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Mental Health in Northern Ireland:

Overview, Strategies, Policies, Care Pathways, CAMHS and Barriers to Accessing Services

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This paper provides background information on mental health and illness in Northern Ireland (NI). It provides definitions of mental health and illness; gives an overview of mental illness (including self-harm and suicide) in NI; highlights the relevant overarching strategies and policies and those specific to mental health, mental illness and suicide for NI; describes the care pathway for treating mental health problems, with specific reference to child and adolescent mental health services (CAMHS); discusses evaluations of mental health service provision in NI in terms of accessing services and barriers to access; and highlights relevant initiatives in neighbouring jurisdictions.

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Key Points

Good 'mental health' concerns a state of positive well-being with respect to how a person feels, and how they are able to cope with how they feel.

A mental illness or disorder concerns a diagnosed clinical condition and can affect anyone in society, irrespective of age, gender, socio-economic status, or ethnic background.

Mental illness is the single largest cause of ill health and disability in Northern Ireland (NI). In children and young people symptoms of a mental illness may manifest in different ways to adults.

NI has higher levels of mental ill health than any other region in the UK - 1 in 5 adults and around 45,000 of children here have a mental health problem at any one time.

318 suicides were registered in NI during 2015 – the highest since records began in 1970 and a 19% increase on the suicides recorded in 2014 (268). Of the 318 suicide deaths 77% (245) were male.

Research has found that patients missing a final appointment with mental health services in NI can be an antecedent to suicide. This does not appear to be the case in England and Scotland where assertive outreach services have an emphasis on maintaining contact.

Despite self-harm being a known precursor to suicide, those who presented to emergency departments in NI with self-cutting alone were the most likely to be discharged after treatment, or leave without being seen.

Mental Health service reform in NI over the past decade has been guided by the Bamford Review. There have been two Action Plans (2009-11 and 2012-15).

There is general endorsement for the strategic direction for mental health services delivered in the community as close to a person's home as possible.

The November 2014 Monitoring Report of the latter action plan highlighted that good progress had been made with 63 of the 76 actions on target. A full review of the 2012-15 Action Plan is expected in the Spring of 2017.

The Bamford Review recommended the 'fusion' of mental health law and mental capacity law. This finally came to fruition at the end of the last mandate with the Mental Capacity Act (NI) 2016 receiving Royal Assent in May 2016.

Recently there have been calls for a new ten-year mental health strategy for NI and a mental health champion to promote, lead and co-ordinate work across NI government departments.

A number of overarching policy documents highlight mental health and related services in NI, including the *draft Programme for Government 2016-2021; Making Life Better*

2012-2023 (NI public health framework); *Transforming Your Care 2011* and related implementation documents; and the Minister's most recent policy direction for the HSC in NI, *Health and Wellbeing 2026*.

The NI *Protect Life Suicide Strategy* was launched in 2006 and *Protect Life Two* is due in 2017.

The Care Pathway for delivery of mental health services in NI follows a stepped care model (for adults and for children and adolescents – CAMHS).

The Care Pathway recognises that treatment and care needs to be personalised and 'recovery' orientated with the service user and professionals working together to determine a path to recovery.

The recovery focus is supported by Recovery Colleges established in each HSC Trust, which were recently highlighted by the Health Minister as a good example of co-production. They offer education and courses on topics around mental health for service users, their carers and families, and professionals.

In NI, stigma is still a major deterrent to seeking help for mental illness. Research found that internalised stigma (holding stigmatised views about oneself), and treatment stigma (stigma associated with seeking or receiving treatment for mental illness), were the main factors in not seeking help.

Access to services is also a key issue for service users with a number of difficulties highlighted including fragmentation of services and particular issues in rural areas. Cutbacks in funding are also blamed for a lack of progress on full implementation of the Bamford recommendations and roll-out of good practice initiatives across NI. Funding in NI has been historically lower and continues to be lower than other regions of the UK, despite higher levels of need.

Research has shown that suicide prevention services for young men are most successful when they are open access in community settings such as non-mental schools, workplaces and sports clubs incorporating peer and professional support.

The paper highlights other issues relating to access and barriers, including that GPs require better training and support to deal with patients with mental health issues; more awareness of support services; a need for a single point of access for information and advice; and better access to services in times of crisis.

Reviews indicate that improved access to psychological therapies including Psychotherapy, Cognitive Behavioural Therapy (CBT), and Trauma Therapy is still needed in NI.

The paper concludes with a brief review of selected initiatives implemented in other jurisdictions of the UK and the Republic of Ireland relating to accessing mental health services.

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1. Introduction – Defining Mental Health and Illness

1.1 Mental Health

Health, overall, is more than just the absence of disease. It is defined as a state of ‘complete physical, *mental* and social wellbeing’, with wellbeing having physical, cognitive, social and emotional dimensions.¹

The Department of Health in Northern Ireland (NI) has a statutory responsibility to promote an integrated system of health and social care designed to secure improvement in the²:

- Physical and *mental health* of people in NI;
- Prevention, diagnosis and treatment of illness; and
- Social wellbeing of the people in NI.

Good ‘mental health’ concerns a state of positive well-being with respect to how a person feels, and how they are able to cope with how they feel. The World Health Organisation (WHO) defines ‘mental health’ as³:

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.

Good mental health is regarded as being as essential to a person’s wellbeing as physical health. It enables a person to get the most out of life whilst maintaining a positive sense of well-being and self-worth.

Mental wellbeing is related to, but not the same as, the absence of mental illness. It is possible to have a diagnosed mental illness and still be coping well with life and enjoy a high level of wellbeing. Likewise, someone can have poor mental wellbeing but have no clinically identifiable mental illness. However, in populations where individuals have higher mental wellbeing, fewer people tend to develop mental illness.⁴

Children and young people who develop good mental health are more equipped for dealing with the emotional challenges they may later face. Should a child not develop

¹ Making Life Better, A whole system strategic framework for public health 2013-2023, DHSSPS, June 2014, page 20, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

² As above, page 27

³ Mental Health: a state of wellbeing, World Health Organisation, 2014, http://www.who.int/features/factfiles/mental_health/en/

⁴ Making Life Better, A whole system strategic framework for public health 2013-2023, DHSSPS, June 2014, page 141, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

such, they can be seen as more susceptible to incurring long-term mental health problems.⁵

1.2 Mental Illness

A mental illness or disorder concerns a diagnosed clinical condition. Many people will have a mental health problem at some point in their lives and whilst this may adversely disrupt the way a person thinks, feels, and behaves, it does not necessarily concern the kind of serious long-term condition which constitutes a diagnosed mental illness.

Although the exact cause of most mental health problems is not known, it is thought that a combination of factors, including genetics, family history, and psychological, social, and environmental influences may all play a part.⁶ If ignored, a mental health problem can, on occasions, develop into a mental illness. The WHO has produced a list of the different conditions which constitute a diagnosis of mental illness in the “ICD-10 Classification of Mental or Behavioural Disorders”⁷. These include:

- Depression
- Anxiety
- Substance abuse/addictions
- Dementia
- Obsessive compulsive disorder (OCD)
- Phobias
- Bipolar disorder (manic depression)
- Schizophrenia
- Personality disorders
- Eating disorders.

The process of obtaining a diagnosis of a specific mental illness is not always easy, and it is not uncommon to have difficulties in either getting an accurate diagnosis or getting access to the appropriate treatment and care. There are no ‘tests’ as such, for mental illnesses as there are for a physical health condition such as heart disease or diabetes.

A diagnosis will usually be made by an experienced psychiatrist, working with other health professionals, after a period of observation of the individual to identify symptoms. A person’s medical history and recent life events will also be taken into

⁵ Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays, Chapter 10: Mental health problems in children and young people, p3. <https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

⁶ Mindwise website Northern Ireland. Available online at: http://www.mindwisenv.org/index.php?option=com_content&view=article&id=63&Itemid=86 Website accessed 20.7.15

⁷ The ICD-10 Classification of Mental and Behavioural Disorder, Available online at, <http://www.who.int/classifications/icd/en/GRNBOOK.pdf>

consideration. The person's physical health will also be checked to 'rule out' any symptoms that could be related to a physical condition.⁸

Dual Diagnosis describes mental health problems co-existing with drug or alcohol problems. The mental health problems may include schizophrenia, depression, bipolar disorder or Personality Disorder. Having a mental health diagnosis significantly increases the risk of misusing alcohol and drugs.⁹

In children and young people symptoms of a mental illness may manifest in different ways. This might be evident in their behaviour, for example; being unable to concentrate, self-harming, a change of eating patterns, not sleeping, mood changes – such as becoming aggressive or disruptive, being fearful or anxious, becoming isolated or withdrawn, poor school performance, or increased use of substances like drugs or alcohol.¹⁰

Mental health issues in those with learning disabilities may be misdiagnosed or overlooked. The Mental Health Foundation (MHF) in the UK reports that 40% of people with learning disabilities experience mental health difficulties. There are also higher levels of psychiatric disorders among children and young people with a learning disability (36%), compared with those without a learning disability (8%). When symptoms of mental illness do present they are often attributed to the learning disability, or classed as challenging behaviour, with disagreements about whether help should be sought from mental health services or specialist learning disability services.¹¹

2. Mental Illness in Northern Ireland - Overview

Mental illness is a major public health issue in NI and is the single largest cause of ill health and disability. NI has higher levels of mental ill health than any other region in the UK and 1 in 5 adults here have a mental condition at any one time, which is a 25% higher overall prevalence of mental illness than England.¹²

Mental illness can affect anyone in society, irrespective of age, gender, socio-economic status, or ethnic background. A range of social, psychological, and biological factors have been identified as contributing towards the development of such illness. These include stressful or traumatic life events (experience of the "Troubles"¹³, in NI for

⁸ *How is mental illness diagnosed*, Mindwise, Northern Ireland, http://www.mindwisenv.org/index.php?option=com_content&view=article&id=64&Itemid=12

⁹ *Dual Diagnosis*, Mindwise (Northern Ireland), http://www.mindwisenv.org/index.php?option=com_content&view=article&id=67&Itemid=88

¹⁰ NI Direct Website *Your child's mental health*, <http://www.nidirect.gov.uk/your-childs-mental-health>

¹¹ *Improving Access to Mental Health Services for People with Learning Disabilities*; Mental Health Foundation available: <https://www.mentalhealth.org.uk/projects/improving-access-to-mental-health-services-for-people-with-learning-disabilities>

¹² *Making Life Better*, DHSSPS, June 2014, page 18, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/making-life-better-strategic-framework-2013-2023_0.pdf

¹³ *Troubled consequences: A report on the mental health impact of the civil conflict in Northern Ireland* (2013), Bamford Centre for Mental Health and Wellbeing at the University of Ulster, <http://news.ulster.ac.uk/releases/2013/6884.html>

example), abuse, lifestyle behaviours, deprivation, conflict, unemployment, bereavement, financial concerns and physical illnesses. In addition, particular mental illnesses are more commonly found within certain groups. Women, for example, are more likely to experience depression, whilst men are more likely to experience personality disorders and suicide.

In the 2015-16 NI Health Survey, one-fifth (19%) of respondents scored highly (greater or equal to 4) on the GHQ12 (General Health Questionnaire), suggesting they may have a mental health problem. This is more likely to be the case for women (21%) compared with 16% of men. Respondents in the most deprived areas were also twice as likely to record a high GHQ12 score (27%), as those in the least deprived areas (13%).¹⁴

Whilst epidemiological data on the prevalence of mental ill health in children and young people in NI is scarce, it is estimated that:

- Around 45,000 of children and young people in NI have a mental health need at any one time¹⁵; and
- More than 20% of young people are suffering “significant mental health problems” by the time they reach 18.¹⁶

The MHF recently highlighted that data on mental health/mental illness generally is far more limited in NI in comparison with England, Scotland and Wales. In terms of economic impact, the MHF highlighted that there are limited figures relating to the economic factors available, but the information is not conclusive and there is a severe lack of information on other determinants of mental health, such as the cost of lost employment, poverty and violence on people’s wellbeing. There is also an absence of information on mental health across all stages of the life course, and for different groups and populations such as BME groups, LGB&T, carers, homeless, refugees and asylum seekers¹⁷:

Similar to the rest of the UK, there is an urgent need for research and data gathering on prevention and early intervention for mental health.

With regard to suicide, 318 suicides were registered in NI during 2015 – the highest since records began in 1970. This was a 19% increase on the suicides recorded in 2014 (268). Of the suicide deaths registered in 2015, 77% (245) were male; 132 were aged between 15 and 34-years-old and five people were 75 or older. 93 people (30%)

¹⁴ Health Survey (NI) First Results 2015/16, Information Analysis Directorate, Department of Health (NI), November 2016, <https://www.health-ni.gov.uk/publications/health-survey-northern-ireland-first-results-201415>

¹⁵ DHSSPS (2015) *Delivering Excellence, Achieving Recovery, A professional framework for the mental health nursing profession in N.I.* p10.

¹⁶ As above

¹⁷ *Mental Health in Northern Ireland: Fundamental Facts* (February 2016), <https://www.mentalhealth.org.uk/northern-ireland>

who took their own lives lived in the Belfast HSC Trust area. Suicide rates in the most deprived areas of NI are three times higher than in the least deprived.¹⁸

The suicide statistics are taken from the Registrar General's four quarterly reports for 2015. Suicide deaths can take time to be fully investigated and there is often a period of time between when the suicide occurs and when it is registered. For example, of the 268 suicides registered in 2014, 133 actually occurred in 2014, 123 took place in 2013 and 12 in 2012 or earlier.¹⁹

It is widely accepted that self-harm is a major risk factor for suicide with between 40% and 60% of those who die by suicide having had a history of self-harm. As self-harm often remains hidden, it is recognised that it is more prevalent than figures based on emergency department presentations suggest.²⁰ Between the years 2012/13 to 2014/15 the rates of self-harm presentations to emergency departments increased by 30% for 15 to 19 year olds.²¹

The PHA in NI introduced the 'Self Harm Registry' initiative in all acute hospitals as part of the Protect Life Strategy Action Plan. The WHO highlighted the Registry as a model of best practice in its 2014 publication 'Preventing Suicide – A Global Imperative'.²²

From 1 April 2012 to 31 March 2015, the Registry recorded 25,620 self-harm presentations to emergency departments in NI, involving 16,301 individuals. In a different category, referred to as 'ideation' presentations, i.e. those who presented to emergency departments with thoughts of suicide who had not taken any action, 10,563 presentations were made by 6,909 individuals. Over half of these (53%) involved alcohol.

One in five self-harm patients re-presented at emergency departments within 12 months of their first attendance. More than a third (36%) of those presenting at emergency departments were as a result of repeat acts. Rates of repetition varied significantly depending on the method of self-harm involved. Self-cutting was associated with increased rates of repeat self-harm. More than one in four who used self-cutting made at least one repeat visit within 12 months. Recommended next care varied according to the method of self-harm used:

- Admission to hospital was most common where intentional drug overdose was used, or drug overdose combined with self-cutting;

¹⁸ Torney, K. (2016), *Suicide rates in Northern Ireland Highest on Record*, The Detail, <http://www.thedetail.tv/articles/suicide-deaths-in-northern-ireland-highest-on-record>

¹⁹ As above

²⁰ Long, M., Manktelow, R., and Tracey, A. (2014) *The Healing Journey: Help seeking for Self-injury among a Community Population*; University of Ulster.

²¹ McCafferty, M. (2016), Chief Executive, NI Commissioner for Children and Young People, 'Children and young people with mental health problems: priorities for tackling a growing trend', presentation at Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

²² World Health Organisation (2014) *Preventing Suicide – A Global Imperative*; WHO, Luxembourg.

- Admission was least likely for those presenting with self-cutting (21%) and these patients were most likely to be discharged following treatment (56%);
- Despite self-harm being seen as a precursor to suicide, those who presented with self-cutting alone were the most likely to be discharged after treatment or leave without being seen;
- Recommended care varied by Health and Social Care Trust (HSCT) area with the proportion of patients leaving emergency departments without being seen varying from 1% in the South Eastern HSCT to 14% in the Belfast HSCT; and
- Those aged under 18 years of age were more likely to be admitted to a general ward following presentation due to self-harm (49%). A small proportion (4%) left without being seen and 2% refused admission. The majority of presentations of those under 18 were for self-cutting (41%) and 87% of those involved those aged 15-19 years.

Recommended next care by method of self-harm, 2012/13 to 2014/15

Next care	Drug overdose only (n=17,244)	Self-cutting only (n=4,859)	Overdose & self-cutting (n=1,204)	Attempted hanging (n=715)	Attempted drowning (n=208)	Other (n=1,390)	Total (n=25,620)
General admission	64%	21%	59%	41%	39%	44%	54%
Psychiatric admission	3%	5%	4%	12%	14%	9%	4%
Refused admission	2%	2%	1%	2%	1%	2%	2%
Left ED before decision made regarding next care	3%	4%	3%	3%	3%	4%	3%
Left ED without being seen	6%	12%	5%	6%	6%	6%	7%
Discharged from ED following treatment	23%	56%	29%	36%	37%	35%	31%

Source: NI Registry of Self-Harm Regional Three-year report, 2012/13 to 2014/15

3. Relevant Policies, Strategies and Actions in Northern Ireland

3.1 The Bamford Review of Mental Health and Learning Disability

In 2002, the then Department of Health, Social Services and Public Safety (DHSSPS) initiated a review of the law, policy and provisions affecting people with mental ill-health or a learning disability. The review (named the Bamford Review in recognition of the

contribution made to it by the late Professor Bamford, Chair of the steering committee),²³ concluded with the publication of eleven reports by 2007.

It followed similar exercises in England and Scotland and the aim was to ensure that the recommendations would chart the course for mental healthcare for the 21st Century.²⁴ The Review's key messages recommended²⁵:

- Continued emphasis on the promotion of positive mental health;
- Reform of mental health legislation (now complete with the Mental Capacity Act 2016 for NI);
- Continued shift from hospital to community-based services;
- Development of a number of specialist services, to include children and young people, older people, those with addiction problems and those in the criminal justice system; and
- An adequate and trained workforce to deliver these services.

The Review envisaged a 10 to 15-year time-scale for the full implementation of its recommendations.

3.2 Bamford Review – Implementation and Evaluation of Bamford Action Plans

The implementation of the Review's recommendations has been led by the Bamford Ministerial Implementation Group and an inter-departmental officials group, which mirrors the Ministerial group and includes representation from the HSC Taskforce (which leads the actions of the HSC with regard to Bamford implementation) and the Bamford Monitoring Group (users and carers).²⁶

In 2009 the Bamford Monitoring Group was set up by the Patient and Client Council to capture the views and experiences of people with mental health needs, learning disabilities and families and carers across NI about the effect of the changes being made to services. The group has 16 members with equal representation from service users and carers who meet on a monthly basis.²⁷

²³ Bamford Review of Mental Health and Learning Disability website: <https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability>

²⁴ As above

²⁵ Evaluation of the 2009-2011 Bamford Action Plan, as at December 2011, DHSSPS Integrated Projects Unit (January 2012), <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/bamford-evaluation-plan2009-2011.pdf>

²⁶ As above

²⁷ The Bamford Monitoring Group, Patient and Client Council, <http://www.patientclientcouncil.hscni.net/bamford-monitoring-group>

An evaluation of the Bamford Action Plan 2009-11²⁸ in 2012 listed the key challenges that were identified in 2009 relating to the delivery of mental health services, including:

- Establishing a stepped care approach to service provision;
- Enhancing the range of options available to primary care professionals to deal with the mental health needs presenting to them;
- Improving access to psychological therapies;
- Streamlining access to all mental health services;
- Providing home-based care and support as the norm for delivery of mental health services;
- Applying a systematic approach to enable the recovery of people with long term conditions;
- Building up the range of specialist mental health services required to meet need; and
- Redesigning and extending roles and retention of an effective workforce.

Bamford actions not completed then continued through the 2012-2015 Action Plan, with the most recent monitoring report published in November 2014.²⁹ The 2012-2015 Action Plan contained 76 actions under the five Bamford 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 better services to meet individual needs
5. Developing structures and a legislative framework.

The November 2014 Monitoring Report of the 2012-2015 Action Plan noted that good progress had been made indicating that of the 76 actions, 63 were 'Green' status (on target) and 13 were 'amber' status (at risk/delayed).³⁰ A breakdown of those actions receiving an 'amber' status in October 2014 is provided as follows:

²⁸ Evaluation of the 2009-2011 Bamford Action Plan as at December 2011 (January 2012); DHSSPS available: <https://www.health-ni.gov.uk/publications/evaluation-2009-2011-bamford-action-plan>

²⁹ Delivering the Bamford Vision: The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan 2012-15, Monitoring Report November 2014 available: <https://www.health-ni.gov.uk/publications/delivering-bamford-vision-action-plan-2012-15>

³⁰ Bamford Monitoring Report 2014, DHSSPS, <https://www.health-ni.gov.uk/publications/bamford-action-plan-2012-15>

Action No.	Key Action
1	Publish and implement a revised cross-sectoral promoting Mental Health Strategy (DHSSPS)
6	Progress the next phase of the suicide prevention strategy (DHSSPS)
13	Resettle long stay patients from learning disability and mental health hospitals (DHSSPS)
25	To support the uptake of self-directed support and individual budgets in line with Transforming Your Care (DHSSPS)
38	To provide support to all carers in order that they may continue in their caring role (DHSSPS)
47	Improve services for children with challenging behaviours and their carers
50	Enhance provision of person – centred day opportunities (including employment provision) for people with a learning disability that facilitate integration into the community (DHSSPS)
51	Complete and maintain a map of learning disability services across Northern Ireland (DHSSPS)
57	Improve the experience of people with LD using acute general hospitals based on the GAIN Guidelines “Caring for people with a learning disability in general hospital settings” (DHSSPS)
60	Implement the Mental Health Service Framework across HSC. (DHSSPS)
61	Provide information on children’s, adolescent and adult mental health services for use by the public, GPs and other clinicians (DHSSPS)
71	Ensure provision of appropriate low secure and community forensic services in line with 2011 Review
76	New mental capacity legislation. (DHSSPS) – this has now been delivered in the form of the Mental Capacity Act (NI) 2016 which received royal assent on 9 th May 2016.

In 2016, the Department of Health (NI) initiated a full evaluation of the Bamford Action Plan 2012-2015.³¹ The Royal College of Psychiatrists highlighted that the current evaluation is:³²

...looking both forward and back, so the new Action Plan will be a very significant document mapping out our path in mental health services for the next number of years and will need to be tied in with the ultimate outcome flowing from the Professor Bengoa report which is already with the Minister.

The publication of the most recent evaluation is now expected in the Spring of 2017. It will assess how Executive Departments have performed against the Action Plan,

³¹ Bamford Evaluation, Department of Health, <https://www.health-ni.gov.uk/consultations/bamford-evaluation-your-experience-matters>

³² Royal College of Psychiatrists Chair update: <http://www.rcpsych.ac.uk/mediacentre/pressreleases2016/nicommissionreport.aspx>

include the views of service users and their carers, and identify needs and gaps in the service. Initial findings from the evaluation include the need to:

- 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 involvement of the voluntary and community sector.

At a recent mental health seminar, a representative of the Western HSC Trust highlighted that since 2005 post-Bamford, there had been significant reform and modernisation of mental health services across NI and that there was a need for the changes to 'bed down'. The Western HSC Trust, for example, has adopted a whole systems approach via the mental health framework with a focus on recovery focus; introduced multidisciplinary functional teams, established an acute mental health inpatient unit; crisis response home treatment (which has reduced inpatient stays by over 40%); and improved working with primary care, including hubs for specific treatments such as talking therapies.³³

The Trust also recognises that gaps remain including financial constraints; implementation of the Mental Capacity Act 2016; the need for increased early intervention; better services for those with dual diagnosis; and improved suicide prevention services.³⁴

The MHF have recently called for a new comprehensive ten-year mental health strategy for NI building on the legacy of the Bamford Review, to include³⁵:

- A mental health champion to act as a connector and consensus builder across government and services;
- A set of Principles;
- A life course approach;
- A places-based approach (services where people learn, work and spend leisure time);
- Digital mental health services for patients, and as a specialist support service for clinicians);
- Tackling the stigma of mental illness;
- Suicide prevention; and

³³ McFadden, A. (2016), Assistant Director, Adult Mental Health and Disability Services, Western HSC Trust, 'Meeting the needs of mental health patients: next steps for care post-Bamford', presentation at Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

³⁴ As above

³⁵ Elliott, Dr I. (2016), Mental Health Foundation (NI), 'Beyond Bamford: addressing mental health in NI', presentation at Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

- Work force issues.

3.3 Mental Capacity Act (NI) 2016

The Bamford Review proposed a single legislative framework and recommended the ‘fusion’ of mental health law (primarily concerned with the reduction of the risks flowing from mental disorder to the patient and others) and mental capacity law (designed to empower people to make decisions for themselves wherever possible, and to protect people who lack capacity). This finally came to fruition at the end of the last mandate with the Mental Capacity Act (NI) 2016 receiving Royal Assent on 9th May 2016.

This is the first time that NI has explicitly defined mental capacity through legislation and is widely recognised to be the first time in the world that mental health law and mental capacity law have been ‘fused’ in one piece of legislation.

The Act defines key terms such as ‘lacking capacity’ and ‘best interests decision making’ and also defines the High Court’s role in making decisions on a person’s behalf, including their ability to appoint deputies to act on someone’s behalf.³⁶ The Act provides for the protection, care, treatment and personal welfare of those who lack capacity and extends further to cover matters relating to the criminal justice system. It also makes provision for Independent Mental Capacity Advocates where additional support is required with best-interests decision making.³⁷

The Department have recently advised RaISe that no commencement dates have yet been agreed but that implementation planning is under way and that any decisions on commencement will be subject to the necessary resources being made available. There are no plans to draft or lay any commencement orders before 2019, at the earliest.³⁸

The Royal College of Psychiatrists noted that it hoped to receive early text of portions of the Code of Practice in autumn 2016 and to the pilot of the capacity assessment process.³⁹ It is accepted that the legislation is only one part of the process of reform⁴⁰:

Appropriate resources must be allocated to enable effective implementation. A detailed Code of Practice is required to provide clarity on many aspects. Training will be needed for a wide range of professionals. A comprehensive information programme must be provided for service users,

³⁶ NI introduces mental capacity legislation, Headway (the brain injury association), News, 23rd August 2016, <https://www.headway.org.uk/news/national-news/northern-ireland-introduces-mental-capacity-legislation/>

³⁷ As above

³⁸ Email response to RaISe from Department of Health, Mental Capacity Implementation, Mental Health and Capacity Unit, received 14th December, 2016

³⁹ The Royal College of Psychiatrists, July update,

<http://www.rcpsych.ac.uk/workinpsychiatry/divisions/rcpsychinnorthernireland/chairsupdate.aspx>

⁴⁰ The Mental Capacity (Northern Ireland) 2016 DNDLAW News Newry, <http://dndlaw.com/the-mental-capacity-northern-ireland-2016-dndlaw-news-newry/>

carers and attorneys. Nevertheless, this legislation provides the framework for a societal shift in its care and treatment of those with a mental disorder.

3.4 Transformation of Health and Social Care - Overarching Strategy and Direction – impact on mental health services in NI

3.4.1 Programme for Government 2016-2021

The NI Executive has made ‘Improving Mental Health’ ‘indicator 6’ in the Draft Programme for Government (PfG) 2016-2021 (completed consultation in December 2016). The lead measure to be used is “% of population with GHQ12 scores⁴¹ ≥ 4 (signifying possible mental health problem)”. The PfG states that the rationale for including ‘Improving Mental Health’ as an indicator is⁴²:

Mental wellbeing can be a key factor in determining physical wellbeing. It can also influence social circumstances such as employment, family relationships and community participation. Addressing mental wellbeing is, therefore, a consideration in a range of government objectives. Mental health issues are often particularly acute with those on the margins of society....

In a recent evidence session with the Health Committee, departmental officials discussed a number of key points about the use of the GHQ-12 measure. The Department stated⁴³:

...Having gone through this with statisticians and TEO, where we have ended up is that it probably is the best score available to us. It is not perfect, but, as you say, it has been fairly static. For about eight years or so, it has not moved. If you think about all the big global and societal events that have happened in eight years, and it has not been affected, that suggests it is a fairly steady number. You can get in underneath that and look at the distribution of scores for individual areas. Even though it is a flat line, there is, underneath the flat line, when you break the scores down, a

⁴¹ The GHQ12 is a screening tool designed to detect the possibility of psychiatric morbidity in the general population. The questionnaire contains 12 questions about recent general levels of happiness, depression, anxiety and sleep disturbance. Responses to these items are scored, with one point given each time a particular feeling or type of behaviour was reported to have been experienced ‘more than usual’ or ‘much more than usual’. A score is then constructed from combined responses to create an overall score of between zero and twelve. A score of 4 or more is classified as a respondent with a possible psychiatric disorder, and referred to as a ‘high GHQ12 score’. GHQ12 information is sourced from the Health Survey Northern Ireland. It is anticipated that it will be included in the health survey on a biennial basis.

⁴² Draft Programme for Government Framework 2016-2021, page 55,

<https://www.northernireland.gov.uk/consultations/programme-government-consultation>

⁴³ Committee for Health, OFFICIAL REPORT (Hansard), Programme for Government 2016-2021: Department of Health, 1 December 2016, page 6, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx?&cid=10>

distribution; there is a curve. Our aim is to move the curve towards the zero axis, in other words, improve the overall score. In GHQ-12, the lower the score, the better.

The GHQ-12 score gives an indication that there are issues, but it is an overall measure⁴⁴:

The GHQ-12 does not necessarily reflect the fact that we know that we have a particular issue with diagnosable mental health conditions in Northern Ireland. By and large, more people tend to have mental health issues here than they do in other comparable jurisdictions, and we know that we need to invest more in mental health....

3.4.2 Making Life Better 2012-2023

Making Life Better 2012–2023 is the ten-year public health strategic framework for NI and it builds on the Investing for Health strategy (2002–2012). A key long-term objective is “Improved Mental Health and Wellbeing, Reduction in Self Harm and Suicide”. Actions for the first few years included⁴⁵:

- Development of new policy to promote positive mental health, reduce self-harm and suicide;
- Increase resilience and improve mental wellbeing in children and young people through initiatives including Family Support, Roots of Empathy, iMatter (pupil’s emotional health and wellbeing programme);
- Reduce the levels of self-harm through roll out of evaluated approaches; and
- As part of the joint healthcare and criminal justice strategy, work to identify and support people with mental ill-health or other vulnerabilities who have offended.

3.4.3 Transforming Your Care

The present direction of healthcare service reform stems from at least 2011 when the then Minister for HSSPS, Edwin Poots MLA, announced a review of the provision of HSC services in NI.⁴⁶ It became known as ‘Transforming Your Care’ (TYC)⁴⁷ and proposed a new integrated model of health and social care; population-based planning of services; care to be provided as close to home as practical; and a shift of resource from hospitals to community health and social care services.

With regard to mental health, TYC acknowledged that the Bamford Review set the agenda for the transformation of those services and noted that, since then, the model

⁴⁴ Committee for Health, OFFICIAL REPORT (Hansard), Programme for Government 2016-2021: Department of Health, 1 December 2016, page 9, <http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx?&cid=10>

⁴⁵ *Making Life Better 2012–2023 - A Whole System Strategic Framework for Public Health 2013–2023*, DHSSPS, page 72, <http://www.publichealth.hscni.net/making-life-better>

⁴⁷ *Transforming your Care*, DHSSPS, 2011, page 89, <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care#toc-5>

of mental health care has evolved to promote greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs (see section 4.3 for further details of the current model)⁴⁸:



Source: TYC (2011)

For Child and Adolescent Mental Health Services (CAHMS), TYC noted that it would continue to be shaped by the Bamford recommendations and that a Review of CAMHS had been undertaken in 2011 by the Regulation and Quality Improvement Authority (see section 5.1 for further details).⁴⁹ The summary of key proposals specific to mental health in TYC included⁵⁰:

- Continued focus on promoting mental health and wellbeing with particular emphasis on reducing the rates of suicide among young men;
- A consistent, evidence-based pathway through the regional four step model and for urgent mental health care;
- Provision of clearer information on mental health services to clients and their families, making full use of technology;
- Promotion of personalised care, including the uptake of Direct Payments among mental health service users; and
- Closure of long stay institutions and complete resettlement by 2015.

3.4.4 Health and Wellbeing 2026

In early 2016, the then Health Minister, Simon Hamilton MLA, appointed an expert, clinically-led panel, chaired by Raphael Bengoa⁵¹, to consider and lead debate on the best configuration of health care services for NI.

⁴⁸ *Transforming your Care*, DHSSPS, 2011, page 89, <https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care#toc-5>

⁴⁹ As above

⁵⁰ As above, pages 92-93

⁵¹ Professor Rafael Bengoa practiced as a doctor for seven years in both hospital and primary care - key to his role in this panel - from 2009 to 2012 he was Minister for Health and Consumer Affairs in the Basque Government in Spain and during that time implemented a transformation of the region's health service during a period of severe austerity. *The former Basque Minister charged with sorting out our health service*, *Scope NI, NICVA Newsletter*, 8 January 2016, <http://scopeni.nicva.org/article/the-former-basque-minister-charged-with-sorting-out-our-health-service>

The Health Minister, Michelle O'Neill, published the Expert Panel's report on 25th October 2016, alongside the Department's report *Health and Wellbeing 2026, Delivering Together*⁵² (the outworking of the Expert Panel's recommendations⁵³). In her proposals she highlighted that mental health is one of her priorities with a commitment to achieving a parity of esteem between mental and physical health, including⁵⁴:

- Better specialist mental health services such as perinatal mental health and inpatient services for mothers; and
- Expansion of services in the community and services to deal with trauma from the past in NI.

The Minister is keen to move overall to a model of co-production, meaning that patients, service users and staff will be empowered to design the system as a whole with a focus on prevention; work together to develop pathways of care and HSC services; and be partners in the care they receive with increased self-management and choice. Mental health Recovery Colleges were highlighted by the Minister as a good example of co-production.⁵⁵ Each HSC Trust has a Recovery College.⁵⁶



Source: *Health and Wellbeing 2026, Delivering Together*

The 'Recovery' focus is about building a meaningful and satisfying life, whether or not there are recurring or ongoing mental health problems. The key themes are⁵⁷:

Agency – a patient gaining a sense of control over their life and illness. Finding an identity which incorporates illness, but retains a positive sense of self.

⁵² *Health and Wellbeing 2026, Delivering Together*, Department of Health (NI) (25th October 2016), <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

⁵³ *Systems, Not Structures: Changing Health and Social Care*, Expert Panel Report, 25th October 2016, <https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report>

⁵⁴ *Health and Wellbeing 2026, Delivering Together*, Department of Health (NI) (25th October 2016), page 17, <https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together>

⁵⁵ As above, page 20

⁵⁶ <http://www.belfasttrust.hscni.net/BelfastRecoveryCollege.htm>; <http://www.westerntrust.hscni.net/3364.htm>; <http://www.mentalhealthrecoverystories.hscni.net/recovery-college/>; <http://www.setrust.hscni.net/about/3002.htm>; <http://www.setrust.hscni.net/services/2960.htm>

⁵⁷ Centre for Mental Health, *What is recovery?* <https://www.centreformentalhealth.org.uk/recovery>

Opportunity - building a life beyond illness. Using non-mental health agencies, informal supports and natural social networks to achieve integration and social inclusion.

Hope – A patient believing that they can still pursue their hopes and dreams, even with the continuing presence of illness and not settling for the reduced expectations of others.

Recovery Colleges provide education as a route to recovery, not as a form of therapy. The colleges stem from the ImROC Project (implementing recovery through organisational change) (see section 4.5.2 for further details) delivered by the Mental Health Network and the Centre for Mental Health (supported by the Department of Health, England).⁵⁸

3.5 Suicide and Self Harm Strategies

3.5.1 Protect Life – A Shared Vision

In October 2006 the NI Suicide Prevention Strategy and Action Plan (2006 – 2011)⁵⁹ ‘*Protect Life – A Shared Vision*’, was published. A refreshed version of *Protect Life – A Shared Vision* was then published in June 2012 to cover the period 2011-2013⁶⁰. The 2006 Strategy set out an action plan including the following areas⁶¹:

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

Main findings from an evaluation of the 2006 Strategy⁶² found it had been successful in a number of areas, including:

⁵⁸ Recovery Colleges, NHS Confederation, <http://www.nhsconfed.org/resources/2012/09/1-recovery-colleges>

⁵⁹ DoH available: <https://www.health-ni.gov.uk/publications/suicide-prevention-strategy-and-reports>

⁶⁰ DHSSPS *Evaluation of the Implementation of the NI Protect Life Suicide Prevention Strategy and Action Plan* (October 2012); Moore Stephens available: <https://www.health-ni.gov.uk/publications/suicide-prevention-strategy-and-reports>

⁶¹ *Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2013* (refreshed December 2011), DHSSPS, June 2012

⁶² *Evaluation of the Implementation of the NI Protect Life Suicide Prevention Strategy and Action Plan* (October 2012); DHSSPS, <https://www.health-ni.gov.uk/publications/suicide-prevention-strategy-and-reports>

- Raising awareness of mental health issues through public information media campaigns and ensuring media guidelines mean that suicide is reported in a sensitive way; and
- Enhancing the support role carried out by the voluntary and community sectors for bereaved families and individuals who had made previous suicide attempts.

The objective of ensuring early recognition of mental ill-health and providing appropriate follow up support services was not wholly achieved, as awareness of support and services still varied among referrers in primary care.

The 2006 Strategy listed risk factors for suicide including depression, alcohol and drug misuse, personality disorder, hopelessness, low self-esteem, bereavement, break-up of a relationship and social isolation. A recent National Confidential Inquiry found the most common risk factors now also include economic adversity and recent self-harm.⁶³ In NI, inequality is still a strong contributing factor, with the suicide rate in the 20% most deprived areas three times higher than in the least deprived.

3.5.2 Protect Life 2

An eight week consultation⁶⁴ on the 'Protect Life 2' draft strategy⁶⁵ was launched on 9 September 2016. Objectives in the draft strategy include:

- An improvement in the understanding and identification of suicidal and self-harming behaviour, awareness of prevention services, and uptake of these services by people who need them;
- Enhancement of the initial response to, and care and recovery of people who are experiencing suicidal behaviour or who self-harm;
- Restriction of access to the means of suicide;
- Ensuring the provision of effective and timely information and support for individuals and families bereaved by suicide;
- Providing effective support for 'self-care' in the voluntary, community, and statutory sectors providing suicide prevention services;
- Enhancing responsible media reporting on suicide; and
- Identifying emerging suicide clusters and acting promptly to reduce the risk of further associated suicides.

A key finding from the National Confidential Inquiry⁶⁶ concluded that patients in NI missing their final appointment with mental health services proved to be an antecedent to patient suicides. This did not appear to be the case in Scotland or England where

⁶³ *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual report and 20-year Review*, October 2016; University of Manchester available:

<http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/>

⁶⁴ DoH available: <https://www.health-ni.gov.uk/publications/suicide-prevention-strategy-and-reports>

⁶⁵ *Protect Life 2: a draft strategy for suicide prevention in the north of Ireland*, Department of Health, September 2016 available:

⁶⁶ *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual report and 20-year Review*, October 2016; University of Manchester available: <https://www.health-ni.gov.uk/publications/suicide-prevention-strategy-and-reportshttp://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/>

assertive outreach services have been introduced with an emphasis on maintaining contact with patients. Statistics based on the last 20 years show that maintaining contact with patients is crucial.

4. Mental Health Service Provision in NI

4.1 Care Pathway for Services

In order to better understand where barriers to accessing mental health services arise for patients, it is useful to consider the care pathways for accessing mental health services in NI. The following information is taken from NI Direct⁶⁷:

The first port of call for an individual is usually the GP who will assess the person's needs and determine the best course of action with them. The GP may treat the patient directly or refer them to mental health services within the HSC Trusts.

If a referral is made to mental health services, they will determine the level of priority and contact the person to make an appointment. If mental health problems are compromising a person's personal safety, mental health services will see them as soon as possible for assessment.

When referred to mental health services, a psychiatrist, psychologist, social worker or a mental health nurse may assess the person. During the assessment, mental health services will ask about the person's:

- Current problems, thoughts and feelings;
- Personal history, including any previous treatments;
- Social history, including details about relationships and family life;
- Previous emotional and mental health problems;
- Lifestyle; and
- Physical health needs, including any medication taken by the person.

Mental health services will explain any diagnosis and will work with the person to develop a personal well-being plan (PWP). The PWP summarises the person's needs and brings together treatment and care options to help recovery (as discussed in section 4.5, the model of care is a recovery model). This may include interventions such as talking therapies; family and social care; occupational and lifestyle coaching; and drug therapy.

⁶⁷ Mental Health Services, NI Direct, <https://www.nidirect.gov.uk/articles/mental-health-services>

4.2 Types of Services

Primary care talking therapies teams - involves support by counsellors or well-being coaches, arranged by a person's GP.

Community mental health services - involves care provided by the local HSC Trust and is provided by one or more of the following professionals – nurses; social workers; psychiatrists; psychologists; occupational therapists; family therapists; and psychotherapists.

Acute mental health services - involves care provided by an HSC Trust Crisis Resolution and Home Treatment Team or specialist hospital care team. These services give support in crisis and can provide intensive home support or admission to hospital when someone is temporarily unable to manage independently.

Specific services - involves care from a specialist team, such as - alcohol or drug addiction; eating disorders; psychological therapies or trauma; personality disorders; and forensic services.

Emergency mental health services - If a person is in danger of harming themselves or others and has refused treatment, there may be an emergency assessment by a doctor and an approved social worker. This may lead to them having to be admitted to hospital against their will for assessment.

Presently, there are three ways to have an emergency assessment - by going to the accident and emergency department at a local hospital; by contacting your GP or your GP out of hours' service; or if the police take you to a place of safety.

Note: The situation regarding admission for treatment against an individual's will change in the future as the Mental Capacity Act (NI) 2016 is implemented. It will then no longer be lawful to detain someone for treatment against their will (under the Mental Health Order 1986), unless it can be proven through a new 'capacity assessment' that they lack 'capacity' to make the specific decision(s) required.

Section 307(2) of the Act refers to the fact that with regard to the commencement of the Mental Capacity Act (NI) 2016, '*provisions of this Act come into operation on such day or days as the Department may by order appoint*'. As already stated above, the Department have recently advised RaISe that no commencement dates have yet been agreed and there are no plans currently to draft or lay any commencement orders before 2019, at the earliest.⁶⁸

⁶⁸ Email response to RaISe from Department of Health, Mental Capacity Implementation, Mental Health and Capacity Unit, received 14th December, 2016

4.3 Stepped Care Model

In 2014, the HSCB in conjunction with the PHA published a regional mental health care pathway, 'You in Mind Mental Health Care Pathway'⁶⁹, which was jointly developed by 'experts by experience', (people with lived experience, family members, partners, friends and/ or advocates for people with mental health needs) and professionals involved in commissioning and providing care.

The Care Pathway recognises that access to all treatment and care needs to be personalised and 'recovery' orientated. Its purpose is to provide guidance on the steps of care to be accessed and delivered but also to enhance the quality of service experience and promote consistency across NI.⁷⁰ It provides for adult mental health services in NI via a stepped care approach to match the needs of the person to the right level of support - 'stepping up' to intensive/specialist services as needs require and 'stepping down' if recovery is at a stage where the same level of care and/or treatment is no longer required. Any changes – stepping up or down are arranged by the person's existing care team.



Source: Regional Mental Health Care Pathway⁷¹

The Care Pathway is specifically focused on the Recovery Model (see section 4.5 for more details).

Mental health services for children and adolescents (CAMHS) also follows a stepped care model. The HSCB has developed a single CAMHS System model which

⁶⁹ *You in Mind* Mental Healthcare Pathway (October 2014); HSCB

⁷⁰ Regional Mental Health Care Pathway, HSCB, PHA NI, http://passthrough.fw-notify.net/download/091854/http://www.northerntrust.hscni.net/pdf/Care_pathway_for_people_who_require_mental_health_care_and_support.pdf

⁷¹ As above, page 16

streamlines the access point for all children and young people with developmental, emotional and mental health needs. Trusts are in the process of aligning their services in line with this model. Section 5 of this paper deals specifically with CAMHS.

4.4 Mental Health Service Framework

A Departmental *Service Framework for Mental Health and Wellbeing* was published in 2012. The Framework is also underpinned by the ethos of 'recovery'.⁷² A full summary of its 58 standards for mental health and wellbeing are available online.⁷³ Service Frameworks for health services set out the standards of care that patients, clients, their carers and wider family can expect to receive in order to help people to⁷⁴:

- Prevent disease or harm;
- Manage their own health and wellbeing including the causes of ill health and its effective management;
- Be aware of what types of treatment and care are available; and
- Be clear about the standards of treatment and care they can expect to receive.

All service Frameworks incorporate a specific set of 'generic' standards to reinforce a holistic approach to health and social care improvement and reflect the importance of health promotion in preventing medical or social care issues occurring. These are intended to apply to all the population, or all HSC professionals or all service users, regardless of their health condition or social grouping. These include - involvement; communication; smoking prevention & cessation; healthy eating and physical activity; alcohol; and palliative care.

The Service Frameworks also identify consistent standards specific to the particular health area as informed by expert advice and by national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

4.5 The Recovery Model

4.5.1 History of the Recovery Model

It is thought that the concept of recovery from mental illness had its inception with deinstitutionalisation in the 1960s and 70s. During the 1980s community support

⁷² Mental health and well-being - service framework documents (20th August 2012), page 61, Department of Health, <https://www.health-ni.gov.uk/publications/mental-health-and-well-being-service-framework-documents>

⁷³ As above, pages 5-51

⁷⁴ As above

systems combined with rehabilitation programmes laid the foundation for the vision in the 1990s of the promotion of 'recovery' from mental illness:

Recovery from mental illness involves much more than recovery from illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.⁷⁵

Around 2008-09 the concept of recovery from mental illness became a key UK government objective:⁷⁶

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable place to live.

4.5.2 Implementing Recovery through Organisational Change (ImROC)

Ten key organisational challenges for implementing recovery were identified in 2009:⁷⁷

1. Changing the nature of day-to-day interactions and the quality of experience;
2. Delivering comprehensive, service user-led education and training programmes;
3. Establishing a 'Recovery Education Centre' to drive the programmes forward;
4. Ensuring organisational commitment, creating the 'culture';
5. Increasing 'personalisation' and choice;
6. Changing the way risk assessment and management is approached;
7. Redefining service user involvement;
8. Transforming the workforce;
9. Supporting staff in their recovery journey; and
10. Increasing opportunities for building a life 'beyond illness'.⁷⁸

⁷⁵ Anthony William A. (1993) *Recovery from mental illness: The Guiding Vision of the Mental Health Service System in the 1990s*; Psychosocial Rehabilitation Journal, 1993, 16(4), 11-23.

⁷⁶ *No health without mental health: a cross-government mental health outcomes strategy for people of all ages* (2011); HM Government, Objective ii.

⁷⁷ *Implementing Recovery: A new framework for organisational change* (2008); Sainsbury Centre for Mental Health available <https://imroc.org/>

⁷⁸ As above

A three year project, ImROC (Implementing Recovery through Organisational Change)⁷⁹ ran in England from 2009 to 2012 with 29 sites in England (NHS, independent sector and users/carers)⁸⁰. It delivered more than 50 joint training sessions that had been ‘co-produced’ between staff and service users to more than 400 staff, service users and managers; supported recruitment, training and support for more than 150 Peer Support Workers to work alongside staff as peer trainers; and established 6 Recovery Colleges offering more than 300 courses.

The project produced conclusions about organisational change to implement recovery⁸¹:

- Methods need to be flexible enough to set locally relevant goals and managers must ensure that local users and carers are engaged as true partners, creating a culture of ‘co-production’;
- Leadership is critical, but must be delivered at different levels with existing staff part of the solution;
- Change needs effective project management at operational level that is supported by an appropriate strategy at organisational level; and
- A different approach to risk assessment and management is needed to move toward a recovery-oriented approach;
- Two service developments are particularly important - Recovery Colleges and Peer Support Workers.

4.5.3 Recovery Colleges

In NI Recovery Colleges are now established in each HSC Trust. They offer education and courses on a wide range of topics around mental health designed to be of interest to service users, their carers and families, and mental health professionals.

Drawing on the experiences and skills of people who use mental health services and those who work in them, they enabled the development of the ‘*You in Mind Mental Health Care Pathway*’⁸² (‘the Care Pathway’). This has redefined how services are delivered to create an environment that builds hope and supports recovery (see section 4.3). The Care Pathway is written in the first person for the service user and:

- Explains how to access mental healthcare and the steps involved from the point of referral to the point that care is no longer required;
- Describes the standards of care to expect by mental health professionals who will be the person’s partners in their recovery;
- Outlines how care decisions will be made for the person and with them; and

⁷⁹ ImROC website at: <https://imroc.org/>

⁸⁰ The project was mainly funded by the DoH and delivered by a partnership between the Centre for Mental Health and the Mental Health Network of the NHS Confederation

⁸¹ ImROC presentation at: <https://imroc.org/>

⁸² *You in Mind* Mental Healthcare Pathway (October 2014); HSCB.

- Puts the person, and/or their family, partner and nominated friends (as appropriate) at the heart of all decision making.

There is a focus on the service user and professionals working together as equals. The service user and professionals decide a path to recovery, and work together to achieve self-management. The Care Pathway is organised round a Step Care Model as described in section 4.3.

The Northern HSC Trust Recovery College website⁸³ acknowledges that recovery means something different to everyone, but “...*at The College, we mean having the ability to live a satisfying life.*” The four signposts for people with lived experience of mental health illness are hope, opportunity, power and education:

- Hope is seen as central to recovery and courses offered at the College are based around the principle of hope;
- Opportunity refers to individuals all having the same life chances with courses designed to enable people to maximise opportunities to understand and tell their own recovery story;
- Power is about individuals having the power within themselves to take control of their difficulties, the services they avail of, and their own lives through self-management; and
- Education is about self-learning and drawing on personal resources and strengths.

In October 2016, the Health Minister, Michelle O’Neill, welcomed the launch of the Recovery College in the Southern HSC Trust and the Wellmind Hubs. The Hubs offer a range of support options for people with common mental health conditions such as anxiety, stress or low mood. Care is offered by a range of independent sector providers, community groups or from within the Hub, depending on the needs of the person. The Wellmind Hubs have been initially set up in the Armagh and Dungannon areas and plans are now underway to extend them into the Craigavon/Banbridge and Newry/Mourne localities.⁸⁴

The Minister reinforced her commitment to move towards ‘parity of esteem’ for mental health. ‘Parity of esteem’ is the principle by which mental health is given equal priority to physical health. It is not a call for 50-50 funding between physical and mental health, rather, according to the Royal College of Psychiatrists, it would ensure that there would be:

- Equal access to the most effective and safest care and treatment;
- Equal efforts to improve the quality of care;
- The allocation of time, effort and resources on a basis commensurate with need;

⁸³ Northern Health and Social Care Trust Steps to Recovery available:
<http://www.mentalhealthrecoverystories.hscni.net/recovery-college/>

⁸⁴ O’Neill Launches New Mental Health Recovery Services, Department of Health, Press Release, October 2016,
<https://www.health-ni.gov.uk/news/oneill-launches-new-mental-health-recovery-services>

- Equal status within healthcare education and practice;
- Equally high aspirations for service users; and
- Equal status in the measurement of health outcomes.

4.5.4 Measuring Recovery

A review in 2011 identified an understanding of recovery that has emerged from accounts around the world.⁸⁵ Two aspects were examined – measures of recovery ‘outcome’ and measures to improve outcomes for users. It was recognised that currently available instruments for measuring recovery required further research. However, principles emerged from an analysis of the review literature:

- Recovery involves more than the absence of illness;
- Recovery is a personal experience – it cannot be ‘done’ to a person;
- The routine assessment of recovery outcome data is necessary to support recovery; and
- A recovery orientation needs to be a ‘permeating’ organisational value.

There are four key policy implications:

- Each person who uses mental health services should assess routinely the experience of personal recovery and associated outcomes, such as social inclusion and well-being;
- The recovery orientation of the mental health service, as judged by the service user, should be assessed routinely and this information should be used to inform action planning with the individual, as well as local, regional and national service developments;
- Routine collection of recovery outcome data will not happen unless politically prioritised and adequately resourced; and
- Developing a recovery orientation involves organisational transformation.

5. Child and Adolescent Mental Health Services (CAMHS) – NI

5.1 Introduction to Mental Health Issues in Children and Young People

⁸⁵ Donnelly, M. et al (August 2011) *Patient outcomes: what are the best methods for measuring recovery from mental illness and capturing feedback from patients in order to inform service improvement*; Bamford Implementation Review Scheme: patient outcomes – COM/4409/10

As stated earlier in the paper, whilst data on the prevalence of mental ill health in children and young people in NI is scarce, it is estimated that:

- Around 45,000 of children and young people in NI have a mental health need at any one time⁸⁶; and
- More than 20% of young people are suffering “significant mental health problems” by the time they reach 18.⁸⁷

Also as mentioned earlier, between the years 2012/13 to 2014/15 the rates of self-harm presentations to emergency departments in NI increased by 30% for 15 to 19 year olds.⁸⁸ As many as 1 in 5 young people in NI self-harm and it is thought that this is mainly ‘goal-directed behaviour’ to try to deal with psychological pain.⁸⁹

With regard to suicide, 318 suicides were registered in NI during 2015. Of these, 132 were aged between 15 and 34-years-old.⁹⁰

Child and Adolescent Mental Health Services (CAMHS) is apportioned less than 8% of the mental health budget in NI, whereas the UK average of 10% (10% in NI would mean around an extra £5million for CAMHS).⁹¹

Research has shown that 50% of mental health problems emerge by age 14⁹² and that childhood adversities associated with dysfunction in families, maternal depression, trauma experienced within families and social deprivation are strongly linked to the onset in childhood and continuation into adulthood of mental health problems. This is thought to be because the duration and types of adversities are persistent and enduring.⁹³

⁸⁶ DHSSPS (2015) *Delivering Excellence, Achieving Recovery, A professional framework for the mental health nursing profession in N.I.* p10.

⁸⁷ As above

⁸⁸ McCafferty, M, (2016), Chief Executive, NI Commissioner for Children and Young People, ‘*Children and young people with mental health problems: priorities for tackling a growing trend*’, presentation at Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

⁸⁹ Professor O’Neill, S. and Professor Heenan D. (Ulster University) ‘*Mental health promotion and screening in schools: a call to action*’, presentation at Institute of Public Health in Ireland (IPH) Open Conference, 11 October 2016; Titanic Centre, Belfast.

⁹⁰ Torney, K. (2016), *Suicide rates in Northern Ireland Highest on Record*, The Detail, <http://www.thedetail.tv/articles/suicide-deaths-in-northern-ireland-highest-on-record>

⁹¹ McCafferty, M, (2016), Chief Executive, NI Commissioner for Children and Young People, ‘*Children and young people with mental health problems: priorities for tackling a growing trend*’, presentation at Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

⁹² Sands, Dr. L. (2017), Council member, RCGP NI, Associate Director, GP Career Development Scheme and GP Training Programme Director, NIMDTA, ‘*Priorities for prevention, intervention and access to mental health services*’, presentation to Policy Forum for NI Keynote Seminar: improving mental health provision in NI: prevention, treatment and developments in care, 17th January 2017, Stormont Hotel, Belfast

⁹³ Margaret McLafferty, Cherie Armour, Aine McKenna, Siobhan O’Neill, Sam Murphy, Brendan Bunting; Childhood adversity profiles and adult psychopathology in a representative Northern Ireland study; *Journal of Anxiety Disorders* 35 (2015) 42-48.

However, there is evidence that it is possible to reverse this situation through early intervention and therefore prevent mental health problems becoming pervasive in families and becoming transgenerational.⁹⁴

Research has shown that in young children up to two years old, there is environmental calibration of a child's stress response (related to neuroplasticity⁹⁵), reactivity to stress is malleable and modified by the child's experiences. If these are adverse experiences, then by the ages of two to eight the child's reaction to stress and their poor stress regulation creates behaviour and relationship problems. However, interventions are effective due to continuing neuroplasticity at this age. By the ages of eight to 12 stress reactivity is becoming more consolidated and difficult to modify. This becomes even more pronounced by young adulthood leading adolescents and young adults to use substances and self-harm to self-regulate their stress response and also to diagnosable mental illness. Young adults may then become parents leading to transgenerational problems.⁹⁶

However, children of primary school age can be taught resilience that will allow them to regulate how they respond to stress and deal with life events that could lead to mental health issues. These include⁹⁷:

- Mindfulness/relaxation – programming the brain to self-regulate;
- Relationship management and negotiation – less stressful relationships and better social support (buffer);
- Help to cope with feelings after loss and trauma;
- Fostering adaptive stress responses (exercise, self-management, harnessing support);
- Developing self-esteem, self-acceptance, authenticity; and
- Skills to identify problems and seek help rather than just knowledge.

The case is strongly made for specialist mental health services in schools along with hard hitting anti-stigma campaigns, with schools assisted to develop whole school approaches to health and wellbeing.⁹⁸

5.2 Recent History of CAMHS in NI

⁹⁴ Professor O'Neill, S. (2017), Professor of Mental Health Services, Ulster University, presentation at 'Policy Forum for Northern Ireland Keynote Seminar: *Improving mental health provision in Northern Ireland: prevention, treatment and developments in care*'; 17 January 2017; Stormont Hotel, Belfast.

⁹⁵ Definition of Neuroplasticity: The brain's ability to reorganize itself by forming new neural connections throughout life, <http://www.medicinenet.com/script/main/art.asp?articlekey=40362>

⁹⁶ Professor O'Neill, S. and Professor Heenan D. (Ulster University) '*Mental health promotion and screening in schools: a call to action*', presentation at Institute of Public Health in Ireland (IPH) Open Conference, 11 October 2016; Titanic Centre, Belfast.

⁹⁷ As above

⁹⁸ As above

In 2011 a Review of CAMHS in NI was published by the Regulation and Quality Improvement Authority (RQIA).⁹⁹ The review examined the quality and availability of services and professional groups in the delivery of *specialist* mental health care for children and young people in hospital and community settings. Non specialist mental health services for children and young people in primary care such as school nurse and health visiting were not included in the review, but were recognised for their importance in early identification of mental health problems.

The five HSC Trusts and the HSCB were reviewed using a framework of standards developed from Departmental circulars and guidance in NI, including the progress of recommendations from the Bamford Independent Review of CAMHS (2006).

The RQIA review team found that progress had been made since the Bamford Review in 2006, including the development of the purpose built inpatient service (Beechcroft) and development of services in areas such as eating disorders and crisis intervention. The review team also found a committed workforce and this was supported by the positive experiences of CAMHS documented in a consultation with young people and their parents as part of the review.

However, the team felt that more work needed to be done to ensure that children and young people with mental health needs will be seen by the right person at the right time in the right place. The absence of an overall CAMHS strategy at that time meant that each HSC Trust was developing services differently across the then tiered service model. For example, access to community and early intervention services was underdeveloped in certain areas especially in the provision of Community CAMHS at Tier 2; and the modelling in Tier 2 and Tier 3 services (specialised and targeted services) was not consistent across the Trusts.¹⁰⁰

As a result of its review, the RQIA made 21 regional recommendations to the five trusts for improvement to the organisation and delivery to CAMHS; nine recommendations to the HSCB and one overarching recommendation to the DHSSPS to confirm through policy guidance a model for service provision in NI.¹⁰¹

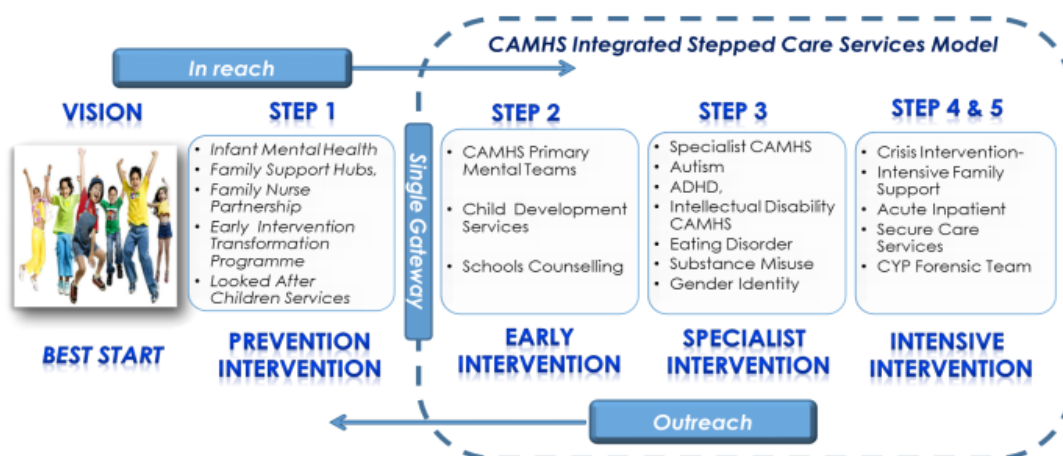
5.3 Model of Service Provision – CAMHS in NI

As a result of the RQIA review, the HSCB has since developed a single CAMHS System stepped care model to streamline the access point for all children and young people with developmental, emotional and mental health needs. HSC Trusts in NI are in the process of aligning their services in line with this model:

⁹⁹ RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in NI, February 2011, <https://www.rqia.org.uk/reviews/review-reports/2009-2012/2010-11/rqia-independent-review-of-child-and-adolescent-me/>

¹⁰⁰ As above, Summary Report, <https://www.rqia.org.uk/reviews/review-reports/2009-2012/2010-11/rqia-independent-review-of-camhs-in-northern-irela/>

¹⁰¹ As above



Source: Department of Health (NI)¹⁰²

An Integrated Care Pathway for CAMHS is also in development, which will set out the quality service standards across the different steps of care. The pathway is being co-produced with parents, young people and voluntary sector organisations that represent service users, along with multi-disciplinary representation from CAMHS across all Trusts (including representation from the professional bodies).¹⁰³

The HSCB have established a Stepped Care Implementation Framework, which is governed by a Regional Steering Group:

Key Outcomes	Key Actions		
1. Promote a Culture of Early Intervention	Establishment of Primary Mental Health Care Team in each Trust.	Establish Regional IMH Health Services Model and IMH practice across all steps	2013 Infant Mental Training and Development Plan
2. Integrate Child Development, Therapeutic and CAMHS Related Services	Establishment of Local Implementation Networks in Each Trust and LIT Plans	Development of Regional Core CAMHS Care Pathway (Step 2-5) including ASD & ADHD Services	Implementation Of Single Care Gateway for Child Development and CAMHS Related Services
3. Improve the Access to Information and Experience of Care	Establishment of Regional CAMHS Web Site . –Family Support Website	Baseline Experience Sense Maker Audit – Establish Young Persons and Parent Network	Adaptation Recovery Co-Production Framework
4. Improve Acute Care Services	Establish CRHT Services in Each Trust	Commission Independent Review for Inpatient Services	Establish Acute CAMHS Services Network
5. Enhance Specialist Services	Establish Forensic Support and Gender Identity Services	Agree LD CAMHS Services Model Agree Addiction Service Model Standardise Eating Disorder Services – Create Managed Clinic Network	Development of Early Intervention Services for Psychosis
6. Evidence Based Practice	Implement Mental Health Services Framework and NICE Guidance	Develop a Continuing Professional Skill Framework in line with Stepped Care Model	Identify enhance MDT Gaps - Occupational Therapy, Creative Therapies Peer Support Psychotherapy .
7. Efficient Systems	Implementation of Choice and Partnership Framework	Development of Regional Outcomes Framework	Development of Case Management Model
8. Multi Agency Working	Joint Working Protocols with Intensive Counselling in Schools service (ICSS)	Joint working with Youth Justice Service	Partnership with Family Support Hubs.

Source: Department of Health (NI)¹⁰⁴

¹⁰² CAMHS REFORM, DHSSPS STEPPED CARE MODEL IMPLEMENTATION REVIEW, May 2016, Information provided to RaISe from the Department of Health, via the Departmental Liaison Officer.

¹⁰³ As above

¹⁰⁴ As above

The HSCB in partnership with Trusts, children and young people has developed a regional guide to CAMHS Services Called *Mind Matters - A Guide to Child and Adolescent Mental Health Services*. The HSCB has also developed the Family Support NI website (www.familysupportni.gov.uk) to improve access to information on Child and Adolescent Mental Health Care. Trusts have also developed their own websites to improve information about CAMHS and are also in the process of strengthening their advocacy services for children and young people and have and/or in the process of establishing Young People and Parent Forums.¹⁰⁵

With regard to early intervention, the HSCB developed Primary Mental Health Step 2 Care Teams and the teams are now operating across NI. The Public Health Agency (PHA) has developed a new infant mental health plan which has just been published.¹⁰⁶

Overall, the CAMHS framework aims to support the adoption of a standardised approach across all children's services and the investments made by PHA within Step 1 and 2 services, as part of the Stepped Care Model are seen as a crucial part of the prevention and early intervention approach. CAMHS services in partnership with Adult Mental Health services are also in the process of developing early intervention teams to support adolescents and young adults with complex mental health problems (psychosis) to receive intensive support.

In terms of family support, across NI there are now 29 multi-agency Family Support Hubs in place. A Primary Mental Health Worker is linked to each Hub which serves to increase capacity and promote earlier access to appropriate services, including step up to more specialist interventions if required. The network accepts referrals of families who need early intervention family support and signposts families with specific needs to appropriate services.¹⁰⁷

5.4 HSCB Reports on CAMHS

The HSCB produced a final report in April 2013 on the implementation of the HSCB specific recommendations from the RQIA review showing that the majority of the recommendations had been achieved. Those not fully achieved remained a work in progress and were absorbed into the implementation process of the regional CAMHS model.

More recently, the HSCB have recently completed a 3 year review of the CAMHS Stepped Care Model (May 2016) and the information in this section is taken from that report.¹⁰⁸ The report included a summary of the progress being made by all HSC Trusts

¹⁰⁵ CAMHS REFORM, DHSSPS STEPPED CARE MODEL IMPLEMENTATION REVIEW, May 2016, Information provided to RaISe from the Department of Health, via the Departmental Liaison Officer.

¹⁰⁶ *Infant Mental Health Framework for NI*, PHA, April 2016, <http://www.publichealth.hscni.net/publications/infant-mental-health-framework-northern-ireland>

¹⁰⁷ CAMHS REFORM, DHSSPS STEPPED CARE MODEL IMPLEMENTATION REVIEW, May 2016, Information provided to RaISe from the Department of Health, via the Departmental Liaison Officer.

¹⁰⁸ As above

against the agreed quality (implementation) indicators. Reports from each Trust detailing their respective improvement actions implemented; the outcomes and evidence of these, and next steps against each of the quality indicators are included in the appendices of that report.

Progress Against the Quality Indicators¹⁰⁹

Establish a Local Implementation Team to lead implementation. This should include membership from Child Health, Social Care, CAMHS, Adult Mental Health and Related Multi-agency/Third sector providers:

Progress: - The HSCB established a Stepped Care Implementation Framework, which is governed by a Regional Steering Group.

Promote a culture of early Intervention, which embeds infant mental health approaches, and enables the development of early intervention teams:

Progress: - The HSCB invested £0.94m in the development of Primary Mental Health Step 2 Care Teams - all Teams are now operating across NI.¹¹⁰ The PHA has also developed a new infant mental health plan which has just been published.¹¹¹ The investments made by PHA within Step 1 and 2 services, as part of the Stepped Care Model and family support via the Family Support Hubs were outlined in section 4.3.

Integrate all Child Development, Therapeutic and CAMHS Services in Single Care System of Care:

Progress: - As outlined in section 5, the HSCB has developed a single CAMHS System model which streamlines the access point for all children and young people with developmental, emotional and mental health needs. Trusts are in the process of aligning their services in line with this model.

Improve the access to local Information about CAMHS and improve Children Young People and their family's experience of CAMHS Services:

Progress: - The HSCB in partnership with Trusts developed a Regional Guide to CAMHS Services called Mind Matters "A Guide to Child and Adolescent Mental Health Services" (outlined in section 5.2). It has also developed the Family Support NI website.¹¹²

¹⁰⁹ CAMHS REFORM, DHSSPS STEPPED CARE MODEL IMPLEMENTATION REVIEW, May 2016, Information provided to RaISe from the Department of Health, via the Departmental Liaison Officer.

¹¹⁰ The HSCB is also in the process of working with Trusts to (resource permitting) to expand the role and functions of these teams to support Children and Young People with Autism.

¹¹¹ *Infant Mental Health Framework for NI*, PHA, April 2016, <http://www.publichealth.hscni.net/publications/infant-mental-health-framework-northern-ireland>

¹¹² www.familysupportni.gov.uk

Improved access to acute and high intensity interventions for all children & young people who are experiencing emotional, behavioural, mental health and psychological crisis:

Progress: - The HSCB, in addition to £1.5 Million, has invested an additional £1 Million in the development of Trust CAMHS Crisis Resolution Intensive Support Teams, now available in each Trust for children and young people. The HSCB in partnership with Belfast Trust, commissioned an Independent Review of CAMHS Inpatient Services. The recommendations of this review are currently being addressed through the development of a new CAMHS High Intensity Managed Care Network. The development work on this model is due to be concluded during 2016/17.

Enhance Specialist CAMHS Services by identifying services gaps, workforce development needs and developing new ways of working:

Progress: - The HSCB has supported the development of a Forensic CAMHS Team (£177,000) and Gender Identity Services (£111,000). Work is also underway in Trusts to create new services for children and young people who have co-occurring intellectual disabilities and mental health needs.

The PHA recently confirmed recurrent investment in Drug and Alcohol Mental Health Services (DAMHS) in Trust CAMHS teams where investment had been non-recurrent.

Improve adherence to Evidence Based Practice. This includes the development of a clear therapeutic model and evidence of the implementation of NICE Guidance:

Progress: - The HSCB has developed a 'Working together Learning Together' Framework for Mental Health and CAMHS to guide continuing professional development in line with NICE Guidelines.

Services are delivered efficiently – including improving access to care, and the capturing of care outcomes and child and family experience:

Progress: - Each Trust has adopted the Choice and Partnership framework (CAPA) to enable the effective management of demand and capacity across CAMHS. As indicated above work is underway to develop a new care pathway this will include, key clinical and experience based outcomes measures. The HSCB has also developed a new CAMHS minimum data base to support the measurement of effectiveness. In addition to capturing demand data, the new data set will also include data on diagnosis and outcomes.

Care is delivered through multiagency partnerships, co-working including education, and Youth Justice:

Progress: - Each Trust has established local implementation teams which include Family Support Hub Coordinators. In addition, education is represented on the Regional Implementation Steering Group. The Project groups overseeing the Sense

Maker Audit and the development of the CAMHS Care pathway have multi-disciplinary/agency representation. Young people, parents and user group representatives are also on the project team for development of the care pathway. Service users of both CAMHS and autism services were involved in the development of the signifiers for the questionnaire for the Sense Maker survey.

6. Evaluating Mental Health Service Provision (NI) in terms of Accessing Services and Barriers to Access

6.1 Stigma – A Key Barrier

The World Health Organisation (WHO) stated, “*The single most important barrier to overcome in the community is the stigma and associated discrimination towards persons suffering from mental and behavioural disorders.*”¹¹³ Stigma surrounding mental health is still an issue in society and is an important influencing factor in someone seeking professional help.¹¹⁴

A key review published in 2015 of research carried out in relation to stigma identified several different types of stigma that would deter a person from seeking help from formal services.¹¹⁵ These are:

- Anticipated stigma – anticipation of personally being perceived or treated unfairly;
- Experienced stigma – the personal experience of being perceived or treated unfairly;
- Internalised stigma – holding stigmatising views about oneself;
- Perceived stigma – views about the extent to which people in general have stigmatising attitudes/behaviour towards people with mental illness;
- Stigma endorsement - participants’ own stigmatising attitudes/behaviour towards people with mental illness); and
- Treatment stigma – the stigma associated with seeking or receiving treatment for mental ill health.

The review found that internalised stigma and treatment stigma had a consistent negative association with help-seeking.

Stigma was classed as having a moderate negative effect compared to other barriers.¹¹⁶ It was reported as a barrier to help-seeking by 21% to 23% across the studies reviewed for shame/embarrassment, negative social judgement and

¹¹³ The World Health Report 2001: Mental Health, New Understanding, New Hope (2001); World Health Organisation available: <http://www.who.int/whr/2001/en/>

¹¹⁴ Clement, S. et al (2015) *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies*; Kings College London.

¹¹⁵ As above

¹¹⁶ The other barriers are not cited in the research paper.

employment related discrimination. Disclosure concerns and confidentiality was a concern reported by 32% of respondents as being a barrier. When comparing gender groups, stigma was ranked lower among studies only involving women, and in mixed gender groups shame and embarrassment and negative social judgement were most frequently mentioned.

The discord between a person's self-perception and common stereotypes about mental illness caused people to avoid telling others about their mental illness and masking the symptoms. Together with anticipated or experienced negative consequences, they were deterred from seeking help.

However, stigma-related factors were identified that enabled help-seeking. Strategies used by individuals included selective disclosure and normalising mental health problems. Service delivery could also be seen as less stigmatising in care offered and confidential services. Non-stigmatising care included non-clinical approaches, talk based care, help in community centres and generic medical settings, care that is welcoming and preserves patients' dignity, and the use of terms that reflect the client's understanding of their problems.¹¹⁷

Based on this research, the implications are that anti-stigma programmes should focus on countering stereotypes such as 'weakness' and 'craziness', social judgement and rejection, employment discrimination and shame/embarrassment. As disclosure issues were found to be a particular concern, interventions that would aid decision making around disclosure would be helpful. There were also implications for individuals already receiving treatment in supporting service users to develop additional strategies to cope with and counter treatment and internalised stigma.¹¹⁸

6.2 Action Mental Health Report – *Regress, React, Resolve?*

Action Mental Health (AMH) is an NI charity working to enhance the quality of life and the employability of people with mental health needs or a learning disability.¹¹⁹ As part of its ongoing work it became aware that post-Bamford:¹²⁰

There has been very limited research on the impact of policy, the costs involved and service users' experiences of services. Also, there has been

¹¹⁷ Clement, S. et al (2015) *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies*; Kings College London.

¹¹⁸ As above

¹¹⁹ Action Mental Health, <http://www.amh.org.uk/about/>

¹²⁰ *Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland*, Report prepared for AMH by QUB, 5 October 2015, Foreword, [http://pure.qub.ac.uk/portal/en/publications/regress-react-resolve-an-evaluation-of-mental-health-service-provision-in-northern-ireland\(7a659cb2-f036-4490-8ccf-8bce2ae256f9\).html](http://pure.qub.ac.uk/portal/en/publications/regress-react-resolve-an-evaluation-of-mental-health-service-provision-in-northern-ireland(7a659cb2-f036-4490-8ccf-8bce2ae256f9).html)

little study of mental health professionals' perspectives on the effectiveness of the services they provide.

AMH commissioned a study by Queen's University, designed to fill gaps in knowledge and highlight challenges and opportunities for developing mental health services. The report (*Regress? React? Resolve?*) was designed to give service users a voice and also to include mental health commissioners from the statutory sector. It focused on three key questions:

- Have mental health services improved in the last decade;
- How do service users perceive their care; and
- How will funding cuts impact already stretched mental health services.

Although the report acknowledges that improvements have been made in service provision since Bamford and TYC, it highlighted issues around accessing services including the difficulty for people in rural areas, where there was fragmentation of mental health services. It also noted that funding cutbacks have curtailed progress and will continue to do so in the coming years:¹²¹

In overview the report highlighted that between 2008 and 2014, actual spend on mental health services by Trusts has been around 25% less than previously proposed and mental health services have experienced year on year decreases in funding since 2009.

The report highlights two areas where AMH believe 'fresh thinking and planning' are required – human and systemic:¹²²

Human

- People still feel that the system fails to treat them as 'people', rather than as problems to be managed or solved;
- Service users identified 'listening' (by healthcare professionals) as among the most important strengths of the care and support they received; and
- Recognition of the role and contribution of carers.

Systemic

- Funding: Mental health commissioners unanimously agreed that the greatest challenge facing mental health services was continuing financial restraint:

Indeed, not only were commissioners worried about securing the continuing financial investment necessary to deliver the Bamford Vision, but

¹²¹ *Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland, A Summary, Report prepared for AMH by QUB, 5 October 2015, page 4, www.amh.org.uk/wp-content/uploads/2010/06/AMH-QUB-report-summary_AW.pdf*

¹²² As above, pages 4-6

several also expressed serious concern about the danger of existing provision being cut-back.

- Fragmentation and communication breakdown - respondents from all groups expressed serious concerns about the fragmentation of mental health services in NI. Feedback suggested increased fragmentation was connected with developments in the specialisation of community-based mental health provision and reductions in hospital beds (which had taken place since the Bamford Review). The interface between the hospital and community was seen as central;
- Young people: Considerable concern was expressed about deficiencies in services for children and young adults, particularly services for teenagers and to support young peoples' transition to adult services; and
- Leadership: It was concluded that post-Bamford, the same drive for service improvement did not exist and that lack of leadership in mental health extended beyond those responsible for managing and commissioning services to politicians and funders.

The report produced ten recommendations as summarised below¹²³:

1. Funding - the NI Executive should ensure that sufficient ring-fenced funding is made available for mental health to achieve the service improvements envisaged by the Bamford Review.
2. Fragmentation - the Department in conjunction with the HSCB and Trusts should establish a regional working group to examine the extent and impact of mental health service fragmentation.
3. Champion - the establishment of an independent Champion for Mental Health in NI to play a key role in ensuring that mental health services continue to be developed.
4. Carers - the central role that carers play in supporting the (cared for) family member should be recognised by professionals.
5. Recovery Ethos - commissioners and providers of mental health services should continue to work towards promoting a recovery ethos.
6. Person-centred - all sectors should continue to strive to promote a person-centred and relationship-based approach to service delivery.
7. Stigma - all commissioners and providers of mental health services should continue to prioritise reducing the stigma associated with mental ill-health and a renewed emphasis on promoting positive mental health with additional resources for developing mental health education in schools.

¹²³ *Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland, A Summary, Report* prepared for AMH by QUB, 5 October 2015, pages 6-7, www.amh.org.uk/wp-content/uploads/2010/06/AMH-QUB-report-summary_AW.pdf

8. Transgenerational Trauma - commissioners of mental health services should review services available to meet the needs of people who have experienced transgenerational trauma as a result of the Troubles.
9. Collaborative working – commissioning agencies in the statutory sector should continue to work with voluntary sector organisations to improve collaborative working in the planning and delivery of mental health provision.
10. Quality Assurance - the Department in conjunction with the HSC Board and Trusts should establish a working group with service users and carers to examine how quality assurance systems in mental health can be further improved.

As part of the way forward, on 24th February 2016, AMH hosted NI's first Mental Health Summit to discuss the key themes and recommendations resulting from *Regress? React? Resolve? A subsequent publication 'Let's Resolve Mental Health Service Provision Together'* set out the views of key stakeholders on how to resolve mental health service provision in NI.¹²⁴

6.3 Review of Acute Inpatient Psychiatric Care

The independent Commission to review the provision of acute inpatient psychiatric care for adults in NI published its report in June 2016.¹²⁵ The Commission was set up by the Royal College of Psychiatrists (RCPsych) and chaired by Lord Nigel Crisp, former Chief Executive of the NHS in England, in response to concerns around a shortage of provision for acute inpatient care for psychiatric patients and a lack of alternatives to hospital admissions.

The Commission found a high prevalence of mental health problems in NI, which it attributed to a legacy of the 'Troubles' and high levels of social deprivation. Compared to 17 other European countries, NI had the second highest rates of mental ill health and a 20%-25% higher incidence than England. Suicide rates were also significantly higher than elsewhere in the UK. Despite a higher level of need, NI per capita spend on mental health and learning disability was less than half of spend in England.

A survey of acute wards found that the system was under strain and that 1 in 4 of inpatients could be treated better in a different setting, and 1 in 5 inpatients were ready for discharge. System wide access issues were found to be contributing to this situation involving:

- Too few community and specialist services and a shortage of supported housing;

¹²⁴ *Let's Resolve Mental Health Service Provision Together, The Final Report – The Voice of the Mental Health Sector in NI*, May 2016, Action Mental Health, <http://www.amh.org.uk/wp-content/uploads/2010/06/The-Final-Report-the-Voice-of-the-Mental-Health-Sector-in-NI.pdf>

¹²⁵ *Building on progress: Achieving parity for mental health in Northern Ireland Final Report*, June 2016; The Commission to review the provision of acute inpatient psychiatric care for adults available: <http://www.caapc.info/>

- Weak commissioning arrangements with organisational boundaries getting in the way of improving quality and efficiency;
- Poor data available on which to base decisions (a UK wide issue); and
- Mental health funding proportionately less than in other parts of the UK.

The Commission's report recommended significant changes to the way mental health services are organised including a Mental Health Service for the region and investment in crisis resolution and home treatment teams, specialist psychiatric services and psychological therapies.¹²⁶

6.4 Young Men at Risk of Suicide – Barriers to Accessing Care

In 2011 a study was undertaken in NI to obtain an understanding of suicidal behaviour in men aged 16-34.¹²⁷ Its aim was to find out how mental health care services can be configured to encourage suicidal young men to access them, and to discover the most appropriate response from mental health care services.

The study conceptualised suicide “as a multidimensional, complex phenomenon” and therefore used in-depth interviews to collect data. Four groups (36 men in total) were selected for interview; those using statutory mental health services; those who had previously used statutory services; those who were using a range of non-statutory community and voluntary counselling services; and those who had not had any contact with statutory or non-statutory services. The latter group were accessed through an advertising campaign across a range of media.

The survey found the ‘type, nature, and geographical location of formal mental health services offered only limited help for young men with suicidal thoughts and behaviours. A recommendation was made that pro-active services should be community based, open access and embedded in non-mental health environments such as sports clubs, schools, the workplace, and community interest and self-help groups.

Major challenges to accessing mental health services were identified as stigma and discrimination. It was recommended that these should be addressed by population level advertising and awareness campaigns, and with educational and workplace initiatives focusing on recovery from mental illness. These initiatives should be publicised through media forms that young men connect with.

¹²⁶ *Building on progress: Achieving parity for mental health in Northern Ireland Final Report*, June 2016; The Commission to review the provision of acute inpatient psychiatric care for adults available: <http://www.caapc.info/>

¹²⁷ Jordan, J. et al (2011) *Providing meaningful care: using the experiences of young suicidal men to inform mental health care services, Short Report*; Queen's University Belfast, University of Ulster and Public Health Agency available: www.publichealth.hscni.net/sites

The young men in the study acknowledged that 'recovery' would be a long-term process impacted upon by their relationship with mental health professionals. Firm interpersonal relationships established early formed the basis for future interventions and counteracted the sense of disconnection felt by the young men in the study. The continued support and involvement of mental health professionals and their peers who were making the journey with them was important for the path to recovery.

Findings confirmed the value in creating community-based informal 'drop-in' suicide centres in line with young men's preferred ways to socially interact. Being part of a peer group was seen as important, allowing them to discuss issues with others. It also meant they were exposed to those who were no longer suicidal, giving them an insight into the pain suicide would inflict, a view of suicide as unacceptable, and allowing them to see that recovery was possible.¹²⁸

Counselling was 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, particularly equipping young men with fundamental cognitive resources, including coping strategies to 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 navigate through contemporary life challenges.¹²⁹

6.5 Evaluations of Bamford – Access Issues

The Bamford Monitoring Group and Western HSC Trust hosted a workshop 'Shaping Information, Knowledge and Access to Mental Health Services' in 2010. Opinions around access included:

- The need for GPs to be properly trained and aware of support services available to people with mental health needs;
- A single point of access for information and advice;
- The right information, at the right time; and
- Involving people and carers in the development of information and advice about accessing mental health services.¹³⁰

The 2011 evaluation of Bamford¹³¹ reported there was still an issue around access to mental health care. Care in the community needed to be developed, particularly since there were fewer hospital based places available and accessing services during a crisis

¹²⁸ Jordan J. et al (2011) *Providing meaningful care: using the experiences of young suicidal men to inform mental health care services: Short Report*; QUB, UU, HSC/Public Health Agency

¹²⁹ As above

¹³⁰ *Annual Report of the Bamford Monitoring Group* (August 2011); Patient Client Council available: www.patientclientcouncil.hscni.net/uploads/research/Annual_Report_FINAL.pdf

¹³¹ As above

was still difficult, with barriers created by the ‘criteria’ set around accessing services. In general, there was believed to be a greater focus on prescribing medication rather than any alternatives, and accessing therapies was difficult.

The Group recommended that the HSCB, HSC Trusts, and voluntary and community organisations should address a need to provide information on available mental health services and how to access them. There was also a recommendation to involve service users and their carers directly in the implementation and evaluation of psychological therapies. The HSCB should also prioritise commissioning of services to support people during a mental health crisis, including 24-hour access to a place of safety.

The evaluation of the Bamford Action Plan 2012-2015 (due to be published early in 2017) will assess how Departments have performed against the Action Plan, include the views of service users and their carers, and identify needs and gaps in the service. Initial findings from the Bamford Action Plan 2012-2015 evaluation include the need to:

- 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 involvement of the voluntary and community sector.

6.6 Access to Psychological Therapies

The 2010 Strategy for the Development of Psychological Therapy Services for NI¹³² recommended that the:

...provision of psychological therapies should be a core component of mental health and learning disability services” and that the “...public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

Psychological therapy encompasses:

*...a range of interventions, based on psychological theory and evidence, which help people to alter their thinking, behaviours and relationships in the present, and process trauma and disturbance from the past, in order to alleviate emotional distress and improve psychosocial functioning.*¹³³

¹³² A Strategy for the Development of Psychological Services (June 2010); DHSSPS available: <https://www.health-ni.gov.uk/publications/strategy-development-psychological-therapy-service-june-2010>

¹³³ As above

Mental health services provided in NI include Psychotherapy, Cognitive Behavioural Therapy (CBT), and Trauma Therapy. In 2007 the Bamford review noted that access to psychological therapy interventions was extremely poor, despite advances in range, sophistication, and effectiveness in the treatment of certain conditions. An evaluation of the Bamford Review Action Plan 2009-2011 also saw access to psychological therapies as a key challenge. In relation to 'stepped care' the Action Plan 2012-2015 stated "...*Early interventions in primary care will continue to be promoted, including better access to psychological therapies*".¹³⁴

Psychological therapies have a strong evidence base, although the impact of 'Troubles' related trauma on the population has meant psychological therapy services have developed in an ad hoc way.¹³⁵ The Bamford Review recognised the importance of the recovery model in mental health care, and viewed psychological therapies as an integral part of this in individual care plans.¹³⁶

The National Institute for Health and Clinical Excellence (NICE) guidance on psychotherapeutic interventions for mental health disorders in children and adults includes interventions for:

- Depression; bipolar disorders;
- Generalised anxiety states and panic disorders;
- Schizophrenia;
- Post-traumatic stress disorder;
- Obsessive compulsive disorders;
- Anorexia nervosa and bulimia nervosa;
- Self-harm; and
- Personality disorders.¹³⁷

In England in 2013 the MHF reported¹³⁸ that mental health patients were having difficulty accessing services suitable for their needs, particularly access to psychological therapies. They recommended that priority be given to integrated care "...*including the skills that different disciplines could bring to enhancing care and treatment*".¹³⁹

In NI in 2015, responding to the use of prescription drugs for anxiety and depression being higher than elsewhere in the UK, Mental Health Hubs were introduced in each of the five Local Commissioning Group areas. These provide GPs with alternatives to

¹³⁴ *Delivering the Bamford Vision – Action Plan 2012-2015* para 7.7; DHSSPS available: <https://www.health-ni.gov.uk/publications/bamford-action-plan-2012-15>

¹³⁵ A Strategy for the Development of Psychological Services (June 2010); DHSSPS available: <https://www.health-ni.gov.uk/publications/strategy-development-psychological-therapy-service-june-2010>

¹³⁶ As above

¹³⁷ As above

¹³⁸ Mental Health Foundation (2013) *Starting Today: The Future of Mental Health Services*, London: King's College London

¹³⁹ Wilson, G et al (2015) *Regress? React? Resolve?: An evaluation of mental health service provision in Northern Ireland*; QUB and Action Mental Health available: [http://pure.qub.ac.uk/portal/en/publications/regress-react-resolve-an-evaluation-of-mental-health-service-provision-in-northern-ireland\(7a659cb2-f036-4490-8ccf-8bce2ae256f9\).html](http://pure.qub.ac.uk/portal/en/publications/regress-react-resolve-an-evaluation-of-mental-health-service-provision-in-northern-ireland(7a659cb2-f036-4490-8ccf-8bce2ae256f9).html)

long-term medication for common mental health issues. The Hubs aim to promote prevention and early intervention with an all-inclusive approach from a variety of providers. Services will include counselling, CBT, group therapy, facilitated self-help, life coaching, signposting to other support services, and support for linking into the community and social activities.¹⁴⁰

One of the alternatives available to GPs and some voluntary and community organisations is to give a patient access to 'Beating the Blues'. This is an online interactive programme based on CBT. An evaluation of the service through a patient questionnaire (41 fully completed questionnaires) by the Patient and Client Council highlighted a number of issues including¹⁴¹:

- Some negative feedback, although 61% (of 31 responses) found it 'very' or 'quite' helpful;
- 19 of 30 respondents would have preferred one to one therapy instead; and
- Varying levels of support by GPs for patients in the programme.

6.7 Voluntary and Community Sector – Access to Services

The voluntary sector is a valuable partner in the delivery of mental health services in the community. Its role in mental healthcare has been recognised by professionals, service users, and carers. A mental health professional in the voluntary sector is quoted:

*[A] positive trend at the moment is the increase in availability of therapeutic type services that are community-based, delivered through the voluntary sector, and more accessible to people who are not necessarily in the care of a psychiatrist ...accessed directly.*¹⁴²

Research investigating the effects of stigma found that services that minimise a stigmatising effect are those that avoid unnecessary labelling, respect confidentiality, and are community based.¹⁴³

Reviews of mental health care reflect support for services delivered by the voluntary sector. This is a valuable endorsement as strategic direction is toward the delivery of all health care in the community and as close to a patient's home as possible. Voluntary sector services tick all the boxes in this regard and also provide a forum where there is a level of peer support.

¹⁴⁰ *Introducing Primary Care Talking Therapy and Well-being Hubs*, HSCB News, 12 February 2015 available: <http://www.transformingyourcare.hscni.net/introducing-mental-health-hubs/>

¹⁴¹ *Beating the Blues, 'The experiences of people in NI'*, Patient and Client Council, November 2012, <http://www.patientclientcouncil.hscni.net/publications/index/reports/date/2012#library>

¹⁴² Action Mental Health (October 2015) *'Regress? React? Resolve? An evaluation of mental health service provision in Northern Ireland'* p71; Queens University Belfast

¹⁴³ Clement, S. et al (2015) *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies*; Kings College London.

A mental health commissioner stated¹⁴⁴

I think the voluntary sector are ahead of us ...their user-led services are much stronger ...Voluntary organisations are very fleet of foot and can turn a very significant difficulty with a gap in services or maybe unmet need.

The community and voluntary sector deliver the Self-Harm Intervention Programme (SHIP) across each of the five HSC Trust areas. SHIP was established in October 2015 for people who have self-harmed and their carers and is funded by the PHA.

SHIP was an initiative launched in the Republic of Ireland in 2004. An evaluation of the service in 2015¹⁴⁵ concluded that it served a client group at high risk of suicide and repeated self-harm. The service was found to be “...successful in supporting short-term outcomes associated with longer-term reduced suicide risk, bringing a number of risk factors from well below to normal functioning levels over the course of treatment.” The evaluation also found that clients benefited from an increase in well-being, including optimism, emotional stability and problem solving skills that included seeking help when needed.

The Together For You (TFY) voluntary sector project was a mental health and well-being project involving nine leading mental health charities in NI¹⁴⁶. Funded by the Big Lottery Fund, the project ran from 2013-2016. TFY’s final evaluation¹⁴⁷ found it had exceeded its target for numbers of beneficiaries and cost efficiency.

TFY used the Stepped Care Model (see section 4.3) to deliver a range of mental health and wellbeing services across NI. A key element of the project was to increase understanding of mental health issues and improve the ability of beneficiaries to identify signs of poor mental health. The project delivered awareness training sessions to adults and young people, training for befrienders, social support events and mental health training sessions. Of the 52,587 beneficiaries of the project, over 90% reported an improvement in their mental health, feeling better able to seek help in relation to mental health, and able to direct others to sources of support. A majority of participants (86%) also stated that they would not have received the support they did elsewhere.

In a research study those working with people who self-harm acknowledged that self-harming is a means of communicating distress for those who find it difficult to articulate feelings. Therefore, it is difficult to seek help from statutory services. The same study was told by some participants who sought help from statutory services that they were treated without compassion as “not a person but a case”. There were also reports of delayed treatment and lack of follow-up care leading to more severe episodes of self-

¹⁴⁴ Action Mental Health (October 2015) ‘Regress? React? Resolve? An evaluation of mental health service provision in Northern Ireland’ p72; Queens University Belfast

¹⁴⁵ Gardner, C., Dermody, A., Browne, R., and Timulak, L. *Responding to Self-harm – An Evaluation of the Self-Harm Intervention Programme (SHIP)*. HSE, Waterford, 2015.

¹⁴⁶ Action Mental Health, Aware, CAUSE, Cruse Bereavement Care, Mind Wise, Nexus, Praxis, Relate and The Rainbow Project.

¹⁴⁷ PACEC *Evaluation of the Together for You Contract Final Report* (May 2016); Action Mental Health.

harm and even suicide attempts. The research findings showed that those presenting to emergency departments were in a vulnerable state and unable to take advantage of the services they were being offered. This is “...*particularly concerning because people who refuse help following a suicide attempt are at significantly higher risk of subsequent completed suicide.*”¹⁴⁸

Recommendations from the research¹⁴⁹ included training for staff across all sectors who respond to self-harm disclosures or presentations. The paper also cites Scotland’s community-based ‘Distress Brief Intervention Programme’. Stemming from Scotland’s Mental Health Strategy (2012-2015), and the Suicide Prevention Strategy (2013-2016) the Scottish government has developed a brief intervention to respond to those presenting in distress when accessing services. The Distress Brief Intervention Programme:

*...provides a framework for improved inter-agency co-ordination, collaboration and co-operation across a wider range of care, settings, interventions and community supports towards the shared goal of providing a compassionate and effective response to people in distress, making it more likely that they will engage with and stay connected to services or support that may benefit them over time.*¹⁵⁰

6.8 Relevant Initiatives in Other Jurisdictions

This section includes an introduction to initiatives implemented in other jurisdictions of the UK and the RoI relating to accessing mental health services.

6.8.1 England

Physical health services have historically diverted resources away from mental health services. However, in 2012 the UK Government signalled its intent to halt this bias by putting in place legislation to ensure that appropriate physical and mental health services are commissioned.

Steps have already been taken to improve mental health services in England. The DoH and NHS England document “Achieving Better Access to Mental Health Services by 2020”¹⁵¹ sets out a pathway and additional spending to ‘kick start’ change in the current year. The setting of access and waiting time standards will be the first of their kind for mental health services as early treatment can make a difference. In his

¹⁴⁸ Long, M., Manktelow, R., and Tracey, A. (2014) *The Healing Journey: Help seeking for Self-injury among a Community population*; University of Ulster

¹⁴⁹ As above

¹⁵⁰ Distress Brief Intervention Programme Briefing 1; Scottish Government available: <http://news.gov.scot/news/early-intervention-in-mental-health>

¹⁵¹ *Achieving Better Access to Mental Health Services by 2020* (2014); DoH, NHS England, <https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

foreword the Minister of State for Care and Support claims that no other country is planning for such change in mental health services.

The Chief Executive of NHS England highlighted that mental health problems are the largest single cause of sickness absence in the UK, making it indefensible that there is a large ‘treatment gap’ with most people with mental health problems receiving no treatment and severe funding restrictions compared with physical health services. Those with mental health problems die, on average, 15-20 years earlier than other people in what he claims is one of the biggest health inequalities in England:¹⁵²

That is why achieving ‘parity of esteem’ between mental and physical health services is so important for the NHS, and for the nation.

Steps that have been taken to improve access to services include:

- Ending the unfair exclusion of mental health services from legal right to choose;
- Rapid expansion of the Improving Access to Psychological Therapies Programme with over 2.4 million people having entered treatment, and over 1.4 million completing it so far. Over 700,000 people having entered treatment during 2013-14, compared to just 340,000 in 2010;¹⁵³
- Transformation of children and young people’s services through funding invested in service improvement and training;
- Publication of the mental health Crisis Care Concordat, an agreement between over 20 national bodies that makes clear the care and support that people in crisis need, so that fewer vulnerable people find themselves inappropriately in police cells; and
- Faster assessment and support for people in the criminal justice system through liaison and diversion services.

The document makes the case that investment in mental health is self-evident for ethical, social and economic reasons. There has been what it refers to as ‘institutional bias’ where resources have been directed toward physical health services, despite the fact that it is estimated that mental health problems cost the country up to £100 billion each year, with the cost to society of treating preventable illness, the impact on quality of life, loss of work days and income when effective care would be good for individuals, their families, and society as a whole.¹⁵⁴

6.8.2 Scotland

Scotland’s Mental Health Strategy 2012-2015 prioritised stigma and discrimination, and in August 2016 the Scottish Government announced, along with ‘Comic Relief’, an investment of £4.5 million in a three-year anti-stigma and discrimination national

¹⁵² *Achieving Better Access to Mental Health Services by 2020* (2014); DoH, NHS England,

<https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

¹⁵³ Health and Social Care Information Centre, September 2014, Psychological Therapies, Annual Report on the use of IAPT services – England, 2013-14 – in “Achieving Better Access to Mental Health Services by 2020”

¹⁵⁴ *Achieving Better Access to Mental Health Services by 2020* (2014); DoH, NHS England,

<https://www.gov.uk/government/publications/mental-health-services-achieving-better-access-by-2020>

programme. It builds on the legacy of the 'See Me' campaign and will be delivered by the Scottish Association for Mental Health (SAMH) and the MHF.

The 'See Me' campaign was originally launched by the Scottish Government in 2002 to address negative attitudes towards people with mental health issues and their friends and families. It was part of the Scottish Executive's National Programme for Improving Mental Health and Wellbeing, and was managed by five mental health organisations.¹⁵⁵

An evaluation of 'See Me' in 2009¹⁵⁶ found that aspects of the campaign that supported developments at local level were perceived to have been limited by funding constraints. However, a strategic review published in 2013 highlighted benefits of the campaign that included long-term (multi-year) government funding and delivery through the voluntary sector, describing these as "...*what were at the time of its creation recognised as key factors for success.*"¹⁵⁷

The aims of the more recent national *Mental Health Strategy 2012-2015* build on the themes of the 'See Me' campaign in delivering a local and national programme of activities to challenge the discrimination and stigma associated with mental ill health. However, there will be a shift in emphasis from changing attitudes and improving knowledge at society level, to changing behaviour, particularly at community level. Key features of the national programme include:

- National campaigns focusing on outcomes and messages about recovery and behaviour change;
- Involvement of people with lived experience central to all programme activities;
- Establishing Change Networks to target delivery both geographically and thematically;
- Innovation labs and grant programmes to encourage innovation and develop programmes for grant funding;
- Development of an iterative evaluation framework enabling programme development and generating new evidence and good practice;
- Local Partnership working to ensure a collaborative approach;
- Equality and human rights framework to underpin the programme; and
- Policy, education and training targeted at where discrimination takes place and action will have the greatest impact, for example, employer engagement with free training and support; a national engagement strategy to build capacity within teams and joint creation of initiatives; building on existing materials targeted at education and young people.

¹⁵⁵ The Scottish Association for Mental Health, National Schizophrenia Fellowship (Scotland), Royal College of Psychiatrists (Scottish Division), Penumbra and Highland Users Group.

¹⁵⁶ *Evaluation of 'See Me' – The National Scottish Campaign Against Stigma and Discrimination Associated with Mental Ill Health*; Scottish Government Social Research 2009.

¹⁵⁷ Pilgrim, D. and Corry, P. (2013) *Strategic Review of Anti-Stigma Approach in Scotland: Final report*; University of Liverpool

6.8.3 Wales

'Together for Mental Health'¹⁵⁸ is the Welsh Government's strategy to improve mental health in Wales and provide a range of support for those who use mental health services, their families and carers. A three year delivery plan from 2016-2019¹⁵⁹ has been developed to embed the requirements of the 'Social Services and Well-being (Wales) Act 2014' that came into force on 6 April 2016. The Act aims to¹⁶⁰

- Transform the way social services are delivered, promoting people's independence to give them a stronger voice and more control;
- Provide greater consistency and clarity to people who use social services, their carers, local authority staff and their partner organisations, the courts and the judiciary;
- Promote equality, improve the quality of services and the provision of information people receive; and
- Encourage a renewed focus on prevention and early intervention.

Among the priorities in the action plan is to make people more resilient in order to be able to better cope with mental ill-health, if it occurs. This involves providing the right information and advice to understand and manage their mental health; reducing the number who commit suicide or harm themselves; promoting better mental well-being and preventing problems early or stop them worsening.

Other priorities include - preventing isolation and loneliness; reducing inequalities for vulnerable groups with mental health needs; ensuring equitable access and provision of services; enabling children and young people experiencing mental health problems to access services as close to home as possible; and ensure timely and appropriate access to services for people with first episode psychosis with NICE compliant psychological therapies (a performance measure will be that a patient has started a treatment management plan within 14 days).

6.8.4 Republic of Ireland

'Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020'¹⁶¹ replaces the previous strategy 'Reach Out (2) 2005-2014' that had been based on research into suicide prior to 2005. The Connecting for Life Report (2014)¹⁶² was part of the development process for the new strategic framework addressing the issue of suicide in Ireland for the period 2015-2020.

¹⁵⁸ *Together for mental health 10-year Strategy (2012)* available: <http://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en>

¹⁵⁹ *Together for Mental Health Delivery Plan 2016-2019* available: <http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en>

¹⁶⁰ As above

¹⁶¹ *Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020*; HSE, National Office for Suicide Prevention.

¹⁶² *Connecting for Life: Report of the Research Advisory Group for the National Framework for Suicide Prevention Strategy*; HSE National Office for Suicide Prevention, December 2014.

The majority who die by suicide in the Republic of Ireland (RoI) are male (82% in 2012) with the highest rate among those aged 45 – 54, and the lowest rate in the 65+ age group. The highest rate for female suicide was also in the 45 - 54 age group.¹⁶³ The previous suicide prevention strategy 'Reach Out (2) (2005 – 2014)' was based on research into suicide prior to 2005. New research was conducted to ensure that the framework had a strong evidence base.

The RoI strategy, as with many other international strategies, have adopted multi-level suicide prevention strategies as recommended by the WHO. These involve broad population approaches combined with targeted prevention for certain population groups. For example, the Suicide Support Information System (SSIS) facilitates access to support for those who had been bereaved.

'Connecting for Life 2015-2020',¹⁶⁴ the national suicide prevention strategy "*...sets out a vision where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing.*"

The strategy is based on seven goals:

1. Better understanding of suicidal behaviour;
2. Supporting communities to prevent and respond to suicidal behaviour;
3. Targeted approaches to those vulnerable to suicide;
4. Improved access, consistency and integration of services;
5. Safe and high quality services;
6. Reduce access to means; and
7. Better data and research.

Systematic evaluation on the progress of interventions will be ongoing in order to refine the best approaches in the national context.

¹⁶³ Connecting for Life: Report of the Research Advisory Group for the National Framework for Suicide Prevention Strategy; HSE National Office for Suicide Prevention, December 2014.

¹⁶⁴ Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015-2020; HSE, National Office for Suicide Prevention.