

Review of Mental Health Policies in Northern Ireland: Making Parity a Reality

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Introduction

There is strong evidence that Northern Ireland (NI) has very high levels of mental illness and the suicide rates are the highest in the UK and Ireland and are showing no signs of declining. The 2008 world mental health survey in NI showed that 23% met the criteria for a mental illness in the past year [1] and 39% of the population had a mental illness in their lifetime [2]. The NI Health Study found that 19% of the population are likely to have had a mental illness in the previous year [3]. The rates of mental illness in NI are higher than any other region in the UK; and at least 25% higher than in England [4]. In NI the legacy of violence and socio-economic factors are cited as major contributors to the high levels of mental illness, with deprivation being a major predictor of area level mental wellbeing. In NI deprivation, and high rates of mental and physical illness co-occur in the areas most impacted by the violence:

“...Multi-morbidities increase with age but are also evident in younger people in areas of high deprivation. Mental health illness is associated with physical health conditions and again these are prevalent in areas of high deprivation which are also areas where the Troubles have had the most impact and the legacy of the Troubles has caused trauma and poor mental health.” [5].

The world mental health survey also showed that NI has high rates of post-traumatic stress disorder (PTSD) and again, that trauma exposure resulting from the conflict accounts for this excess [6]. Mental health issues are the largest cause of ill health and disability in the population [7] [8]. NI's suicide rates are also high. 2015 saw the highest number of suicides (318) since records began in 1970 and of these, 77% were male [9].

More people in NI have taken their own lives since the signing of the peace agreement in 1999 than were killed as a result of the Troubles between 1969 and 1997 [10]. Despite over £7million having been spent annually on the services delivered as part of the Protect Life suicide prevention strategy, the male rate of suicide in NI is currently twice that of England and the Republic of Ireland, and NI has not seen the reduction in suicide rates experienced in Ireland and the other UK regions [11]. The legacy of the conflict, and the high levels of deprivation have once again been acknowledged as major contributory factors [12] [13].

Health, and the provision of mental health services, is a devolved matter. Despite these statistics, NI is the only region in the UK that does not have an overarching mental health strategy and the delivery of mental health treatments and care is fragmented and not properly resourced. Nonetheless,

steps have been taken to address the unique mental health needs of the population. The Victims' Service was established in 2013 and provides support to those who have been affected by the Troubles including those who have mental illnesses. The development of a new service to provide treatments for people with trauma related mental illness was included in the Stormont House Agreement. In 2016 £175,000 funding for the service for the regional trauma network was announced and, three years later, plans are underway for the commencement of the service.

The need to reform how healthcare services are delivered is a global issue. Changing demographics and medical advancements mean that ageing populations are living with multi-morbidities and long-term illnesses. NI emerges as the worst region in the UK in terms of waiting lists for healthcare, with the relationship between lengthy waiting times and the resulting impact on mental health often being overlooked. A study by the Patient and Client Council in NI in 2018 [14] supported key findings from previous research, that long waits for treatment lead to poorer health, increased levels of anxiety and can impact upon social life and employment. Waiting for excessive periods of time for investigation and treatment was shown to have a devastating impact on patients and their families.

Figures released by the Department of Health highlighted once again that hospital waiting times are continuing to spiral out of control. In some cases, waits of up to four years for a first outpatient appointment are not uncommon. Patients are expected to endure waits of more than two years after being referred as an urgent case. The figures also highlighted a “postcode lottery” for patients, with the wait time for a first outpatient appointment in the same specialty varying by more than three years.

In March 2019 there were 120,000 people waiting more than a year in NI, compared to 5000 across England and Wales combined. The equivalent of one in 16 people in NI has been waiting more than a year, compared to at most one in 750 in Wales, and one in 48,000 in England. This means that a citizen of NI is more than three thousand times as likely as a citizen of England to have been waiting more than one year for healthcare year [15].

The Permanent Secretary of the Department of Health, Richard Pengelly, advised in May 2019 that the public should not expect change to waiting times soon. He noted that the transformation agenda could not tackle waiting lists as a cash injection of around £1 billion was required [16]. Clearly long waits for any type of diagnosis, treatment and support can have devastating knock on mental health effects and be distressing for people. The longer people wait, the more problems are likely to escalate to crisis point and the greater the enduring negative impact for their physical and mental health.



Whilst policy on waiting lists is a priority in other regions of the UK, with specific initiatives to address them, this is not the case in NI. Pockets of money have been released to ease pressures, but as expected, have had very limited impact. It is difficult to gain the trust of the public for a transformation agenda when the situation regarding waiting lists is so poor. Tinkering at the margins, and short-term sticking plasters will not address fundamental underlying issues. Lack of scrutiny and accountability around performance is compounding a challenging situation.

Whilst advances in talking therapies and medical treatments mean that many mental illnesses are now widely regarded as treatable, but access to evidence-based services has been identified as a key problem in NI, with mental health services in NI having been viewed as the 'Cinderella service' of the health sector. In February 2018 a group of campaigners and experts in mental health services presented statistics for suicide, self-harm and mental illness to MPs at Westminster, expressing concern for what they described as NI's "worsening mental health crisis". In a briefing paper from voluntary organisations delivering community mental health services [17], it was stated that suicide rates were highest in the most deprived areas where some of the poorest wards in the UK had experienced the highest levels of violence. In presenting

their findings they called for:

1. The appointment of a Mental Health Champion.
2. Investment in mental health support for people of all ages, with a commitment that public spending will deliver a dividend for mental health, particularly in the areas of health (including public health), social care, education, employment, housing and criminal justice.
3. The delivery of a 10-year Mental Health Strategy.
4. Funding for a prevalence study on children and young people's mental health.

In December clinicians from NI were invited to present oral evidence to the NI Affairs Committee on funding priorities for the NI 2018-19 health budget [18]. The expert witnesses included mental health practitioners from the statutory and voluntary and community sectors, and together they called for additional resources for a struggling mental health service and a new regional trauma centre to deal with the mental health legacy of the Troubles. Whilst the lack of a mental health strategy remains a significant issue, strategies have included initiatives which address areas relating to mental health. This paper reviews those that have been published in the previous 10 years, summarises their main points and assesses the extent to which they have been implemented.

Healthcare Reform in NI: Key Policies and Strategies

The World Health Organisation (WHO) defines good mental health as:

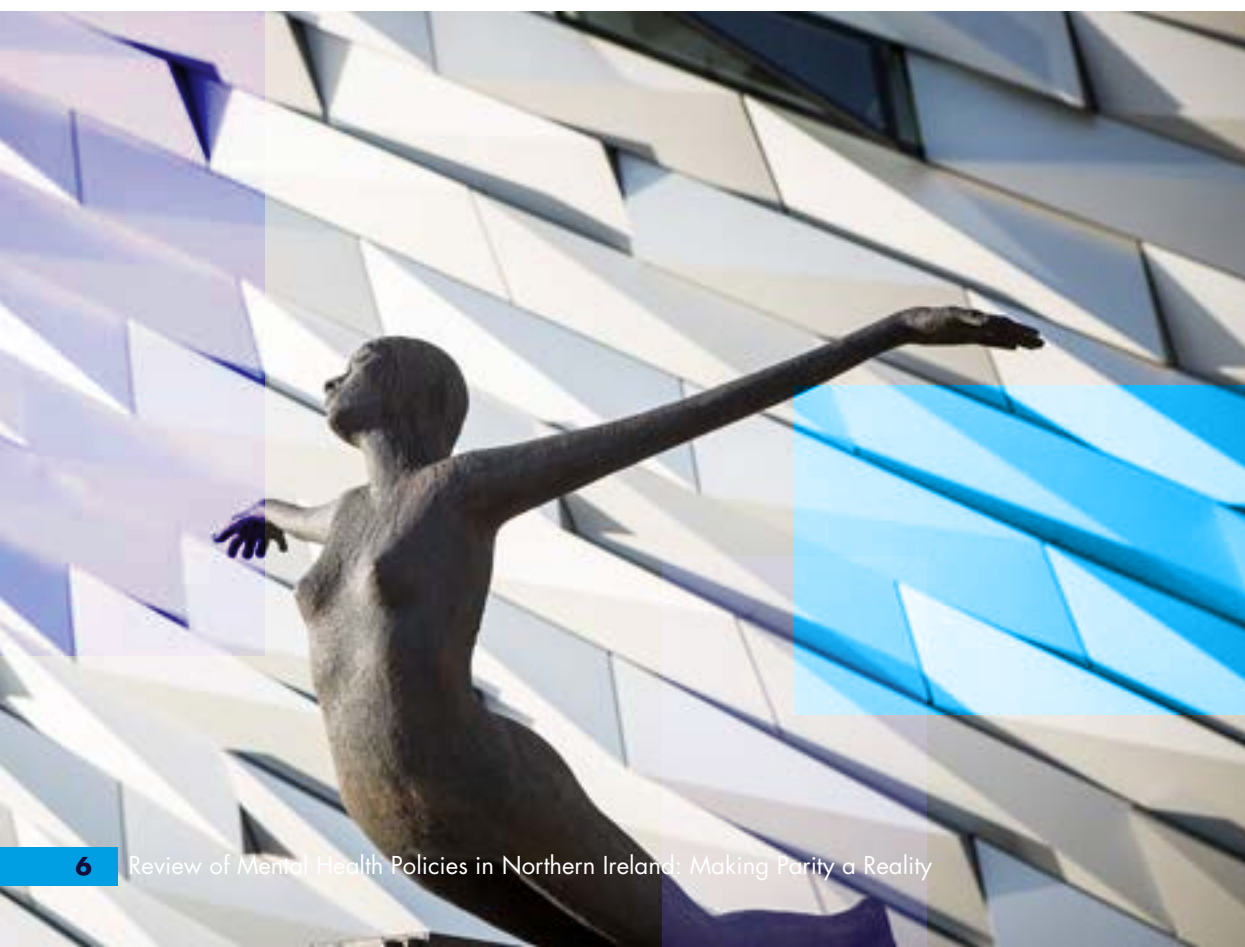
A state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. [19]

The World Health Organisation provides three main goals for the organisation of mental health services: to deinstitutionalise mental health care; to integrate mental health into general healthcare; and to develop community mental health services [20]. These goals were integral to the recommendations resulting from the Bamford Review of mental health and learning disability. The issue for NI mental health care is not a lack of knowledge or awareness of what is required. Rather, it is a lack of commitment to prioritise, adequately resource and implement recommendations that have already been made.

The most recent 10-year plan for the delivery of health care services in NI was launched by the (then) Health Minister, Michelle O’Neill in October 2016, prior to the collapse of the NI Assembly. ‘Health and Wellbeing 2026: Delivering Together’ [21] (‘Delivering Together’) was the response to recommendations contained in a report from an expert

international panel appointed to review how health and social care was being delivered. ‘Systems, Not Structures: Changing Health and Social Care’ [22] became known as the Bengoa Report, named after its Chair Professor Rafael Bengoa. It was published in October 2016 and emphasised the need to move services into the community to relieve the pressures on acute services. The Department of Health’s response to the Bengoa Report recognises the high rates of mental illness in NI, listing mental illness (and trauma) as areas of priority investment stating: “We will expand services in the community and services to deal with the trauma of the past.” [21]. However, the ways in which mental health care should be delivered are not discussed. In the Health Minister’s statements at the launch of Delivering Together, she emphasised her awareness of the current crisis in mental health in NI and vowed to be a champion for mental health in taking the plan forward. However, with the collapse of the NI Assembly and the broad political agreement for the demands of lobbyists on behalf of mental health services, it is feared the momentum has been lost.

The health reform agenda in NI precedes the Department’s proposed Delivering Together 10-year plan. The Bamford Review of Mental Health and Learning Disability [23] continues to form the foundation for the delivery of mental health services in healthcare policy and strategy in NI, although the direction of travel in recent policies and strategies demonstrate an evolution towards the ‘health and wellbeing’ of the general population.



Bamford Review of Mental Health and Learning Disability

Mental health service reform continues to be guided by the Bamford Review that was completed in 2008. The Bamford Review of Mental Health and Learning Disability ('the Bamford Review'), named after Professor Bamford, Chair of the review's steering committee, was an independent review initiated by the DHSSPS in 2002 with a remit to review the law, policy and service provision for those affected by mental ill health or a learning disability in NI. The scope of the Review took into account recent policy and developments in the European Union and would address the needs of those with specific mental health needs or a learning disability in accordance with the statutory equality obligations of the NI Act 1988 and the Human Rights Act 1998 [23]. The Bamford Review's steering committee presided over 10 expert working groups and published 11 phased evidence-based reports between 2005 and 2007. These outlined areas that needed addressing including legal issues, older people, CAMHS, adult mental health services and learning disability services. The publications drew on existing information and commissioned new research where necessary [24].

The first publication, "Review of Mental Health and Learning Disability (NI): A Strategic Framework for Adult Mental Health Services" (June 2005) [24], set out a vision for adult mental health services for the next 15-20 years when it was envisaged that the Bamford Review recommendations would be implemented over a 10 to 15 year period. Key recommendations called for:

- A continued emphasis on promoting positive mental health;
- A reform of mental health legislation (the Mental Capacity Act 2016 for NI has not been implemented at the time of writing);
- A continued shift from hospital to community-based services;
- Development of specialist services for children and young people, older people, those with addiction problems, and those in the criminal justice system; and
- A fully trained workforce to deliver mental health services.

As part of the Department's commitment to the 2009-2011 Action Plan the then Minister of Health, Michael McGimpsey, launched 'A Strategy for the Development of Psychological Therapy Services (June 2010) [25].



Its overarching aim was to improve the health and wellbeing of the population, providing early intervention and improved access to psychological therapies. It also highlighted the need to provide information to the public on what services were available and acknowledged that "... *Almost 40 years of civil unrest during the Troubles continues to impact on society, with services becoming more aware of the impact of trans-generational trauma on children and families. ...*".

Despite recognising the impact of the Troubles and their continuing inter-generational affect, the development of psychological therapies has not been realised [18]. However, preliminary research shows that low level Cognitive Behavioural Therapy has proven useful in improving mental health in an NI population, with a pilot study to evaluate the effectiveness of low-intensity cognitive behavioural therapy (CBT) in primary and community settings showing a recovery rate of 47.9%, improvement rate of 76.7% and deterioration rate of 6% [26].

The Bamford Review was notable for emphasising partnership with service users in the planning, development and evaluation of services and also in the various aspects of assessment and therapy. Interestingly, during the course of the review, service users objected to being invited to be involved only at a late stage of the proceedings, and commentators have noted negligible changes to the extent of involvement in areas such as service level planning [27]. To date, though there has been relatively little research on the nature and extent of service user involvement in NI. In their assessment of the future of the NHS in NI the Royal College of Surgeons [28] emphasised the need for authentic engagement to empower people to engage in the design of their own care. Turning away from a hospital-based delivery system requires co-production based around community contribution to a sustainable system of health and social care.

Bamford Review Implementation

Recommendations from the Bamford Review were to be implemented in 'Delivering the Bamford Vision – Action Plan (2009-2011)' by the Health and Social Care (HSC) Bamford Task Force. This was jointly led by the Health and Social Care Board and the Public Health Agency. In 2009 the Patient and Client Council also set up the Bamford Monitoring Group to gather views and experiences of service users, their families and carers across NI on the effect of changes to services.

An evaluation of the 2009-2011 Action Plan [29] identified the key challenges in 2009 for the delivery of mental health services. These identified the need for the following:

- Establishment of a stepped care approach to service provision;
- The enhancement of the range of options available to health care professionals for the range of mental health needs presented;
- Improved access to psychological therapies;
- Streamlining of access to mental health services generally;
- Provision of home-based care and support as the norm for mental health services;
- A systematic approach for the recovery of people with long term conditions;
- Building up the range of specialist mental health services to meet need; and
- The redesign, extension and retention of an effective workforce.

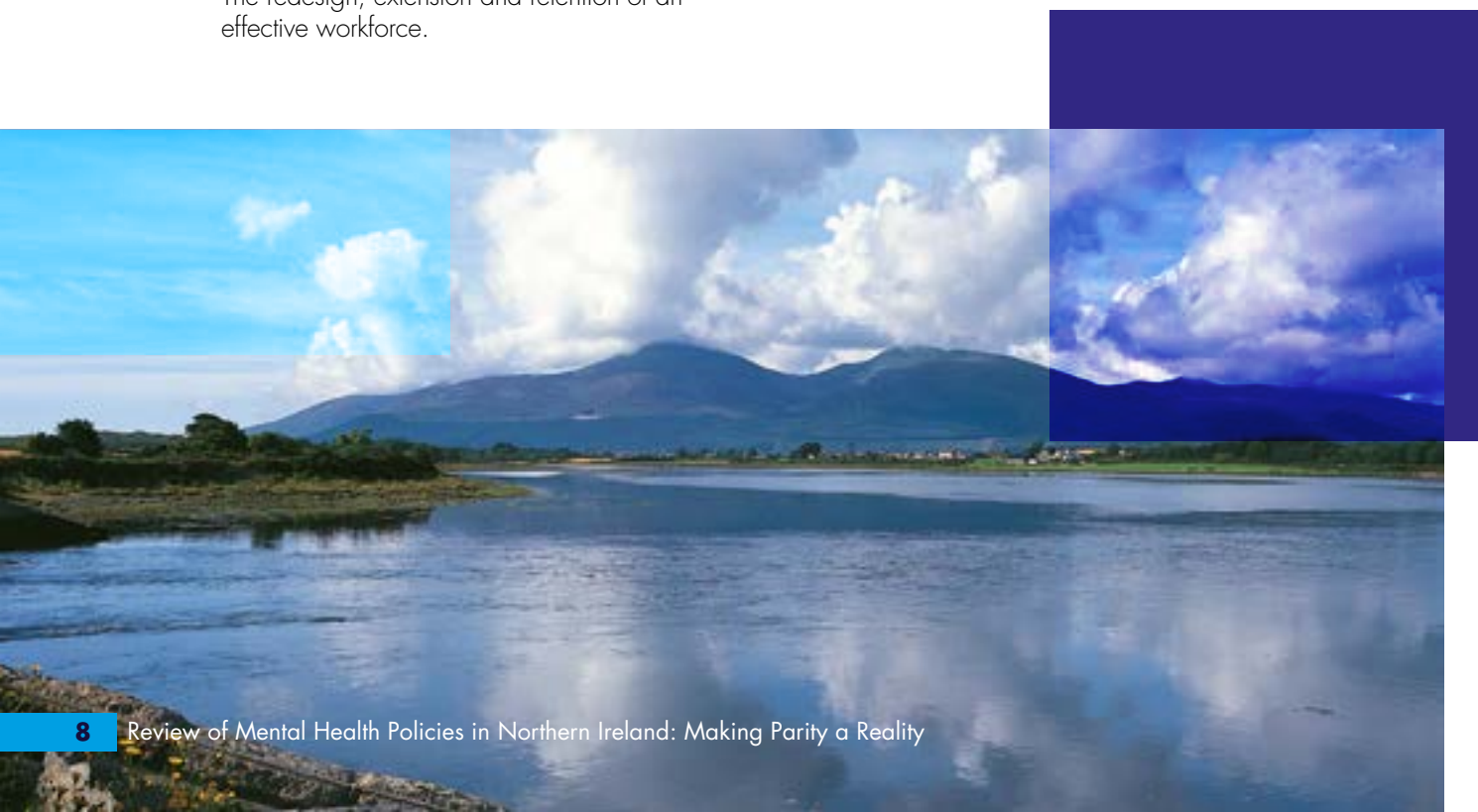
A revised Action Plan (2012-2015) [30] to continue actions not completed in the previous 2009-2011 Action Plan was published in March 2013. It was to represent "...the Northern Ireland Executive's continued commitment to the development of mental health and learning disability services in Northern Ireland, and to the promotion of independence and social inclusion for those people within our community" and described as a "...truly cross-cutting agenda" requiring a "...commitment across all parts of Government ...". [30]

The new revised action plan contained 76 actions under the Bamford Review's delivery themes of:

1. Promoting positive health, wellbeing and early intervention.
2. Supporting people to lead independent lives.
3. Supporting carers and families.
4. Providing services to meet individual needs.
5. Developing structures and a legislative framework.

A Monitoring Report of the 2012-2015 Action Plan was published in November 2013 [31] when progress at October 2013 showed that of the 76 actions, 63 were on target, and 13 were at risk or delayed. A further Monitoring Report was published in November 2014 and stated that in general terms there had been good progress made on the Bamford Action Plan 2012-2015 [32].

The table opposite compares progress on key action points that were at risk/delayed in October 2013, October 2014, or both.



Bamford Monitoring Reports November 2013 and November 2014: Progress on key action points considered to be at risk/delayed

Action No.	Key action	Progress October 2013	Progress October 2014
1	Publish and implement a revised cross-sectoral promoting Mental Health Strategy (DHSSPS)	A suicide prevention and positive mental health promotion strategy is expected to be published for consultation May 2014. Final strategy expected September 2014.	A suicide prevention and positive mental health promotion strategy is substantially drafted. The aim is to issue for consultation in March 2015.
6	Progress the next phase of the suicide prevention strategy	A suicide prevention and positive mental health promotion strategy is expected to be published for consultation May 2014. Final strategy expected September 2014.	A suicide prevention and positive mental health promotion strategy is substantially drafted. The aim is to issue for consultation in March 2015.
13	Resettle long stay patients from learning disability and mental health hospitals (OFMDFM)	On target Oct. 2013. Resettlement ongoing. 2012/13, 28 patients resettled from mental health hospitals and 41 from learning disability hospitals. Target for 2013/14, 33 long stay patients from mental health hospitals and 75 from learning disability hospitals.	At risk/delayed Oct. 2014. The resettlement target is largely on track for completion by March 2015 and figures for 2014/15 are in line with the expected profile of plans for this year which expects the majority of placements to take place in the 4th quarter.
25	To support the uptake of self-directed support and individual budgets in line with Transforming Your Care (DHSSPS)	On Target Oct. 2014. "Who Cares" published September 2012. Review to be completed by 2015. HSCB committed to increasing uptake of direct payments and by March 2015 aims to provide a personal care budget to 100% of those eligible for social care services and that 20% of these people will access self-direct support.	At risk/delayed Oct. 2014. "Who Cares?" the first stage of the reform of adult care and support was published in September 2012. A Project Board has been established and work ongoing to carry out essential financial modelling of the cost reforms. Anticipated that consultation on stage 2 proposals will be launched in the Autumn 2016. HSCB has committed to increasing uptake of direct payments – mental health has seen an increase of 26% from 2012/13 to 2013/14.
27	Implementing "Developing Advocacy Services – A Policy Guide for Commissioners (DHSSPS)	Service user groups and implementation teams are in place. Key actions being taken forward include a scoping study of advocacy provision, development of commissioning guidance and training awareness raising for health and social care staff and practitioners.	An independent Advocacy Code of Practice and Standards Framework was launched in June 2014. Members of the Advocacy Network NI have committed to the code of practice and are using it as part of their induction and training programmes for new staff and volunteers.
35	Enhance and develop the services to assist clients who transfer from incapacity benefit to Job Seekers Allowance (JSA) (DEL)	The Condition Management Programme (CMP) is available to JSA clients who have come through the Incapacity Benefit Reassessment process. Around 40% of people referred to CMP have mental health and around 25% have a learning disability.	The CMP is available to all JSA clients throughout the Jobs and Benefits Offices/Job Centre Network. All front-line advisers have been provided with a desk-aid designed by Disability Sector consortium to help them recognise behaviours and traits of people who have a mental health condition or learning disability and advises them how to respond and appropriate referral, including to CMP.
38	To provide support to all carers in order that they may continue in their caring role (DHSSPS)	The HSCB is striving to ensure that all carers are offered a carers assessment. The number of carers assessments offered has increased by 35% from 2011 to 2013. The number of carers assessments completed has increased by 18% in the same period.	The HSCB is striving to ensure that all carers are offered a carers assessment. The number of carers assessments offered has increased by 27.5% from 2012/13 to 2013/14.
60	Implement the Mental Health Service Framework across HSC (DHSSPS)	On target Oct 2013. The HSCB and PHA are developing agreed care pathways as part of an ongoing incremental process to develop Integrated Care Pathways (ICPs) which reflect the Framework and NICE guidance. Pathways currently in preparation include those for General Adult Mental Health, Addiction Treatment and Eating Disorders – these are in addition to the existing regional Care Pathways for Perinatal Mental Health, Forensic Mental Health Care and Autism/ASD.	At risk/delayed Oct 2014. There has been some progress on some of the standards. A fundamental review of the Mental Health Framework is under way and a revised framework is expected by April 2016.
61	Provide information on children's, adolescent and adult mental health services for use by the public, GPs and other clinicians (DHSSPS)	On target Oct 2013. A web-based map of all mental health services is due to go live by the end of 2013.	At risk/delayed Oct 2014. Data collection for the Mental Health Service Mapping was completed in 2013 and work is ongoing with NI Direct to resolve technical difficulties in relation to hosting the web page. It is anticipated these pages will be fully operational on or before April 2015.
64	Enhance availability of psychological therapies	Additional £1M has been invested in primary mental health will provide greater access to GPs to psychological therapies and clarity on referrals. Additional training is also being provided for existing staff.	Pilot Primary Care Talking Therapy Hubs have now been established in each Trust.
71	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review (DHSSPS)	Community forensic teams are now in place and a centrally funded training programme continues. 3 newly refurbished low secure facilities are now in use.	Community mental health forensic teams are now in place and a centrally funded training programme continues. 3 newly refurbished low secure facilities are now in use. Work is ongoing to prepare a bid for the required resources to support these.
76	New mental capacity legislation DHSSPS)	The timescale for completion of this legislation has slipped to March 2016. Consultation on a full draft of the Bill is expected to take place in 2014 and the Bill is to be introduced to the Assembly by Spring 2015.	Consultation on the civil provisions for the draft Bill was completed on 2 nd September 2014. The consultation included a policy statement on the criminal justice provisions (Department of Justice). It is intended to submit the Bill to the Executive in March 2015 for approval to introduce in the Assembly, with a view to attaining Royal Assent by March 2016. ³³

A full evaluation of the Bamford Action Plan 2012-2015 was initiated by the Department of Health in 2016 to assess the performance of Executive Departments against the targets for action. The evaluation was to include the views of service users and carers in order to identify needs and gaps in the service. The evaluation was expected to have been published in Spring 2017. However, the last available minutes of a meeting of the Bamford Review Monitoring Group [34] held on 2nd February 2018 notes that the previous meeting had agreed that in the continued absence of the Bamford Evaluation Report it was suggested and approved that no new members of the Monitoring Group should be recruited at present [35]. To date (June 2019) the final evaluation of the Bamford Review has still not been published by the Department of Health.

The Royal College of Psychiatrists had highlighted the importance of the expected evaluation due to the significance of the Action Plan in mapping the future of mental health services for the next number of years and the need for it to align with the outcomes from the Bengoa Report.

Although the final evaluation has not been published, initial findings include the need to [7]:

- Further embed and promote psychological therapies and the concept of recovery;
- Provide more practical support to carers;
- Improve access to services in times of mental health crisis;
- Improve the experience of patients admitted to acute mental health facilities; and
- Increase the involvement of the voluntary and community sector.

Recent oral evidence to the NI Affairs Committee [18] from experts in the field of mental health in NI reported that psychological therapies are still poorly developed despite having a psychological therapies strategy that was published in 2010 [25].



Mental Health Capacity Law

Medicine in general has shifted away from paternalism and places increasing emphasis on patient choice and autonomy. A review of mental health legislation was included within the remit of the Bamford Review. It concluded that existing legislation was no longer fit for purpose as it was not compliant with principles of autonomy, justice and human rights. A single comprehensive framework for the reform of mental legislation was recommended. Following extensive consultation it was agreed that, uniquely in the UK, the mental health law and mental health capacity would be fused into a single bill [36]. The Mental Health Order which had been in place since 1986 was replaced by the Mental Capacity Act (NI) 2016. This legislation marked a dramatic move away from involuntary psychiatric treatment and was more compatible with a right-based framework. However, as Szmukler and Kelly [37] have noted the collection and evaluation of robust evidence on its effect

and implementation are essential if this ground-breaking Bill is to meet its potential.

In December 2016 the Department advised [38] that no commencement dates had been agreed for the Mental Capacity Act (NI) 2016, but that plans were under way and decisions on commencement were subject to the necessary resources being made available. However, there were no plans to draft or lay any commencement orders before 2019 at the earliest.





Transforming Your Care: A Review of Health and Social Services in NI

In June 2011, Edwin Poots the then Minister for Health, Social Services and Public Safety (DHSSPS) announced a major review of health and social care in NI to make recommendations for the future of services and provide an implementation plan. Its focus was on how services were structured and delivered in order to make the best use of resources and examine the extent to which the needs of patients, service users and carers were being met [39]. The independent review panel engaged with the public, clinical and professional health care leaders, health and social care organisations and stakeholders in the voluntary and community sector.

When Transforming Your Care (TYC) was published the number of registered suicides in NI had risen from 146 in 2005 to 313 in 2010. One of the main drivers for reviewing health and social care services in NI had been

"...the shadow of our recent history in NI, particularly in the mental wellbeing of the citizenry..." (DHSSPS, 2011).

The focus for Transforming Your Care was:

- Improving care provided for individuals and families in NI;
- More care to be delivered at home rather than in hospitals;
- People supported to live as independently and healthily as possible for as long as possible;
- Better prevention of ill health; and
- Easier access to health and social care.

The goal of delivering services as close to a patient's home as possible was not a new one. In 2005 DHSSPS had published 'Caring for People Beyond Tomorrow - a 20-year strategic framework for primary care' [40], that recognised the need to further develop community-based alternatives to hospital admission. Key to this had been the introduction

of Primary Care Partnerships (PCPs), with GPs developing voluntary alliances of health care professionals working together with the voluntary and community sector for closer integration of primary and community care, hospital specialists and the social services.

Following publication of the Review Panel's report a public consultation 'Transforming Your Care: Vision to Action Consultation' [41] was launched in October 2012 outlining how a new model of care was to be organised with four key themes:

- Keeping individuals healthy by helping them to improve their own health and wellbeing;
- Delivering services as locally as possible;
- Ensuring emergency and specialist care was safe and sustainable; and
- Collaboration with neighbouring jurisdictions.

The TYC Consultation states that NI has greater mental health needs than other parts of the United Kingdom and the reasons for this include "...persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history." Despite its relatively long history of an integrated health and social care system enabling different parts of the system to work together, services were often fragmented and poorly co-ordinated [42].

Key proposals for mental health services were:

1. Better earlier intervention by joining up how mental health services work with GPs and other primary care providers.
2. A reduction in the number of people in institutional care and inpatient beds.
3. The development of 6 in-patient mental health units for those aged 18+ - one site in Northern, Southern, South Eastern and Belfast areas, with two in the Western area.
4. Enhanced support for carers.
5. Promotion of uptake of self-directed support and other programmes in order that people would have choice and control over the care they receive.

The Consultation responses showed broad support for the proposals relating to mental health services, particularly for the need to progress the Bamford recommendations. Commenting on the health and social care in NI the Public Accounts Committee (PAC) said "Transforming Your Care is heralded as the great transformation saviour for health and social care, but the pace of change has been, at best, mediocre." [43]

The Psychological Therapies Strategy [25] recommended that those with mild to moderate mental health problems should be able to access psychological therapies and in its submission to the TYC Review, the Royal College of Psychiatrists emphasised the need for a system capable of early intervention. TYC introduced the Stepped Care model adopting a graduated approach to meet the service user's individual needs.

Stepped Care Model

- Step 1** Recognition, Assessment and Support
- Step 2** Treatment for Mild Disorders
- Step 3** Treatment for Moderate Disorders
- Step 4** Treatment for Severe / Complex Disorders

Source: TYC (2011)

Operational planning and delivery for TYC was undertaken by the Health and Social Care Board and the Public Health Agency. However, by 2014 the focus for health care reform was on 'governance'. 'The Donaldson Review: The right time – the right place' [44] was established to review how health and social care in NI was governed. During the review process the Review Team heard criticism that TYC was not being implemented due to a lack of planning and resources. This led to Professor Liam Donaldson [45] including as one of his 10 recommendations a call for 'action not words' in relation to TYC. He recommended "...that a new costed, timetabled implementation plan for Transforming Your Care should be produced quickly." (P.44)[44]

The progress of health and social care reform was also being monitored by the NI Assembly Committee for HSSPS during the 2011-2016 mandate. The Committee was concerned that the Department was not working to a measurable, costed plan and raised questions regarding the monitoring, governance and funding of TYC.

A key component for the delivery of TYC was a shift of £83 million from hospital services to community services. This was not being achieved due to the Department's finances, and although the Department were making bids during Monitoring Rounds to achieve the £83 million, these were not always successful [5].

Providing an update on TYC to the Assembly in 2014, the then Health Minister, Edwin Poots, described it as a 3-5 year-journey to deliver 'the Right Care, at the Right Time, in the Right Place' [46]. In February 2015, his successor Jim Wells stated that the three to five-year implementation plan for TYC was dependent on financial considerations. He also acknowledged that John Compton, the author of TYC "...could not have envisaged the current financial backdrop" [47]. By 2015 TYC was virtually abandoned when it became clear that the resources were not available to sustain its implementation [5].

Making Life Better – Framework For Public Health

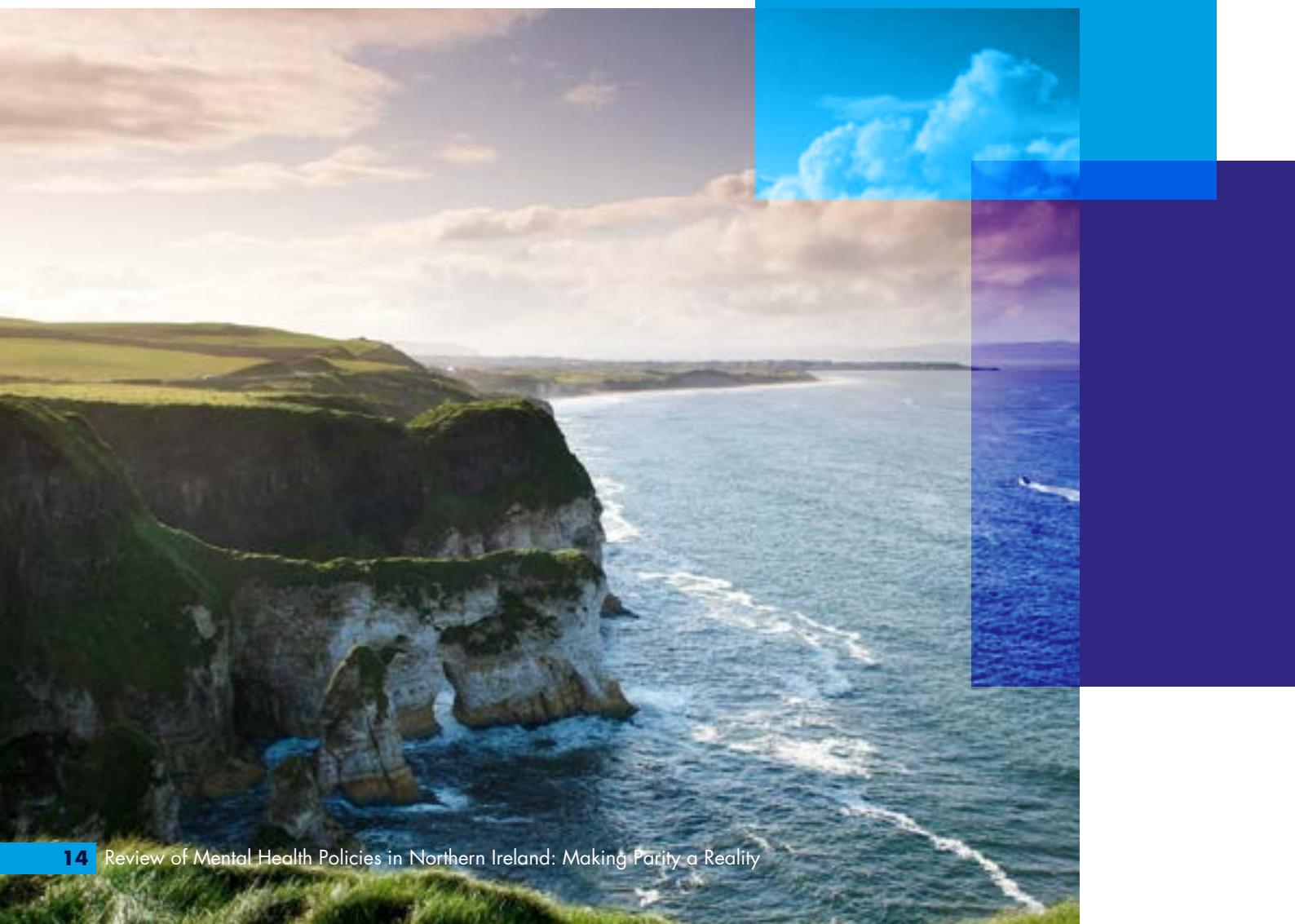
The Executive’s framework for public health ‘Making Life Better – a whole system framework for public health 2013-23’ [4] (‘Making Life Better’) was published in 2014 and builds on the previous public health strategy ‘Investing for Health’. It takes account of consultation responses on the draft framework ‘Fit and Well – Changing Lives’ [48]. This plan proposed adopting a ‘life course approach’, focusing on how the social determinants of health operate at many levels to influence health in later life. For each life stage the framework proposed a policy aim, long term aspirational outcomes and shorter outcomes to be achieved by 2015.

Outcomes were based on encouraging action around:

- Securing safe and supportive environments.
- Seeking to maximise potential.
- Promoting good physical and mental health and wellbeing.

A progress report for Making Life Better 2014/15 [49] reflected the Executive’s commitment to improve health and wellbeing and reduce health inequalities by focusing on action on the wider social, economic and environmental determinants of health working across departments. On the theme of giving every child the best start, projects included increasing Family Support Hubs through coalitions of agencies; Early Intervention Transformation to deliver social change by equipping parents to give their children the best start; as well as creating and sustaining child-care places.

In 2015-16 the Department identified a number of key overarching issues that would be likely to impact on the Making Life Better framework including: “... *At a policy level the need to consider population health and wellbeing as integral to the development of the next Programme for Government and underpinning strategies both economic and social*”. [49]



Health and Wellbeing 2026: Delivering Together

Health and Wellbeing 2026: Delivering Together' [21] ('Delivering Together') is a ten-year strategy and action plan for the transformation of NI health and social care published in response to the expert panel report 'Systems Not Structures: Changing Health and Social Care' [22], known as the 'Bengoa Report'.

The then Minister of Health, Michelle O'Neill, said mental health was one of her priorities. She wanted to provide better specialist mental health services as part of a commitment to achieving parity of esteem between physical and mental health. The impact of health inequalities on communities means 30% of those in the most deprived areas report a mental health problem; this is double the rate in the least deprived areas.

Delivering Together was to be delivered in line with PfG 2016-21 and the Executive's population health framework "Making Life Better". Its aim is to build community capacity and support the vulnerable in society; those living in deprivation, the elderly and those with learning disabilities and mental health issues. It moves the focus to people rather than buildings, providing care and support, where possible, in community settings. This is in line with the direction of travel in healthcare reform from the Bamford Review to Bengoa. Delivering Together promises more support in primary care for preventive and proactive care for treatment of both physical and mental health problems.

Addressing the NI Assembly on 25 October 2016 to launch Delivering Together, the then Minister said she intended to be a 'Mental Health Champion' and stressed the need for continued co-production in service planning. The Bengoa Report (2016), Donaldson Report (2014) and Transforming Your Care (2011) were all instrumental in the development of Delivering Together. However, Delivering Together was now described as "*the only roadmap for reform*" and is intended to address issues where socio-economic factors influence a person's quality of life, health outcomes and ultimately their life expectancy. Delivering Together is to provide the roadmap for a radical transformation in the way health and social care services are delivered. The Minister said there would be no 'quick fix' given the size and scale of the challenge, and she expected the transformation process to take two mandates to plan, implement and embed.

Delivering Together was to provide more funding for early support services, particularly mental health interventions and Mental Health Hubs in primary care. Mental health issues are mainly referred to in relation to 'services for physical and mental health'. However, a section consisting

of two paragraphs is specifically devoted to mental health and acknowledges the particular challenges in relation to mental health in NI. Professionals in the statutory and community sector are commended for the services they provide, acknowledging that the mental health services they provide need to evolve, improve and build on the Bamford reforms from the last decade.

A Progress Report for Delivering Together in October 2017 [50] refers directly to mental health on four occasions, rather than referring to 'physical and mental health' generally. Mental health is specifically mentioned in relation to reforming hospital and community services and achieving parity of esteem, which continues to be a priority. It states that investment is dependent on funding, although at the time of publication work had progressed on establishing a Regional Mental Trauma Service to address conflict legacy issues. A year on from the launch of Delivering Together "*...a Partnership Board and Implementation Group have been put in place to take forward this service, and recruitment of staff to manage trauma caseload across the Trusts is underway.*" A paper setting out the options for the future development of perinatal services, including proposals for a specialised Mother and Baby Unit, was also "*... ready for consideration by an incoming Minister.*" (para. 44). However, since there has been no Minister for over 30 months, to-date these plans have not been progressed. Paragraph 63 refers to £200m under the confidence and supply agreement to be made available for transformation of HSC, with a further £50m is to be invested in mental health services over 5 years. The progress report states it is important that the funding is invested in initiatives for the future, rather than addressing current pressures. A link to the latest position in January 2018 lists 18 key deliverables and their current position. These do not mention the proposed Regional Mental Trauma Service or the specialised Mother and Baby Unit [51].

The importance of workforce planning has been highlighted in policies and strategies since the Bamford Review recommendations. An action of Delivering Together has finally seen the publication of a workforce strategy for the next 10 years. It outlines the current problems and challenges going forward.

Health and Social Care Workforce Strategy 2026: Delivering for Our People

The Health and Social Care Workforce Strategy 2026: Delivering for Our People [52] ('the workforce strategy') is a long-term strategy to match the requirements of health care transformation in NI. An initial allocation of £15 million was to be spent workforce development, from the £100 million transformation fund for 2018-19. A third of the £15 million was to be spent on nursing, midwifery and Allied Health Professional workforce with 74 additional pre-nursing places, and an additional 25 midwifery places, meaning there will be a total of 1,000 nursing and midwifery places commissioned from universities in NI. Transformation funding was also allocated to support training investment in nursing assistants, physiotherapy, radiography, paramedics and medical specialities [53]. There is no specific mention of mental health service staff recruitment or training, despite the Workforce Strategy outlining urgent areas needing addressed in relation to mental health service staff.

There are significant pressures on social workers including those who work in adult mental health, child protection and services for looked-after children. There will also be increased demand on social work services from the Executive's target to improve social wellbeing through person-centred care, community development, self-directed support and co-production. New legislation including the Mental Capacity Act (NI) 2016 [54] and the Draft Adoption and Children's Bill [55] will also mean additional statutory roles and responsibilities. In the next five to 10 years, social workers will be expected to have more specialist knowledge and skills.

The unprecedented increase in recognition of the relevance and need for psychological interventions in health and social care is reflected in NICE guidance for physical as well as mental health presentations. Psychological interventions are relevant to improved health and wellbeing, also reducing costs associated with disability, healthcare dependence and social exclusion. The implementation of the Mental Capacity (NI) Act 2016 will impact on demand for clinical psychologists. In line with NICE guidelines, in recent years there has been increased diversification of the areas of employment including staff wellbeing, Autistic Spectrum Disorder services, and early intervention services. However, NI has the lowest rate of clinical psychologists per head of population across the UK and the Republic of Ireland. It also has the lowest number of training places per head of the population. Approximately 19% of the workforce are recruited from

outside NI with a 19% vacancy rate across Trusts who report being unable to keep up with increased demand [56].

Since the Strategy for the Development of Psychological Therapy Service (June 2010) developments in recruitment have seen other professions recruited into psychological services. These include psychological therapists, behaviour support workers, autism workers and rehabilitation assistants and effective governance arrangements are required for professionals delivering psychological interventions.

Mental health nurses are the largest mental health workforce and a mental health nursing review is underway to examine and strengthen their role. There is also a need to revise the undergraduate curriculum to support the provision of psychological therapies and promote the development of advanced practice roles. Recruitment and retention remain a challenge and a new career framework is being developed to enhance the role of learning disability nursing. The aim is to enable them to contribute more significantly in "... improving physical, psychological, behavioural and social outcomes across primary care, community care, and acute and specialist learning disability services." The Mental Capacity (NI) Act 2016 will also impact on the work of nurses, nursing assistants and midwives [57].



Draft Programme for Government Framework 2016 – 21

The Draft Programme for Government Framework [58] was published in May 2016. The focus was on measured outcomes based on results rather than intentions and would “require significant change to approach and behaviour to deliver the outcomes.” (p.7). It reiterates that mental wellbeing is a consideration of a range of government objectives as it influences social circumstances that can include employment, family relationships and participation in the local community.

Following Executive agreement on the framework there was a period of consultation during the Summer of 2016. Based on this, the Executive published its Programme for Government Consultation Document [59], with a foreword that stated: “Government first and foremost must be about making people’s lives better”. The introduction also begins with “...This Programme for Government is designed to help deliver improved wellbeing for all our citizens.”

GHQ 12 is used as an indicator of mental wellbeing. This is a tool designed to detect “...the possibility of

psychiatric morbidity in the general population” and is a questionnaire containing 12 questions relating to recent general levels of happiness, depression, anxiety and sleep disturbance. However, ‘wellbeing’ is a concept meaning different things to different people at different times and is circumstantial. The use of the term runs the risk that efforts will focus on initiatives that generate improvements in indicators of well-being for the majority who enjoy good mental health, rather than tackling the factors that contribute to creating meaningful change for those with mental illness and suicidal behaviour. Without measurable outcomes that are meaningful for those who are the most vulnerable to illness there will be a lack of accountability.

In the outcomes-based model that will inform the approach, each outcome will be supported by several indicators so that we can measure the extent to which the outcome is being achieved, “...the important principle being that indicators are attached to outcomes rather than strategies.” [59]

Gray and Birrell have outlined a number of conceptual concerns around the use of Outcome Based Accountability. They suggest that in this iteration of Outcome Based Accountability the term outcome is conflated with a range of performance management metrics including objectives, goals, targets, benchmarks and outputs. Generally, in public administration outcomes relate to what has been achieved and are tangible. Here, outcomes refer to desired outcomes, rather than actual outcomes which can be somewhat misleading. Additionally, a significant number of these outcomes are extremely vague, such as we ‘enjoy long healthy, active lives’. They further caution against focusing on proxy measures and making assumptions about cause and effect [60]. In their response to the consultation on the Programme for Government, the BMA expressed concern that the framework was based solely on Outcome Based Accountability and questioned if this was an appropriate, reliable evidence base.

The NI Budget 2018-19 [61] was announced in March 2018 to provide clarity to Departments planning for the financial year ahead. An extra £25 million was generated by increasing the regional rate and a decision was taken to allow £100 million of capital funding to be used for ongoing public service provision. There was an increase for the DoH, although with the pressures on existing services and increases in demand, it is likely that the increase will preserve rather than enhance services. However, £4 million was set aside to enable Departments to transform the delivery of services. In addition, through the Confidence and Supply Agreement, £100 million was to be invested to progress health transformation; £20 million in severe deprivation programmes, £10 million in mental health services and £80 million in health and education programmes.



The 'Outcomes Delivery Plan 2018-19: Improving wellbeing for all – by tackling disadvantage and driving economic growth' [62] is being taken forward by civil servants during 2018-19 "... to give effect to the previous Executive's stated objective of improving wellbeing for all – by tackling disadvantage and driving economic growth." (p.3).

The Delivery Plan will guide Departments based on the framework agreed by the previous Executive and Assembly following public consultation in 2016. "That framework reflects population conditions in 12 key areas of economic and societal wellbeing that people said mattered most to them." (p.3). It will require Departments to work together to deliver 'wellbeing' to the population of NI, presumably reflecting the 'joined-up government' that has been called for by lobbyists for a number of years.

Outcomes	Indicators
Outcome 4: We enjoy long, healthy, active lives	<ul style="list-style-type: none"> • Healthy life expectancy at birth • Preventable mortality • % population with GHQ12 scores ≥ 4 (signifying possible mental health problem) • Satisfaction with health and social care • Gap between highest and lowest deprivation quintile in healthy life expectancy at birth • Confidence of the population aged 60 years or older (as measured by self-efficacy)
Outcome 8: We care for others and help those in need	<ul style="list-style-type: none"> • % of population with GHQ12 scores ≥ 4 (signifying possible mental health problem) • Number of adults receiving social care services at home or self-directed support for social care and a % of the total number of adults needing care • % of population living in absolute and relative poverty • Average life satisfaction score of people with disabilities • Number of households in housing stress • Confidence of the population aged 60 years or older (as measured by self-efficacy)
Outcome 12: We give our children and young people the best start in life	<ul style="list-style-type: none"> • % babies born at low birth weight • % children at appropriate stage of development in their immediate pre-school year • % schools found to be good or better • Gap between % non-FSME school leavers and % FSME school leavers achieving at Level 2 or above including English and Maths • % care leavers who, aged 19, were in education, training or employment
Outcomes delivered through collaborative working across Departments and beyond government and through the provision of high quality public services	

Source: Outcomes Delivery Plan 2018-19 [62]

Outcome 4 that we enjoy long, healthy, active lives will be based on the cross-cutting strategic framework for public health. The planned actions are intended to capture the ethos of 'Making Life Better'⁴ published in June 2014 and addressing wider social determinants of health. Delivering

Together published in 2016 also provides a "... clear vision for the transformation of Health and Social Care by putting citizens at the centre both in terms of access to care and the quality of the care they receive." [21]

The priority Issues to be addressed in relation to achieving long, healthy, active lives and preventable deaths are prioritised as poverty, unemployment, and health behaviours such as smoking, alcohol/drug misuse, poor diet, lack of physical activity and being overweight or obese. Other key factors include road safety, accidents in the home and work, and suicide. However, it is acknowledged that these factors and behaviours are not simply a matter of personal responsibility but are influenced by socio-economic circumstances.

In response to the issues identified, and in collaboration between Government Departments, Local Government, other agencies, the private sector and the public it is intended to undertake a 'Healthier Lives' programme. One focus of the programme will be on healthier pregnancy with others on healthier places, care and workplaces, supporting people to take more control of their lives. Importantly, in recognition of the impact of social circumstances on mental health, the programme proposes action to reduce health inequalities implemented on an intensity and scale that reflects the levels of disadvantage ('proportionate universalism'). Key areas to be targeted also include alcohol and drug misuse and suicide.

Under the heading 'Improve Mental Health' (outcome 4: p.30 and outcome 8: p.60), research the NI study of Health and Stress [63] is cited estimating that approximately 213,000 people in NI are suffering from mental health issues directly related to the Troubles. Due to budget restraints any actions need to have maximum impact, and therefore it is intended to focus resources on a Regional Mental Trauma Network for NI. This will be based on the Psychological Therapies Stepped Care Model to provide a range of services in clinical settings and in the community to deal with the spectrum of severity of need.

Specifically, actions to be taken in 2018-19 to create the Regional Mental Trauma Network ('the Network') include:

- The recruitment of a Network Manager to drive the development of and co-ordinate the Network;
- The recruitment of 10 additional therapists to begin to build the capacity of the HSC element of the Network;
- Training 10 therapists to Masters level in Cognitive Behavioural Therapy (CBT);

- Developing and implementing a regional referral pathway which spans across statutory and non-statutory domains for all five Health & Social Care Trusts.

The rationale for this is to benefit from better co-ordination across the five HSC Trusts and voluntary and community organisations to ensure there is timely access to high quality support and therapy.

The scale of the Self-Harm Intervention Programme is to be increased with an improved pathway to support and counselling for those who present to Emergency Departments (EDs) as a result of self-harm. This is intended to reduce the occurrence of self-harm and reduce suicides. Research has shown that although self-harm is a known precursor to suicide, those who presented at emergency departments in NI with self-cutting alone were the most likely to be discharged without treatment, or to leave without being seen. Research has shown that although presentation to an ED is a known precursor to suicide in NI [64], those who presented at EDs in NI with self-cutting alone were the most likely to be discharged without treatment, or to leave without being seen. Missing a final appointment with mental health services in NI can also be an antecedent to suicide, whereas this is not the case in England or Scotland where outreach services focus on keeping contact with patients [7].

Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services (CAMHS) continue to be shaped by the Bamford Review [65]. In 2006 the Bamford Review identified that CAMHS was under-resourced, fragmented, and lacked strategic direction. Recent research from the Children's Commissioner, the NSPCC, Princes Trust and the Education and Training Inspectorate show that these continue to be issues in the provision of mental health services experienced by children and young people in NI.

It is estimated that around 45,000 children and young people in NI have a mental health problem at any one time and that more than 20% of young people have suffered from 'significant mental health problems' by the time they reach the age of eighteen [7]. In a 2018 survey of over 2,000 16 – 25 - year olds in NI [66], 44% of young people had experienced a mental health problem and;

- 68% always or often feel stressed.
- 60% always or often feel anxious.
- 33% always or often feel hopeless.

In July 2012 a 'preferred' model for the organisation and delivery of (CAMHS) was published. Rather than





being a strategy for CAHMS, it provided a framework for service commissioners and practitioners to use in order to remodel CAHMS [68]. The development of the service model introducing a stepped care approach was a direct response to a recommendation of the RQIA review of CAMHS⁶⁸ and aligned with the overall strategic direction set out in the Bamford Review. Five levels of support were introduced in the stepped care approach; prevention, early intervention, specialist intervention services, crisis intervention and inpatient and regional specialist services.

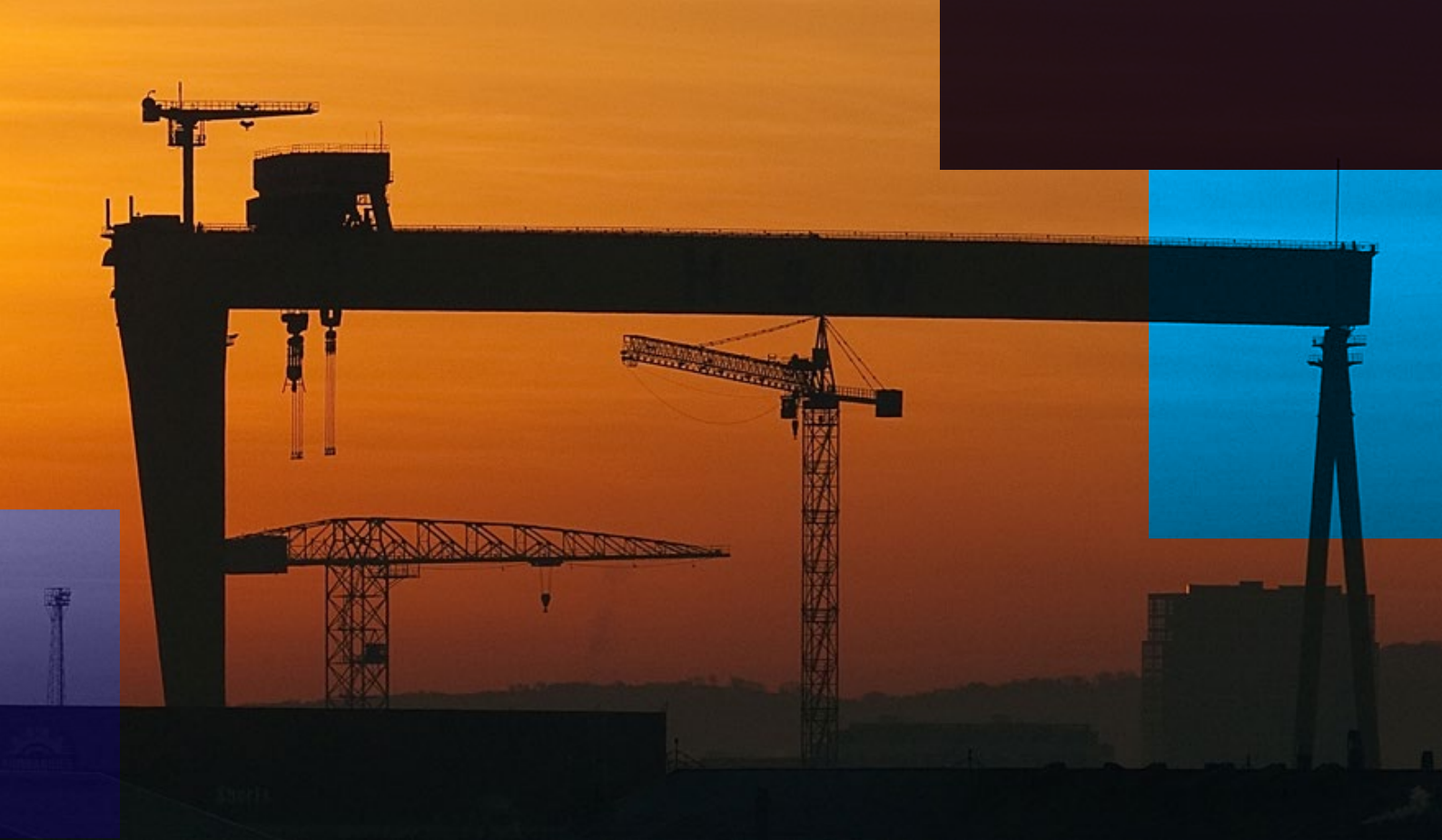
However, the stepped care model has been criticised by practitioners and service users for a lack of resources, with children being passed from service to service within the model due to the individual services struggling to cope with the demand [69].

An Education and Training Inspectorate (ETI) evaluation of emotional and wellbeing support in schools [70] points out that the Children's Services Co-operation Act (2015) [71] "places a number of duties on all children's authorities to work together in the best interests of children and young people". In response a draft strategy 'New Children and Young People's Strategy 2018–2028' [72] aims "To work together to improve the well-being of all children and young people in Northern Ireland - delivering positive long-lasting outcomes" (DE, 2018). ETI also welcomed an integrated approach to support young people [73] and the publication of the Children and Young People's Strategy consultation response report [74]. However, ETI's evaluation

found that schools were struggling with diminishing resources, to cope with the demand on available services. Although schools and EOTAS centres can access support services through the Education Authority and healthcare services, some schools have had to use their own resources to access support in urgent cases due to the long referral process. It was also reported that counselling services and other interventions were too short to be effective.

In the ETI report the five most common reported areas that impacted on pupils' emotional health and wellbeing were anxiety, stress, anger, relationships and home life. Bereavement, suicidal ideation, identifying as transgender, negative body image, self-harm and poverty or high social deprivation were also identified as being important. Anxiety was the most common issue throughout all ages, generally relating to school work, friendships and family issues. The misuse of social media was highlighted as having a negative impact, with the inappropriate sharing of information online leading to bullying and social isolation. Self esteem appeared to be tied to peer social media endorsement, and parents lacked knowledge of online services, the age appropriateness of online games, and of how to use 'parental controls' on devices.

An evaluation of Nurture groups [75] reported that they led to a consistent and significant improvement in social, emotional and behavioural outcomes among children who had been having difficulty in mainstream classes. The Department of Education provides funding for 32 Nurture



Groups in primary schools in NI. ETI's report found that just under a third of primary schools had developed Nurture provision.

The NICCY Review also found that the mental healthcare services for children and young people were unable to cope with the demands and complexity of issues being presented. It was clear that the core budget for services for children and young people has not kept pace with the recommendations for service reform. There was chronic under-investment with funding allocated to services that were not based on known mental health needs. This was resulting in a mixed experience for young people in the availability, accessibility and quality of services.

Reviews of services for children and young people also identified problems with missed appointments for mental health services. The RQIA review of CAMHS⁶⁸ recommended that Trusts find a way to more carefully monitor 'Did Not Attend' (DNA) and 'Could Not Attend' (CNA) as these were a drain on resources. The issue was raised again in 2018 [69] when GPs reported incidences where service users were discharged from care in the case of CNA or DNA. This was happening at step 3 (treatment for moderate disorders) without the service user's knowledge and GPs viewed this as potentially significant since it did not comply with the regional IEAP guidelines [76]. These require that "... if a patient/client DNA/CNA their appointment, a review of the risk factors should be undertaken in partnership with the patient/client's General

Practitioner (GP) and a second appointment offered if required. Any decision to discharge should be fully documented and the patient/client informed in writing." [76]

Schools also reported frustration around DNAs and CNAs, explaining that some parents did not attend necessary review appointments. This could be due to perceived stigma or as a result of their own emotional or mental health issues. The pupil was then deregistered from the service and had to be referred again by the school and go back on a waiting list [70].

Responding to NICCY's 'Still Waiting' review, a spokesperson for the Royal College of Paediatrics and Child Health (RCPCH) [77] said that due to the stigma around mental health having shifted, services have failed to keep up with and increased demand. The resulting lack of support could have a lasting influence on children's lives leading to poor employment prospects and an increased risk of alcohol and drug abuse. She called for policy makers to ensure that those working with children had mental health training to allow them to identify signs of mental health issues for early intervention to take place. Secondly children need to be able to access mental health services at any time and any place, whether this is through the education system, primary care, or child health services. However, in order for this to happen effectively services need to be integrated and properly funded [77].

Protect Life – A Shared Vision (2006 – 2011)

Suicide rates in NI continue to be higher than other regions in the UK or Republic of Ireland.

Table: Suicide rates per 100,000 of population by gender

NI		England		Scotland		Wales		RoI	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
27.3	9.2	14.0	4.6	19.9	5.7	20.9	5.8	13.2	3.3

Source: Samaritans suicide statistics report, September 2018

In the table above, suicide rates for England, Scotland, Wales and RoI relate to 2017. However, the NI rates are for 2016 as the 2017 suicide data was not available at the time of publication in September 2018. Although the rates are not directly comparable, “...Rates in NI have increased dramatically over the last 30 years, particularly in men.” [11]. The Samaritan’s report calls for improvements in the availability of statistics from the NI Statistics and Research Agency (NISRA), to align with other agencies and quotes a World Health Organisation report on suicide: “...Measuring the success, or lack thereof, of efforts to reduce suicides, suicide attempts or the impact of suicide on society at large requires access to reliable and valid data.” [78]. There is also a call for a review of the registration process in NI, England, Wales and the Republic of Ireland, where suicides are registered following an inquest which can cause a delay of up to a year or more. This is unlike Scotland where the maximum time between a death and its registration is 8 days [11].

“Suicide rates in the general population in UK countries have shown a recent downward trend, although this is less clear in Northern Ireland which continues to have the highest rate.” [79] In 2009/10 it was estimated that the total cost of suicide in NI was in the region of £436 million [80]. A series of recent studies into suicide in NI demonstrated the associations between suicide and adverse life events, mental illness and showed that suicide deaths were associated with deprivation and conflict-related trauma. The research also showed that high proportions of those who died had attended their GP in the period prior to death, and attendance at the ED was also a predictor of death by suicide. Nonetheless, only 29% of those who died by suicide in NI between 2000 and 2008 had been in contact with the secondary mental health services in the 12-month period prior to their death [81].

In October 2006 the NI Suicide Prevention Strategy and Action Plan (2006 – 2011) for the first suicide prevention strategy “Protect Life – A Shared Vision” was published,

with a refreshed version published in June 2012 to cover the period 2011-2013 [80].

The 2006 Strategy set out an action plan to include the following areas:

- Community-led suicide prevention and bereavement support services;
- Local research into suicide;
- GP depression awareness training;
- Enhanced crisis information services;
- All-island public information campaigns;
- Lifeline crisis referral telephone helpline;
- Self-harm registry;
- Development of local suicide cluster response plans; and
- Support for recovery from suicidal behaviour and self-harming.

The main findings from an evaluation of the implementation of the 2006 Strategy [82] found it had been successful in areas including:

- Raising awareness of mental health issues with public information media campaigns and media guidelines to ensure suicide is reported sensitively; and
- Enhancing the support role of the voluntary and community sector for bereaved families and those who had made previous suicide attempts.

Ensuring early recognition and intervention with appropriate follow up support services was not wholly achieved due to a variable awareness of support services among primary care providers.

The first Protect Life 2006 Strategy identified depression, alcohol and drug misuse, personality disorder, hopelessness, low self-esteem, bereavement, relationship breakdown and social isolation as risk factors for suicide. However, it was found in 2016 that the most common risk factors included economic adversity and recent self-harm [83]. In NI inequality is seen as a strong contributing factor in the incidence of suicide.

Following an eight-week consultation the Protect Life 2 Draft Strategy [84] was launched in September 2016 with the purpose of reducing the suicide rate and the differential in the rate between the most and least deprived areas in NI. Objectives included:



- Improvement in the understanding and identification of suicide and self-harming behaviour;
- Awareness of prevention services and uptake by those who need them;
- Enhancement of the initial response to, and care and recovery of people experiencing suicidal behaviour or self-harming;
- Restriction of access to the means of suicide;
- Provision of effective and timely information and support for individuals and families bereaved by suicide;
- Provision of effective support in the community through voluntary, community, and statutory sectors providing suicide prevention services;
- Responsible media reporting of suicide; and
- Identification of emerging suicide clusters and prompt action to reduce the risk of further associated suicides.

The Protect Life 2 objectives are heavily dependent on other Executive Departments as suicide is impacted by a range of factors including unemployment, the legacy of the Troubles, low educational achievement, and drug and alcohol misuse. At consultation stage it was to be considered by the Department of Health whether the 'purpose' of the strategy should include self-harm. Self-harm has not been included in the purpose statement to "Reduce the suicide rate in the north of Ireland" and "Reduce the differential in the suicide rate between the most deprived areas and the least deprived areas". Given that self-harm and ED attendance are precursors to suicide [7] this would appear to be questionable.

The Protect Life 2 Strategy has been finalised but cannot be published without a Health Minister in place. However, the Chief Medical Officer Dr Michael McBride, has stated that suicide prevention remains a priority for the Department and new initiatives are being implemented [85]. He states that as Protect Life 2 is an "enhancement and development" of the existing Protect Life strategy, the "Public Health Agency continues to invest over £8m a year to deliver suicide prevention, and emotional health and wellbeing services." In addition, new initiatives that are a part of Protect Life 2 are being funded separately as part of wider transformation proposals. These are:

1. The Lifeline 24/7 crisis response helpline was transferred to Belfast HSC Trust on 1 April 2018 and is available for anyone in distress or despair.
2. A Belfast crisis de-escalation pilot service will commence in early 2019. This will be an out-of-hours facility providing a 'safe place' for individuals in crisis. It will provide de-escalation support over a period of hours following presentation to ED or community and voluntary sector providers. A similar pilot led by Derry and Strabane Council is also expected to start shortly.
3. A street triage pilot commenced in July 2018 in the South Eastern Area. This involves a multi-agency triage team who are available to respond to people in emotional crises who have accessed the 999 system.
4. A new programme to enhance post primary pupil resilience is planned to commence in 2019/20. A programme to embed mental wellbeing in further and higher education is also planned to commence in 2019/20.
5. In total for 2017/18 there were 14,932 participants who attended and completed training in a chosen mental health and/or suicide prevention area.

It is clear that suicide prevention is a cross-departmental responsibility. An analysis of consultation responses for Protect Life 2 identified factors to be addressed in relation to suicide prevention that included: equality; debt; homelessness; domestic and sexual violence; victims and survivors of conflict; impact of crime; drugs and alcohol abuse; prison reform; rehabilitation following psychiatric and prison release; employability; education and training. Protect Life 2 identified priority groups for suicide prevention: LGBT people; migrant populations and ethnic minorities; homeless people; those who have experienced abuse/conflict, including sexual and domestic; Looked after children; those with PTSD as a result of the conflict; long-term unemployed; certain occupations including farmers, the military, dentistry and low status occupations; males aged 19-55, especially living in high deprivation areas; those in contact with the judicial system; people with mental illness including addiction disorder; and the travelling community.

The investment by the Department of Health when the Draft Protect Life 2 Strategy was published was £7 million annually. There was an additional significant contribution to suicide prevention from charities and the voluntary sector, mental health services, and from other Departments. The funding covered a range of services including Lifeline; training; counselling; Self-harm Registry; Self-harm Intervention Service; public information campaigns; and community response plans.

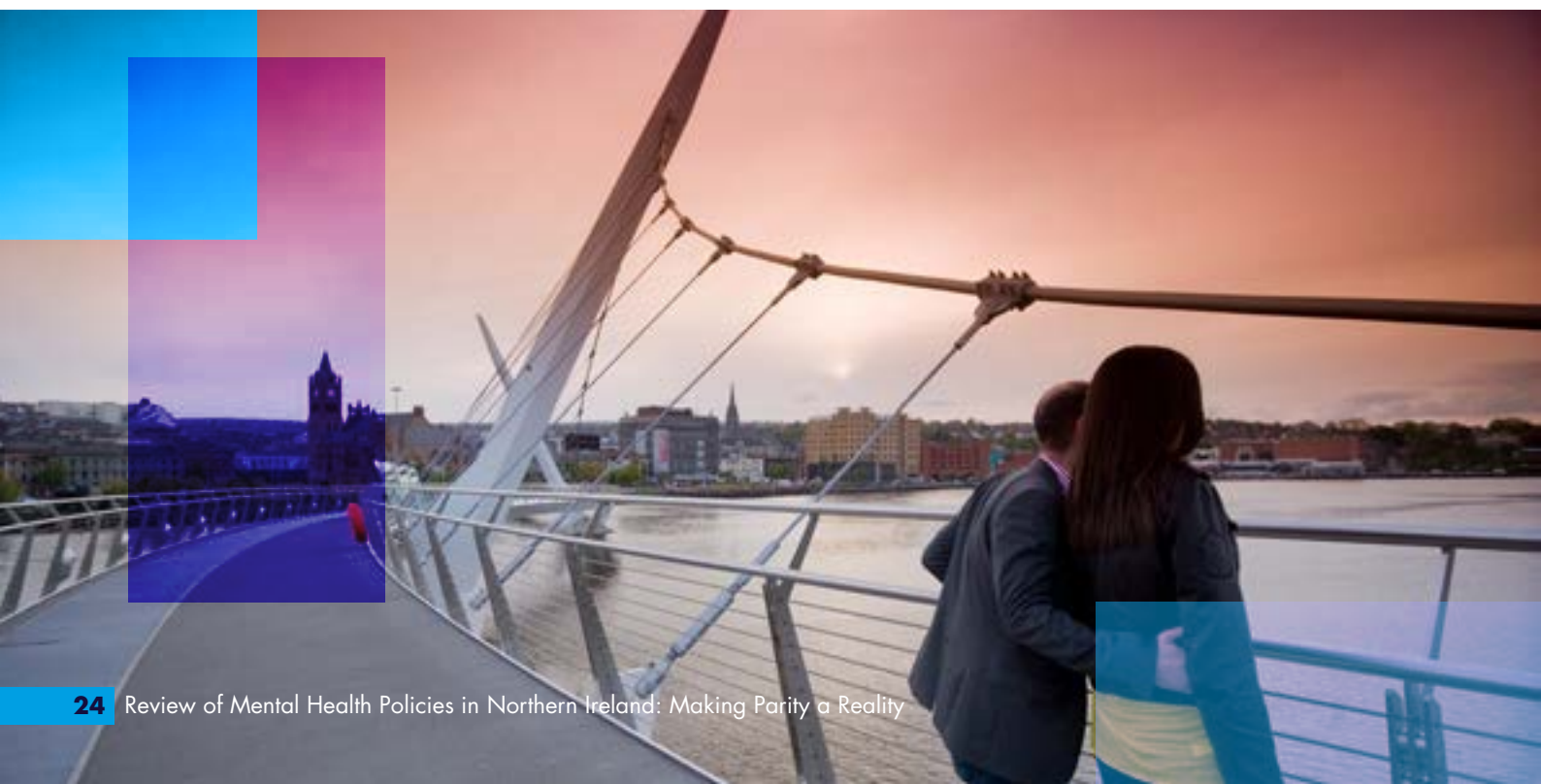
A study of young men aged 16-34 in NI [86] identified major challenges to accessing mental health services; stigma and fear of discrimination. The type, nature and geographical location of formal mental health services offered limited help for young men contemplating suicide. A study recommendation was for pro-active services to be community based with open access. These should be in

non-mental health service environments such as sports clubs, schools, work places, and community interest and self-help groups.

The findings confirmed the value of community-based informal 'drop-in' suicide centres where young men could socially interact. Being part of a peer group was important, providing an opportunity to discuss their concerns with others. They were also able to interact with those who were no longer suicidal and exposed to an insight into the pain suicide would inflict, a view of suicide as unacceptable, and allowing them to see that recovery was possible. Recovery was seen as a long-term process that would be impacted by their relationship with mental health professionals. When firm relationships were established early, these formed the basis for future interventions.

Continued support and involvement from mental health professionals and their peers who were making the journey with them was important for the path to recovery and counselling was also found to be useful. However, a variety of forms of counselling were required to address issues such as child abuse, relationship problems, addictions, loss and bereavement and family dysfunctionality. Psychological therapies need to be made available in routine care to equip young men with coping strategies that can deal with stress, anxiety and disappointment, and help to build self-esteem. Learning life skills, social skills and taking part in educational programmes provides a range of skills to equip them for facing day to day life challenges.

Recovery has proven important, particularly for young men. The next section looks at recovery and Recovery Colleges established in each of the five Health and Social Care Trusts in NI.



ImROC (Implementing Recovery through Organisational Change)

The notion of recovery from mental illness dates back to the 1980s when a major study showed that the course of mental illness did not inevitably lead to deterioration [87]. A conceptual model of recovery was developed in Wisconsin in America almost two decades ago [88] with the aim of developing a 'recovery-oriented' mental health care system.

Recovery referred to both internal and external conditions experienced by people who described themselves as being in recovery. Internal conditions described in laying the conditions for recovery were hope, healing, empowerment, and connection. The external conditions facilitating recovery were *"the implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services"*. The aim of the recovery healthcare model was to link abstract concepts defining recovery with practical actions and strategies that could be used to facilitate recovery from mental illness [88].

The concept of recovery from mental illness became a UK government key objective. A strategy for England in 2011 [89] provided shared objectives for health and wellbeing, supporting the aim of achieving parity of esteem for physical and mental health. The strategy stressed connections between mental health, housing, employment, and the criminal justice system.

In 2008 ten key challenges to implementing recovery were identified [90]. These included:

- Changing the nature of day-to-day interactions and quality of experience;
- Delivering comprehensive, service user-led education and training programmes (co-production);
- Ensuring organisational commitment to create the 'culture';
- Increasing personalisation and choice;
- Redefining user involvement;
- Transforming the workforce and supporting staff on their recovery journey; and
- Increasing opportunities for building a life 'beyond illness'.

Ten years after the key challenges to implementing recovery were identified, an ImROC briefing paper highlights the

success of recovery colleges [91]. Since the idea of a 'Recovery College' was suggested in 2007-08 and piloted in London in 2009, their number has grown to over 75 in the UK with others established globally.

An international Community of Practice has been established and in 2017, the European Union Development Fund invested 7.6 million Euros to build on existing initiatives and create a 'Cross-Border Recovery College Network' serving 8000 people facing mental health challenges in Northern Ireland and the border counties of the Republic of Ireland. [91]

Recovery Colleges are based on co-production. This differs from previous initiatives such as the 'Expert Patient Programme' in the UK in 1999. While peers with lived experience of mental health issues co-facilitated the courses, the content was largely prescribed by professionals. Recovery Colleges represent a departure from this in terms of the model and approach. Eight principles of a Recovery College are:

1. They are founded on co-production bringing together the expertise of lived experience and professional expertise.
2. They reflect recovery principles in all aspects of their culture and aspiration.
3. They operate on College principles with students choosing their courses from a prospectus.
4. They are for everyone including service users and those close to them, staff from mental health and related agencies, and people from the local community who are outside of the mental healthcare system.
5. There is a personal tutor (or equivalent) who can offer information.
6. There is a physical base with classrooms and a library. Most Recovery Colleges adopt a 'hub and spoke' approach with a base and satellite courses in different locations.
7. They are not a substitute for the specialist assessment, treatment and therapy offered by clinical teams.
8. They are not a substitute for mainstream colleges.

In NI, Recovery Colleges are established in each Health and Social Care Trust. They offer a range of classes and courses on aspects of mental health to service users, their carers and families and mental health professionals. Based on co-production, those with lived experience of mental health issues (service users), their carers and families work together with professionals to develop services. This enabled the development of the regional mental healthcare pathway 'You in Mind Mental Healthcare Pathway' [92] ('the Care Pathway') in 2014 that changed how services are delivered in order to create an environment and culture of recovery and support.

The work being taken forward at operational level depends on colleagues across health and social care and beyond bringing skills from a wide range of backgrounds. Partnership working and co-production “...remain key tenets of the way change is developed and implemented moving forward”. Co-production is key in mental health services, with Delivering Together citing the example of Recovery Colleges operating in each of the five Health Care Trusts as good practice to be built on.

The Care Pathway:

- Explains how to access mental healthcare services from referral to recovery;
- Describes the standards of care service users

should expect from healthcare professionals who will be their partners in their recovery;

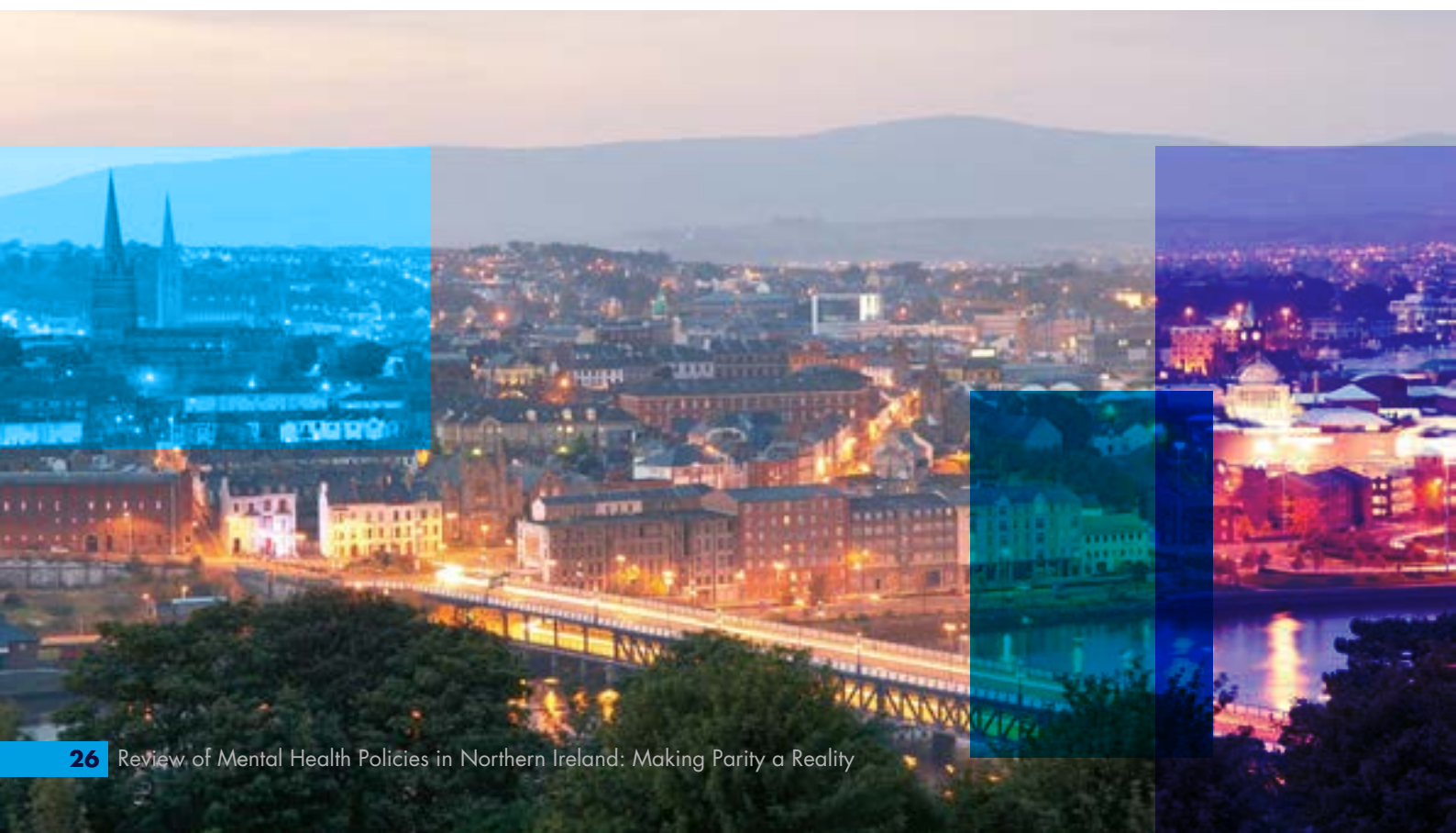
- Outlines how decisions about their care will be made both for them and with them; and
- Puts the person and/or their family or nominated friend at the centre of all decision making.

The Care Pathway emphasised the need for access to treatment to be specific to the individual needs of service users and based on a stepped care approach dependent on the level of need at the time. In line with the focus on recovery, the level of care can be stepped up or down based on decisions taken by the health care team.

Stepped Care Mental Healthcare model

Step 1: Self-directed help and health and wellbeing services	Step 2: Primary Care Talking Therapies	Step 3: Specialist Community Mental Health Services	Step 4: Highly Specialist Condition Specific Mental Health Services	Step 5: High intensity Mental Health Services
Responding to stress and mild emotional difficulties which can be resolved through making recovery focused lifestyle adjustments and adopting new problem solving and coping strategies.	Responding to mental health and emotional difficulties such as anxiety and depression. Recovery focused support involves a combination of talking therapies and lifestyle advice.	Responding to mental health problems which are adversely affecting the quality of personal / daily and/or family / occupational life. Recovery focused support and treatment will involve a combination of psychological therapies and/or drug therapies.	Involves providing care in response to complex/ specific mental health needs. Care at this step involves the delivery of specialist programmes of recovery focused support and treatment delivered by a range of mental health specialists.	Responding to mental health problems which are adversely affecting the quality of personal / daily and/or family / occupational life. Recovery focused support and treatment will involve a combination of psychological therapies and/or drug therapies.

Source: Regional Mental Healthcare Pathway



Perinatal Mental Health

NI has had a 'Regional Perinatal Mental Health Care Pathway (PNMHP) since 2012, (revised in 2017) [93]. The PNMHP guidance states that this is a major public issue due to the impact it can have on the family unit, yet 80% of NI does not have access to the specialist perinatal mental health services it needs [94]. However, PNMHP guidance for health care professionals in NI says "...Perinatal mental health issues which may complicate pregnancy and the postpartum year are common with 10-20% of women developing mental ill health during this time." [95]

Perinatal mental health illnesses can include anxiety and depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. These conditions can range from mild and moderate to severe, requiring different kinds of care and treatment [94]. Key recommendations for perinatal mental health care from the Royal College of Psychiatrists in 2015 [96] included the provision of specialised units with at least 6 mother and baby beds to serve the needs of large populations with 15,000 – 20,000 deliveries. In NI in 2017 there were over 23,000 births [97], yet there is no specialist in-patient baby unit in NI.

A NI study in 2013 had confirmed that a mental health mother and baby unit was required [98]. The study was carried out to test the assumption of service providers in NI that numbers of women requiring mental health care did not justify a mother and baby unit. At the time of the study there were estimated to be around 860 women per year with a serious mental health disorder, either associated with childbirth or a pre-existing condition that deteriorated. Data collection took place during a 32-week period. It included women admitted to acute psychiatric units who were over 32 weeks pregnant or had a child under one year. During this period there were 87 admissions of women in NI who fitted the criteria to require acute psychiatric care.

Perinatal mental health problems are a major public health concern. Childbirth is known to increase the risk of mental ill health for a mother, and also the risk of a recurrence of an existing mental illness. Conditions such as depression and anxiety are common during and following pregnancy. Where perinatal mental health issues are not managed, they can have long lasting effects on family relationships and the mental health and social adjustment of children. If a condition is acute it can lead to in-patient care and separation of mother and infant during early development of the infant. This can cause distress for the mother also and prevent breast feeding. Depression and anxiety when it is chronic or left untreated, can also affect an infant's mental health and have long-standing effects on a child's emotional, social and cognitive development. Perinatal

psychotic disorder is also associated with an increased risk of suicide [96].

A recent report [99] estimated the total number of women affected by perinatal psychiatric disorders in 2016 to be:

Number	Condition
48	Postpartum psychosis – severe mental illness with symptoms such as confusion, delusions, paranoia and hallucinations. Rate: 2/1000
48	Chronic serious longstanding mental illnesses such as schizophrenia or bipolar disorder. Rate: 2/1000
722	Post-traumatic stress disorder. Rate 30/1000
2,408 - 3,611	Mild to moderate depressive illness and anxiety states. Rate: 100-150/1000
3,611 - 7,223	Adjustment disorders and distress exhibiting distress reaction that lasts longer or is more excessive than would normally be expected. Rate: 150-300/1000
Note: Some women may experience more than one of these conditions	

Source: NSPCC Report, November 2018

The report found that NI remained the only part of the UK that had not committed to investment of funds for perinatal mental health. This was despite major funding having been pledged via the Barnett formula for the purpose. Inconsistencies were also found between policy and practice in the use of screening tools across HSC Trusts. There were concerns among professionals regarding the response when perinatal mental health issues were identified, and a need for closer alignment between infant mental health and perinatal mental health practice [99].

A review of perinatal health services carried out by RQIA [100] found that all HSC Trusts had adapted the PNMHP and women would generally be seen and managed using a stepped care model as recommended by the National Institute for Health and Care Excellence (NICE). However, the Belfast Trust provides small scale specialist perinatal mental health services comprising part time psychiatry, social work and a community psychiatric nurse. There is also a Perinatal Mood Disorder Service to identify women at risk and provide treatment during the ante-natal period. There was no specific funding for these services. However, having identified a need, the Belfast Trust took the risk of responding without additional funding. A recommendation of the review was that a single mother and baby unit should be established in NI.



Conclusion

The challenges associated with designing and delivering efficient, effective health and social services are well-documented. In NI health and social care are integrated [42] therefore in theory the delivery of change should be easier. The findings and recommendations of numerous expert reports on healthcare have not be progressed or implemented. Departments such as health and education operate in silos which works against strong effective integrated governance.

In the last decade the health service has been subject to seven major reviews culminating in the Bengoa Report, “systems not structures”. This wide ranging review formed the basis of Delivering for Change in 2016 described as

an ambitious ten year plan for change. In Bengoa Report user participation is strongly advocated but as already stated, NI is starting from a low base. These reports said relatively little about mental health focusing instead on the reconfiguration of existing systems for delivery. The Bamford review continues to inform policy on mental health in NI, despite having begun in 2002 and been completed in 2008.

Despite a plethora of evidence-based research being cited in strategies for health care in NI, there is still no overarching mental health strategy here. The challenges around mental health require radical action where stakeholders including politicians, healthcare leaders, clinicians, academics, the voluntary sector and service users work together to develop and deliver an agreed vision for the future.



It would be naive to pretend that resourcing the healthcare sector is easy. However, evidence shows that not doing so, or not doing so adequately is a false economy. Suicide is one manifestation of failing to adequately fund and develop psychological therapies and the voluntary and community sector. Strategies cite the importance of early intervention. This needs to start in schools, even at primary level where nurture groups have been found to be effective.

Mental health professionals from NI provided expert witness oral evidence to the House of Commons NI Affairs Committee in December 2018 [18]. The Committee were informed that "... Bamford had its time. It raised the issue of psychological therapies, implementing the NICE guidelines and the shift to the community...". However, the Committee heard that although a psychological therapies strategy was launched in 2010, psychological therapies in NI are

poorly developed and have not been fully implemented. The voluntary and community sector is under-resourced, particularly given the reliance that is placed upon them to support the mental health care system.

Research has shown the mental health impacts and inter-generational effects of over 30 years of violence [101]. In addition, statistics show that NI has the highest rates of suicide in the UK. In what has been described as a "mental health crisis" NI is still waiting for a regional trauma centre, the implementation of the most up to date suicide prevention strategy, the development of psychological therapies, and last, but not least the publication of the final evaluation of the Bamford Review which was to have been published in 2017.

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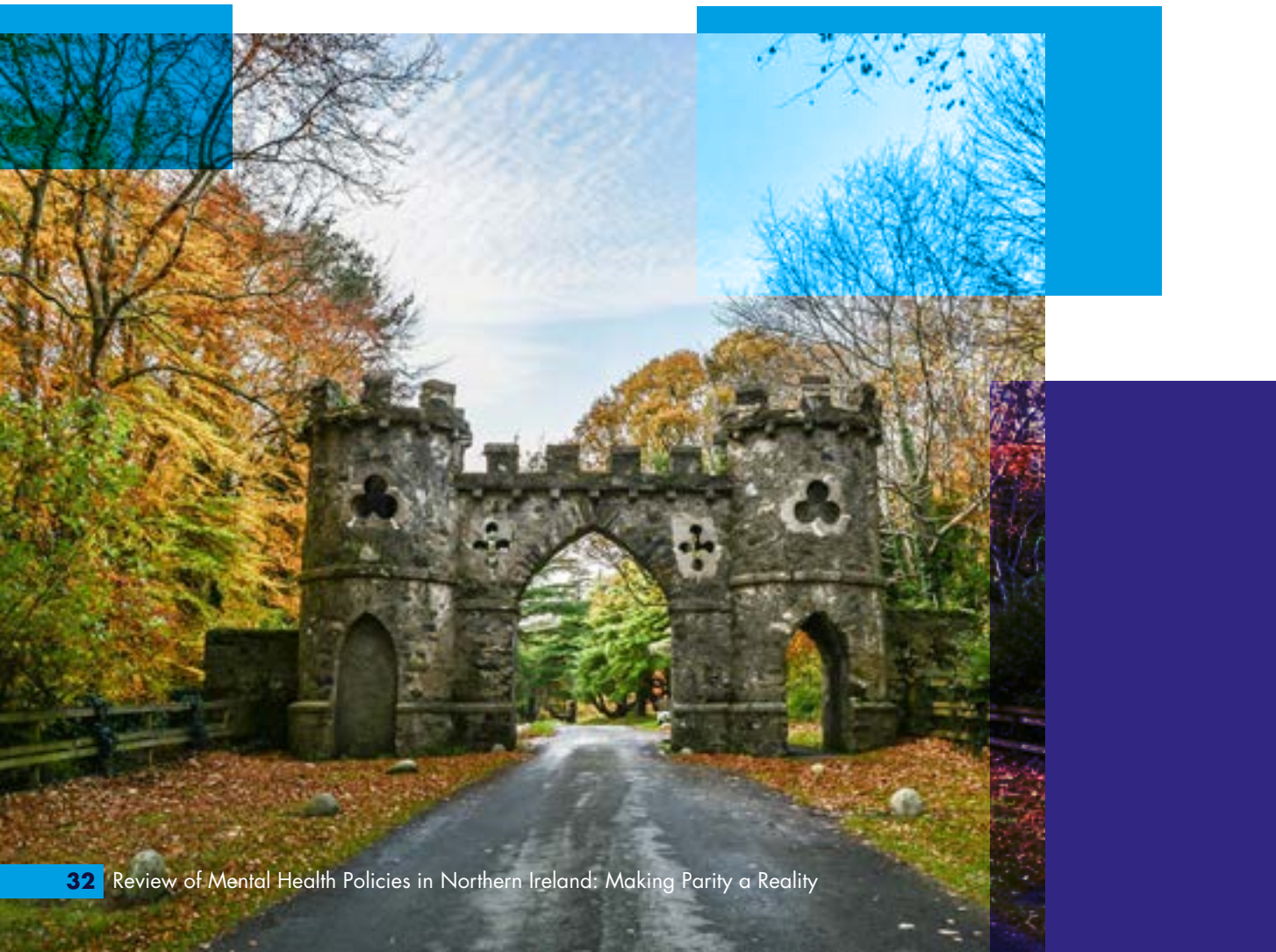
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