Northern Ireland
Audit Office

Mental Health Services in Northern Ireland

Report by the Comptroller and Auditor General

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Dorinnia Carville
Comptroller and Auditor General

Northern Ireland Audit Office
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List of Abbreviations

CAMHS	Child and Adolescent Mental Health Services
EPIC	Regional Electronic Patient Record
GHQ12	General Health Questionnaire
GP	General Practitioner
HSCB	Health and Social Care Board
NHS	National Health Service
OECD	Organisation for Economic Cooperation and Development
OSR	Office for Statistics Regulation
PfG	Programme for Government
PHA	Public Health Agency
POC	Programme of Care
PTSD	Post-traumatic stress disorder
QoF	Quality and Outcomes Framework

Key Facts

£3.4bn

The estimated cost of mental ill-health in Northern Ireland

21%

The proportion of the adult population with a possible mental health problem identified in the Northern Ireland Health Survey 2021-22

£345m

The 2021-22 budget for the mental health programme of care, equivalent to around 5.7% of the overall health and social care budget

£1.2bn

The estimated cost of the actions included within the 10-year Mental Health Strategy 2021 to 2031

1 in 8

The proportion of young people who experience emotional difficulties

1 in 6

The proportion of young people who exhibit indications of an eating disorder

1 in 8

The proportion of young people who meet the criteria for anxiety and depression

7.7%

The estimated share of the mental health budget in 2021-22 relating to child and adolescent mental health services

£117m

The estimated additional funding requirement over the three years to 2023-24 associated with the expected pandemic-related increase in referrals to mental health services

16,000

The number of people on mental health waiting lists at 31 March 2022

7,983

The number of people on mental health waiting lists at 31 March 2022 who were waiting longer than the target of 9 and 13 weeks to access mental health services

Executive Summary

Executive Summary

1. Improving mental health is a key priority for the Northern Ireland Executive, recognised in its 2016-2021 draft Programme for Government. This reflects the significant levels of mental health problems in the population, with Northern Ireland reported to have the highest prevalence of mental health problems in the United Kingdom, around 25 per cent higher than in England. The higher prevalence levels in Northern Ireland are associated with both greater levels of deprivation and the impact of the 'Troubles'.

2. Results of the Northern Ireland Health Survey for 2021-22 highlight that around one fifth of adults show signs of a possible mental health problem. General Practitioner registers indicate that, at March 2022, there were almost 189,000 adults in Northern Ireland diagnosed with depression. In addition around 18,900 people were recorded as having been diagnosed with more serious mental health conditions such as schizophrenia, bi-polar disorder and other psychoses, and a further 13,300 people were registered with dementia. Over time, there has been a particular rise in numbers diagnosed with depression, which increased by 43 per cent between March 2016 and March 2022. The impact of the pandemic is expected to add to these already considerable levels of mental health problems.

The cost of mental ill-health in Northern Ireland is estimated at £3.4 billion

3. There are significant costs associated with mental ill-health, not only in terms of the impact it has on people's lives and those of their families and carers, but also the wider costs to society in terms of the costs of care and treatment and lost production. A report, published by the London School of Economics and the Mental Health Foundation in February 2022, conservatively estimated the overall cost of mental ill-health in Northern Ireland in 2019 at £3.4 billion. There is potential, therefore, for significant benefits to be derived from improving mental health in Northern Ireland.

4. Strategic direction in mental health over the last two decades has been informed by the Bamford Review and the outworking of its two related action plans (covering the periods 2009-11 and 2012-15). While credited with increasing investment in mental health and improvements in services, there has been a loss of momentum in the development of services and in strategic direction, particularly associated with the period of suspension of the Northern Ireland Executive between 2017 and 2020. A number of reviews identified the need to address the fragmentation of services, limitations in the provision of, and gaps in, services and the need for greater focus on prevention and early intervention. In particular, these highlighted underfunding in mental health services and a lack of parity of esteem with physical healthcare.

5. The restoration of the Northern Ireland Executive, in early 2020, marked a renewed focus on mental health, notably through the development of a mental health action plan, the appointment of a mental health champion, and the launch of a mental health strategy for the 10 years 2021 to 2031. The estimated cost of £1.2 billion associated with the strategy's planned actions will require sustained additional investment throughout its lifetime, a level of funding which is not available from within Department of Health resources. Without dedicated long-term funding, the delivery of the strategy and achievement of its vision for mental health remain at risk.

Mental health funding in Northern Ireland is the lowest in the United Kingdom

6. Mental Health funding in Northern Ireland represents around 6 per cent of the overall health and social care budget and, over time, has not kept pace with increases in the wider health budget. Benchmarking of 2019-20 funding identifies that, at around £300 million, levels in Northern Ireland were lower than elsewhere across the United Kingdom and Ireland. Bringing funding levels in Northern Ireland closer to that elsewhere in the United Kingdom would require substantial additional investment of £80 - £190 million per annum.

7. While the increased investment signalled in the new mental health strategy may go some way to closing the gap in funding levels, on the basis of its planned cost profile, funding would not reach the level necessary until close to the end of the strategy period (in 2030-31). In addition, the impact of the pandemic is likely to add further cost pressures, with expected additional demand for services projected to cost some £117 million over the three years to 2023-24. As £45 million of this estimated additional cost relates to 2021-22, we note that the £22 million increase in funding (from £323 million to £345 million) provided by the Department between 2020-21 and 2021-22 fell short of this level.

Waiting lists for mental health services had been growing prior to the pandemic

8. Referrals data identifies a substantial increase in the level of demand for mental health services over the five years to March 2020, in the region of 50 per cent. Within this, there has also been an increase in the complexity of cases presenting to mental health services, particularly the co-presentation of drug and alcohol addiction alongside mental health issues.

9. Associated with the increasing demand for mental health services, the number of people on mental health waiting lists (awaiting their first appointment) also increased. Waiting lists, which reached just over 14,000 by March 2020, saw a particular jump in 2018-19 which coincided with a peak in the number of referrals to services. In particular, there was an increase in numbers waiting to access psychological therapies, reflecting an acknowledged underinvestment and underdevelopment of services. Despite specific funding to address therapies waiting lists, numbers waiting increased by almost 40 per cent between March 2018 and March 2020.

10. The impact of increasing demand was also reflected in a deterioration in performance against waiting time targets. Maximum waiting time targets were not met regionally in any of the seven years included in our review (from 2015 to 2022).

11. Workforce issues are also a key factor in the poor performance against waiting time standards. Health and Social Care Trusts identified mental health nurses as a particular area of concern, with data at the end of March 2022 indicating a vacancy rate of around 11 per cent. The 2021-2031 mental health strategy does, however, recognise the importance of workforce in achieving its vision for mental health, and includes an action for a review of the mental health workforce.

The full impact of COVID may not yet have been felt by services

12. While mental health services were maintained throughout the pandemic, they did not function as normal. In particular, staffing reallocation impacted on capacity, while service delivery was adapted towards telephone and virtual contact. Changes in the public's health seeking behaviour, however, resulted in a significant reduction in the number of referrals being made to mental health services in 2020-21. Despite some recovery in 2021-22, total referrals remain around one fifth below pre-pandemic levels (2018-19).

13. Initially, this resulted in a reduction in numbers on waiting lists, although by March 2021 overall waiting lists were similar to those at March 2020. Within this, however, there was a large increase in waiting lists for dementia services, resulting from its inability to embrace the alternative delivery methodologies promoted throughout the pandemic which are less appropriate for its patient group.

14. The increase in waiting lists continued so that, by March 2022, just under 16,000 people were awaiting a first appointment. With the return of greater levels of face-to-face appointments, however, there was some improvement in terms of dementia waiting lists.

15. Alongside the increase in waiting lists, performance against waiting time standards deteriorated further, with over 7,000 waiting time breaches recorded at March 2021 (i.e. half of those on waiting lists had been waiting longer than the 9 and 13 week standard). Again, performance in dementia services was a matter of concern with around two thirds of those on the waiting list at March 2021 having waited longer than 9 weeks. While performance against waiting times continued to deteriorate in 2021-22, with around 8,000 people waiting longer than target standard at March 2022, there was some small improvement in the number of waiting time breaches in dementia services.

16. The full impact of the pandemic on mental health services, however, remains to be seen. The Department of Health estimates that, over the three years to 2023-24, demand for services will increase by around one third. As a result, the impact of the pandemic on mental health will add further pressure on services.

There are significant limitations with mental health data in Northern Ireland

17. A review by the Office for Statistics Regulation in 2021 highlighted significant limitations in mental health data in Northern Ireland, with the scarcity of robust data leading to significant data gaps. In particular, there is a lack of outcome data in respect to mental health services, without which the Department of Health and Health and Social Care Trusts cannot determine whether the services provided improve patient mental health and reflect value for money.

18. The development and implementation of an outcomes framework is being progressed, as an enabling action under the 2021-31 mental health strategy. However, its implementation timeframe is tied to the information technology systems through which it is to be facilitated, which are currently scheduled to be fully brought into use in March 2025.

Value for money conclusion

19. In the absence of an identified outcome framework and appropriate measures to assess whether services are making a difference in terms of improving mental health, we are unable to conclude on whether mental health services in Northern Ireland are providing value for money.

Recommendation 1

The Department of Health's renewed focus on mental health through its mental health action plan and the development of a mental health strategy is welcomed. The 2021-31 strategy, in particular, provides a framework for improvements in mental health and mental health services going forward, although, because of a lack of confirmed funding, there is already evidence of delay in its implementation.

Without dedicated funding the pace of delivery and ultimate completion are uncertain. While the draft Executive Budget provides a positive signal of intent, the Department of Health, in conjunction with the Executive, needs to secure adequate and sustained funding for the implementation of the strategy over its lifetime. Failure to do so would jeopardise the achievement of its long-term vision for mental health and run the risk that, like Bamford before it, necessary reform and improvement is curtailed or delayed as a result of a lack of commitment to prioritise and adequately fund implementation. Security of funding would also support implementation plans beyond a single year.

Recommendation 2

Mental health funding levels in Northern Ireland do not compare well with those elsewhere in the United Kingdom and Ireland. Bringing funding levels in Northern Ireland into line with those elsewhere, within a reasonable timeframe, will require a substantial increase in funding. This will be made more difficult by the additional pressures placed on service costs over the next number of years as a result of COVID-19 pandemic.

To do this will require a commitment towards sustained budget increases over the medium to long term. In this regard, and while acknowledging the intentions identified in its Mental Health Strategy Funding Plan, the Department of Health should establish an explicit long-term funding ambition for mental health services, together with stepped interim targets aimed towards its achievement.

Recommendation 3

There is a clear need to improve data around mental health services, both to address significant information gaps and to improve the quality of data produced. There is also a need to improve data accessibility, making it easier for users to find and use the information currently available by putting more data into the public domain. To support decision making and better monitoring of the effectiveness of services in improving people's mental health, there is a particular need to develop an appropriate outcomes measurement framework.

While the Department of Health has recognised the need for both a robust dataset across services and an outcomes framework, tackling the weaknesses in mental health data will involve substantial change and require investment in data systems (both human and technological resources). Consequently, the Department of Health should produce a data strategy setting out its aims for improving mental health data and how it intends to achieve them in line with the Office for Statistics Regulation's recommendation.

Part One:
Introduction and Background

Introduction and Background

1.1 Mental health is recognised as an integral and essential component of health, and is fundamental to the ability to live and enjoy life. It is defined by the World Health Organization as "*a state of wellbeing in which the individual realizes 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*".

1.2 There is a wide range of mental health conditions with varying symptoms and severity including anxiety, depression, bipolar disorder and schizophrenia. The term mental illness, however, generally refers to the more severe and enduring of these problems. Mental health problems also vary in terms of duration and may be short term, be recurrent over longer periods, or can last for most of life.

1.3 The Department of Health in Northern Ireland (the Department) has a statutory responsibility to promote an integrated system of health and social care designed to secure improvement in (among other things) the physical and mental health of people in Northern Ireland. The Department recognises mental illness as one of the four most significant causes of ill-health and disability in Northern Ireland alongside cardiovascular disease, respiratory disease and cancer. While the exact cause of most mental health problems is not known, they are acknowledged to result from a combination of factors including genetics, family history, and psychological, social, economic and environmental influences.

1.4 The Northern Ireland Executive recognised mental health as a priority, with the inclusion of a key indicator to 'improve mental health' within its 2016-2021 draft Programme for Government. The (then) Minister of Health also identified mental health as one of his key priorities. Additionally, an Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention was established in 2020.

Northern Ireland is reported to have the highest prevalence of mental ill-health in the United Kingdom

1.5 A number of reports have highlighted the higher prevalence of mental health problems in Northern Ireland than elsewhere in the United Kingdom, indicating that the prevalence among adults is 25 per cent higher than in England. This higher prevalence in Northern Ireland is associated with both greater levels of deprivation and the legacy of the 'Troubles'.

1.6 The 2008 Northern Ireland Study of Health and Stress[1] , which estimated that 39 per cent of the Northern Ireland population had experienced a conflict-related event, identified significantly higher prevalence of mental health disorders among men and women who had experienced this type of traumatic event compared to those who had not. In particular, it also noted elevated rates of post-traumatic stress disorder (PTSD) in relation to other countries. Indeed, at that time, the prevalence of PTSD in Northern Ireland was the highest among comparable studies across the world. This impact on mental health is long lasting and can be seen across generations.

1 An epidemiological study of mental health disorders in Northern Ireland, conducted from 2007 to 2008, forming part of the World Mental Health Survey, an initiative under the auspices of the World Health Organization which incorporated regional and national surveys in 27 countries across the world.

1.7 Past comparison of suicide rates with those elsewhere suggested that Northern Ireland had the highest level in the United Kingdom. However, issues with the statistical collection and collation process in Northern Ireland make these past comparisons unreliable. Revised data indicates that, while suicide rates in Northern Ireland are notably higher than those in England and Wales, they are more closely aligned to those in Scotland. In 2021, the age standardised rate in Northern Ireland was 14.3 suicides per 100,000 population, compared to 10.5 in England and Wales and 14.0 in Scotland[2].

1.8 A significant proportion of mental health problems develop in childhood and adolescence. The Youth Wellbeing Prevalence Survey, commissioned by the (then) Health and Social Care Board (HSCB) and published in October 2020, provides information on the extent of mental health issues in children and young people in Northern Ireland. This highlighted that approximately one in eight (11.9 per cent) young people (between the age of 2 and 19 years old) experienced emotional difficulties, with significantly higher rates among those in deprived areas. In addition, one in six young people exhibited indications of an eating disorder. Close to one in eight adolescents (aged 11-19) also reported thinking about or attempting suicide and almost one in ten reported self-injurious behaviour.

1.9 The Youth Wellbeing Prevalence Survey also found that around one in eight (12.6 per cent) young people met the criteria for anxiety and depression. When compared against rates in England in 2017[3], at one in twelve or 8.2 per cent, this suggests that the prevalence of anxiety and depression among children and young people in Northern Ireland is 25 per cent higher than in England.

1.10 The Northern Ireland Health Survey indicated that, in 2021-22, approximately one in five adults in Northern Ireland (21 per cent) showed indications of possible mental health problems, based on GHQ12[4] data. Levels were higher among women, at 25 per cent, compared with men (16 per cent). In addition, levels in the most deprived areas were around one and a half times those in the least deprived areas (30 per cent compared to 20 per cent).

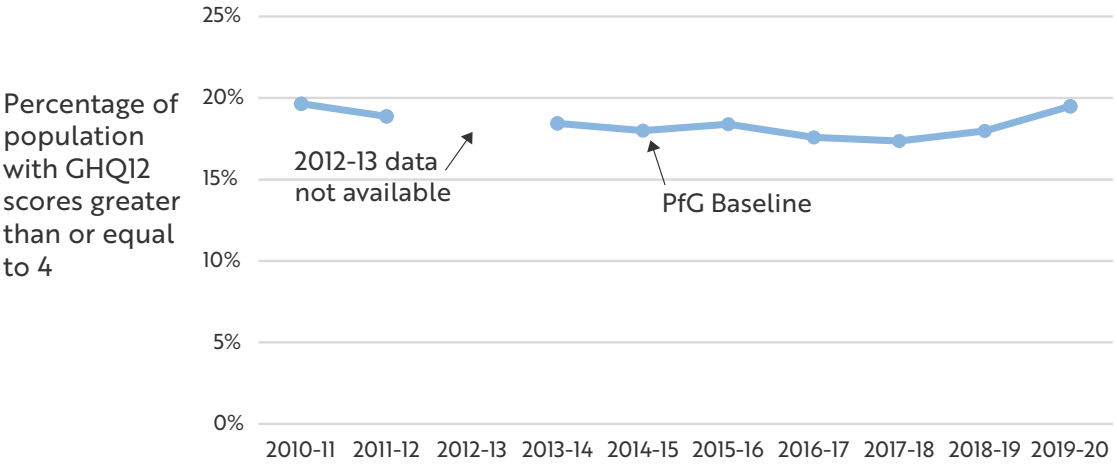
1.11 GHQ12 is also identified as an outcome measure under the Northern Ireland Executive's draft Programme for Government 2016-21, in relation to improving mental health, referred to above (at paragraph 1.4). Over time, Health Survey data indicates that there has been no statistically significant change in the proportion of those assessed, under GHQ12, with possible mental health problems from the 2014-15 base year (see **Figure 1**). In addition, while there has been some fluctuation from year to year, the gap between levels in the most deprived and in the least deprived areas has remained broadly unchanged over the last decade, at around 10 percentage points.

2 Northern Ireland Statistics and Research Agency (2022) Finalised Suicide Statistics in Northern Ireland 2015 – 2021.

3 Survey of the Mental Health of Children and Young People in England (2017).

4 GHQ 12 (General Health Questionnaire) is a screening tool which assesses the possibility of psychiatric morbidity in the general population. It is widely used, forming part of the Department of Health's Health Survey of Northern Ireland and similar surveys in England and Scotland. The questionnaire contains 12 questions about recent general levels of happiness, depression, anxiety and sleep disturbance, with scores of four or more (in a possible range from 0 to 12) indicating possible mental health problems.

Figure 1: Around 20 per cent of the adult population in Northern Ireland have possible mental health problems



Source: Department of Health Health Survey Northern Ireland

1.12 Health surveys in England and Scotland also collect GHQ12 data. The 2012 Health Survey England and the Scottish Health Survey identified similar levels of mental health problems in England and Scotland, at 15 per cent of the population, while the 2011-12 Northern Ireland Health Survey identified levels at 19 per cent. At that time, therefore, the level of possible mental health problems in the population in Northern Ireland (as measured by GHQ12) was around 25 per cent greater than in England and Scotland. More recent comparisons suggest some convergence in the level of mental health problems across the United Kingdom (see **Figure 2**).

Figure 2: GHQ12 rates across the United Kingdom show some convergence over time

	PERCENTAGE OF POPULATION WITH HIGH GHQ12 SCORES %		
	2012	**2016**	**2019**
Northern Ireland	19%	18%	19%
England	15%	19%	-
Scotland	15%	15%	17%

Source: Department of Health Health Survey Northern Ireland, NHS Digital Health Survey and Scottish Government Scottish Health Survey

Notes:

(i) GHQ12 did not form part of the Health Survey for England in 2019

(ii) Both the English and Scottish Health Surveys are undertaken on a calendar year basis, while the Northern Ireland survey relates to the financial year. The Northern Ireland figures applied above reflect those for 2011-12 (as no GHQ12 data was collected in 2012-13), 2016-17 and 2019-20.

1.13 Raw disease prevalence data published by the Department, based on Quality and Outcomes Framework (QoF) disease registers, indicate that, at March 2022, there were almost 189,000 adults on General Practitioner (GP) lists diagnosed as suffering from depression – a rate of almost 120 per 1,000 patients aged 18 and over (or 12 per cent of registered patients aged 18 and over). Some 18,900 people were diagnosed with more serious mental health conditions (schizophrenia, bi-polar disorder and other psychoses), a rate of 9.3 per 1,000 patients, that is just under 1 per cent of patients. The rate of those registered with dementia was slightly lower at 6.6 per 1,000 (13,300 people). QoF registers show a gradual increase in numbers diagnosed over time, with a particular increase in numbers registered with depression (increasing by some 43 per cent over the period 2015-16 to 2021-22).

COVID-19 is expected to result in additional demand for mental health services

1.14 The COVID-19 pandemic is expected to add to the already significant levels of mental health problems in Northern Ireland, arising both from the direct impact of the disease on individuals and as a consequence of the measures taken to safeguard against it. This reflects the effect of sickness and trauma, bereavement, stress and worry about the disease, social distancing and isolation, unemployment, financial hardship and the inability to access services. The impact of these factors is expected to result in a surge in demand for additional mental health services, including both new users and those with pre-existing conditions, the effect of which will be felt for some time into the future. This issue is explored further in Part 4 of this report.

The cost of mental health is substantial

1.15 While mental ill-health has a serious impact on the lives of people and their families, it also brings with it wider economic and societal costs. The OECD's 2018 'Health at a Glance: Europe' reported the costs of mental ill-health in the United Kingdom in 2015 at around £94 billion annually, inclusive of treatment, care and social support costs and losses to the economy. At this level, the wider costs of mental ill-health equate to around 4.1 per cent of gross domestic product.

1.16 In February 2022, the London School of Economics and the Mental Health Foundation published a report which contained an estimate of the cost of mental health problems in Northern Ireland. This estimated that the costs of mental ill-health in the United Kingdom in 2019 conservatively amounted to £117.9 billion. Within this, costs in Northern Ireland were estimated at £3.4 billion, most of which (approximately 65 per cent) reflects the cost of informal care (£1.15 billion) and the cost of lost productivity associated with people living with mental health conditions (£1.07 billion). In addition, the cost of lost quality of life due to mental ill-health was valued at a further £580 million, with the cost of specialist mental health care services, at £420 million, making up only around 12 percent of total costs.

1.17 The majority of the estimated costs in Northern Ireland (approximately 67 per cent) relate to 4 main conditions, with anxiety making up the largest proportion of overall costs, at around 22 per cent, and depression making up a further 20 per cent. Bipolar disorder and schizophrenia represent 16 per cent and 8 per cent of estimated costs respectively.

1.18 As the cost of mental health problems in Northern Ireland is substantial, there is potential for significant benefits to be derived from improvements in mental health.

Scope and Structure

1.19 This report is intended to provide a high-level overview of mental health services in Northern Ireland and is structured as follows:

- **Part Two** outlines mental health strategy and policy;
- **Part Three** provides analysis of mental health funding and expenditure;
- **Part Four** details mental health service activity; and
- **Part Five** considers mental health data and outcomes.

1.20 Details of our audit methodology are set out at **Appendix One**.

Part Two:

Mental Health Strategy and Policy

Mental Health Strategy and Policy

Strategic direction in mental health over the last two decades has been informed by the Bamford Review

2.1 The Review of Mental Health and Learning Disability (Northern Ireland), a review of the law, policies and provision of services relating to mental health and learning disabilities, was commissioned by the (then) Department of Health, Social Services and Public Safety in October 2002. The Bamford Review, as it became known, produced a total of 11 interlinked reports between 2005 and 2007, in particular covering mental health services for adults, children and adolescents, older people, and those with learning disabilities. Its reports also covered issues relating to mental health promotion, alcohol and substance misuse and mental health legislation (particularly in respect of human rights and mental capacity).

2.2 Importantly, these set out a vision for mental health services aimed at making a real and meaningful difference to the lives of those with mental health problems and made recommendations for the development and improvement of services. Key recommendations included:

- an emphasis on promoting positive mental health;
- a continued shift from hospital to community-based services;
- the development of specialist services for children and young people, older people, those with addictions problems and those in the criminal justice system;
- a fully trained workforce to deliver mental health services; and
- a reform of mental health legislation.

The Bamford Review also emphasised the need for a person-centred and recovery focused approach to the provision of services which, together with its other recommendations, firmly aligned it within the wider health transformation agenda identified under 'Transforming your care'.

2.3 The Bamford Review envisaged a 10 – 15 year time scale for the full implementation of its recommendations, dependent on the availability of additional resources. Implementation was undertaken through two action plans; the first covering 2009 to 2011 and the second relating to the period 2012 to 2015 (subsequently extended for a year to allow for evaluation). An evaluation of the later action plan was commissioned in 2016 but, having been affected by the suspension of the Executive between January 2017 and January 2020, has yet to be published.

Reviews have identified a number of consistent issues in mental health policy and services

2.4 While credited with increasing investment in mental health and improvements in services, in particular the development of community-based services and a move away from long stay care in mental health hospitals, a number of reviews and reports[5] highlighted problems with regard to:

- the lack of an overarching mental health strategy;
- the fragmentation of services and poor communication between different parts of the system, particularly connected with the development of specialist community-based services;
- limitations in the provision of, and gaps in, services, particularly in community-based services, services for children and young adults, and for crisis services;
- a lack of access to, and availability of, psychological therapies, due to poorly developed provision, which has resulted in long waiting lists (despite the existence of a specific strategy to develop psychological therapy services);
- the need for greater focus on prevention and early intervention;
- limited integration/involvement of the community and voluntary sector in service provision;
- that funding levels have curtailed progress in the development of services; and
- a lack of parity with physical healthcare.

2.5 In particular, the coincidence of the suspension of the Northern Ireland Executive (between 2017 and 2020) and the hiatus in the implementation of Bamford (associated with a delay in the evaluation of the 2012-15 Action Plan) was criticised (notably by the House of Commons Northern Ireland Affairs Committee) as resulting in a loss of momentum in developing services and a lack of strategic direction for mental health in Northern Ireland.

The Department launched a 10-year strategy for mental health in June 2021

2.6 With the restoration of the Northern Ireland Executive in January 2020 there has been renewed focus on mental health, with two notable developments. The Department launched a Mental Health Action Plan in May 2020. Subsequently, on 29 June 2021, it introduced a new Strategy for Mental Health. Both of these reflect the fulfilment of commitments set out in the Executive's 'New Decade, New Approach' document which formed the basis upon which the Executive was restored. The latter also addresses the Northern Ireland Affairs Committee's call for a comprehensive strategy.

5 For instance, the 2015 QUB/Action Mental Health 'Regress? React? Resolve? An evaluation of mental health service provision in Northern Ireland' and the 2019 University of Ulster 'Review of Mental Health Policies in Northern Ireland: Making Parity a Reality'.

2.7 The Mental Health Action Plan was designed as a short-term measure, both to deliver some immediate improvement in services and to facilitate the development of a long-term strategy. The first action was to develop a 10-year mental health strategy, co-produced with key stakeholders (including service users and carers). The Action Plan also confirmed plans for the appointment of a mental health champion. In addition, it contained a number of actions to review services to inform the new strategy, including those for eating disorder, personality disorder, mental health crisis and rehabilitation services. It also included the publication of the evaluation of the second Bamford Review Action Plan by September 2020.

2.8 In total, the Mental Health Action Plan identified 38 separate actions. Alongside those actions related to developing the long-term strategy, the Action Plan made a number of proposals for improving mental health services. In particular, this included: developing new perinatal services; expanding talking therapies and other community-based support through mental health hubs in primary care; implementing a regional trauma network (a commitment under the 2014 Stormont House Agreement); and developing a managed care network[6] for child and adolescent mental health services (CAMHS). Overall, the costs of these service improvement actions (estimated at just over £1.5 million in the first year, 2020-21) account for around half of the Action Plan's overall estimated additional costs of £2.8 million. This is over and above those costs where actions reflected decisions already taken and for which funding had already been identified.

2.9 The Department's June 2021 implementation update provided a summary of progress over the first 12 months of the Action Plan. This indicated that, despite the impact of COVID-19 on operations, the majority of the Action Plan's 38 actions were either complete (8), on target for completion (6), or progressing with slight delay (8). In particular, the progress report highlighted the completion of actions in respect of the:

- appointment of a mental health champion;
- approval of the business case and securing of £4.7 million funding for the development of a specialist perinatal mental health service, anticipated to begin partial delivery later in 2021-22;
- establishment of the CAMHS and Forensic Mental Health Managed Care Networks; and
- launch of a Mental Health Innovation Fund to support local level initiatives, allocating some £450,000 to Health and Social Care Trust (Trust) projects in 2020-21.

2.10 A number of actions are noted as having been delayed, largely due to COVID-19 pressures. Among others, these include the publication of the Bamford evaluation report and the evaluation of the 2010 psychological therapies strategy, which are intended to inform the development of the long-term strategy. Only one action, relating to a prevalence study in adult mental health, is identified as not progressing on the basis that it is not cost efficient. The Department believes that adequate evidence of prevalence levels is available elsewhere, providing a good indication of the levels of need in Northern Ireland. Undertaking such an exercise would not, therefore, represent value for money.

6 Managed care networks bring together those involved in particular areas (health and social care services, community and voluntary sector organisations, and user and carer organisations) to improve services through co-ordination and co-operation.

2.11 The Action Plan's remaining 15 actions are identified as on-going and of such importance that they are to be carried forward as part of the new strategy, with the introduction of the strategy marking the cessation of the Action Plan. Importantly, these include a number of actions around better mental health care and treatment in primary care (including training for GPs, the roll out of mental health workers in multi-disciplinary teams and the expansion and integration of talking therapy hubs within primary care); actions to create a stronger and more resilient workforce (including a workforce review); the development of an outcomes framework; and a review of the involvement of the community and voluntary sector in services.

2.12 Past reviews have criticised the lack of an overarching strategy for mental health in Northern Ireland, identifying Northern Ireland as the only region of the United Kingdom not to have such a strategy in place. This has now been addressed with the launch of a mental health strategy in June 2021, covering the period 2021 to 2031 (the Strategy). Aiming to improve mental health outcomes, the Strategy identifies a new vision for the future of mental health in Northern Ireland (see **Figure 3**) and sets out 35 key, high-level actions for reforming mental health services. These actions are founded upon seven core principles stressing the need for services to: incorporate meaningful co-production and co-design; be person-centred across the whole life span; offer choice to fit individual needs and recognise the specific needs of particular at risk groups; be trauma informed; focus on prevention and early intervention and recovery; and be evidence based.

2.13 While recognising the effectiveness of mental health promotion, prevention and early intervention in averting or delaying the onset of mental health problems, or reducing their impact where they do arise, the Strategy also acknowledges the need for appropriate support and care for those who do suffer mental ill-health. In addition, it recognises the need for the right structures and supports to facilitate the change required to achieve its vision. To reflect this, the Strategy's actions are grouped around three overarching themes:

- promoting mental wellbeing, resilience and good mental health across society;
- providing the right support at the right time; and
- new ways of working.

Figure 3: Vision for the Future of Mental Health in Northern Ireland

Our vision for Northern Ireland is a society which promotes emotional wellbeing and positive mental health for everyone with a lifespan approach, which supports recovery, and seeks to reduce stigma and mental health inequalities.

We want a system that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice.

We want to break down barriers so that the individual and their needs are placed right at the centre, respecting diversity, equality and human rights, and ensuring people have access to the most appropriate, high-quality help and treatment at the right time, and in the right place.

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

Source: Mental Health Strategy 2021-2031

2.14 The Strategy identifies five 'stand out' actions. These include:

- creating an action plan for promoting mental health through early intervention and prevention, with year-on-year actions covering a whole life approach from infancy to old age, which takes account of those groups disproportionately affected by mental ill-health who struggle to access early intervention, and seeks to reduce stigma associated with mental ill-health services;
- increasing the share of funding for CAMHS to 10 per cent of that provided to adult mental health services, improving delivery to ensure the needs of young people, their families and their support networks are met;
- changing the structure of service delivery, refocusing and reorganising more towards community-based services, centred around GPs and primary care teams;
- improving the integration of the community and voluntary sectors in service delivery; and
- developing a regional mental health service, across the five Trusts, to ensure consistency in service delivery and development.

2.15 These, and the other actions identified in the Strategy, are intended to address the recurring issues identified in mental health services (noted at paragraph 2.4 above). In particular, with regard to gaps in services, the Strategy identifies plans for the development and expansion of a number of services noted as areas of need in our discussions with Trusts, including rehabilitation services and low-secure inpatient provision.

2.16 The Strategy also highlights the importance of the workforce in achieving the desired changes in mental health services, identified as a key barrier to the expansion of service provision and access to services in our discussions with Trusts. To this end, the Strategy (as part of its 'new ways of working' theme) identifies the need for a comprehensive review of the workforce to consider existing and future needs.

Costs associated with the implementation of the mental health strategy are substantial and are not available from within departmental resources

2.17 The level of funding necessary to fully implement the Strategy is substantial. A funding plan, published alongside the Strategy, estimates the total cost associated with the implementation of its actions at around £1.2 billion (over its 10 year period). This includes £287 million capital costs, mainly related to a programme of works involving the construction of three new inpatient facilities, and £920 million revenue costs, predominantly related to the development and implementation of new and improved services. While relatively low in the early years of the Strategy, revenue costs build as new services are fully implemented, with additional on-going costs estimated to reach around £158 million per annum in 2031-32.

2.18 The (then) Minister of Health acknowledged that this level of funding is not available from within departmental resources, without severe implications for its existing activities, and called for collective effort across the Executive to prioritise mental health funding in future budgetary processes. The Executive's draft budget for the years 2022-23 to 2024-25 includes full provision for the implementation of the Strategy over these three years. However, this budget was not approved, as a result of the failure to re-establish an Executive after the May 2022 elections. In the absence of additional funding, the Department has, however, identified funding from within in its existing resources to progress a number of enabler actions, including the workforce review, in 2021-22 and 2022-23.

2.19 The Strategy does not provide specifics around implementation, other than to highlight the Department's commitment to full implementation and to acknowledge that implementation will require significant work in its own right. The associated Funding Plan also notes that it will not be possible to start implementation of all actions simultaneously, and that prioritisation, workforce mapping and planning would be required to ensure delivery. The Department has signalled its intention to facilitate the implementation of the Strategy by way of annual delivery plans, with a delivery plan for 2022-23 published in July 2022.

A lack of available funding is likely to threaten the delivery of the mental health strategy

2.20 The 2022-23 Delivery Plan provides detail both in relation to actions currently being progressed and those prioritised for action in 2022-23. Importantly, however, it identifies that the Department's resources are insufficient to take forward actual implementation of the Strategy, and that those actions prioritised for 2022-23 can only be taken forward where the additional funding signalled in the draft Executive Budget becomes available. Delay in the confirmation of the Department's funding position, therefore, represents delay in the implementation of the Strategy.

2.21 As a result of the limited resources available to take forward the implementation of the Strategy, progress to date has been focused on taking forward a range of preparatory activities and work towards completion of key enabling actions initiated in 2021-22. Progress to date in relation to these preparatory and enabling actions includes the:

- continued roll out of specialist perinatal mental health services;
- completion of a draft review report in relation to the development of a regional mental health service;
- establishment of a steering group, appointment of an external review team and development of a project plan for the review of the mental health workforce; and
- commencement of work to develop an outcomes framework and implementation plan.

The Department has indicated that it expects enabling actions to be completed or substantively progressed during 2022-23.

Recommendation

The Department's renewed focus on mental health through its mental health action plan and the development of a mental health strategy is welcomed. The Strategy, in particular, provides a framework for improvements in mental health and mental health services going forward, although, because of a lack of confirmed funding, there is already evidence of delay in its implementation.

Without dedicated funding the pace of delivery and ultimate completion are uncertain. While the draft Executive Budget provides a positive signal of intent, the Department, in conjunction with the Executive, needs to secure adequate and sustained funding for the implementation of the Strategy over its lifetime. Failure to do so would jeopardise the achievement of its long-term vision for mental health and run the risk that, like Bamford before it, necessary reform and improvement is curtailed or delayed as a result of a lack of commitment to prioritise and adequately fund implementation. Security of funding would also support implementation plans beyond a single year.

Part Three:

Mental Health Funding and Expenditure

Mental Health Funding and Expenditure

It is difficult to identify the total funding and expenditure on mental health in Northern Ireland

3.1 Our discussions with the Department highlighted that because of the complicated nature of delivery and recording systems in health, overall funding and spend cannot be readily identified. This reflects the fact that aspects of mental health care are provided across a range of activities and services, the costs of which cannot always be disaggregated. This includes, for instance, costs associated with health promotion and children's services aimed at promoting mental health and wellbeing. It also includes support for mental health provided by GPs within family health services and certain aspects of mental health care for older people.

3.2 Available funding and expenditure information reflects the mental health programme of care[7] only. While our analysis focuses on the period 2010-11 to 2019-20 i.e. pre-pandemic, information has also been obtained in relation to planned expenditure for 2020-21 and 2021-22 in order to identify the impact of the pandemic on funding. However, because of distortions caused by COVID-19, reliable data in respect of actual spend for these years was not available. Further detail on our analysis is provided in **Appendix One**.

In 2019-20, mental health funding represented almost 6 per cent of the total health and social care budget, equating to around £160 per person in Northern Ireland

3.3 Total planned investment in the mental health programme of care in 2019-20 was just under £300 million. With an overall health and social care budget for 2019-20 of some £5.2 billion, mental health represented 5.7 per cent of the overall health budget. Also, at just under £300 million, and with a total population in Northern Ireland of around 1.89 million[8], this equates to nearly £160 per person.

3.4 Within the £300 million budget, the Department estimated that just over £22 million related to CAMHS. As such, funding for CAMHS in 2019-20 made up around 7.5 per cent of the overall mental health budget. There are, however, other services provided to meet the emotional and mental health of children and young people, under children's services and Public Health Agency (PHA) investment, although it is not possible to disaggregate this funding.

7 Programmes of care are divisions of health care into which activity and finance data are assigned. There are 9 programmes of care, one of which relates to mental health. Funding information provided derives from the HSCB's Strategic Resource Framework, a planning tool linked to the Commissioning Plan, which provides spending plans at a programme of care level. Actual spend details are derived from Trust Financial Returns to the HSCB.

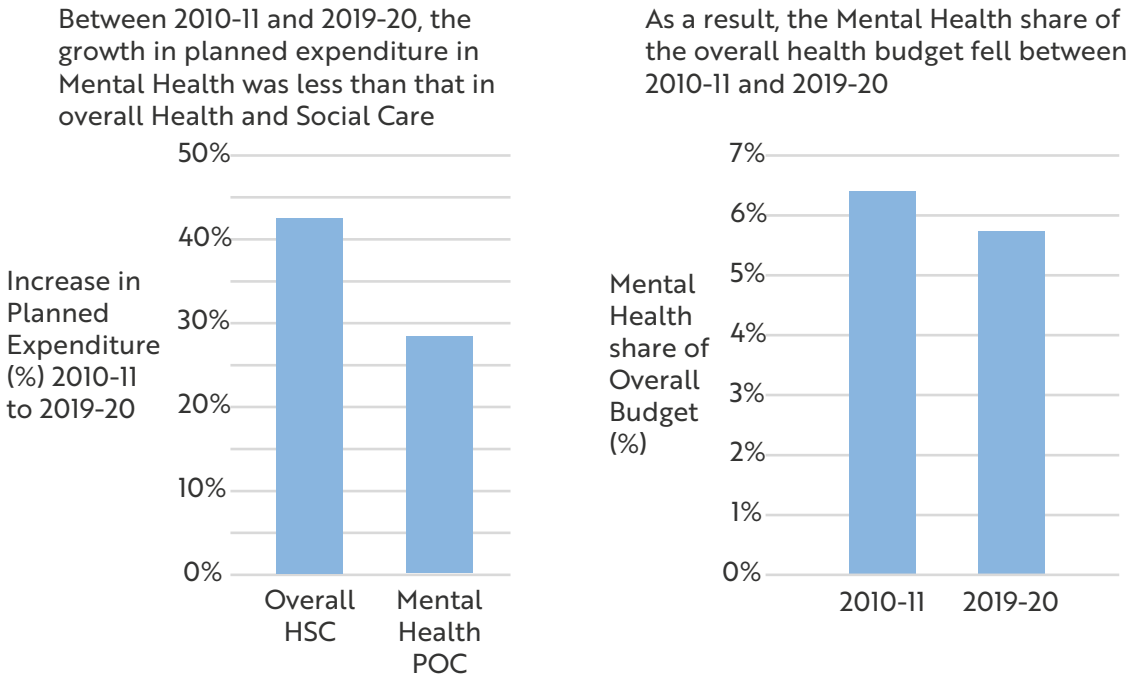
8 Per Northern Ireland Statistics and Research Agency mid-year estimate (June) 2019.

While overall funding levels have increased over time, mental health's share of the health and social care budget has reduced

3.5 Over the 10 years to 2019-20, planned expenditure in the mental health programme of care totalled just under £2.6 billion. While the general trend in funding over this period was upward, from just over £230 million in 2010-11, the level of funding increase accelerated after 2017-18. Between 2010-11 and 2019-20, planned expenditure in the mental health programme of care increased by £66 million in cash terms, or 28 per cent. Although, taking account for inflation, this represents a real terms increase of around 9 per cent.

3.6 The increase in the mental health budget, at 28 per cent, did not keep pace with increases in the overall health and social care budget, which increased by 43 per cent over the 10 years to 2019-20. As a result, the mental health share of the overall health care budget fell, from 6.4 per cent in 2010-11 to 5.7 per cent in 2019-20 (see **Figure 4**).

Figure 4: Planned investment in the mental health programme of care (POC) has not kept pace with increases in the health and social care budget



Source: Department of Health

CAMHS share of the mental health budget remained below levels advocated

3.7 Between 2010-11 and 2019-20, on the basis of departmental estimates, funding for CAMHS increased by around one third (from £16.7 million to £22.2 million), although, as with the overall mental health budget, the real terms increase was lower (at around 13 per cent). Over the 10 years, planned expenditure in mental health services for children and adolescents totalled some £200 million.

3.8 The proportion of the mental health budget attributable to services for CAMHS also increased (from 7.2 per cent in 2010-11 to 7.5 per cent in 2019-20), although 2019-20 levels were below peak levels achieved between 2012-13 and 2013-14 (of 8.1 per cent). Nevertheless, at 7.5 per cent of the mental health budget in 2019-20, funding levels fell short of the 10 per cent the (then) HSCB calculated should be invested in CAMHS, based on levels across the United Kingdom. This suggests a funding gap in the region of £8 million in 2019-20.

Actual spend in mental health demonstrates a move towards more community-based services

3.9 Actual spend in the mental health programme of care in 2019-20 was greater than that planned, reflecting additional in-year funding provided through budget monitoring processes. At £340 million, mental health spend accounted for some 5.7 per cent of the nearly £6 billion overall health and social care spend in 2019-20. The bulk of this spend related to services provided by Trusts (almost £323 million), with the remainder (£17 million) reflecting areas for which the (then) HSCB and the PHA have direct responsibility. These are regionally commissioned services, mainly delivered by the voluntary and community sector.

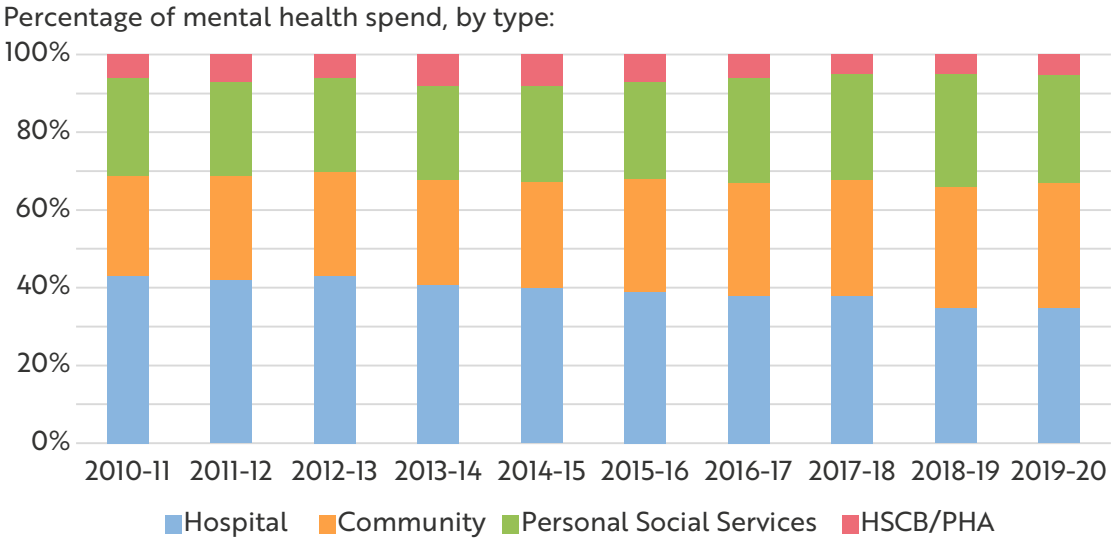
3.10 In 2019-20, Trusts spent just under £120 million on mental health services in hospitals (comprising mostly acute inpatient care and outpatient services) and £110 million in relation to community-based mental health provision (including community outreach teams, community services for addiction and children and young people, community psychiatric nursing and clinical psychologists). Within the mental health programme of care, Trusts also spent over £90 million in providing personal social services, including supported accommodation, nursing and residential homes costs, domiciliary care and day care facilities etc. No analysis was available in respect of HSCB and PHA spend.

3.11 Within Trust spend in the mental health programme of care, just over £30 million related to CAMHS (approximately £16 million in hospitals and £15 million in community settings). This, however, does not include the costs of other services provided to meet the emotional and mental health needs of children and young people though children's services and via PHA expenditure. In addition to this, approximately £16 million was spent on addiction services by Trusts, most of which (around £11 million) related to community addictions teams.

3.12 In the 10 years to 2019-20, just over £2.7 billion was spent in the mental health programme of care. Over the period, there was an increase in spend on mental health of just over £100 million (from £243 million in 2010-11 to £340 million in 2019-20), representing a real terms increase in spend of just under 20 per cent. This, however, is affected by a substantial increase in spend in 2019-20 of around £40 million, which results from a number of contributing factors including (among others) the recategorization of cost allocations, revised apportionment of overhead and support costs, together with increased costs (for instance in locum and agency staff costs).

3.13 Over time, there is evidence of a change in spending patterns, with the proportion of mental health spend in hospital-based services decreasing, while those in community-based services (and personal social services) have increased (see **Figure 5**). Despite this, in 2019-20 hospital-based services still accounted for more than a third of spend in the mental health programme of care.

Figure 5: There has been a change in spend, away from hospital-based mental health services



Source: Department of Health

Mental health funding in Northern Ireland is lower than elsewhere in the United Kingdom

3.14 For some time, criticism has highlighted the historic underfunding of services when compared to other jurisdictions. This issue is identified in a number of reviews, particularly the Northern Ireland Affairs Committee's 2019 inquiry on health and social care funding in Northern Ireland, and indeed is acknowledged by the Department in its 2021 Mental Health Strategy.

3.15 Direct comparison of funding levels between countries can be complicated by differences in the structure and nature of mental health services, together with the coverage of data collected and methodologies applied. However, while not always fully accurate, benchmarking can provide a broad indication of differences in funding.

3.16 **Figure 6** provides a comparison of funding levels across the United Kingdom and Ireland for 2019-20. Notwithstanding the caveats placed on comparisons noted above, this shows that Northern Ireland has the lowest level of mental health funding across the British Isles. On the basis of per capita figures, funding levels in Northern Ireland are around three fifths of those in Wales, two thirds of those in England and just over three quarters of those in Scotland. Funding levels in Northern Ireland are, however, closer to those in Ireland.

Figure 6: Northern Ireland has the lowest level of mental health funding across the United Kingdom and Ireland

REGION	FUNDING 2019-20	PROPORTION OF HEALTH BUDGET SPENT ON MENTAL HEALTH SERVICES	PER CAPITA BUDGET
	£m	%	£
NHS England	13,055	14.1	232
NHS Wales	810	11.1	257
NHS Scotland	1,100	7.7	201
Ireland	870*	6.2	177*
Northern Ireland	298	5.7	157

* Funding of €987.4 million and per capita funding of €201, using an exchange rate of €1 = £0.88

Source: Northern Ireland Audit Office

Notes:

(i) Funding details are derived from:
England – NHS Mental Health Dashboard (2019-20)
Scotland – Scottish Government: Scottish Budget 2019-20
Wales – StatsWales: NHS Programme Budgets 2019-20
Ireland – HSE: National Service Plan 2019 and relating to the 2019 calendar year
Northern Ireland – HSCB Strategic Resource Framework

(ii) Per capita figures for Northern Ireland, England and Scotland are based on Northern Ireland Statistics and Research Agency and Office for National Statistics mid-year population estimates at June 2019, while those for Ireland are based on Central Statistics Office Population and Migration Estimates, April 2019. Per capita funding in Wales is taken from StatsWales NHS Programme Budget details

(iii) Euro exchange rates applied taken from HMRC Yearly Average, for the year to 31 Dec 2019.

The additional funding needed to bring levels in Northern Ireland into line with that elsewhere is substantial

3.17 Matching levels elsewhere in the United Kingdom would require a substantial increase in funding levels in Northern Ireland. On the basis of per capita funding levels in 2019-20, the additional annual investment in mental health required to bring funding in line with that elsewhere in the United Kingdom is in the range of £80 - £190 million. With a relatively lower level of funding, matching that in Ireland would require additional annual funding of around £40 million.

3.18 Proposals in the June 2021 Strategy for the reform of mental health services estimate additional annual costs of around £150 million. While future budget availability will be within the context of wider Executive priorities, if fully funded, this would appear to provide the level of uplift necessary to bring mental health funding levels in Northern Ireland closer in line with others in the United Kingdom and Ireland. The strategy funding plan's profile, however, indicates that this level of additional funding would not be reached until towards the end of the strategy period (2030-31). As part of the NHS Long-Term Plan, in England there is a commitment to grow funding for mental health faster than the overall NHS budget, and in real terms by at least £2.3 billion by 2023-24 (compared to 2019-20 levels). In Ireland, the government has set a target for mental health funding to be 10 per cent of overall health expenditure by 2025.

3.19 Planned spend on mental health in England increased to around £14 billion in 2020-21 and £14.8 billion in 2021-22 (and to 14.8 per cent of the health budget). While planned expenditure also increased in Northern Ireland in 2020-21, to £323 million, and again in 2021-22 to £345 million, its share of the overall health and social care budget remained unchanged at 5.7 per cent. Within this, funding for CAMHS also increased, to £23.3 million in 2020-21 and £26.7 million in 2021-22. While indicating an initial reduction in its share of the mental health budget, to 7.2 per cent in 2020-21, funding in 2021-22 represents an overall increase to around 7.7 per cent of the mental health programme of care.

The impact of the COVID-19 pandemic adds additional cost pressures in Northern Ireland

3.20 COVID-19, together with the restrictions to everyday life imposed to contain it, is expected to impact negatively on mental health in Northern Ireland and result in additional demand for support services. This reflects both new demand from those directly or indirectly affected by the pandemic and additional demand in respect of those whose mental health problems have deteriorated during the pandemic. As people tend to remain in contact with mental health services for some time, its effect is likely to be felt beyond the end of the physical crisis itself.

3.21 The Department has estimated that referrals to mental health services will increase by around a third over the 3 years to 2023-24[9] as a result of the pandemic. Calculated on the basis of 2020-21 funding levels, this could result in an additional funding requirement of £117 million (£43 million in 2021-22, £45 million in 2022-23 and £29 million in 2023-24). We note, however, that the actual increase in the mental health budget between 2020-21 and 2021-22, at around £22 million (see paragraph 3.19 above), reflected only around half of the amount identified in the Department's estimate of additional funding needed.

9 HSCB (June 2021) 'Mental Health Surge & Rebuild Plan'.

Recommendation

Mental health funding levels in Northern Ireland do not compare well with those elsewhere in the United Kingdom and Ireland. Bringing funding levels in Northern Ireland into line with those elsewhere, within a reasonable timeframe, will require a substantial increase in funding. This will be made more difficult by the additional pressures placed on service costs over the next number of years as a result of COVID-19.

To do this will require a commitment towards sustained budget increases over the medium to long term. In this regard, and while acknowledging the intentions identified in the Department's Mental Health Strategy Funding Plan, the Department should establish an explicit long-term funding ambition for mental health services, together with stepped interim targets aimed towards its achievement.

Part Four:

Mental Health Service Activity

Mental Health Service Activity

The Department collects a significant amount of operational data on activity in mental health

4.1 The Department maintains a number of databases in relation to mental health, broadly reflecting the main mental health services – adult mental health services, CAMHS, dementia services and psychological therapies. These are derived from information provided by Trusts through regular returns. Data collected is used primarily to monitor Trust activity and for commissioning purposes, and is focused on Trust secondary care provision.

4.2 In order to provide a high-level overview of activity, the Department provided us with summary data covering the five year period 2015-16 to 2019-20. Separate detail has also been provided in respect of the 2020-21 and 2021-22 years, in order to assess the impact of COVID-19 on mental health service activity. In providing data, the Department identified a number of issues in terms of the completeness or consistency, which in certain cases has required estimations to be incorporated within our analysis. These are identified, as appropriate, in the relevant sections below. Data for 2021-22 is, however, particularly affected by a data migration issue at the Northern Trust, such that no referral and contact data is available in respect of adult mental health, psychological therapies and dementia services.

4.3 Our discussions with the Department and Trusts also highlighted an acknowledgement that data in mental health is less well developed than in other areas of health care, with a number of recognised information gaps. This is discussed further at Part 5 of this report.

Demand for mental health services increased year-on-year prior to the pandemic

4.4 Demand for mental health services had been increasing, year-on-year, prior to the pandemic. Demand peaked in 2018-19 when almost 125,000 referrals were made to mental health services. As data prior to 2017-18 is incomplete, we estimate from our analysis of available data that overall demand for mental health services increased by around 50 per cent between 2015-16 and 2018-19. This is clearly a substantial growth in demand over a relatively short period.[10]

4.5 Trusts suggested to us that the increased demand for mental health services reflects a growing acceptance and understanding of mental health and mental illness in society, and a reduction in the stigma associated with mental illness. Our discussions also indicated that, in addition to the increasing numbers being referred to mental health services, there has also been an increase in the complexity of presentations. In particular, Trusts noted the co-presentation of drug and alcohol addiction alongside mental health issues. The Northern Ireland Audit Office published a report on Addiction Services in Northern Ireland in June 2020.[11]

10 Estimated on the basis of growth in adult services, the largest service.

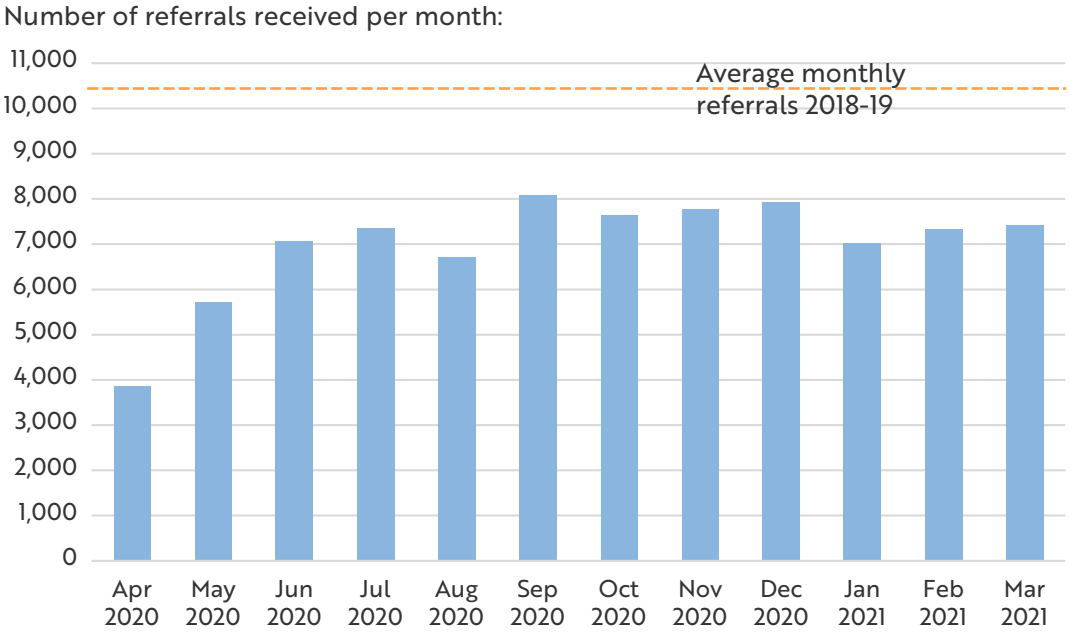
11 Addiction Services in Northern Ireland, Northern Ireland Audit Office, June 2020.

4.6 Mental health services in Northern Ireland were maintained throughout the pandemic, although they did not function as normal. Like other services, they experienced some restructuring and changes in delivery methods. In particular, reductions in staff, due to allocation to other duties, together with adherence to social distancing rules necessarily impacted on capacity, with services prioritised towards those most in need. Trusts indicated that, while inpatient services remained open, a number of lower risk services such as addiction services, condition management and day care facilities were stood down. Services also adapted in terms of delivery, with a focus towards non-face-to-face contact via telephone and online. In addition, the availability of online resources to support mental health and wellbeing was increased (for instance the development of an online apps library to support young people within CAMHS), with an expanded role for Trust Recovery Colleges. However, Trusts stressed that while delivery pivoted towards phone and video contact, face-to-face contact and home visits did remain available for those who needed it.

4.7 Despite the ongoing availability of mental health services during the pandemic, there was a change in the public's health seeking behaviours, resulting in reduced attendance at both GPs and Accident and Emergency. This, combined with the impact of reduced service availability, resulted in a reduction in referrals to mental health services. With the onset of the pandemic at the end of the 2019-20 year, referrals decreased to approximately 112,000. However, the impact on 2020-21 was more significant. At around 85,000, total referrals in 2020-21 were 25 per cent lower than the previous year.

4.8 The reduction in 2020-21 was most pronounced in the earlier part of the year, during the initial lockdown, with referral levels recovering thereafter. No services were stood down in later lockdowns. Despite the recovery in referrals in the latter part of the year, referral levels remained lower than pre-pandemic levels (**Figure 7**) and, at around 85,000, represented around two thirds of pre-pandemic levels (2018-19). Variation throughout the 2020-21 year coincided with the relaxation and re-imposition of COVID-related restrictions.

Figure 7: Referrals received in 2020-21 remained below pre-pandemic levels



Source: Department of Health

Note: As a result of IT issues, March 2021 figures above exclude referrals received in the Northern Trust in respect of adult mental health services, dementia services and psychological therapy services.

4.9 Related to the reduction in health seeking behaviour, Trusts highlighted an increase in the acuity of mental health problems (and urgency of referrals) among those presenting during the pandemic, as a result of delaying the point at which help and support was sought (for instance in young people with eating disorders). The Department was, however, unable to provide us with data in relation to the priority of referrals received.

4.10 Data suggests that the recovery in referrals identified in the latter part of 2020-21 continued into 2021-22. Overall, however, despite an estimated increase of about one sixth (16 per cent) between 2020-21 and 2021-22, the total level of referrals into mental health services in 2021-22 still remains around one fifth below pre-pandemic levels (2018-19).

In 2020-21, around 85 per cent of referrals received were accepted

4.11 Not all referrals received are accepted. In line with the regional mental health care pathway, a decision is made as to whether each referral received is appropriate (that the patient requires the level of service to which they have been referred and that they meet the particular criteria set for the specific services). Accepted referrals are registered and passed on to Trust services to arrange an appointment, at which point the patient joins the service waiting list, with the timing of the appointment aimed to match the priority of need identified in the referral and confirmed in the triage process (whether emergency, urgent or routine[12]).

4.12 The Department does not collect details on the reasons why referrals have not been accepted and therefore there is no assessment of the appropriateness of rejections. In 2019-20, just over 90,000 referrals were accepted into mental health services (i.e. approximately 80 per cent of referrals received). Analysis also indicates that referral acceptance levels varied across the different mental health services, with acceptance levels in CAMHS and adult mental health services lower (at between 7-8 in 10) than those in psychological therapies and dementia services (at around 9 in 10).

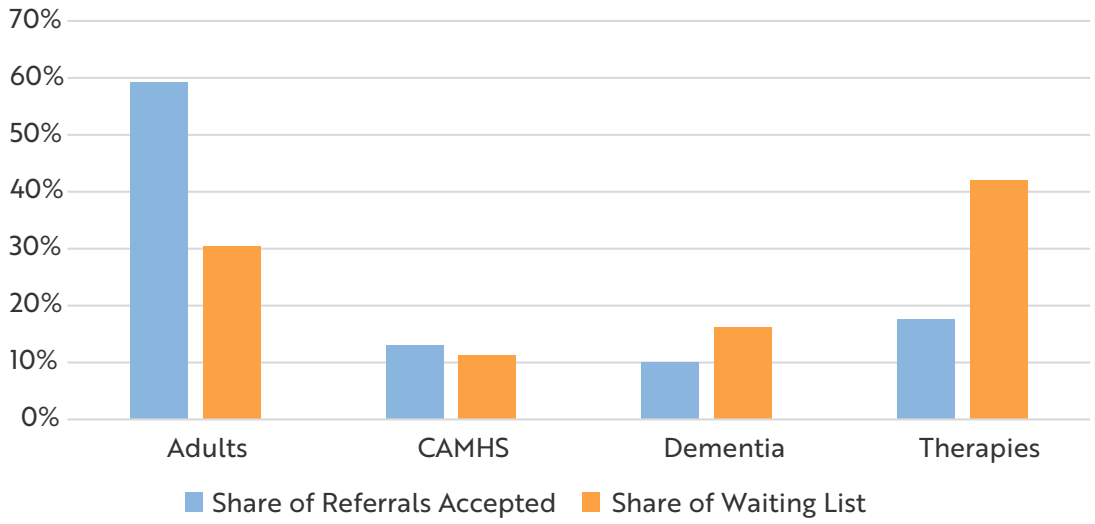
4.13 In line with the lower number of referrals received in 2020-21, the total number of referrals accepted also decreased, falling by around a fifth (to approximately 72,500). The overall proportion of referrals accepted did, however, increase in 2020-21 to around 85 per cent, although this broadly reflects an increase in the proportion of referrals accepted into adult mental health (levels in other services remaining broadly unchanged). We estimate that referrals accepted recovered somewhat in 2021-22, increasing by around 18 per cent compared to 2020-21 (based on data for 4 of the 5 Health Trusts). Nevertheless, levels in 2021-22 remain around 20 per cent lower than those in 2018-19.

12 The 'You in Mind' Regional Mental Health Care Pathway (2014) identifies standards in terms of referral priority. In emergency cases, mental health services will make face-to-face contact within 2 hours of receiving the referral, while for urgent referrals an appointment will be given within 5 days. Routine referrals will receive an appointment within 9 weeks (and 13 weeks for psychological therapies).

Numbers on mental health waiting lists are above pre-pandemic levels

4.14 When referrals are accepted, the patient enters the waiting list for mental health services. At the end of March 2022, almost 16,000 patients were on mental health waiting lists. The bulk of these, approximately three quarters, were waiting for psychological therapies and adult mental health services. Indeed, we estimate that while psychological therapies made up under a fifth of referrals accepted, those awaiting appointments in psychological therapies made up approximately two fifths of mental health waiting lists at 31 March 2022 (**Figure 8**).

Figure 8: Psychological therapies made up a disproportionate share of mental health waiting lists at 31 March 2022



Source: Department of Health

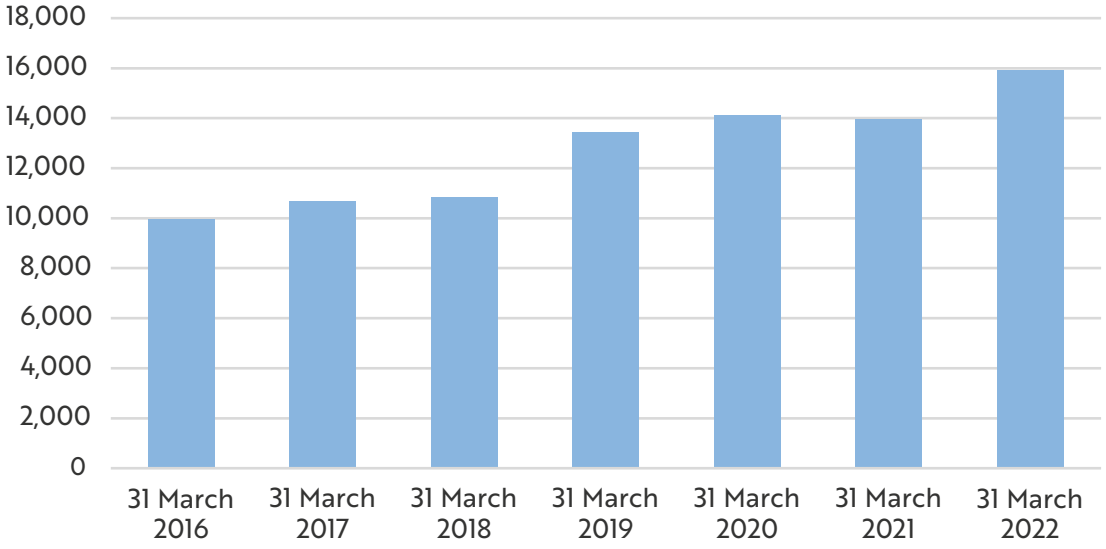
Note: The detail above excludes the Northern Trust. Because of a data migration issue, no referral data is available in relation to the Northern Trust for 2021-22.

4.15 The number of patients on mental health waiting lists has increased since 2015 (**Figure 9**). Data indicates a particular jump between March 2018 and March 2019, with waiting lists increasing by around 25 per cent. This coincides with the peak level of referrals in 2018-19. Commissioning plans have acknowledged that there are:

- underlying gaps between capacity and demand;
- a continuation of the trend in increased demand for services to treat substance misuse and associated health problems; and
- a funding gap between need and provision in respect of mental health services and the level of funding available to invest in psychological therapies.

Figure 9: Mental health waiting lists have increased over time

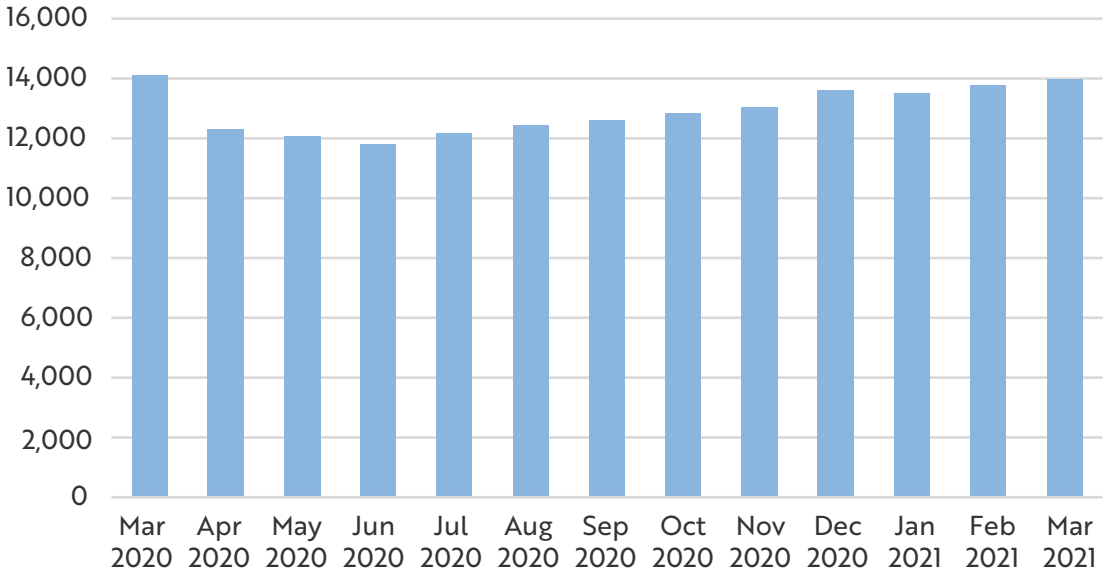
Numbers on mental health waiting lists by year, 2016 to 2022:



Source: Department of Health

Figure 10: While falling initially, by the end of March 2021 waiting lists had returned to levels similar to those at March 2020

Numbers on mental health waiting lists by month, March 2020 to March 2021:



Source: Department of Health

Note: As a result of IT issues at the Northern Trust, no data is available for waiting lists at 31 March 2021. The figures for March 2021 above incorporate an estimate for the Northern Trust, based on the February waiting list total uplifted in line with increases to March 2021 at the other Trusts.

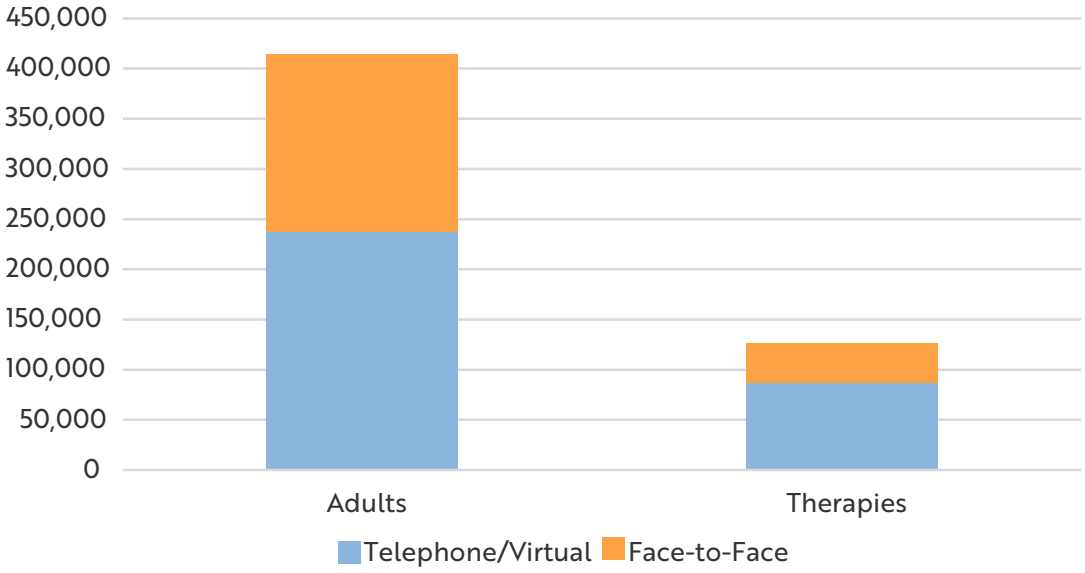
4.16 However, as a consequence of the reduction in referrals accepted during the pandemic, and despite service reductions, waiting lists reduced during 2020-21. The fall in numbers on waiting lists was most pronounced in the early months of 2020-21 during the initial lockdown. With the easing of restrictions and a recovery in referrals in the second half of the year, waiting lists began to grow again. By the end of the year the total number of patients on mental health waiting lists had increased to around 14,000 (**Figure 10**), close to the level recorded at the end of March 2020.

4.17 While the overall number on mental health waiting lists at March 2021 was similar to that at March 2020, separate waiting lists were affected differently. Waiting lists for CAMHS and adult mental health services fell between March 2020 and March 2021 (by around 30 per cent and 15 per cent respectively). In contrast, the dementia services waiting list increased by around 60 per cent. The waiting list for psychological therapies also increased, although by only around 3 per cent. The Department suggested that this divergence is explained in the ability of the particular services to accommodate alternative delivery methods. Dementia services, because of its particular client group, was less able to facilitate non-face-to-face contact.

4.18 The Department was unable to provide specific detail in respect of the level of the alternative contact in CAMHS and dementia services. Detail was, however, made available in relation to adult mental health services and psychological therapies. This indicates that over half of all contacts made in adult mental health services were undertaken through telephone and virtual means in 2020-21. The level of non-face-to-face contact in psychological therapies was even higher, at around three quarters (**Figure 11**). Our discussions with Trusts highlighted the receptiveness of CAMHS patients to these revised delivery methods, suggesting that they more closely reflected young people's usual methods of communication and interaction.

Figure 11: A significant proportion of patient contacts made in mental health services during 2020-21 was delivered via telephone or virtually

Number of mental health contacts seen in adult mental health services and psychological therapies in 2020-21:



Source: Department of Health

4.19 The increase in waiting lists in the latter part of 2020-21 continued into 2021-22, with overall numbers rising to almost 16,000, some 18 per cent higher than pre-pandemic levels (March 2019). This increase in waiting lists is evident in all services except dementia services, where waiting list totals fell by around 170 (or about 6 per cent) between March 2021 and March 2022. This may reflect the return to more face-to-face contact in 2021-22 – while limited, data relating to adult mental health services and psychological therapies suggests a decrease in virtual and telephone contact in the region of 20 per cent compared to 2020-21.

There has been a regional failure to achieve mental health waiting time targets

4.20 The mental health care pathway identifies standards in relation to the time within which mental health services should provide appointments, and which are encapsulated within Ministerial targets set as part of the commissioning plan process. These require that:

- no one waits longer than 9 weeks to access (i) adult mental health services, (ii) CAMHS and (iii) dementia services; and
- no one waits longer than 13 weeks to access psychological therapies.

4.21 These targets focus on Trust secondary care provision. No targets have been set in respect of mental health provision in primary care. Targets also relate to the first appointment only. Despite the majority of activity relating to treatment beyond the initial contact, there are no specific targets relating to the wider patient journey.

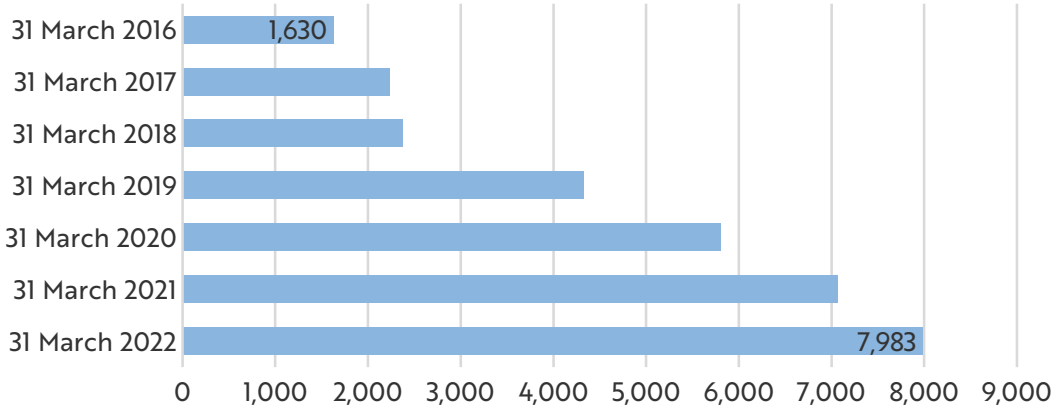
4.22 A significant number of people wait longer than intended to access mental health services. However, data is not collected to measure the average length of time people wait for their first appointment. Detail on longest waits does, however, indicate that some people can wait a considerable length of time. At 31 March 2022 the longest wait in adult mental health services was around a year (321 days). For CAMHS, the longest wait was 549 days, with the longest wait in dementia services greater at around 912 days (i.e. two and a half years). The longest wait in psychological therapies was, however, over 6 years (2,229 days).

4.23 Waiting time targets were not met regionally in any of the seven years included in our review (from 2015 to 2022). Over this period, the number of those waiting longer than the target has steadily increased, including a particular step increase after March 2018 with the overall total number of breaches almost doubling by the end of March 2019 (**Figure 12**). This increase broadly coincides with the peak in referrals and increase in waiting lists identified earlier (see paragraphs 4.4 and 4.15). The Department anticipated this increase, outlining in the Draft Commissioning Plan for 2018-19 that growing demand for services alongside a funding gap between need and provision is likely to impact negatively on performance against waiting time targets.

4.24 Overall, in the period from 2015 to 2022, the number of people waiting longer than the maximum standard waiting time to access mental health services increased by almost 400 per cent. By March 2022, around 8,000 people were waiting longer than the maximum target to access mental health services – about half of all those on mental health waiting lists.

Figure 12: The number of people waiting longer than the maximum target time to access mental health services at March 2022 was almost five times the number at March 2016

Total breaches of waiting time targets at year-end from 31 March 2016 to 31 March 2022:

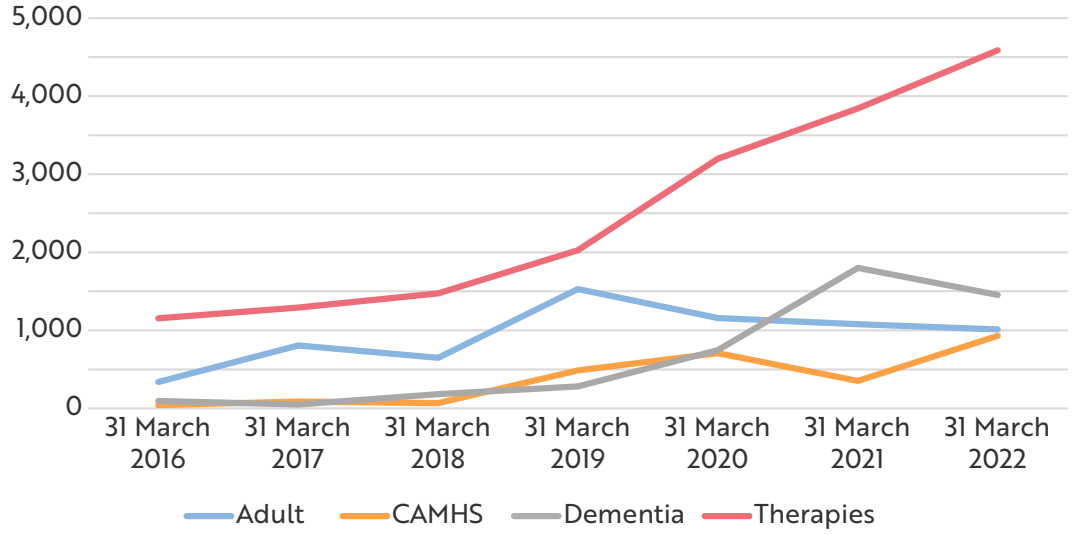


Source: Department of Health

4.25 The upward trend in the number of breaches of waiting time standards is broadly reflected across mental health services (**Figure 13**). In particular, this highlights poorer performance against waiting time targets in psychological therapies, with the number of people waiting longer than 13 weeks to access services quadrupling over the seven years to March 2022. At 31 March 2022, the level of breach of waiting time standards in psychological therapies (at around 4,600) was almost five times that in adult mental health services.

Figure 13: Performance against waiting time targets is poorer in psychological therapies

Total breaches of waiting time targets, at year-end from 31 March 2016 to 31 March 2022, by service:



Source: Department of Health

4.26 There are a number of factors behind the increase in breaches of waiting time targets. These include: funding (especially in psychological therapies), increasing demand for services, increasing complexity in case presentation, and service capacity/workforce issues (resulting from staff vacancies, sickness absence and inability to recruit or delays in recruitment). In our discussions with Trusts, all identified workforce as the key barrier in access to services, limiting the level of service that can be provided and the development of new services. Discussions also highlighted that the expansion of new services (such as mental health practitioners in primary care) is often at the expense of existing services, as staff leave one area to take up new posts in another. Indeed, Trusts suggested that even where additional funding is made available, workforce constraints have limited its effective use.

4.27 In identifying poor workforce planning to meet the increasing demand for services, and while indicating that issues exist across all key professions, Trusts highlighted mental health nurses as a particular area of concern. Workforce data provided by the Department[13] indicates that, at the end of March 2022, nursing (both mental health nurses and nursing support) is the largest professional group within mental health services. With an overall headcount of almost 1,700, the 211 mental health nurse vacancies being recruited at the end of 2021-22 suggests a vacancy rate[14] of around 11 per cent, although (as mentioned in the Mental Health Strategy) some Trusts experienced vacancy rates of over 20 per cent.

4.28 The challenges and deficiencies in workforce planning with respect to nursing is an issue identified in our 2020 report on 'Workforce planning for nurses and midwives'. We note, however, the increase in pre-registration nurse training places commissioned in recent years, and specifically the increase in mental health nursing places. We also note that the new Mental Health Strategy recognises the importance of workforce in achieving its vision for mental health services and the Department's intention to undertake a mental health workforce review to consider current and future needs.

13 Data sourced from the HSC Human Resources, Payroll, Travel and Subsistence (HRPTS) system.

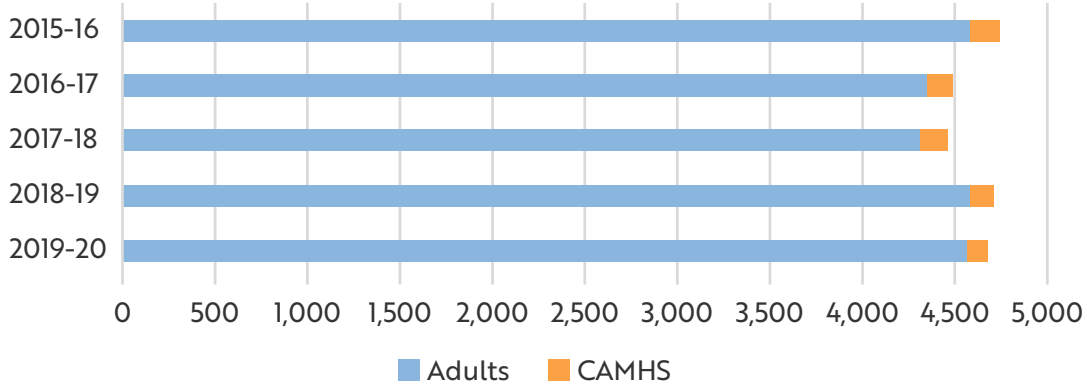
14 The vacancy rate is calculates the number of vacancies as a proportion of the staff complement (staff in post plus vacancies).

Admissions in mental health services remained fairly constant over the 5 years to March 2020

4.29 In 2019-20, there were just under 4,700 people admitted as inpatients to acute mental health wards in Northern Ireland. The vast majority of these, approximately 4,600, were adult mental health inpatients, with only a small number (just over 100) admitted to the regional children's mental health unit.

4.30 Overall, between 2015-16 and 2019-20, there was a slight decrease in numbers admitted to mental health inpatient facilities, although this mainly reflects a reduction in CAMHS admissions. Admissions in adult mental health in 2019-20 were broadly similar to those in 2015-16, although admissions did reduce slightly between 2015-16 and 2017-18 before returning to previous levels in 2018-19 and 2019-20 (**Figure 14**). While relatively small in number, the trend in CAMHS admissions was downwards over the five year period.

Figure 14: Admissions to acute mental health inpatient facilities (2015-16 to 2021-22)



Source: Department of Health

4.31 Within the general trend, over the period 2015-16 to 2019-20 the number of patients admitted from the Western Trust area[15] increased while admissions for patients from other Trusts areas decreased. As a result, the proportion of admissions relating to patients normally resident in the Western Trust area increased. In 2019-20, approximately one third of all patients admitted came from the Western Trust area.

4.32 During the pandemic, admissions to CAMHS inpatients did increase in 2020-21, by around one quarter (from 111 to 141), although total numbers were relatively small. This increase was, however, reversed in 2021-22, with CAMHS admissions falling below previous levels (to 81), and indicating a return to the decreasing trend identified in earlier years. The effect of the pandemic on adult mental health admissions is less clear, as a result of limitations in the data available. However, our analysis suggests a reduction in admissions during 2020-21, followed by an increase in 2021-22, although overall admissions were likely to be lower than those in 2019-20. Available data also indicates that the heightened level of admissions of patients from the Western Trust area continued.

15 Admissions data is collated in relation to the patient's 'Trust of Residence'. This may be different to the Trust in which the admission takes place.

Part Five:

Mental Health Data and Outcomes

Mental Health Data and Outcomes

There are limitations in data collected on mental health services

5.1 Good data is a fundamental building block in understanding service delivery, supporting strategic and operational decision making, measuring service quality and assessing the effectiveness of strategies. It is important not only to policy makers, commissioners of services and those bodies responsible for service delivery, but also other groups including service users, their families and carers, charities and third sector organisations, professional bodies, academics and researchers and, indeed, the wider public.

5.2 Concerns have been raised with respect to the adequacy of mental health data available, most notably in the Commissioner for Children and Young People's 2018 'Still Waiting' report[16]. This identified 'alarming gaps' in operational data necessary to efficiently plan, commission and deliver mental health services for children and young people. Our discussions with the Department and Trusts highlighted that data in mental health is less well developed than in other areas of health care, with a number of recognised information gaps. These discussions also noted variation between services in the level and type of data collected.

5.3 A 2021 review of mental health statistics in Northern Ireland by the Office for Statistics Regulation[17] (OSR) underscored these limitations, concluding that there is a scarcity of robust data which has led to significant data gaps. In particular, current data does not provide a complete picture of mental health care provision. As noted at Part 4, available information is focused towards Trust activity and no detail is available in relation to mental health services in primary care. Similarly, there is a lack of information on services provided by the community and voluntary sector (other than as an integral part of Trust services, provided under contract). In the absence of such information, available data can only provide a partial understanding of important aspects of mental health, for instance the overall level of demand for services, the locus and nature of that demand, numbers being diagnosed with particular conditions, the characteristics of those using services, the level of activity across services and the type of interventions provided. This also extends to the need for better information and analysis of funding and expenditure in mental health services identified in Part 3 of this report.

5.4 Data quality issues are a considerable barrier to reducing information gaps, primarily resulting from a lack of regional standardisation and a fragmented information technology infrastructure. OSR did, however, acknowledge plans under the Encompass programme[18] for the introduction of a new system across both physical and mental health by 2025. The importance of the new system in facilitating improvements in mental health data was also emphasised in our discussions with the Department and Trusts.

16 Northern Ireland Commissioner for Children and Young People (2018) 'Still Waiting': A Rights Based review of Mental Health Services and Support for Children and Young People in Northern Ireland'.

17 The Office for Statistics Regulation is an independent body responsible for the regulation of official statistics across the United Kingdom. Its September 2021 'Review of mental health statistics in Northern Ireland' forms part of an ongoing programme of work, having previously carried out a similar review in England which was published in September 2020.

18 Encompass is a Northern Ireland-wide initiative to introduce a digital integrated patient record across health and social care to improve patient safety and health outcomes, with a single system across physical and mental health replacing the numerous systems currently in place.

5.5 In recognising that the full implementation of the new system is some way off, OSR stressed the need to prioritise development of a minimum dataset across all settings. This, it noted, should be supported through the development of clear, regionally agreed definitions and guidance, pointing to the information standards in England (the Mental Health Services Dataset) and the associated data published by NHS Digital as an example upon which to base the development of mental health data in Northern Ireland.

5.6 The OSR report also noted that, while Trusts and the Department collect a wealth of activity and other data in relation to mental health services, in general, it is not publicly available. This applies to much of the data applied in our analysis at Part 4 of this report. Whilst neither publicly documented nor acknowledged, OSR suggested that concern around data quality is a contributing factor in the limited publication of mental health data in Northern Ireland. In addition, OSR indicated that even where data is published, access is hampered by the lack of a central data hub or adequate signposting to and within numerous sources.

5.7 OSR recommended that the Department should use the findings of its report to augment and improve the availability of data on mental health, identifying a standardised data collection across Trusts as a first and most important step. Given the extent of change needed to improve mental health statistics in Northern Ireland, and the level of investment required (both in technological and human resources), OSR recommended that the Department should consider whether a separate data strategy is required.

The lack of patient outcome data means that the Department has no assurance on the effectiveness of services provided

5.8 The OSR review noted that the only published statistic associated with the Programme for Government's intentions to improve mental health is the GHQ12 measure, which is derived from the Northern Ireland Health Survey. As identified at paragraph 1.11, data indicates that there has been no statistically significant change in the proportion of those assessed with possible mental health problems when compared to the base year (2014-15).

5.9 An important information gap in mental health services data highlighted by OSR reflects the lack of outcome data, although it did recognise the difficulty in measuring outcomes. Its 2020 review in England[19] identified the same issue. In the absence of outcomes measures, there is no means to evaluate the effectiveness of services in improving people's mental health, and in particular to provide evidence on what works. Consequently, the Department and Trusts remain unsighted as to whether the services provided represent value for money. The Mental Health Strategy (2021-31) does, however, commit to the development of a regional outcomes framework for mental health, which as an enabler for the wider strategy has been prioritised within the associated funding plan.

5.10 While the lack of outcome data was acknowledged in our discussions, the Department and Trusts noted that there is no generally accepted measure of outcomes in mental health. However, the current CAMHS dataset includes some aspects of outcome detail, relating to patient and family experience and a clinician-based assessment on discharge of whether the patient's treatment goals have been achieved. We requested details on both these aspects, however, only data on clinician assessments could be provided. With regard to patient experience, the Department told us that Trusts are currently unable to provide this metric.

19 OSR (2020) 'Mental Health Statistics in England'.

5.11 Data obtained in relation to CAMHS discharges provides an illustration of how outcome data can provide some indication of the impact of services. While identified as only partially reliable, this indicates that in 2019-20, where clinician assessments were recorded, patient goals were either fully or partially achieved in approximately two thirds of cases. Patient goals were not achieved (no change) in only a small proportion of cases (around 6 per cent), although just over a quarter of patients were recorded as having disengaged with services.

5.12 As a key enabling action for the implementation of the Mental Health Strategy, funding has been made available in 2020-21 and 2021-22 to progress the development of the framework and related implementation plan. The Department has indicated that recommendations for the framework were approved by the (then) Minister of Health in October 2022. The Department also noted that, because its implementation will be facilitated through the regional electronic patient record – EPIC (part of the Encompass programme), the timeframe for implementation of the outcome framework is closely linked to those for EPIC and Encompass. At present, EPIC is scheduled to be in use across all Trusts by March 2025.

Recommendation

There is a clear need to improve data around mental health services, both to address significant information gaps and to improve the quality of data produced. There is also a need to improve data accessibility, making it easier for users to find and use the information currently available by putting more data into the public domain. To support decision making and better monitoring of the effectiveness of services in improving people's mental health, there is a particular need to develop an appropriate outcomes measurement framework.

While the Department has recognised the need for both a robust dataset across services and an outcomes framework, tackling the weaknesses in mental health data will involve substantial change and require investment in data systems (both human and technological resources). Consequently, the Department should produce a data strategy setting out its aims for improving mental health data and how it intends to achieve them in line with the OSR's recommendation.

Appendices

Study Methodology

In gathering evidence for this study we:

- Reviewed a range of key strategy and policy documents produced by the Department;
- Examined a number of reviews of mental health services and policies undertaken by the Department, academic and other bodies;
- Reviewed and analysed key data, statistics and financial information relating to mental health services provided by the Department; and
- Interviewed key staff at the Department and engaged with other stakeholders (including participation in a number of policy seminars relating to the mental health strategy and priorities for mental health).

Analysis of funding and expenditure

Our analysis of funding and expenditure for mental health services is generally presented at an overall level. This reflects limitations in the source data such that it cannot separately identify funding or spend in relation to particular mental health services – adults, child and adolescent, older age or psychological therapies or at model of care level. The Department has, however, provided an indicative estimate of funding for CAMHS[20].

In providing data, the Department has cautioned against comparison between planned and actual spend, as the two sets of data have been generated on differing bases. Planned expenditure reflects the position at the beginning of the year, based on the initial allocation, while actual spend relates to the position at the end of the year (and includes additional in-year funding, non-recurrent and recurrent, and any monitoring round funding allocated during the year). As a result, separate analysis is provided in respect to planned and actual spend.

20 These have been derived, according to the HSCB, from both Board and Trust information systems updated by indicative pay and price levels.

NIAO Reports:
2022 and 2023

NIAO Reports 2022 and 2023

Title	Date Published
2022	
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