Mental Health Strategy 2021-2031

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Contents

The Road

I've been on the road many a day
Since I got into trouble and lost my way
I walk sometimes til' my feet do blister
My mind envisions my brother and sister

It was my decision to leave I know
For I had nowhere else to go
I couldn't go home, it wouldn't be fair
The police searched for me everywhere

I didn't want my mother troubled
So I left on my own, on the double
They'll all get by, I had no doubt
They'd no need for me, a common lout

I walked the length of each road I met
Stopping only to seek a room to let
With money earned along the way
Helping farmers bailing hay

The days were long and arduous
I kept my head down and made no fuss
Painting fences, feeding hens
Before moving on, yet again

Years later, I lost my way
Once again, I was led astray
I was in trouble with the law
Just the same as I was before

I lost my mind
I was twenty-nine
I counted with a life of crime
And was sent to prison to serve my time

Fifteen years later I was free
And twice the man, a whole new me
I'd spent my time in prison well
Learnt many crafts from that dark, cold cell

The road still long but I was tough
I kept on going through the rough
I met a man who gave me a chance
Not like others who didn't give me a second glance

I worked hard in the knacker's yard
Glad to have a brand new start
Every day new treasures delivered
Another man's scrap by to me gold and silver

I crafted, created and made the metal shine
Fashioned figurines, then redesigned
All my pieces, works of art
Made with love from my heart

Then came those who appreciated
The intricate pieces I created
They offered me money for my creations
I was left with feelings of pure elation

Success was swift after that
Demand was high, I earned a lot
Soon, I was a wealthy man
Helping others because I can

I may have had a rocky start
But I could teach others my precious art
Many young men came to my gate
I taught them well.
THE ROAD WON'T BE THEIR FATE

By MG - Beechvalley Community Wellbeing Service, Dungannon

I have struggled with depression and anxiety for many years. I've had times when I've felt so afraid, lost, lonely and isolated, fearing I would never recover. It was during my darkest days - there were many and still are - that I found writing about my feelings in poetry form not only cleared my mind but also brought me a sense of achievement and pride with each poem or story that I completed. Putting my thoughts and emotions down on paper became a lifeline. Gradually, I found I began to enjoy writing - creating poems not only about my illness but a wide range of subjects, some serious, some even comedic. Putting my innermost thoughts, worries and fears onto paper gave me a little release, an outlet. I could express myself, explain to myself and teach myself. Almost every day, whether good or bad, I record my mood, my thoughts and my feelings and use them for some of my poetry. Some I am able to share, while others are raw and private.

Ministerial foreword

Mental ill health is one of the greatest challenges facing us today. It is accepted that the COVID-19 pandemic and restrictions to everyday life have had, and continue to have, a significant impact on our population's mental health. Too many people in our communities are struggling with mental ill health, which is impacting on their life choices and outcomes.

This is at a time when our mental health services are under considerable pressure. Such pressures were present before the pandemic and unfortunately they have only increased over the past 15 months. Inpatient services are under extreme pressure, with HSC Trusts consistently operating above 100% bed occupancy levels in adult mental health inpatient units and the regional child and adolescent unit at full capacity. Our community services are seeing increased referrals and a heightened acuity of patients. It is heart breaking to hear about people as young as 8 needing specialist mental health support with eating disorders and to hear stories about people desperately seeking help without being able to receive what they need.

Since becoming Health Minister, I have repeatedly noted that mental health is one of my top priorities. I am determined to reduce the number of people who struggle with mental ill health and I want to ensure that people get the help they need when they need it. I have therefore put a focus on mental health, which has included the publication of a Mental Health Action Plan and a COVID-19 Mental Health Response Plan on 19 May 2020 and the appointment of Northern Ireland's first ever Mental Health Champion. I have also approved the creation of a perinatal mental health service, established a £10m Mental Health Charities Support Fund and initiated change across mental health services.

I am very pleased to continue this drive for reform in mental health services by publishing this Mental Health Strategy. The Strategy sets out a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, provide the right response when a person needs specialist help and support, as well as outlining how the system will work to implement these changes.

To drive the strategic reform needed, the Strategy sets out 35 actions under three overarching themes. The first – promoting mental wellbeing, resilience and good mental health across society – is key to ensure that we reduce the stigma around mental health, provide early intervention and prevention and provide support across the lifespan and to those caring for people with mental ill health. The second – providing the right support at the right time – covers a range of service improvements, including improvements in child and adolescent mental health services, integration of old age psychiatry and psychology into mainstream mental health services, community mental health and in-patient services and specialist services.

This theme outlines a number of service improvements that ensure better access to support when it is needed, putting the person's needs at the centre. The third theme – new ways of working – sets out the changes that will support the improvements needed across the systems, including a single mental health service, data and outcomes, workforce planning and research.

Of the 35 actions, five stand out. Firstly, I am 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 older age. The action plan will consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health. Secondly, I am creating an action to increase the funding for Child and Adolescent Mental Health Services to 10% of the funding for adult mental health services. This will allow improvement in the delivery of the stepped care model for children and young people to ensure services meet the needs of young people, their families and their support networks. Thirdly, I am changing how mental health services are structured, with a greater focus on the community. This means reorganising mental health services around the community, with an increased focus on our GPs. This will involve increasing the availability of therapy hubs to meet local needs and will ensure a focus is maintained on people and not on systems, thus improving outcomes for individuals. Fourthly, I am intending to improve the integration between the statutory and community and voluntary sectors by fully integrating the community and voluntary sector in mental health services delivery, including the development of a protocol to make maximum use of the sector's expertise. Finally, I am creating a single mental health service. I will do so, not by changing organisational boundaries to create new silos, but by creating enhanced regional co-operation and consistency. Implementing these five actions, together with the other 30 actions in the Strategy, will provide the reform our mental health services need.

The need for reform is particularly important in the current context of the COVID-19 pandemic. However, it is important to note that we are not starting from a zero base, and our mental health professionals already are providing high quality, dedicated services to enhance mental health outcomes. By providing the professionals with the right tools as outlined in this Strategy, we can further enhance the good work that they do.

I would like to thank all those who have been involved in drafting this Strategy. Your voice and continued support in the process has been highly valued and we could not have created what we have without your support! Going forward, we will continue working together to implement the vision of this Strategy. In so doing, we can collectively ensure that Northern Ireland has world-class and leading mental health services that deliver the best outcomes for everyone in society.

Robin Swann, MLA

Summary of actions

Theme 1 – Promoting mental wellbeing, resilience and good mental health across society

Promotion and prevention

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

ACTION 5. Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.

Promoting positive mental health across a person's whole life

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Theme 2: Providing the right support at the right time

Child and adolescent mental health

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

ACTION 11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

ACTION 20. Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.

ACTION 21. Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

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

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

ACTION 29. Ensure there are specialist interventions available to those who need it. In particular:

a. Continue the rollout of specialist perinatal mental health services.

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

c. Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.

d. Enhance the regional eating disorder service.

e. Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.

Theme 3: New ways of working

Digital mental health

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

ACTION 32. Undertake a comprehensive workforce review considering existing workforce need, training and development of new workforce, such as allied health professions, therapists and physician associates.

ACTION 33. Create a peer support and advocacy model across mental health services.

Data and outcomes

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

ACTION 35. Create a centre of excellence for mental health research.

The current state of mental health in Northern Ireland

Mental health problems

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

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

3. The legacy of the Troubles is also recognised as having a significant impact on mental health in Northern Ireland. In 2008, 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles. Deprivation and high rates of mental and physical illness co-occur in the areas most impacted by the violence.[2] It is important to recognise and address the specific context of this trauma on people in Northern Ireland. The impact of the violence, fear, bereavement, political unrest and the associated economic hardship has had a significant and long term effect on our population's collective wellbeing. The trauma can be seen across generations, and continues to impact on both individuals and communities today.

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

1 Boardman et al, 2010, *Social exclusion and mental health - How people with mental health problems are disadvantaged: An overview.*
2 Ulster University, 2019, *Review of Mental Health Policies in Northern Ireland: Making Parity a Reality.*

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

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

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

6. Loneliness affects all ages and all backgrounds. 1 in 5 people in Northern Ireland report feeling lonely always or often, which represents 380,000 people. Recent surveys conducted by NISRA show that loneliness is higher in urban areas at 40% compared to 33% in rural areas. The COVID-19 pandemic has exacerbated this issue due to the restrictions to everyday life.

1 IN 5 PEOPLE IN NORTHERN IRELAND REPORT FEELING LONELY

7. The mental health impact of these restrictions on everyday life has been widely documented and discussed. The older and frailer tend to experience social isolation and loneliness for longer periods of time and may not have resources to keep in touch with anyone. While loneliness is not a mental health problem in itself, it can contribute to mental health difficulties; likewise, mental health difficulties can cause loneliness.

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

8. Loneliness is both a cause and contributor to depression and can lead to increased mortality. People who are lonely are more likely to develop mental ill health than those with strong social connections. We also know that loneliness is associated with an increased risk of dementia. For children, loneliness can exacerbate mental ill health, affecting their development, education and long term outcomes.

Strategic context

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

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

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

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

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

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

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

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

16. To tackle some of these issues in the short to medium term, and put the foundations in place for longer term strategic change, the Department of Health published a new Mental Health Action Plan in May 2020. The 38 actions in the Action Plan fall into three broad categories: immediate service developments; longer term strategic objectives; and preparatory work for future strategic decisions. With the publication of this Strategy, the Action Plan will stop, and remaining actions are subsumed into the actions in this Strategy.

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

17. There are also a number of other strategic documents already in place or under development by the Department of Health which complement this Mental Health Strategy. It is important to note the linkages between these policies and this Strategy to ensure the broader picture of support is coherent and reflective of the needs of our communities.

18. The Protect Life 2 Strategy to prevent suicide and self-harm will continue to work in tandem with this Mental Health Strategy and ensure synchronized service delivery. A wide number of actions, services and initiatives delivered under Protect Life 2 complement our mental health work. This includes services such as Multi Agency Triage Team, Lifeline, Towards Zero Suicide programme, bereavement support services, self harm services and stigma reduction.

19. Northern Ireland's new Substance Use Strategy Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle Substance Use has been co-produced by the Department of Health, working in partnership with key stakeholders, both inside and outside government, including service users. The new strategy issued for public consultation on 30 October 2020. 78 formal responses were received from a wide spectrum of stakeholders, in addition to significant feedback from the formal facilitated consultation events and the individual meetings groups had with Departmental officials. Underscored by five population-level outcomes, the proposed vision of the new strategy is that people in Northern Ireland: are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs; have access to high quality treatment and support services; and will be empowered to maintain recovery. The strategy is expected to be published during summer 2021. As part of this process, consideration is being given to the investment required to deliver the new strategy, including funding for alcohol and drug services.

20. An interim Autism Strategy has recently been launched and the development of a fully co-produced longer term strategy is about to commence. In addition, a Learning Disability Service Model is also being developed by the Health and Social Care Board. These are important strategic drivers that aim to bring about improvements to services for people with autism/learning disability beyond mental health. It is therefore important that this Strategy dovetails with these other strategies.

21. There are also a wide range of policies in place or under development by other government departments which have an impact on the mental health of our communities. Some of these are highlighted in Theme 1 as of particular relevance and a more comprehensive list is provided in Annex A. It is important to recognise the links between these policies, and it is essential that government departments and other agencies continue to collaborate and communicate to ensure their work is joined up and in line with the high level ambition to ensure good mental health across Northern Ireland.

What needs to change

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

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

24. Across Northern Ireland, targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 170 children and young people waiting more than 9 weeks for core CAMHS and more than 1,800 people waiting more than 13 weeks for psychological therapies.[5]

2,000 PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR ADULT MENTAL HEALTH SERVICES

170 CHILDREN AND YOUNG PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR CORE CAMHS

1,800 PEOPLE ARE WAITING MORE THAN 13 WEEKS FOR PSYCHOLOGICAL THERAPIES

5 Correct as of 28 February 2021.

25. We know that if we can provide effective mental health interventions early, the outcomes for individuals, unpaid carers and families are much better. Care and treatment must therefore be available when and where they are needed. We must create systems that work together to reduce waiting lists and that support people at their time of crisis, including a reduction of the use of Emergency Departments as a crisis response. This will help people in their recovery and promote full participation in society. Our mental health system needs to be family focused to ensure that individual recovery also supports family recovery.

26. In the same way as ensuring there is a continued strategic focus on parity of esteem between mental and physical health, attention must also be given to parity within mental health services themselves, to ensure equality and equity of access for all, with a focus on recognising and meeting the individual's specific needs.

27. It is vital that we recognise the ongoing impact of the COVID-19 pandemic on our population's emotional wellbeing and mental health and that we build our response to it into the long term strategic direction. We must use the learning from the pandemic to ensure we have a system that works to prevent or delay the onset of mental health problems and which truly meets the needs of its users.

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

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

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

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

THIS STRATEGY IS CO-DESIGNED AND CO-PRODUCED WITH SERVICE USERS, CARERS, PEOPLE WITH LIVED EXPERIENCE, PROFESSIONALS, MANAGERS AND ACADEMICS

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

33. We have also been told that we need to focus on putting the person and the family at the centre and model services around their needs; that we need to ensure that the same services are available across Northern Ireland, regardless of where a person lives; and that services and interventions must be based on clear evidence.

Vision for the future

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

35. We have translated the views shared with us into a vision which sets out what we want to achieve for mental health in Northern Ireland over the next decade.

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.

36. To achieve this vision, we need to invigorate and energise our communities and organisations, to promote a culture change that will bring about real improvements for the population in Northern Ireland. We need to focus on learning from our experiences and supporting each other. We need to stop people falling through gaps in services by putting the foundations in place for true collaboration and integration, working together with and supporting our partners in the Community and Voluntary sector to provide high quality support and services on the ground. We need to work hard to reduce the "silo" mentality, and create a holistic system where all partners are valued and respected for the important role they play, including families, unpaid carers and wider support networks. We need to ensure that people get care and support when they need it and most fundamental of all, we need to prevent avoidable deaths.

37. In addition to the vision, we have developed seven core principles, which represent the foundations upon which each of the actions set out in this Strategy are based:

I. *Meaningful and effective co-production and co-design at every stage, involving all partners equally.*

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

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

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

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

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

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

38. This Strategy builds upon this vision and core principles to set out 35 actions to bring about change to mental health services in Northern Ireland. The actions are set out under three overarching themes:

- **Theme 1: Promoting mental wellbeing, resilience and good mental health across society**
- **Theme 2: Providing the right support at the right time**
- **Theme 3: New ways of working**

Theme 1

Promoting mental wellbeing, resilience and good mental health across society

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

Mental Health Champion

In April 2020, cross-Departmental support was secured, through the Northern Ireland Executive, to formally establish a Northern Ireland Mental Health Champion role. The creation of such a role was in response to wide ranging calls from across the mental health sector for the creation of a strong, effective and independent voice to advocate on their behalf. The Mental Health Champion is therefore a joint initiative across the NI Executive and is fully supported by all Executive Ministers. As a signal of the collaborative will for the role to succeed, funding for the role is shared across Departments.

The purpose of the Mental Health Champion is to integrate a mental health friendly ethos into all policies and services developed and delivered by the NI Executive and to enhance the level of collaborative working on, and awareness of, psychological wellbeing, mental health, suicide and recovery in Government Departments. The role is also to be a voice for people with lived experience, who are often not heard in the public debate.

41. If we want a system that promotes positive mental health and seeks to enable people to achieve their potential, it is critical to invest in societal measures to promote and support mental wellbeing and resilience, raise awareness of mental health and reduce the stigma associated with it and prevent and delay the onset of mental health problems as far as possible.

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

Promotion and prevention

42. Outcomes:

- Better mental health among the wider population, evidenced by a reduction of % of population with GHQ12 scores ≥4 (signifying possible mental health problem).
- Greater public understanding of the differences between mental wellbeing, mental ill health and mental illness.
- A reduction in the stigma associated with mental ill health and mental illness.
- Better inter-agency cooperation to promote wellbeing and resilience.
- Wider awareness of mental health within the health and social care sector outside the mental health profession.
- Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

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

The Healthy Wigan Partnership

A partnership between primary care, community services, Start Well (early years), mental health and public health is driving reform in Wigan, a deprived area of Greater Manchester. This has resulted in Wigan's Deal for Health and Wellness, which communicates the actions the NHS and residents can take across the life span to improve all aspects of health. The citizen-led, asset-based approach to health adopted by this partnership has seen tangible outcomes and is regarded as an effective way to build and sustain communities and system-wide commitments.

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

Connswater Community Greenway

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

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

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

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

45. A key part of this as we move forward has to be about ensuring that mental health remains high on the public agenda, to encourage open dialogue, understanding and acceptance. This is a key element in addressing the stigma that still shadows mental health and those who suffer from mental ill health, in particular, individuals with severe mental illness. Severe mental illness, such as schizophrenia, psychosis and Bi-polar affective disorder, often commence when a person is young, and are associated with long-term disabilities or recurrent episodes throughout the lifespan. Early intervention and effective treatments have improved outcomes, and it is important to ensure people are aware of this.

46. By ensuring mental health remains part of everyday conversation, it will also support and encourage people to seek help when they need it, and will ensure we as individuals, families, friends, employers and colleagues are better equipped to recognise and understand mental health problems in ourselves and others, and skilled to access or provide help, support and guidance in an appropriate and considerate manner.

47. We must also work across the whole of the population to promote a better understanding of what good mental health is, and clarify the distinction between mental wellbeing, mental ill health and mental illness. We need to encourage open dialogue and public discourse around how the many challenges life presents can impact on our mental wellbeing, but recognising that this does not necessarily lead to mental ill health. We need to encourage public recognition that "it's ok not to feel ok", that while life's ups and downs can have an impact on our wellbeing, this is normal, especially in the context of pandemic which has affected everyone across the globe. We also need to continue to promote the important steps that everyone can take to look after their own mental health and mental wellbeing.

WE MUST CONTINUE THE DISCUSSION AROUND MENTAL HEALTH ACROSS SOCIETY

48. This could be achieved through public awareness campaigns that increase people's mental health literacy, and may also include targeting specific groups of people who may be vulnerable to mental ill health, for example, peer support programmes for LGBT+ young people, debt advice for people on low incomes, or outreach programmes for ethnic minorities, refugees and asylum-seekers.

Sport Wellbeing Hub

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

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

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

Buy Social - mental health in procurement

Buy Social works to maximise the social benefits delivered through public investment. This includes social considerations on public contracts, which require Public Sector Contractors to deliver certain initiatives as part of the contract. Work is ongoing by the Department of Finance to consider the possibility of including Buy Social on relevant public sector contracts to benefit the mental health of employees working on these contracts, through for example, employment opportunities for those that are disadvantaged from the labour market, work experience and business in education opportunities, digital skills training for people at risk of digital exclusion and a requirement that contractors have a health and well-being policy in place in for staff.

50. For certain sectors, for example, the rural and farming community, mental health is a particular concern. This can be due to physical isolation from communities, worries about livelihood, or anxiety regarding personal and family safety. Research by the Farm Safety Foundation revealed that 84% of farmers under the age of 40 believe that mental health is the biggest hidden problem facing farmers (up from 81% in 2018).[7] It is important to reach out to harder to reach groups to intervene early and prevent the onset of mental health problems.

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

Tackling Rural Poverty and Social Isolation Framework

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

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

Through the Farm Families Health Checks Programme, 2,600 rural dwellers per annum avail of a comprehensive physical and mental health screening service.

51. Prevention actions in later life should focus on promoting active and healthy ageing, as well as addressing the living conditions and environments that support wellbeing and allow people to lead a healthy life.[8] For many older adults, social contact is key to building emotional resilience and staying mentally well. For others, staying active, both physically and mentally, contributes to their mental wellbeing. As a society, we must continue to value the contribution older adults make to our communities and provide opportunities and support for them to look after their mental health, whether through social groups or befriending schemes, access to physical activity, or other advice and support. The Executive's Active Ageing Strategy, which has been extended to May 2022, includes a number of actions which contribute to positive mental health among our older population.

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

Arts Council and NI Screen

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

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

52. For those with a recognised mental disorder in Northern Ireland, mental health promotion, prevention and early intervention is often secondary to the delivery of specific mental health services. Often, this is not in the patient's best interests.

53. To improve this, we need to ensure that promotion, prevention and early intervention is mainstreamed in service delivery and across different sectors.

WE WILL CREATE AN ACTION PLAN TO PROMOTE MENTAL HEALTH FOR THE WHOLE POPULATION

54. Going forward, this will require a renewed focus to ensure that mental health promotion meets the needs of those who need early intervention. This can include targeted approaches to groups more likely to be adversely affected by mental ill health, such as BAME groups, refugees and asylum seekers, people with a specific trauma exposure, LGBT+ people, people with a physical or sensory disability and persons with an intellectual disability.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

55. Outcomes:

- Increase in the number of people who receive help and support to improve their lives in difficult social circumstances.
- Greater ability in the population to access easy to use social support, including social prescribing.

56. A person's mental health is shaped by a range of social, economic, cultural and environmental factors. Evidence shows that poverty and mental ill-health are closely associated, and disadvantage can have long-term consequences.[9] We also know that the Troubles has had a lasting impact on both social deprivation and levels of mental ill health. In Northern Ireland, we need to continue to work together across government, sectors and the whole of society to implement existing policies designed to address deprivation, poverty, loneliness and social cohesion issues, and other social determinants of mental ill health. The four new social inclusion strategies that are currently being developed by the Department for Communities in relation to Disability, Anti-Poverty, Gender and Sexual Orientation, are likely to include interventions from across Government Departments that will contribute to improving our population's mental health and wellbeing.

57. Poor housing and unemployment are particularly relevant when considering mental health outcomes. Again, action across government to provide financial and emotional support to those who have become unemployed, and to help people back into work where possible, plays an essential role in preventing the occurrence of mental health problems.

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

Employment Support

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

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

58. For many of these issues, the solutions lie in tackling root causes and the impact of root causes and the responses need to sit across a range of Government departments and agencies. However within health and social care, an acknowledgement of the psycho-social aspects of the needs of individuals, families and communities is also very important. In addition to the more clinically orientated interventions, mental health services should also offer help and support with the social context of people's lives where this is impacting upon their mental health. Social work and social care services are important in this regard.

THERE WILL BE INCREASED SOCIAL SUPPORT FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

59. Going forward we will increase the social support available and work across government to improve the outcomes for those in difficult situations.

Improving Social Wellbeing

Social wellbeing is a broad concept encompassing the quality of people's relationships, their sense of belonging and the choice and control people have about decisions affecting them and their lives. It also includes having purpose and meaning in life as well as feeling safe and secure.

The purpose of social work is to improve and safeguard people's social wellbeing. In this case study, Paula, a young mother who is experiencing severe anxiety and panic attacks, has been referred to a social worker in a primary mental health team with the suggestion that she would benefit from relaxation and mindfulness teaching. When the social worker visits, she finds that Paula is caring for two young children on her own, that she has fallen out with her mother who was her main source of support, that she is working two low-paid part-time jobs to make ends meet, that the flat is cold and damp and that Paula is tortured by noise and nuisance from drug dealing taking place in the hall of the apartment block she lives in.

The social worker feels that Paula is not in a place at the minute to benefit from relaxation and mindfulness teaching, and that the source of her anxiety and panic is most probably her current life circumstances. She therefore suggests to Paula that they work together on relieving some of those stressors.

The social worker refers Paula to the Make the Call service to see if she can increase her income in any way and she offers her a sponsored day-care placement for her youngest child, where support groups for parents are also involved. The social worker spends time talking Paula through the relationship with her mother, how complicated it can be and the very mixed emotions it can evoke. She helps Paula to prepare for a conversation with her mother to lay the ground for a reconciliation. The social worker also supports Paula to make a complaint to the landlord responsible for the apartment block about the damp in her flat and the lack of security in the entrance hall.

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

60. Outcomes:

- Increased access to early intervention services.
- More people being seen early, with a long term reduction in people requiring higher intensity interventions.

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

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

63. Going forward, we also need to consider other methods of providing therapy, such as art or music therapy and use this in our every day delivery models. The talking therapy hubs should therefore be considered more widely as mental health therapy hubs which encompass a wide range of different interventions that are focused on the needs of individuals.

Music therapy

Music Therapy is a low-cost, low-risk, and high-impact intervention that can be used in isolation or together with other interventions. It requires minimal equipment and is flexible in terms of settings, timing and length of intervention, making it highly adaptable to meet a range of service user needs. It can add value through: improving clinical outcomes for service users; enhancing the services of other healthcare colleagues; reducing demand for medication; and avoiding future costs to the system through prevention-based services..

64. By expanding the availability of therapy through local Hubs, we can ensure early intervention services are available to the whole population. This needs to happen together with primary care. In that context, the Hubs should therefore become part of primary care services and be developed in conjunction with the development of the primary care multi-disciplinary teams.

65. In practice, this means ownership of the therapy hubs would be transferred to primary care, with further integration with the multi-disciplinary teams and with the community and voluntary sector.

66. Expansion of therapy hubs with involvement from the community and voluntary sector will increase the availability of psychological interventions and other interventions that will help and support good mental health. This means waiting times can be reduced and people will have easier access to therapies when they need it.

THERAPY HUBS WILL EXPAND AND WILL SEE FURTHER INVESTMENT

ACTION 5. Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.

Promoting positive mental health across a person's whole life

67. Outcomes:

- Improved mental health among children and young people using key indicators from the 2020 Youth Wellbeing Child and Adolescent Prevalence Study.
- Increased access to specialist mental health provisions, including for those with underlying disabilities.
- Improved mental health outcomes for students.
- Increased engagement with support for families and carers, including unpaid carers, and a greater involvement of families and carers in decision making processes.

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

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

70. Children's mental health and emotional wellbeing is nurtured primarily in the family. Therefore a key priority for all services is to support parents and carers. Across mental health services, a Think Family approach is therefore expected.

71. A secure parent/child relationship is a key building block for the development of positive attachment and helps to build emotional resilience in children. This support needs to continue into childhood and adolescence. Like cognitive capabilities, resilience, social and emotional skills can be taught and developed throughout childhood, adolescence and beyond.

72. Work needs to continue across sectors to promote positive social and emotional development throughout the period of childhood and adolescence. This means building on existing good practice and areas of collaboration, for example between the health and education sectors, and seeking new, innovative ways of working to ensure children have the best start to improve their chances of a happy, healthy life.

73. As adverse childhood experiences (ACEs) have been found to account for 29.8% of mental disorders,[10] prevention of ACEs is key to preventing mental ill health among children and in later life. For children, a key focal point for prevention is in connection with schools. Evidence shows that school-based programmes for children and adolescents have achieved a reduction in depressive symptom levels of 50% or more a year after the intervention; and anxiety disorders can successfully be prevented by strengthening emotional resilience, self-confidence and cognitive problem-solving skills in schools.[11]

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

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

Mental health in schools

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

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

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

74. Children with global developmental delay or neurodevelopmental disorders can present with particular behavioural challenges which require specialist support for the child and their parents. Seven out of ten people with autism also have a condition such as anxiety, depression, Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder. One helpful way of supporting children and young people with an intellectual disability is to provide specialised parenting education and support programmes. Services must also adapt to ensure that their provisions are suitable and available for children with such needs.

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

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

77. We must also consider specific psychological interventions in services for infants, children and young people living with persistent physical symptoms or who have been hospitalised for medical reasons. Evidence suggests that while the majority of children with a medical condition or chronic illness do not have a psychiatric disorder, a significant minority do have difficulties with adjustment or symptoms of psychological distress. Their needs are therefore often best met by a paediatric clinical psychology intervention rather than a psychiatric intervention.

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

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

Mental Health of Students

79. Mental health among students is also an area that has come into increasing focus, particularly in the context of the COVID-19 pandemic. There is clear evidence that the student population in Northern Ireland is vulnerable to mental ill health. An NUS-USI survey in 2017 identified that 78% of students were struggling with their mental health, with many living away from home.[12] Anxiety and stress about exams, money worries, housing and social interactions can all contribute to poor mental health among students. It is important that we continue to work across government and sectors to intervene early to provide support to help students stay emotionally well and build resilience to support them in their learning journeys and lives beyond.

12 NUS-USI Northern Ireland (2017) *Student Wellbeing Research Report 2017*, https://www.nusconnect.org.uk/resources/nus-usi-student-wellbeing-research-report-2017

Mood Matters for Students

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

The programme is based on cognitive behavioural concepts and introduces the 'Five Areas Approach', which participants use to challenge and change unhelpful thinking and behaviour in order to make a positive difference to their lives. It also features the 'Take5 for Your Emotional Wellbeing' which focuses on the five most evidenced ways of looking after our mental health (Connect, Be Active, Take Notice, Keep Learning and Give) and highlights how we can build these into our everyday lives.

80. Going forward, the unique position of students is identified as crucial for prevention and early intervention. In addition, the student population is very mobile, moving between home, university campuses and work placements, which provides challenges for students who need to be seen by secondary care mental health services. Research has found that 75% of people with both common and serious mental health conditions first experience symptoms before the age of 25.[13] As approximately two-thirds of third level students are between the ages of 18 and 25, we must ensure this group is targeted for preventative work and early intervention.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

Unpaid carers and families

81. Unpaid/informal carers and families are in a unique position to help and support people with their mental health. A good support network can help prevent mental ill health, provide help during mental health difficulties and assist with recovery.

13 Kessler, R. C., et. al. (2007). *Age of Onset of Mental Disorders: A Review of Recent Literature*. Current Opinion in Psychiatry 20(4), 359-364.

82. At all times, mental health services should be taking a Think Family approach, which considers the wider family, unpaid carers and others close to the person with mental health problems in the decision making.

83. Promoting and developing the involvement of families and unpaid carers is relevant across the whole lifespan. Structured advocacy services, peer support and other support platforms to inform, educate and support carers in their caring role are invaluable. These should be in place and accessible as part of the proposed reconfiguration of early intervention and prevention services.

GOING FORWARD THINK FAMILY SHOULD BE AN ADOPTED APPROACH ACROSS ALL MENTAL HEALTH SERVICES

84. On occasions, the person with mental ill health does not want the involvement of family or particular people around them. When such a decision is capacitous and made by an adult, it must at all times be respected, to ensure the privacy and autonomy of the person.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Learning Disability / Autism

85. It is accepted that people with a learning disability or autism are at higher risk of having negative mental health outcomes. While it is vital that such individuals have good and equitable access to mental health services, and that those services are able to cope with their specific needs, it is not considered appropriate to develop dedicated mental health services designed to treat those individuals. Doing so would mean people are treated primarily according to their underlying disability or circumstance, as a homogenous group, rather than receiving the most appropriate intervention they need for their mental ill health- which is different for everyone. Instead, this Strategy aims to put in place a truly person-centred service that is focused on the presenting mental health needs of the individual, with consideration of how best to meet those needs given their underlying disabilities and/or circumstances.

86. However, it is acknowledged that often interactions with general mental health services are more difficult than they should be for this client group.

87. This Strategy recognises that there are barriers currently preventing this client group, and other marginalised groups, from accessing mental health services and support. It therefore actively seeks to reduce barriers and to implement a "no wrong door" approach to access to services, ensuring staff are appropriately trained to identify and address the specific needs of particular marginalised or at risk groups, and ensuring that services can be flexible to meet individual needs at the point of contact. In many cases, this can be addressed by the provision of appropriate social support, rather than dedicated mental health interventions. In other cases, information sharing and close working between teams can alleviate some of the challenges faced by such groups in accessing appropriate mental health support.

88. It is important that mental health services are fully equipped to identify the specific needs of individuals and address these appropriately, whether through engagement with support services such as social work teams, speech and language therapy or interpreting services, onward referral to specialist services or interventions if required, or by the employment of innovative solutions such as digital mental health interventions.

Theme 2

Providing the right support at the right time

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

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

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

Child and adolescent mental health

92. Outcomes:

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

93. The 2020 Youth Wellbeing Child and Adolescent Prevalence Study[14] provides estimates of common mental health problems in children and young people in Northern Ireland. At any time, one in ten children and young people are experiencing anxiety or depression, which is approximately 25% higher when compared to the other UK jurisdictions. One in 20 young people aged 11-19 years display symptoms of post-traumatic stress disorder. One in six children and young people in Northern Ireland engaged in a pattern of disordered eating and associated behaviours. About one in ten of 11-19 year olds reported self-injurious behaviour, with nearly one in eight reporting thinking about or attempting suicide.

1 IN 20 - POST-TRAUMATIC STRESS DISORDER

1 IN 10 - ANXIETY OR DEPRESSION

1 IN 6 - PATTERNS OF EATING DISORDER

1 IN 10 - SELF-INJUROUS BEHAVIOUR

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

95. The stepped care model with its recovery ethos has provided a foundation which has facilitated improvements to the delivery of CAMHS. However, this model has become a system which tends to define itself in terms of services, meaning that young people with complex needs, or who do not meet narrow criteria for a particular service, may have difficulty accessing treatment. Combined with resource limitations, this has led to long waiting times, with 170 children and young people waiting longer than 9 weeks for core step 3 CAMHS, with over 15 waiting longer than 26 weeks.[15]

14 Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*
15 Correct as of 28 February 2021.

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

97. Currently CAMHS funding is approximately £20-25m per year, which is between 6.5% and 8.5% of the total mental health budget. This must increase to 10% of the overall mental health budget. This will allow meaningful investment to ensure the stepped care model can be flexible and meet the needs of young people.

CAMHS FUNDING WILL INCREASE TO 10% OF THE OVERALL MENTAL HEALTH BUDGET

98. The structures of CAMHS need to change to ensure that the needs of young people are met. The focus of CAMHS needs to shift towards a model where the steps provide an indication of the level of care modelled on the individual child or young person's needs.

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

99. Children between 0-3 regularly do not have access to CAMHS. Such a position does not recognise that the path to good mental health starts in infancy. Infants should therefore also be part of our mental health services approach. This will require clear and committed leadership across CAMHS services and inter-agency working with the Community and Voluntary sector to help and support the full age spectrum in CAMHS.

100. Going forward, we will ensure that infants' mental health is on the agenda, and that the needs of children under 3 are included in the development of mental health services and in the delivery of CAMHS.

INFANTS MENTAL HEALTH WILL BE PART OF THE DEVELOPMENT AND DELIVERY OF CAMHS

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

Co-located mental health services for young people in contact with the justice system

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

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

The service has enabled children coming into contact with the YJA to be assessed and supported directly, with referrals made to CAMHS where appropriate, including the promotion of services available within their multi-disciplinary team. Mental health assessment tools have also been developed for use by YJA to support early intervention with children and their families. The co-location of these services is delivering improved outcomes for children involved with the youth justice system and has been positively received from the children involved, their families, CAMHS and YJA alike. The pilot has resulted in more children having better access to mental health services, which in turn, contributes to their desistance from offending. This pilot has been co-funded by SHSCT and YJA in 2020 and, such has been its success to date, consideration is now being given to rolling it out across Northern Ireland.

102. Whilst policy direction in Northern Ireland is based on equality of access, CAMHS services vary from Trust to Trust in terms of their organisation and remit. In that context, it is possible for children to be 'bounced around' or to 'fall through gaps' and to face barriers to accessing CAMHS.

Equal Access to services

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

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

CAMHS WILL HAVE A NO WRONG DOOR APPROACH

ACTION 11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

104. The regional care pathway and Stepped Care Model has improved the consistency in acute and crisis care for children and young people across Trusts. However, there are still significant variations across Trusts, with reports of some young people waiting too long in Emergency Departments.

105. A quarter of CAMHS referrals in Northern Ireland are emergency or urgent, compared to the UK average of just over one in ten. On average, 40% of children assessed in crisis do not need CAMHS treatment, so having highly skilled staff at crisis points is essential to ensure that children and families get the best and most appropriate care, including within the community and voluntary sector.

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

WE WILL CREATE CRISIS SERVICES FOR CHILDREN AND YOUNG PEOPLE

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

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

108. Young people who continue to need mental health treatment and care transition from CAMHS to adult mental health services with the aim of completing the transition around their 18th birthday. There is no regional protocol in Northern Ireland for the transition of young people from CAMHS to adult mental health services, and transition pathways vary across the Trusts.

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

TRANSITIONS FOR CHILDREN AND YOUNG PEOPLE WILL BE IMPROVED

110. The transitions process therefore needs to be improved to ensure that the impact on the young person is minimised.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

111. Outcomes:

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

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

40% OF OLDER ADULTS ATTENDING GP

50% OF OLDER ADULTS IN GENERAL HOSPTAL

60% OF CARE HOME RESIDENTS HAVE MENTAL HEALTH PROBLEMS

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

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

18 YEAR OLDS AT THE START OF THE TROUBLES TURNED 68 IN 2020

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

Ageility NI

Ageility NI (2020 – 2023) is a social circus project designed to engage with older adults across Northern Ireland The project is funded by the Lottery's 'People and Communities' fund and designed and delivered by Streetwise Community Circus. The project provides circus skills workshops that address specific areas of need relevant to older people, with a particular focus on loneliness, social isolation and other aspects of wellbeing. The proposed impacts for this project are based on academic research into the arts as a therapeutic tool, and in particular, the efficacy of using circus skills. Social circus is based on the belief that learning new skills – such as juggling, acrobatics, balancing or aerial skills – can have positive effects on those who participate in the programme. The positive benefits that participants generally experience are not restricted to the acquisition of a new skill; instead, social circus practitioners refer to concepts of improved wellbeing – physically, emotionally, cognitively and socially. As such, social circus is distinct from other forms of circus, such as traditional tented or theatre-based circus shows; or hobbyist organisations such as juggling clubs or fitness acrobatic classes.

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

117. Respect for personal autonomy and human rights should be central tenets in ensuring the needs of older people are identified and met. When circumstances arise whereby older people require treatment or assessment for mental health, they themselves should play an active role in the decision-making process. Including people over 65 in adult mental health services should not mean a reduction of services, but rather it will ensure that they will be able to access the same expertise as those under 65.

MENTAL HEALTH SERVICES TO OLDER PEOPLE WILL BE NEEDS BASED AND NOT AGED BASED

118. That means we need to plan services based on the needs of the person, rather than their age.

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

119. Outcomes:

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

120. According to the Mental Health Foundation, it is estimated that only 40% of those with mental health problems in Northern Ireland were able to access effective mental healthcare. 79% of those with a mental disorder who sought treatment felt they had not received the service they need.[16]

16 Mental Health Foundation (2016). *Mental Health in Northern Ireland: Fundamental Facts 2016.* https://www.mentalhealth.org.uk/sites/default/files/FF16%20Northern%20Ireland.pdf

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

121. Going forward, community based services will be evidence based, organised on a Stepped Care Model, the core principle of which is that people are matched to interventions that are appropriate to their level of need and preference. At all times, the services must be adaptable to people and their needs. This includes understanding and responding to the underlying factors, such as social factors, trauma and addictions, including gaming and gambling.

122. Secondary care and community mental health services must therefore be focused on and integrated with the community, with primary care as the hub for mental health care. This will involve a fundamental change in the operation of secondary care mental health, moving away from current service structures towards joined-up locality based approaches that are based on populations in GP Federation areas. Services will be organised to work collectively in responding to the spectrum of need of the population, including those with more severe mental health problems, through collaborative and consultative models of care across primary, secondary and community care. This will put professionals where the people are to ensure the system fits the needs of the people.

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

123. In practice, this means co-designing local pathways of care across primary and secondary care and across the range of available Community and Voluntary sector resources in local areas. It will mean involvement of all actors in the delivery of mental health: GPs, Trusts, the Community and Voluntary sector and other services such as community pharmacists. It will also mean including people with lived experience, their family and carers in the co-design process.

124. At the heart of this is the primary care multi-disciplinary team, which will include mental health workers. We already have mental health practitioners in primary care covering five GP Federation areas. Over the next few years, we will seek to improve access to mental health workers and other professions who can provide mental health support in the primary care multi-disciplinary team.

125. The GP with the primary care multi-disciplinary team will be the first port of call in the newly structured mental health system. In conjunction with greater accessibility of a wider range of therapies through new mental health therapy hubs, many people will have their needs met without requiring further escalation. This will lead to quicker access to services, less referrals and better outcomes for people.

126. The reorganisation of mental health services towards the community will also mean fully involving those who deliver wider health and social care functions across Northern Ireland. The accessibility of community pharmacy and their relationship with their local populations, including individuals suffering from mental ill health, means that they can play a vital role in providing accessible services to support people's mental health. Not only can they help people to get the most from their medicines, they also help people look after their general health and wellbeing, using preventative approaches and behavioural interventions. Whether it is spotting early signs of mental health problems, managing long-term conditions, providing expert medicines advice to patients or signposting to other forms of support, pharmacists working across the health service are ideally placed to ensure people get the support they need. Going forward, pharmacy teams in all settings, including community pharmacy, primary care and hospitals, must be included as key partners in mental health service development to ensure the best outcomes for those with mental health support needs.

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

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

128. The new models of service delivery across mental health will be based on a principle of recovery based care. This will ensure that all those with mental ill health receive the support they need. We will therefore create a recovery model where care is provided using a person centred approach with continuous involvement with the service user throughout the recovery period.

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

WE WILL CREATE A RECOVERY MODEL WHERE THE RECOVERY COLLEGES ARE IDENTIFIED AS CORE ASSETS

130. In practice, that means creating a recovery model and consolidating the role of Recovery Colleges, ensuring they are accessible to those who need it, wherever they are in Northern Ireland.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

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

132. Historically, work with the Community and Voluntary sector has developed incrementally and whilst essential, availability of services, focus and configuration is not consistent across Northern Ireland. It is important that support from this sector is available to those who need it, wherever they are. We must harness the skills and experience that exist in this sector to ensure that this is used to benefit people with mental ill health.

Impact of the Community and Voluntary Sector

Kourtnie: "I feel like my life was all a bad dream before I joined The Prince's Trust, with the help of the Team programme I grew into the confident, bubbly person I am today."

Kourtnie, 23 from Belfast, was just 13 when her 17-year-old sister died by suicide. The death had a profound impact on Kourtnie, and she became emotionally withdrawn from her friends and family. She became pregnant aged 16 and left school without the qualifications she wanted. By 17 she was a single parent and moved out of the family home. She was very isolated and rarely left her house other than to go shopping or visit her Grandmother. When her Grandmother sadly passed away, Kourtnie became even more depressed and lonely. She was put in touch with the leader of The Prince's Trust Team programme in East Belfast.

Team is a 12-week personal development programme for young people to gain new skills, take a qualification and meet new people. "When I first met the Team Leader, I confessed to him that it was the first time I'd spoken to anyone in months. None of my friends had children so our friendships faded away after I had my daughter. When I started on Team my confidence was very low and I had no idea what I wanted to do. But around the fifth week it was like a light went on within me, my confidence started to grow, and I even put myself forward as the leader for a community project we were working on."

After the Team programme Kourtnie secured a job in a restaurant where she worked happily until she had a bad experience with another employee. The situation caused her to seek counselling where she finally began to deal with the impact her sister's death had on her. With the help of her counsellor and her own determination, she was able to face the issues head on. Kourtnie went on achieve her English and Maths GCSEs and met a new partner, who she is now engaged to.

"I've always wanted to work as a receptionist. Last year I saw my ideal job advertised working in an admin and reception role, I applied and was delighted to get the job! After that, my fiancée and I bought our first house. I'm now happy and enjoying life, constantly setting new goals and planning a future with my family."

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

GOING FORWARD THE COMMUNITY AND VOLUNTARY SECTOR WILL BE FULLY INTEGRATED IN DEVELOPMENT AND DELIVERY OF MENTAL HEALTH SERVICES

134. This will mean the development of protocols for formal involvement and integration of the sector in the development of mental health services.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

135. Outcomes:

- Better understanding of the use of medication in mental health services.
- More help and support to professionals prescribing mental health medication.
- Improved outcomes for people on mental health medication.

136. For many people with mental ill health, the help and treatment they receive involves medication. Medicines when carefully selected and used appropriately are an important factor in the sustainability of treatment for those with long term mental ill health and can play a pivotal role in the recovery process. The Medicines Optimisation Quality Framework (2016) sets out a Regional Model for Medicines Optimisation that outlines what patients can expect when medicines are included in their treatment.

137. When a person receives medication for their mental ill health, it is vital that they have access to the necessary level of expertise, especially for those people with severe mental health problems, including those who have coexisting physical health problems and are on complex medication regimes. Specialist mental health pharmacists not only link with their relevant mental health teams, but also with Health and Social Care Board and pharmacists in general practice and community pharmacies by facilitating training and providing medicines advice on complex cases.

STAMP STOMP

The STAMP STOMP initiative was launched in December 2018 by NHS England and The Royal College of Paediatrics and Child Health, pledging to ensure that children and young people with a learning disability, autism or both are able to access appropriate medication (in line with NICE guidance,) but are not prescribed inappropriate psychotropic medication. Regular and timely reviews should be undertaken so that the effectiveness of the medication is evident and balanced against potential side effects. This will mean that children and young people are getting the right medication, at the right time, for the right reason.

138. Community and GP practice pharmacists are ideally placed to initiate medication review for children and young people who are prescribed psychotropic medication. However, systems for referring complex cases for specialist mental health pharmacist review are also required.

139. Many of the medicines used to treat mental health problems are associated with health risks, some of which can be severe. As experts in medicines and their use, pharmacists can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and unplanned admissions to hospital, while ensuring resources are used more efficiently to deliver the level of care that people with mental health conditions deserve.

140. The World Health Organisation's third Global Patient Safety Challenge "Medication without Harm" focuses on strengthening the systems for reducing medication errors and avoidable medication related harm, with priority given to actions to reduce harm from inappropriate polypharmacy, high risk situations and transitions of care. "Transforming medication safety in Northern Ireland" is the HSC response to the WHO Challenge, and this recognises that utilising the knowledge and skills of pharmacy teams in all settings is essential to minimising avoidable medication related harm. This is particularly important in mental health service delivery models, with many medicines used for mental health conditions having the potential to cause serious harm if used incorrectly.

WE WILL INCREASE THE USE OF PHARMACISTS IN MENTAL HEALTH SERVICES TO HELP ENSURE THE BEST USE OF MENTAL HEALTH MEDICATION

141. Going forward we will continue to work to ensure that specialist medication is available to those who need it and that the usage of medication is in accordance with best practice. This means integrating the medicines Optimisation Quality Framework and better usage of pharmacists across mental health services.

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

142. Outcomes:

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

143. An important part of community mental health services is the use of psychological therapies. However, there are currently inequalities in the provision of and access to these services across Northern Ireland. Waiting lists for psychological therapies are long, with over 2,400 adults and over 260 children and young people waiting longer than 13 weeks and over 700 adults and over 90 children and young people waiting longer than a year.[17]

OVER 700 ADULTS AND OVER 90 CHILDREN AND YOUNG PEOPLE HAVE WAITED OVER A YEAR FOR PSYCHOLOGICAL THERAPIES

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

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

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

WE WILL INCREASE ACCESS TO PSYCHOLOGY ACROSS MENTAL HEALTH SERVICES BY EMBEDDING PSYCHOLICAL SERVICES IN MAINSTREAM MENTAL HEALTH SERVICES

17 Correct as of 28 February 2021.

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

148. This will reduce the time people have to wait for psychological therapies.

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

149. Outcomes:

- People with mental health difficulties will be supported to enjoy the same quality of life as the general population and have the same life expectancy.
- People with Serious Mental Illness will be offered, and encouraged to participate in, an annual health check.
- Reduction in % of mental health patients who are smoking.
- People with a physical illness will receive appropriate help and support to deal with mental ill health.

150. In Northern Ireland, people with severe and enduring mental illness have a reduced life expectancy of 15 to 20 years because of poor physical health. Addressing this requires a cultural change and systematic approach across our communities, primary care, secondary care and specialist acute services. Every part of the mental health system should take all appropriate opportunities to support people with mental health problems where they have difficulties with smoking, weight, alcohol or drug use and exercise – the physical healthcare of people with mental health problems is everybody's responsibility.

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

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

152. The physical wellbeing of mental health patients must continue to be a priority for secondary care mental health services, particularly in relation to patients who are cared for in acute settings.

WE WILL INCREASE THE PHYSICAL HEALTH OUTCOMES FOR PEOPLE WITH MENTAL ILL HEALTH

153. In practice, this means that all mental health patients should be offered and encouraged to take up physical health screening where appropriate. All patients should also have a combined healthy eating and physical activity programme as part of medication initiation and as part of their recovery plan.

ACTION 20. Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.

ACTION 21. Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.

154. It is accepted that many people with physical health problems experience mental ill health, often as result of their physical illness. This is particularly relevant for those with serious and chronic physical health diagnoses. The needs among these groups of people are wide and varied, however, many experience difficulties accessing appropriate mental health help and support.

155. Going forward, we will ensure that those with physical health problems that lead to mental ill health will be provided with the care and treatment they need. In practice, this will mean further integration of psychology in multi-disciplinary teams, to ensure that psychological support is mainstreamed across physical health. It also means that those working in physical health teams where mental ill health is common among clients, should be trained in identifying mental health needs and in responding to such needs. This may also include providing counselling or therapies within physical health services.

GOING FORWARD THOSE WITH PHYSICAL ILL HEALTH THAT LEAD TO MENTAL ILL HEALTH WILL RECEIVE THE CARE AND TREATMENT THEY NEED

156. For those with more specialist mental health needs, access to mental health specialist support must be available. This does not mean the provision of dedicated mental health resources within physical health services; instead, it requires the creation of efficient pathways to allow individuals to access this specialist support, thereby ensuring patients get the care and treatment they need, when they need it.

Our Hearts Our Minds

Our Hearts Our Minds (OHOM) is a model of high quality preventative cardiology care. It is a nurse-led programme delivered under the Department of Health's Transformation agenda that supports patients after a cardiovascular event helping them to achieve healthier lifestyles, manage their blood pressure and cholesterol, as well as making sure that they are on the right cardioprotective medications.

The multi-disciplinary team is the first of its kind in Northern Ireland, as it has psychology practitioners as integral members of the team and also comprises a Specialist Clinical Psychologist and a Psychological Wellbeing Practitioner. Dedicated psychology provision is an integral and critical aspect of the programme.

The Psychology service, along with all the OHOM team, reconfigured service provision to meet issues which have arisen due to COVID-19 – individual sessions were conducted virtually by either phone or video call as per patient preference. Analysis shows statistically significant improvements in anxiety and depression levels for patients who have completed their cardiac rehabilitation through this programme.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

157. Outcomes:

- Increased user satisfaction for people with severe and enduring mental ill health.
- Increase in % of people with severe and enduring ill health that are actively engaged with society.
- Improved engagement with service users, families and carers in the development and delivery of services and personal care plans.

158. It is important to recognise that there are some individuals who will always need specialist help and support that is often long term. All practicable help and support will be provided to people with severe and enduring mental ill health, in line with the vision of person-centred care and a "no wrong door" approach.

159. It is accepted best practice that a partnership approach should be employed for those living with severe and enduring mental ill health. This recognises informal carers and families as having informed experience in the needs of the service user and in identifying potential person-centred solutions. This approach should be based on the Triangle of Care, which encourages joined-up working between the informal carer/family, the person using services and professionals.

A PARTNERSHIP APPROACH TOGETHER WITH PEOPLE WITH SEVERE AND ENDURING MENTAL ILL HEALTH SHOULD BE ADOPTED ACROSS MENTAL HEALTH SERVICES

160. Service developments relating to people with severe and enduring mental ill health should value and include the expertise of the user, as well as informal carers and family members. This would mean a cultural change, where users with severe mental ill health and their support networks are not just valued, but are sought out and identified for their input.

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

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

162. Whilst community mental health services provide the best outcomes for most people who experience a mental illness, inpatient services are required for those where an effective community intervention is not possible.

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

AVERAGE ADULT ACUTE MENTAL HEALTH IN-PATIENT BED OCCUPANCY BETWEEN 1 JUNE 2020 AND 21 MAY WAS 101%

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

165. The provision of therapeutic improvements in an in-patient setting is further hampered by an old in-patient infrastructure. About half the acute in-patient beds are in facilities that have not seen significant upgrades for decades and do not meet recognised best practice standards, including the routine availability of single-bed bedrooms.

166. Over the last decade, the Department has invested significantly in new mental health units across Northern Ireland. This has provided state of the art, single bed bedroom units where the physical infrastructure is helping in the recovery journey of the patient.

WE HAVE INVESTED IN NEW MENTAL HEALTH UNITS AND WILL INVEST A FURTHER £206M

167. The capital works programme to replace the existing in-patient units will continue over the next decade, with a further £206m to invest in a further three new units. When continuing this programme, it is important that new inpatient developments meet the changing needs of the population. This means considering how to get the best outcomes for patients, and not remain in old ways of thinking. It also means considering how to integrate learning disability wards in mental health units, considering the need and design of a specialist perinatal mother and baby unit and provisions of other specialist in-patient care.

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

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

170. For the small cohort of detained patients, the recent first phase commencement of the Mental Capacity Act provides a framework for deprivation of liberty in the community. This allows us to consider new ways of responding to patients who require detention. Going forward, we will use this change in legislation to consider if these patients can be cared for safely in the community. This will allow for greater community integration and a more normal life for patients.

Different ways of working in in-patient care

When I lived in Germany, we had access to "recovery rehab centres". I would spend up to eight weeks there when I felt I couldn't cope with my illness but was not severely unwell. This was very different from an in-patient stay in hospital. I received support with all areas of my life. A holistic approach was used. We did mindfulness, art therapy, horse therapy, one-to-one and group counselling, emotional testing. I developed some great relationships there. It is badly needed in Northern Ireland, away from acute hospital.

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

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

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

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

WE WILL CREATE A SUSTAINABLE REHABILITATION SERVICE ACROSS NORTHERN IRELAND

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

Community Mental Health Rehabilitation Team (CMHRT)

The Southern Health and Social Care Trust has spearheaded the introduction of a multi-disciplinary Community Mental Health Rehabilitation Team, the first dedicated tertiary service of its kind in Northern Ireland.

Occupational therapists working in the area of Resettlement and Rehabilitation holistically look at all areas of a person's life and functioning, including activities of daily living, cognition, meaningful education and employment opportunities, with the desire to develop and maintain skills, promote social inclusion, community integration and enable service users to achieve maximum independence.

For example, Aiden is a young man with a psychotic disorder which has resulted in several lengthy admissions for acute inpatient care. Living in a supported living facility, he faced problems with motivation, looking after himself and his space, social isolation and low confidence. He wanted to make friends again while avoiding anti-social behaviours and misuse of substances.

The occupational therapists in the CMHRT worked with Aiden using the Recovery Star outcome measure tool, which helped prioritise goals for Interventions. These included improved home management skills, healthy eating habits, daily routines and social activities with others. The team led a combined effort to help him achieve his goals which initially focused on a personalised weight management programme, making healthy food choices and increased physical exercise activities, including engagement in graded exercise sessions such as weekly walking, cycling and gym activities. The occupational therapists also introduced him to new skills in the kitchen to help with his goal of healthy eating.

The result of these interventions is that Aiden's life and skills have improved to the point where he can successfully live in his own flat within his local home town. He has maintained his new living arrangements for a substantial period of time, with significant reduction for the need of CMHRT support. He has identified his next goals as gaining paid employment and his driver's licence which would help promote the quality of his life.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

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

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

WE WILL PROVIDE LOW SECURE SERVICES

177. We will therefore provide regional specialist in-patient services for patients with a higher need in dedicated low secure settings. This will support patients with severe presentations that are gravitating towards the criminal justice system, which could ultimately result in a lost opportunity for recovery. It will also lead to less conflict on existing mental health wards and overall shorter patient stays in hospital.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

178. Outcomes:

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

179. A recent report by the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services and one in ten people in distress end up in Emergency Departments.[18] People in crisis require help and support and no-one should have to wait for that help.

180. Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years, a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage Team), and the community crisis intervention service in Derry/Londonderry. Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments.

Multi Agency Triage Team

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

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

181. Going forward, we need to improve crisis services, which will include the use of new delivery methods such as MATT. We will establish a Regional Mental Health Crisis Service, that will help to integrate practitioners trained in Distress Brief Intervention, or similar, into existing mental health crisis pathways. These pathways will include primary care multi-disciplinary teams, out of hours primary care, Emergency Departments, MATT, Lifeline, 999, PSNI, the Ambulance Service and the Regional Emergency Social Work Service.

WE WILL CREATE A REGIONAL CRISIS SERVICE

18 Royal College of Psychiatrists (2020). *Two-fifths of Patients Waiting for Mental Health Treatment Forced to Resort to Emergency or Crisis Services*. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services

182. It is anticipated that the crisis services will have four strands, including crisis resolution home treatment, mental health liaison, community crisis support and primary care and interagency partnership. The crisis service will be developed on a regional basis and will provide consistency for those with crisis needs.

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

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

183. Outcomes:

- A reduction of patients with a co-current mental health and substance use issue that are non-compliant with mental health treatment
- A person centred approach to care that focusses on the person, rather than expecting the person to fit the system.
- Better health and social outcomes for those with co-current mental health and substance use issues.
- People with co-occurring mental health and substance use issues receive high quality, holistic and person-centred care.

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

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

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

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

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

A MANAGED CARE NETWORK WILL BE CREATED TO ENSURE A NO WRONG DOOR APPROACH

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

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

189. Outcomes:

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

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

191. Evidence from other countries is clear: specialist interventions provide better outcomes for patients and shorter recovery times when they have been set up correctly within a wider generalist mental health system. Going forward, we will address the shortfall in specialist services and will provide specialist interventions where they are needed.

WE WILL CREATE SPECIALIST INTERVENTIONS WHEN THEY ARE NEEDED

192. When developing specialist interventions, we must remember that we have a relatively small population. It will not be possible to provide some specialist interventions in Northern Ireland as they cannot be provided safely.

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

Perinatal mental health

194. Perinatal mental health is a priority for prevention and early intervention. Poor perinatal mental health affects not only mothers but also increases the risk of poorer outcomes in health, educational and social outcomes for children. This potentially creates a cycle of poorer mental health in subsequent generations.

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

196. We have started the work to develop a regional specialist perinatal community mental health service. This will play a key role in: helping expectant and new mothers who are experiencing mental ill health; reducing in-patient care; and promoting strong, secure, attachments with their children. We will continue to roll out specialist perinatal mental health services, including in-patient services.

WE WILL CONTINUE TO ROLL OUT SPECIALIST

PERINATAL MENTAL HEALTH SERVICES

Psychosis

197. Early intervention in the treatment of psychosis has been shown to reduce the severity of symptoms, improve relapse rates and significantly decrease the use of inpatient care. A recent meta- analysis of outcomes at 6 to 24 months concluded that an early intervention in psychosis approach was associated with better outcomes compared with standard treatment, including hospitalisation risk, bed-days, symptoms, and global functioning.[19]

198. NICE guidance on psychosis and schizophrenia states that early intervention services in psychosis should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, irrespective of age or illness duration. Treatment with an oral antipsychotic, combined with psychological interventions, is the recommended first line choice. The Medicines Optimisation Quality Framework domains of patient/client focus, safety and effectiveness must be incorporated into first episode services.

The STEP service

The STEP service (Service, Treatment, Education and Prevention) in the Northern Health and Social Care Trust is made up of psychology and psychiatry staff, and has been developed to identify young people (14-34 years) that have an increased risk of developing psychosis. The service uses evidence-based assessment procedures and offers a range of treatment packages aimed at delaying / preventing psychosis from occurring. Most people seen by the STEP service never develop a psychotic disorder.

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

WE WILL CREATE A PSYCHOSIS NETWORK

19 Correll, C. U. et. al. (2018) *Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis* JAMA Psychiatry 75(6): 555-565

Personality disorders

200. Up to 50% of those attending psychiatric outpatient clinics, 50% of those in psychiatric inpatient services and 80% of the prison population, meet the criteria for a personality disorder. 45% of those presenting at Emergency Departments with self-harm have a personality disorder and 9%-10% of those with a personality disorder die by suicide.[20] The ethos of the 2010 'Personality Disorder Strategy: Diagnosis of Inclusion' will be retained and people considered to have a personality disorder will have access to mental health services in a way that is equitable with all other patients who access treatment.

201. Specialist psychological treatments are often needed for people with a personality disorder and this sits closely alongside the vital role of community mental health teams. Personality disorder services will be further developed on a regional basis in a tiered approach to enhance both community mental health team expertise and the provision by specialist services, alongside an integrated approach with the community and voluntary sector.

SPECIALIST PERSONALITY DISORDER SERVICES WILL BE FURTHER DEVELOPED

202. In making best efforts to reduce the transfer of patients to England and Scotland for the specialist in-patient treatment of personality disorders, there needs to be a focus on increasing day treatment services and providing therapeutically-informed supported accommodation regionally. In addition, people with personality disorder will be considered in the development of general in-patient settings and of low-secure provisions in order to access inpatient treatment locally when appropriate.

Eating disorders

203. While Northern Ireland already has a regional network for the provision of services for people with an eating disorder, outcomes for these patients could be improved. In particular, evidence suggests that early intervention is key. This means supporting services to offer specialist treatment to all those who are presenting with eating disorders, including mild to moderate cases, without delay.

20 RCPsych, 20220 (PS 01/20 Services for People Diagnosable with Personality Disorder. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2 last accessed 9.4.2021)

204. We will provide further investment so that eating disorder services can achieve optimum staffing levels and skill mix to deliver effective care across the pathways. In practice, this will include additional medical, nursing, dietetic, psychology, occupational therapy and social work staff working in the community, and providing in-reach to medical and mental health wards. It may also involve other therapies and allied health professions.

EATING DISORDER SERVICES WILL BE IMPROVED WITH AN ENHANCED SKILL MIX TO DELIVER MORE EFFECTIVE CARE

205. Additional investment will allow for the development of intensive day treatment facilities in line with National Institute for Health and Care Excellence (NICE) guidance.

206. The future of in-patient services will involve adequately supporting our local in-patient units, medical and mental health, with in-reach and clinical consultation. We need to ensure that there are sufficient staffing levels for the management of high-risk patients with eating disorders. Support includes facilitating the development of Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) groups.

Other specialist interventions

207. We acknowledge that there are many other specialist interventions required across mental health services. Going forward, we will continue to develop our understanding of specialisms within a general mental health service.

208. For example, this includes consideration of neuropsychiatry or services for those with ADHD. Such services provide a contribution to assessment and treatment for people with cognitive, behavioral or psychiatric symptoms associated with neurological disorders, such as Parkinson's Disease, epilepsy and acquired brain injury (including alcohol and drug related brain injuries); those with functional neurological symptoms such as dissociative seizures or conversion disorders; as well as for other neuropsychiatric conditions which may include sleep disorders or complex neurodevelopmental disorders. Such conditions must be considered across the whole course of human development from birth to old age.

209. Interventions across mental health focused on specialist areas should be delivered through multi-disciplinary teams including psychiatric specialists, clinical psychologists, occupational therapists, speech and language therapists, nurses and social workers.

ACTION 29. **Ensure there are specialist interventions available to those who need it. In particular:**

a. **Continue the rollout of specialist perinatal mental health services.**

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

c. **Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.**

d. **Enhance the regional eating disorder service.**

e. **Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.**

Theme 3

New ways of working

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

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

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

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

Digital mental health

214. Outcomes:

- Increase access to digital mental health solutions.
- Support the traditional delivery of mental health services with new digital methods.

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

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

THE PANDEMIC HAS HELPED US FIND NEW WAYS OF DELIVERING SERVICES

217. Going forward, we must build on our experiences from the pandemic and bring in the many good new practices that have been developed into the ongoing delivery of services. This means further developing and providing digital delivery of mental health services. We recognise that digital services are not the most suitable option for some individuals, and traditional therapy options should and will remain available for those who need them. However, by increasing access to digital options we will increase choice, availability and access across a broader range of services, leading to improved outcomes for all.

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

218. Outcomes:

- A regional approach to mental health with regional consistency in service delivery.
- Less confusion for patients using services across Trusts measured through service user satisfaction surveys.
- Improved experience for those transitioning between Trusts.
- People have access to high quality, regionally consistent but locality-based services within local communities.

219. In Northern Ireland, mental health services are delivered through the Health and Social Care Trusts. The integrated structures between health and social care have significant advantages, including a single employer and budgets, integrated management (which fosters inter-professional working) and integrated approaches to hospital discharges.

220. However, Lord Crisp's report into mental health services in Northern Ireland noted that whilst there are significant strengths in this system, there are also weaknesses around commissioning arrangements and that the organisational boundaries get in the way of improving quality and efficiency. Mental health does not always get the same attention as physical health, which can offset the positive impact of an integrated health and social care system across physical and mental health.

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

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

A REGIONAL MENTAL HEALTH SERVICE WILL ENSURE CONSISTENCY IN SERVICE PROVISIONS

The Regional Eating Disorder Network Group

When developing a regional mental health service, it is important to recognise those existing structures that already exemplify regionalisation and equity in service planning with local delivery. The Regional Eating Disorders Network Group is one such example. This group has been meeting for many years involving: multi-disciplinary clinicians from each Eating Disorder Service within Adult and CAMHS; individuals from Community and Voluntary sector user and carer groups (EDANI); representation from the HSCB; and the Department of Health, when required. The work of the group has revolved around the collation and interpretation of data, sharing best practice and ensuring a collective vision for the future direction of Eating Disorder Services across the region. It has also created a culture of good working relationships and open, honest communication. The group is empowering, inclusive and takes proud ownership of steering its chosen specialist field of work.

223. It is not the intention to limit local areas' ability to respond to the needs of their communities. Trusts will still be responsible for service delivery in their area, and patients will interact with the Trusts. Even so, a regional mental health service will directly benefit patients by removing variations in service availability, ensuring everyone in Northern Ireland has access to similar types of services regardless of where they live. It will improve the movement of patients across Trust boundaries and will aid understanding of the system among users.

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

224. Outcomes:

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

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

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

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

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

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

228. The number of approved social workers in Northern Ireland has increased over the last few years. However, it is estimated that at least a further 25% are required in order to meet demand.

229. Occupational Therapy vacancy rates across Northern Ireland are approximately 10% and in the past ten years, there has been a decrease of 16.6% in undergraduate commissioned places. National shortages mean that Occupational Therapy has recently been added to the Priority Immigration Shortage Occupation List.

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

231. Going forward, multidisciplinary working – with a skilled, supported workforce that is equipped to meet the demands – is central to the future provision of mental health services, as it provides the strength of the biopsychosocial approach and creates an effective working environment that enables each professional and group of professionals to use their own unique skills, knowledge, and abilities. Teams with wide skillsets can better meet the individual's needs by creating a tailored blend of personalised interventions that provide consistency, cohesion, and choice. Strong, well-trained multidisciplinary teams therefore can deliver safer, more effective services that can meet the depth and breadth of the challenges faced during the individual's recovery journey by developing and implementing a shared intervention plan from each profession's unique perspective.

232. Going forward, this also means investing in areas of the health and social care workforce that have often not been included. Development and improvement of the mental health workforce must include the full range of allied health professionals, counsellors and therapists.

Speech and Language Therapy - Children with disabilities

The speech and language therapy community paediatric service in the Southern Health and Social Care Trust, works with children with special educational needs in Child Development Clinics and Special Schools. The children supported by the service also experience a range of mental health needs and difficulties.

Speech and language therapists work alongside occupational therapy, physiotherapy and education staff in special schools to help understand any behaviours of concern, adopting a trauma informed approach. Speech and language therapists have started working with intellectual disability CAMHS and are supporting the completion of assessments. Speech and language therapists have also joined with multi-disciplinary team therapeutic planning meetings, provide recommendations to the therapeutic plan and set goals.

Challenging behaviour is often communicating an unmet need or a distress particularly if a child is feeling unsafe, insecure and disconnected. Speech and language therapists, as part of the multidisciplinary team, can provide important information on speech, language and communication needs, training and advice on alternative communication tools and strategies, as well as contributing to the development of a more comprehensive plan and effective practice across all aspects care. This can help the child's feeling of safety and security and therefore lead to better outcomes.

233. In practice, this means considering the existing workforce and new models of working in a comprehensive workforce review. This will allow informed decision making as to where the focus on training, recruitment and retention needs to be, and help us create a workforce for the future that will meet the needs of our population. This may include bringing in new professions and skillsets to the mental health workforce, ensuring such skills and expertise are available across Northern Ireland, and normalising new care and treatment options.

WE WILL COMPLETE A COMPREHENSIVE WORKFORCE REVIEW TO ENSURE WE HAVE A WORKFORCE FOR THE FUTURE

234. The current definition of the mental health workforce needs to be broadened to capitalise on all of the specialist skills available. This will help to ensure equity of access for people and will enable them to make an informed choice of the service which best meets their needs. Flexibility and innovative thinking will be required in the workforce review. Its scope will need to incorporate all professions that are trained and equipped to meet the needs of the whole population, including those professions whose services are not currently provided within the health service or whose skills are currently underutilised. This could also help to address the current recruitment and retainment issues, staff vacancies and workforce pressures which are so critical in mental health services at the present time.

ACTION 32. Undertake a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates.

235. Greater engagement and support for the peer support worker role and advocacy is critical to the development of mental health services now and into the future. Peer support workers and advocates use their own lived experience and knowledge to help and support individuals in their recovery journey. In Northern Ireland, peer support workers have been partially rolled out, but there is uneven coverage across the Trusts. Clearer regional guidance, a consistent approach and job descriptions across all Trusts will help improve the impact that peer support and advocates can have.

WE WILL CREATE A REGIONAL PEER SUPPORT AND ADVOCACY MODEL

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

ACTION 33. Create a peer support and advocacy model across mental health services.

Data and outcomes

237. Outcomes:

- A clear, evidence based outcome framework which allows evidence to be the foundation for decision making.

- A robust data set which is comparable across Trusts to measure performance and to determine what works.

238. To ensure we have the right services that meet the needs of the population, we must have data to measure outcomes. In Northern Ireland, only a small number of mental health services have adopted successful outcomes frameworks.

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

240. Development of outcomes will also be part of the implementation of each action in this Strategy to ensure we can measure what works and where we can improve.

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

241. Outcomes:

- A regional approach to mental health research which produces quality outcomes.
- Increase in mental health related research across Northern Ireland.

242. To ensure that mental health in Northern Ireland benefits from innovation and research, we will seek to create a more innovative and research focussed culture. This will allow us to shape research to include our specific needs, including the legacy of the Troubles, and the use of technology, particularly given the experience during the COVID-19 pandemic.

243. In practice, there needs to be a renewed emphasis on mental health research and innovation through increased research funding and by establishing a centre of excellence which supports research and innovation. This will act as an exemplar and a point of reference for clinical staff and Community and Voluntary sector providers seeking to innovate, test ideas, or implement emerging knowledge. It is important to note that the Centre would not replace the existing research that is conducted at the local Universities. Rather, it is envisaged it would help and support the research carried out at these institutions.

WE WILL HELP AND IMPROVE MENTAL HEALTH RESEARCH ACROSS NORTHERN IRELAND

244. It is also important that we avoid duplication of research effort and we learn from other places, rather than seeking to answer questions locally which have already been answered elsewhere. A central centre of excellence will ensure effective working and tangible outcomes. It will also ensure that mental health patients in Northern Ireland can be at the forefront of experiencing new and innovative ideas.

ACTION 35. Create a centre of excellence for mental health research.

Funding of the Strategy and next steps

245. As we move forward, it is important that we acknowledge the difficult financial context in which this strategy is being issued. At the time of publication, all actions are subject to confirmation of funding and will therefore require prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required to deliver the Strategy is significant, and is in addition to existing expenditure in mental health services. It is not possible to fund implementation from within the Department's existing resources and delivery is therefore dependent on the provision of significant additional funding for the Department. Where it is possible, the Department will also seek to release resources through service efficiencies and reconfiguration, however, this in itself will not be sufficient to fund implementation. The pace of change outlined in this strategy will also be considered in the context of other service priorities and with regard to the Department's overall financial settlement.

246. Implementation of the Strategy will require significant work. A number of workstreams will be required and the support of all stakeholders will be essential. The Department is fully committed to implementing the Strategy based on the core principles set out above, with the overall aim of making the vision a reality. As such, it is expected that implementation will be fully co-designed and co-produced.

Annex A: Other Government Strategies

Published Strategies			
Title	**Timeframe**	**Headline Objective**	**Owner**
Improving Health within Criminal Justice Strategy and Action Plan	Published 2019 (5 year lifespan)	The joint Strategy and Action Plan seeks to address the health and social care needs of children, young people and adults at all stages of the criminal justice journey (as suspects, defendants and serving sentences) in Northern Ireland. In doing so, it aims to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.	DoJ & DoH
Community Safety Framework	Published October 2020	The Framework provides a model for multi-agency collaborative working and aims to link the strategic and operational response to community safety issues, including addressing harm and vulnerability which may lead to risk taking behaviours, for example mental health.	DoJ
Stopping Domestic and Sexual Violence and Abuse	2016 - 2023	The strategy is a cross Executive strategy led jointly by Health and Justice, including Education, Finance, Communities. Potential to cut across issues of mental health in relation to: prevention; protection; support for offenders; and at the point of reviewing cases of domestic homicide to learn lessons (Domestic Homicide Reviews).	DoJ & DoH
Suicide and Self-Harm Prevention Policy 2011 (revised 2013)	Published 2011 (revised 2013)	Support for those at risk of suicide or serious self-harm.	NIPS - DoJ

Special Educational Needs (SEN) Framework	Phased implementation commencing late 2021	A new SEN Framework which focuses on early identification and assessment of children who have, or may have, SEN and making special educational provision for those children with SEN, so that they get the support they need, when they need it in order to help them make progress and improve outcomes.	DE
Children & Young People's Emotional Health & Wellbeing in Education Framework	Published February 2021 Implementation ongoing	To ensure that children & young people are empowered and assisted to understand and manage their emotional health & wellbeing; identify and address need early; establishing an integrated model of support which will ultimately result in fewer numbers of children & young people will require specialist intervention from mental health services.	DE & DoH
A Life Deserved: "Caring" for Children & Young People in Northern Ireland	2021-2025	To improve the wellbeing of looked after children & young people.	DE & DoH
Nurture provision	Ongoing	To continue to support 46 Nurture Groups in primary schools; the development of a Nurture in Education Programme which will be available to all educational settings, including Education Otherwise Than at School (EOTAS); and establish a Nurture Advisory & Support Service within the Education Authority.	DE
Active Ageing Strategy	2016-2022	The purpose of the Strategy is to transform attitudes to, and services for, older people. It aims to increase the understanding of the issues affecting older people and promote an emphasis on rights, value and contribution.	DfC

Executive's Child Poverty Strategy	2016-2022	Children in poverty are more likely to suffer from poor mental health and contains actions to promote good health and wellbeing.	DfC
NI Wellbeing in Sport Action Plan	2019-2025	To encourage a positive mental health culture to the National Governing bodies of Sport and their clubs and to help raise awareness of mental health.	DfC
Uniting Communities and Creativity Programme	Ongoing	Uniting communities through leadership, community activity and building capacity.	DfC
People and Place - a strategy for Neighbourhood Renewal	Ongoing	Supports delivery of projects in most deprived urban areas.	DfC
Social Inclusion Strategies	2020-2025	Anti-Poverty, Disability, Gender and Sexual Orientation/LGBTQI+ - aim to tackle inequalities and obstacles that directly affect the everyday lives of most vulnerable people in society.	DfC
Strategic Planning Policy Statement for Northern Ireland 2015 'Planning for Sustainable Development' (SPPS)	ongoing	To secure the orderly and consistent development of land whilst furthering sustainable development and improving well-being - the SPPS includes '*Improving Health and Well-being*' as one of five core planning principles of the two-tier planning system.	DfI
Exercise - Explore - Enjoy: a Strategic Plan for Greenways	2016-2026	By 2026 75% of Primary Network delivered 25% of secondary network delivered 50 million journeys on the greenways and NCN	DfI

NI Changing Gear - a Bicycle Strategy	2015-2040	By 2040 40% of all journeys less than 1 mile, to be cycled 20% of all journeys between 1 and 2 miles, to be cycled 10% of all journeys between 2 and 5 miles, to be cycled	DfI

Published Strategies			
Title	**Timeframe**	**Headline Objective**	**Owner**
Empowering Change in Women's Lives' Draft Framework for supporting and challenging women and girls in contact with the justice system	Currently subject to development. Publication is due in Autumn.	The framework relates to those who offend or those who are at risk of offending. Research and evidence available suggests that the needs of women and girls are complex including a high risk of alcohol and substance misuse, mental health issues, and self-harm.	DoJ
Adult Restorative Justice Strategy	The final strategy and action plan will be published by March 2022.	The proposed strategy will provide a strategic approach to restorative practices at all stages of the criminal justice system, from early intervention in the community, formal diversion by statutory agencies, court-ordered disposals, custody and reintegration. The use of restorative justice provides an opportunity to focus on repairing harm and minimising the impact of offending on victims as well as finding positive ways of dealing with children, young people and adults. The use of restorative practices can only impact positively on mental health outcomes, whether those concerned are victims of crime or offenders.	DoJ

Victim and Witness Strategy for Northern Ireland	Planned July 2021	The Victim and Witness Action Plan is intended to give effect to the specific recommendations made by CJINI. However in doing so it lays a foundation for further work by the Department, in partnership with criminal justice organisations and victim and witness support providers, to develop a revised Victim and Witness Strategy. This will include strengthening cross-departmental collaboration and identifying solutions that will improve health and justice outcomes for victims and witnesses.	- DoJ
Interdepartmental Homelessness Action Plan	Planned May 2021	Priority is to focus on non-accommodation services such as health and wellbeing including mental health and substance abuse.	DfC
Disability Employment Strategy	2021-2026	To Support those with disabilities and heath conditions to move closer, find, remain and progress within employment.	DfC
New Strategy for Sport and Physical Activity (S2020)	To be published by 31 March 2022 (subject to Ministerial and Executive approval)	The aim is to provide a flexible strategic framework for a cross-departmental, ambitious, and comprehensive approach to promoting participation and excellence in sport and physical activity.	DfC
NI Debt Respite Scheme/ Breathing Space	Early planning stage	DfC is bringing forward plans for a Debt Respite Scheme in the next NI Assembly mandate. This will include consideration for a Breathing Space for those receiving mental health crisis treatment.	DfC

Delivery of the UK Financial Wellbeing Strategy and Development of NI Financial Wellbeing Strategy	2020-2030 for the UK Financial Strategy NI Financial Wellbeing Strategy planned publication August 2021	The UK Strategy for Financial Wellbeing, through close collaboration with industry and stakeholders, is to build a financial wellbeing movement in the UK – to collectively improve financial wellbeing in the UK. DfC will bring forward plans for a post Covid 2021 Financial Wellbeing strategy. There is a strong relationship between Financial Wellbeing indicators and Mental Health Wellbeing.	DfC
Culture, Arts and Heritage Strategy	To be published by end 2022	Includes activity to raise aspirations, build skills and inspire people.	DfC
New Rural Policy Framework	In development	Includes a theme 'to reduce loneliness and social exclusion in rural areas, to minimise the impacts of rural isolation and to promote the health and well-being of rural dwellers'.	DAERA

Mental Health Strategy 2021-2031

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