future provision of mental health services as it provides the strength of the biopsychosocial approach and creates an effective working environment that enables each professional and group of professionals to use their own unique skills, knowledge, and abilities. Teams with wide skill sets can better meet the individual's needs by creating a tailored blend of personalised interventions that provide consistency, cohesion,

and choice. Strong, well trained multidisciplinary teams therefore can deliver safer, more effective services that can meet the depth and breadth of the challenges faced during the individual's recovery journey by developing and implementing a shared intervention plan from each profession's unique perspective.

183. In practice this means considering the existing workforce and new models of working in a comprehensive workforce review. This will allow informed decision making as to where the focus on training, recruitment and retention needs to be and help us create a workforce for the future. This may include bringing in new professions and skill sets to the mental health workforce and normalising new care and treatment options.

**ACTION 26. Undertake a review of the mental health workforce, including consideration of increasing training places and training of the existing workforce.**

184. Critical to the development of mental health services now and into the future must also be greater engagement and support for the peer support worker role and advocacy. Peer support workers and advocates use their own lived experience and knowledge to help and support individuals in their recovery journey. In Northern Ireland peer support workers have been partially rolled out, with uneven coverage across the Trusts. Clearer regional guidance, a consistent approach and job descriptions across Trusts will help improve the impact that peer support and advocates can have and improve outcomes for patients.

185. Going forward we will create clear roles and guidance for peer support workers and advocates and integrate peer support fully in the multi-disciplinary team.

**ACTION 27. Create a peer support and advocacy model across mental health services.**

### *Data and outcomes*

186. Outcomes:

- A clear, evidence based outcome framework which allows evidence to be the foundation for decision making.
- A robust data set which is comparable across Trusts to measure performance and to determine what works.

187. To ensure we have the right services that meet the needs of the population we must have data to measure outcomes. In Northern Ireland, only a small number

of individual mental health services have adopted successful outcomes frameworks.

188. Going forward, we will create a new regional outcomes framework together with professionals and service users. Broadly, this framework should include areas such as patient safety, accessibility (timely access, appropriate demand, demographics), acceptability (person centred, service-user views on intervention), efficiency, equitability (geographical parity), and integration (inter-service interfaces). This will help us in evaluating what works and ensuring we are providing services that deliver good outcomes for people while providing value for money. The Encompass programme, which will be replacing a number of existing software systems, provides us with the opportunity to access a much richer pool of data and information to help inform and improve practice. We will need to work together regionally to exploit this opportunity.

**ACTION 28. Develop a regional outcomes framework in collaboration with service users and professionals, to use as a method to underpin service development and delivery.**

### *Innovation and research*

189. Outcomes:

- A regional approach to mental health research which produces quality outcomes.

190. In Northern Ireland research is coordinated through the Public Health Agency Research and Development office. However, there is only one dedicated mental health research nurse, with a stronger focus on physical healthcare issues. To ensure that mental health in Northern Ireland benefits from innovation and research we will seek to create a more innovative and research focussed culture. This will allow us to shape research to include our specific needs, including the legacy of the Troubles on the population's mental health, and the use of technology, particularly given the recent experience during the Covid-19 pandemic.

191. In practice there will be a renewed emphasis on mental health research and innovation through increased research funding and by the establishment of a centre of excellence which supports research and innovation, acting as an exemplar and a point of contact for clinical staff and voluntary and community sector providers seeking to innovate, test ideas, or implement emerging knowledge.

192. When we do this, it is important that we avoid duplication of research effort, and we learn from other places rather than seeking to answer questions locally which have already been answered across other nations. A central centre of excellence will ensure effective working and tangible outcomes. This will also ensure that mental health patients in Northern Ireland are the first to experience innovative ideas.

**ACTION 29. Create a centre of excellence for mental health research with dedicated funding.**