EQUALITY COMMISSION FOR NORTHERN IRELAND

Response to the consultation by the Department of Health on the draft Mental Health Strategy 2021-2031

Introduction

1.1 The Equality Commission welcomes the opportunity to respond to the Department of Health's consultation on the draft Mental Health Strategy 2021-2031[1].

1.2 Mental health is now recognised as one of the four most significant causes of ill health and disability in Northern Ireland along with cardiovascular disease, respiratory disease, and cancer[2]. It is considered that one in five people in Northern Ireland have a mental health problem at any one time[3].

1.3 An independent evaluation of mental health provision in 2015 found that whilst considerable progress has been made in realising then Bamford Vision for improving mental health provision, there were also significant limitations in current services.

1.4 The evaluation highlighted the need to improve funding, address problems with fragmentation and gaps in service provision, and provide a new vision and leadership in mental health. Most notably the evaluation warned that there was a real danger that the gains made in recent years may be reversed by continuing financial restraint[4].

---

[1] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft
[2] Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C and Faulkner, L. (2015): Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland, page v (Action Mental Health and Queens University Belfast).
[3] Mental Health Foundation (2016): Mental Health in Northern Ireland - Fundamental Facts 2016, page 4.
[4] Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C and Faulkner, L. (2015): Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland, page 1 (Action Mental Health and Queens University Belfast)

1.5 The Commission has maintained an ongoing focus on mental health policy since its inception, including drawing attention to key inequalities related to mental health experienced by Section 75 groups; responding to key mental health related public policy consultations such as the Bamford Review and monitoring the implementation of the rights set out in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

1.6 In the Commission's response to the consultation on the Programme for Government 2016-21, we recommended actions to:

- identify and remove barriers to health and social care and well-being experienced by particular Section 75 equality groups, including older people; lesbian, gay, bisexual people; trans people; Irish Travellers and other minority ethnic communities; and people with disabilities
- ensure investment in health care to address the specific needs of equality groups, including the health care needs of people with disabilities; and young people's mental health needs.

Key UNCRPD rights

1.7 Article 25 (Health) of the United Nations Convention on the Rights of Persons with Disabilities requires State Parties to recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability[5].

1.8 Persons with disabilities must be provided with the same range, quality and standard of free and affordable health care and programmes as provided to other persons.

1.9 Persons with disabilities must also be provided with those health services needed specifically because of their disabilities, including early identification and intervention as appropriate, including among children and older persons.

1.10 Furthermore, Article 25 requires that health professionals provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent

[5] Article 25 Health UN Convention on the Rights of Persons with Disabilities

by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities, through training and the promulgation of ethical standards for public and private health care.

1.11 Article 26 (Habilitation and rehabilitation) of the Convention requires that State Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life[6].

1.12 Habilitation and rehabilitation services must begin at the earliest possible stage, be based on multidisciplinary assessment of individual needs and strengths an, support participation and inclusion in the community, and all aspects of society and are available to disabled people as close as possible to their own communities, including in rural areas.

1.13 Article 15 (Freedom from torture or cruel, inhuman or degrading treatment or punishment) requires that States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment[7].

1.14 Article 19 (Living independently and being included in the community) requires recognition of the equal right of persons with disabilities to live in the community, with choices equal to others, including the opportunity to choose their place of residence and where and with home they live on an equal basis with others and are not obliged to live in a particular living arrangement[8].

Concerns raised by the UK Independent Mechanism to the UN Committee on the Rights of Persons with Disabilities

1.15 In our submission, as part of the UK Independent Mechanism (UKIM)[9], to the examination (2017) of the United Kingdom by

[6] Article 26 Habilitation and rehabilitation UN Convention on the Rights of Persons with Disabilities
[7] Article 15 Freedom from torture or cruel, inhuman or degrading treatment UN Convention on the Rights of Persons with Disabilities
[8] Article 19 Living independently and being included in the community UN Convention on the Rights of Persons with Disabilities
[9] The Equality Commission for Northern Ireland and the Northern Ireland Human Rights Commission jointly perform the role, under Article 33 (2) of the United Nations Convention on the Rights of

the UN Committee on the Rights of Persons with Disabilities, we highlighted the high prevalence of mental health conditions among the general population attributed to the history of violent conflict and high levels of social and economic deprivation[10]. A further factor is mental health issues arising from a legacy of institutional abuse[11].

1.16 The submission also drew attention to evidence that suggested that mental health services in Northern Ireland have been funded more poorly than elsewhere in the UK for some time, both with respect to Northern Ireland's share of the overall health budget and on a per capita basis.

1.17 We highlighted research carried out in 2011 found that actual spending per capita on mental health services in Northern Ireland was 10-30 per cent lower than in England, even though it necessitated almost 44 per cent higher per capita funding[12].

1.18 We also pointed out that the suicide rate in Northern Ireland is significantly higher than elsewhere in the UK[13].

1.19 The submission also expressed concern that many people experience long waits for treatment, have unmet needs or have to travel very far from home for treatment; a lack of hospital beds, and reliance on emergency services[14].

1.20 UKIM has **recommended** that devolved governments should ensure there are sufficiently funded, appropriate and high quality mental health services to meet demand.

1.21 UKIM has also called for the devolved governments to resource long-term positive awareness-raising campaigns, training and education to address prejudice and negative attitudes towards

---

Persons with Disabilities (UNCRPD), of 'Independent Mechanism' in Northern Ireland (IMNI) to promote, protect and monitor the implementation of the Convention. Together with the Equality and Human Rights Commission (EHRC) and the Scottish Human Rights Commission (SHRC), we are designated as the United Kingdom Independent Mechanism (UKIM).

[10] Research shows that individuals who experienced a conflict-related traumatic event relating to the 'Troubles' are more likely to have a mental health condition at some point in their lives

[11] Mental Health Foundation (2016): Mental Health in Northern Ireland - Fundamental Facts 2016, page 2.

[12] Independent Mechanism for Northern Ireland (2017): Jurisdictional 'Parallel' Report, page 61;

[13] The most recent figures (for 2017) show a suicide rate of 16.7% per 100,000 of the population for Northern Ireland, 14.7% for Scotland, 13.6% for Wales and 9.6% for England (source: University of Manchester: National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report: England, Northern Ireland, Scotland and Wales (HQIP: 2019), Figure 1, page 11).

[14] UKIM (2017): Disability Rights in the UK, paragraph 123, page 64.

all disabled people, including those with mental health conditions[15]

1.22 Furthermore, UKIM has recommended that the UK and devolved governments should ensure that people with learning disabilities and/or autism:

- Can access community-based services to avoid involuntary placement in psychiatric hospitals, assessment and treatment units, or general acute wards. This includes ensuring that sufficient community-based provision is in place;
- Remain in inpatient care (for the purpose of assessment and treatment) for the shortest possible time, and do not stay in a short-term facility on a long-term basis;
- Are provided with appropriate services for their needs, and are not placed in the psychiatric estate unless they have a mental health need;
- Are protected by effective safeguards, including access to advocacy, peer support and supported decision-making**[16]**.

1.23 Finally, UKIM has raised concerns regarding the use of physical and chemical restraint for reasons related to disability, including mental health-related disability, in all settings and the non-consensual use of electroconvulsive therapy in Northern Ireland.

1.24 The UN Committee on the Rights of Persons with Disabilities to call upon devolved governments, particularly in Northern Ireland, 'to take steps towards eradicating the use of restraint for reasons related to disability within all settings'[17] and to 'prohibit and withdraw practices of non-consensual electro-convulsive therapy on the basis of any form of impairment, in all regions, and in particular work through appropriate authorities to ensure monitoring of this development in Northern Ireland'[18].

[15] UKIM (2017): Disability Rights in the UK, paragraph 10, page 11.
[16] UKIM (2017): Disability Rights in the UK, paragraph 95, page 25-26.
[17] UN Committee on the Rights of Persons with Disabilities (2017): Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland, paragraph 37(a), page 8.
[18] Ibid, paragraph 37(d), page 8.

Context

1.25 The publication of a 10 year Mental Health Strategy was identified as an immediate priority of the Northern Ireland Executive in New Decade, New Approach (NDNA).

1.26 The Commission welcomes the whole of Government approach[19] set out in the consultation document and acknowledges that the establishment of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention; and the appointment of the NI Mental Health Champion, are positive steps in recognising the wider social determinants of health and giving greater priority to the need to promote mental health.

1.27 The Commission notes that the Department acknowledges that the overall context for the development of the Strategy is substantially the same as that identified by IMNI in its reporting to the UNCRPD Committee as part of its examination of the UK's implementation of the Convention i.e. Northern Ireland has a higher prevalence of mental ill health (by 25%) and a lower per capita spend on mental health (£160) than England (£220) or Ireland (£200)[20].

1.28 The Department concedes that across Northern Ireland targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 240 children and young people waiting more than 9 weeks for core CAMHS services and more than 900 people waiting more than 13 weeks for psychological therapies[21].

1.29 The Strategy admits that barriers to accessing mental health services remain, particularly for some marginalised groups who are considered to be at higher risk of mental ill health. This may

[19] So that, for example, action led by the Department for Education to tackle bullying in schools on grounds of sexual orientation, disability, ethnicity, gender etc will lead to a reduction in mental ill-health among children and young people.
[20] The Department accepts that, even allowing for differences in how mental health spend is calculated, there is significant under investment in Northern Ireland.
[21] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 16, page 11.

be due to social exclusion or isolation, communication barriers, or they may be in some way stigmatised by society[22].

1.30 The Department acknowledges that it 'consistently hears 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'[23].

1.31 To tackle some of the issues in the short to medium term, and set the foundations in place for longer term strategic change, in May 2020 the Department of Health published a new Mental Health Action Plan[24].

1.32 The Department acknowledges the need for investment in mental health:

'If we want to achieve our vision of a system that promotes positive mental health and seeks to enable people to achieve their potential, it is hugely important to invest in measures to promote and support emotional wellbeing and resilience, to raise awareness of mental health and reduce the stigma associated with it, and prevent and delay the onset of mental health problems as far as possible.'[25]

1.33 However, the cost implications of implementation of the Strategy as a whole are not identified.

1.34 The recent Department of Health Draft Budget Outcome does not provide funding for the Department to deliver on the further priorities set out in "New Decade, New Approach" including £10.6 million towards the Mental Health Action Plan[26].

---

[22] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 12, page 10.
[23] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 15, page 11.
[24] Department of Health (2020): Mental Health Action Plan. The 38 actions in the Action Plan fall into three broad categories: immediate service developments; longer term strategic objectives; and preparatory work for future strategic decisions.
[25] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 32, page 15.
[26] Department of Health (February 2021): 2021/22 Draft Budget Outcome, paragraph 13, pages 10-11.

1.35 The Budget states that this is reliant on receipt of the funding earmarked under the Confidence and Supply arrangement negotiated with the Conservative Government.[27]

1.36 Action 11 of the draft Strategy is to fully integrate the community and voluntary sector in mental health service delivery across the lifespan including the development of a protocol to make maximum use of the sector's expertise[28].

1.37 However, NICVA has highlighted that without funding not only will the Department of Health's own services be reduced, but such cuts will put more pressure on voluntary, community and social enterprise organisations who deliver essential public services supported by the Department[29].

2 General comments

2.1 The Commission broadly welcomes the seven key principles set out in the draft Mental Health Strategy 2021-2031.

2.2 The Commission notes the 29 strategic actions under three overarching themes[30] with four of these identified as having particular significance:

- a year on year action plan for mental health promotion
- Significant improvements in primary care mental health services, with greater responsibility for our GPs, working through their GP Federations (this will involve completing the roll out of psychological therapies hubs and additional investment to increase availability and accessibility of talking therapies at a local level);
- Better integration between statutory and community and voluntary sectors;
- The creation of a single mental health service (structures in place to deliver regional consistency, quality and access across Northern Ireland).

2.3 The Commission welcomes the acknowledgement by the Department of the prevalence of mental health issues in Northern Ireland, the historic under-resourcing of mental health

[27] Ibid, paragraph 2.
[28] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, page 35.
[29] See: https://www.nicva.org/article/the-2021-22-budget-less-for-the-same-or-more-for-what-works
[30] These are set out at Annex A for ease of reference.

services and a wide range of issues regarding access to services identified by stakeholders.

2.4 The Commission also welcomes the acknowledgement that there must be a continued strategic focus on parity of esteem between mental and physical health[31].

2.5 Given that fragmentation of services has been a long-standing problem for the mental health sector, we also welcome the Department's commitment towards the better integration of mental health services both across Government and other sectors; and with regard to more uniform availability of services across urban and rural settings.

2.6 The Commission is broadly supportive of the ethos and direction of travel set out in the draft Strategy.

2.7 We acknowledge the emphasis in the draft Strategy that statutory and voluntary sector service providers promote a recovery ethos, a person-centred approach and further develop service user involvement in the planning and delivery of provision.

2.8 We are pleased to see a commitment to ensuring equality and equity of access to mental health services for all, with a focus on recognising and meeting the individual's specific needs[32].

2.9 The Commission also broadly welcomes the priorities for action set out under the key themes in the draft Strategy as targeted in the right areas.

2.10 However, a major shortcoming of the draft Strategy is that there is limited detail with regard to which body within the health service is responsible for leading on specific actions and how it is envisaged that particular actions will be realised.

2.11 Furthermore, without a detailed action plan or road map setting out the stages by which target actions will be progressed or a firm commitment by the Department or the Northern Ireland Executive to resourcing[33] the actions set out in the draft

[31] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 18
[32] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 18
[33] The Commission notes that the independent evaluation of mental health provision in Northern Ireland carried out by Action Mental Health and Queens University Belfast in 2015 called for funding for mental health to be ring-fenced from budget cuts. See: Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C and Faulkner, L. (2015): Regress? React? Resolve? An Evaluation of Mental

Strategy, it is vulnerable to the criticism that it is simply an aspirational wish list.

Specific issues

Theme 1: Promoting wellbeing and resilience through prevention and early intervention

ACTION 1: Year on year mental health promotion action plan.

2.12 The Commission welcomes the proposed whole-life approach to mental health promotion, including interventions at school and in the workplace, set out in the draft Strategy.

2.13 The Commission notes that the draft Strategy refers to the Department for Communities developing a suite of new programmes to improve the employment prospects of those impacted by the Covid-19 pandemic as an initiative related to health promotion[34].

2.14 However, in its recent equality impact assessment of its draft budget for 2021-22, the DfC highlighted that it did not have the financial allocation necessary to enable it to develop labour market interventions to address the sharp increase in unemployment arising from the Covid pandemic crisis[35].

2.15 The Commission welcomes the acknowledgment in the draft Strategy that barriers to access mental health services remain, particularly for some marginalised groups who are considered to be at higher risk of mental ill health. This may be due to social exclusion or isolation, communication barriers, or they may be in some way stigmatised by society[36].

Health Service Provision in Northern Ireland, page 2 (Action Mental Health and Queens University Belfast).

[34] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph , page 20.

[35] Department for Communities (January 2021): Equality Impact Assessment Draft Budget Allocation 2021/22, paragraphs 6.12-6.16, pages 15-17.

[36] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 12, The Strategy highlights initiatives to address mental ill-health in the farming community (Rural Support), students (Mood Matters for Students), older people (Arts Council Arts & Older People Programme.

2.16 The Commission agrees that there is a need to ensure that promotion, prevention and early intervention is mainstreamed in service delivery and across different sectors, including targeted action at groups who are at particular risk

2.17 We have highlighted the particular vulnerability of the Irish Traveller community who have been found to have a suicide rate that is seven times that of non-Travellers[37] and **recommend** that the year-on-year mental health promotion action plan incorporate targeted actions to include the Irish Traveller community.

2.18 The Commission notes that the outcome for the promotion, early intervention and prevention proposes the use of a GHQ12 score greater than or equal to 4 to signify possible mental health problems[38]. However, the draft Children and Young People's Strategy 2017-2027 considered its use to be unsuitable for children aged under the age of 16[39].

2.19 The Commission **recommends** that the Department provide clarification on how the mental health and emotional well-being of children, including disabled children under the age of 16 will be appropriately assessed.

2.20 The draft Strategy does not identify how achievement of the other outcomes under this theme will be measured:

- Better interagency cooperation to promote wellbeing and resilience.
- Wider awareness of mental health within the health and social care sector outside the mental health profession.
- Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

[37] Kelleher, C. et al, (2010): All Ireland Traveller Heath Study, University College Dublin (Department of Health and Children & DHSSPS) cited in Equality Commission for Northern Ireland (2014): Racial Equality Policy Priorities and Recommendations, paragraph 7.2, pages 28-29.
[38] Department of Health (Dec 2020): Mental Health Strategy 2021-2031 consultation draft, paragraph 33, page 16.
[39] Department of Education (Mar 2017): draft Children and Young People's Strategy 2017-2027, page 100.

2.21 The Commission **recommends** that in the final Strategy the Department sets out how the above outcomes will be measured.

ACTION 2 Expand talking therapy hubs to create NI-wide coverage

2.22 The Commission welcomes the Department's commitment to transfer talking therapy hubs to primary care, with further integration with the multi-disciplinary teams and with the community and voluntary sector, which it is anticipated will result in increased access and reducing waiting times.

2.23 The Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

Promoting children and their families' positive mental health

ACTION 3 Further promote positive social and emotional development throughput childhood

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

2.25 The Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 4 Promote enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities.

2.26 The draft Strategy states that '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', it does not identify any mechanism or proposed actions to ensure that this is the case or identify who will take lead responsibility.

2.27 The Commission **recommends** that Department should respond to the 2016 Concluding Observations of the Committee on the Rights of the Child by putting in place systems to regularly collect comprehensive data on child mental health; rigorously investing in child and adolescent mental health services; and developing strategies with clear time frames, targets, measurable indicators, effective monitoring mechanisms and sufficient human, technical and financial resources[40].

Theme 2: Providing the right support at the right time

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

2.28 A 2018 report by the Northern Ireland Commissioner for Children and Young People on mental health services for children and young people in Northern Ireland found that the core budget for children and young people's mental health services had not 'changed significantly enough to meet its ambitions for system reform'.

2.29 It also revealed 'chronic under-investment, historical patterns of funding allocations which are not based on known mental health needs, and a very mixed experience from young people on the availability, accessibility and quality of services provided'[41].

2.30 The Commission therefore welcomes the commitment in the draft Strategy to increase funding for CAMHs services.

[40] UK Independent Mechanism (2017): Disability Rights in the UK, paragraph 90, page 24.
[41] NI Commissioner for Children and Young People (2018): Still Waiting? A rights based review of mental health support and services for children and young people in Northern Ireland Summary Report, page 7 (Belfast: NICCY)

2.31 The Mental Capacity Act (Northern Ireland) 2016[42] requires age appropriate accommodation and we welcome progress on the proposal within the inter-departmental action plan to reduce children treated on adult wards, evaluate and analyse need for psychiatric intensive care, and secure funding for PICU beds at Beechcroft[43].

2.32 However, we continue to **recommend** that the Department of Health ensures that the provisions for CAMHS are adequate to ensure services support the mental health needs of all children and young people[44].

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

2.33 The NICCY Review (2018) also found that there was limited understanding of the stepped-care model among non-mental health professionals, whilst Accident and Emergency did not have a clear strategic position in the stepped care pathway, despite being a key interface with young people who had to wait too long to access services[45].

2.34 The Commission welcomes the commitment in the draft Strategy to develop a 'no wrong door' approach but **recommend** that the final Strategy identify the lead body with responsibility for co-ordinating implementation e.g. the CAMHS managed care network and partnership board, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.35 The Commission supports the ambition set out in the draft Strategy to create clear and regionally consistent emergency crisis services for children and young people.

---

[42] Mental Capacity Act (NI) 2016
[43] Department of Health (Dec 2020): Interdepartmental action plan Theme 4: Specialist support
[44] ECNI (Dec 2017) Age Equality: Policy Priorities and Recommendations – Full Report, pages 9-11.
[45] NI Commissioner for Children and Young People (2018): Still Waiting? A rights based review of mental health support and services for children and young people in Northern Ireland Summary Report, page 8 (Belfast: NICCY)

2.36 We continue to **recommend** that effective processes are put in place to ensure the successful transition from youth to adult services[46]. It is vital that individuals are not left without support, simply due to a change in their age. Overarching policy processes are needed to provide early planning and preparation for adolescents during their transition to adult health, social care and well-being services.

2.37 The Commission welcomes Objective 7 in Mental Health Action Plan to 'consider a new model for CAMHS smooth transitions when a child turns 18, subject to funding'[47]. Consideration should be given to the National Institute for Health and Care Excellence's guidance 'Transition from children's to adults' services for young people using health or social care services'[48] provides recommendations on providing a better experience of transition between services.

2.38 The guidance cites groups of young people who are at particular risk of a loss of continuity of care. The groups identified were: 'young people with complex and multiple needs (Crowley et al.: 2011), child and adolescent mental health service users (Singh et al.:2010), young people with palliative care needs and life limiting conditions (Children and Young People's Health Outcomes Forum: 2012) and young people leaving residential care (Beresford and Cavet: 2009)'.

2.39 The Commission **recommends** that the commitment that the expert panel review will inform policy direction and a way forward for emergency and crisis services for children and young people is strengthened in the final Strategy to commit to implementation of the panel's key recommendations.

2.40 We also **recommend** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 8. Ensure adult mental health services cater for older adults with mental ill health, provide adequate support and structures and are mindful of the particular

[46] ECNI (Dec 2017) Age Equality: Policy Priorities and Recommendations – Full Report. Pgs 13-15
[47] Department of Health (May 2020) Mental Health Action Plan
[48] NICE guidelines [NG43] (Feb 2016) Transition from children's to adults' services for young people using health or social care services

challenges older people face. The artificial cut off in adult services at the age of 65 will stop and people will be supported by the right service based on their individual needs.

2.41 The Commission has highlighted evidence of ageist stereotypes and prejudices towards older people in the health service as well as concern amongst older people about attitudes towards them and access to health care[49].

2.42 For example, ARK's 2015 survey found that 20% of older people felt that they did not have equal access to health or social care[50].

2.43 Further, the 2014 Northern Ireland Life and Times survey found that 30% of respondents thought that health and social care workers treat older people less favourably as a result of their attitudes to them[51].

2.44 The Commission has called for targeted research to examine any prejudicial attitudes in the delivery of health, social care and wellbeing services, and their impact on older people's health[52].

2.45 The Commission **recommends** action to protect people of all ages from unjustified age discrimination in the provision of goods, facilities and services[53].

---

[49] Equality Commission for Northern Ireland (2017): Age equality policy priorities and recommendations, paragraph 9.9, page 50.
[50] ARK (2014): NILT: Attitudes to Older People
[51] Age Sector Platform (2014): Northern Ireland Pensioners Parliament Report 2014 p12
[52] Equality Commission for Northern Ireland (2017): Age equality policy priorities and recommendations, paragraph 9.5, page 50.
[53] See: https://www.equalityni.org/Delivering-Equality/Addressing-inequality/Law-reform/Policy-responses/strengthening-protection-for-all-ages-(1)
The introduction of age discrimination legislation would mean that health and social care service providers and practitioners would have to justify, if challenged, any age-based decisions. In particular, providers would have to show any treatment complained of was a proportionate means of achieving a legitimate aim.
The proposed age discrimination legislation will not prevent age being taken into account in decision-making when justifiable. The Equality Commission believes that age should not be used as a proxy for need and that each person's needs must be assessed individually. The legislation will ensure that older people have a fairer or more equitable access to diagnoses and treatment. This means that individuals may be able to challenge a decision not to refer an older person for treatment based solely on their age, or where a service provider has not considered the wellbeing or dignity of older people.

2.46 The Commission therefore welcomes the commitment in the draft Strategy that mental health services should be available to adults aged over 65 years of age.

2.47 The Commission recommends action to raise awareness of ageist stereotypes

2.48 However, the Commission notes concerns raised by stakeholders that the changes proposed do not result in a 'one size fits all' service where the particular needs of specific groups of older people such as older persons with intellectual disabilities, older persons with chronic neurological disease, older people with brain injuries and older people with dementia, are not taken into account. We **recommend** that these concerns are taken into account and addressed in the final strategy.

2.49 Furthermore, we note that the draft Strategy includes no detail as to how the change in eligibility will be managed.

2.50 The Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.51 The Commission notes the Department's commitment in the draft Strategy to bring about 'fundamental change in the operation of secondary mental health, moving away from current service structures towards joined-up locality based approaches centred upon populations in GP Federation areas.'

2.52 The Commission welcomes the commitment to co-design, with people with lived experience, their family and carers, of local pathways of care across primary and secondary care and across the range of available community resources in each Federation area.

2.53 The commitment to spend over £1m per year to improve access to mental health in the primary care multidisciplinary

team, one of the few explicit references in the Strategy to resourcing, is also welcome.

2.54 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought and a timetable for implementation.

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

2.55 The Commission welcomes the commitment in the draft Strategy to further develop recovery services but **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.56 The Commission welcomes the commitment commitment in the draft Strategy to fully integrate the sector in the provision of mental health services and develop appropriate protocols to facilitate this.

2.57 However, the draft Strategy does not acknowledge the likely resource implications of asking the community and voluntary sector to play a greater role in the planning, development and delivery of mental health services.

2.58 The Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.59 The Commission welcomes the ambition in the draft Strategy that access to psychological therapies must encompass a whole life approach and be embedded in mainstream services in both primary and secondary care.

2.60 Whilst the Commission also welcomes the commitment that no one will wait more than one year to access talking therapy, this nonetheless seems a long time for a person who may be experiencing a mental health crisis.

2.61 We **recommend** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome removing regional variation in access, resource implications and a timetable for implementation.

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

2.62 The Commission acknowledges the commitment in the draft Strategy to use digital technology as a means of delivery of mental health services but notes that the areas of service in which it is planned to be rolled out are not identified and would welcome further detail.

2.63 When introducing systems that make use of IT and/or the internet, account should be taken of the lower rates of IT awareness and/or internet usage by older people[54] or people with sensory disabilities compared to that of the general population. In the United Kingdom, 13% of adults, and over half (51%) of people aged 75 and over do not use the internet[55].

2.64 In terms of promoting new technologies, the Northern Ireland Executive's campaign to promote awareness of the digital switchover from analogue to digital television[56] was evaluated as effective[57] in raising awareness of the new technology amongst older and disabled people. The lessons from this or other relevant campaigns could be considered with regard to their application to raising awareness of the benefits of new

[54] Age UK: Introducing another World: older people and digital inclusion,
[55] OFCOM (Jun 2020): Online Nation: 2020 Report
[56] Digital UK (2012): Digital TV switchover 2008-2012
[57] Digital UK (2012): Digital TV switchover 2008-2012

assistive technologies in the provision of health, social care and well-being services.

2.65 The Commission **recommend**s raising awareness and uptake amongst older people of assistive technologies to access health, social care and well-being services[58].

2.66 The Commission also **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

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

2.67 Research[59] carried out for the Independent Mechanism for Northern Ireland[60] has highlighted that people with mental health disabilities have higher rates of ischemic heart disease, stroke, high blood pressure and diabetes among people with schizophrenia or bipolar disorder compared to the rest of the population.

2.68 People with schizophrenia are 90% more likely to get bowel cancer and 42% more likely to get breast cancer (women only). 31% of people with schizophrenia and chronic heart disease (CHD) are diagnosed under 55 years, compared to 18% of others with CHD; these figures are 41% and 30% respectively for diabetes. After five years, 28% of people who have had a stroke and have schizophrenia have died, as have 19% of

[58] ECNI (Dec 2017) Age Equality: Policy Priorities and Recommendations – Full Report. Pgs 18-19
[59] Harper, C., McClenahan, S., Byrne, B. and Russell, H. (2012): Disability programmes and policies: How does Northern Ireland measure up? Monitoring Implementation (public policies and programmes) of the United Nations Convention on the Rights of Persons with Disabilities, pages 203-204 (Belfast: Equality Commission NI).
[60] Independent Mechanism for Northern Ireland (2017): United Nations Convention on the Rights of Persons with Disabilities – Jurisdictional 'Parallel' Report on Implementation in Northern Ireland, page 63. Ireland.

people with bipolar disorder, compared with 12% of people with no serious mental health issues.

2.69 The Commission therefore welcomes the commitment in the draft Strategy that the physical health of mental health patients must become every day practice during routine interactions with mental health patients in primary care.

2.70 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.71 The draft Strategy notes that in Northern Ireland the acute inpatient care system has for many years been under extreme pressures. Bed occupancy has consistently been around 100%, even though the Royal College of Psychiatrist's recommended occupancy level is 85%.

2.72 Although the Department outlines its intention to invest £170m in a further three new inpatient units - a commitment welcomed by the Commission - the draft Strategy does not give any indication of the extent to which this investment will meet unmet need.

2.73 The Commission recommends that the final Strategy provides further detail of the extent to which the planned provision meets unmet need and that greater clarity is provided with regard to lead responsibility, key actions to achieve the outcome sought and a timetable for implementation.

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

2.74 The Commission welcome the commitment in the draft Strategy to create a regional structure for rehabilitation, including the provision of rehabilitation in a variety of settings incorporating

both inpatient and community based services, as a further step towards reduction of institutionalisation.

2.75 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.77 The Commission welcomes the Department's commitment to provide regional specialist in-patient services for patients with a higher need in dedicated low secure settings with the stated outcome of supporting patients with severe presentations and reducing conflict on existing mental health wards and shortening patient stay in hospital.

2.78 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.79 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.

2.80 The Participation and the Practice of Rights Group has highlighted that what they describe as a mental health emergency happening in GP surgeries across Northern Ireland.

2.81 PPR point out that between 30-40% of GP appointments concern mental health, that Northern Ireland has one of the world's highest prescription rates for antidepressants whilst access to counselling is patchy and often very limited[61].

[61] BBC Northern Ireland News (15 February 2021): Mental Health Counselling in Northern Ireland a 'postcode lottery'

2.82 Furthermore, PPR emphasise that the high rate of suicide is at risk of escalating as families who have lost loved ones to suicide themselves three times more at risk of taking their own lives.

2.83 The Group have called for two key steps to be undertaken:

- An increase in the funding for in-house counselling from £1.6million to £3.2million
- The introduction of a 28 day waiting time target for a mental health referral[62].

2.84 Whilst the draft Strategy acknowledges the need for effective crisis services so that fewer people with mental health problems attending Emergency Departments, no detail is provided on the means to achieve this outcome. Instead, reference is made to an ongoing expert review whose outcome 'will inform the policy direction and a way forward'.

2.85 The Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.86 The Commission welcomes the recommendation to embed experts in dual diagnosis in both mental health and substance use services and for collaborative working between the two services.

2.87 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

[62] See: Who are the mental health rights movement?

2.88 Lack of access to perinatal mental health services in Northern Ireland has been increasingly highlighted in recent years[63]

2.89 Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby[64].

2.90 Between 7,599 and 12, 374 women per annum in Northern Ireland experience perinatal mental health issues, including post-partum psychosis, chronic serious mental illness, severe depressive illness, PTSD, mild to moderate depressive illness and anxiety status, adjustment orders and distress[65].

2.91 A 2014 study found that, on a UK-wide basis, the long-term cost is estimated to be approximately £8.1 billion for each one-year cohort of births in the UK. The majority of this cost (72 per cent) relates to the adverse impacts of these illnesses on children. The study concluded that the cost to the public sector of perinatal mental health problems is 5 times the cost of improving services, making a case for investment that cannot be ignored[66].

2.92 For women in Northern Ireland, specialist provision continues to operate as a postcode lottery[67]. The Belfast Health and Social Care Trust is the only Trust which provides a specialist service, and this is small scale in nature.

2.93 A 2013 report has recommended the establishment of a specialist mother and baby in-patient unit in Northern Ireland[68].

2.94 A 2018 report found that within both health visiting and midwifery the main challenges are regarded overwhelmingly as systemic with underfunding, overwork and growing levels and

---

[63] BBC News NI (24 February 2016): Northern Ireland Health: Lack of perinatal services 'endangering lives'
Cunningham, C., Galloway, S., Duggan, M. and Hamilton, S (20218): Time for action on perinatal mental health in Northern Ireland - A report on the perspectives of health visitors and midwives (Unite/CPTMA/The Royal College of Midwives).
[64] Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. and Adelaja, B (2014): The costs of perinatal mental health problems, page 3 (London School of Economics and Centre for Mental Health).
[65] Cunningham, C., Galloway, S., Duggan, M. and Hamilton, S (20218): Time for action on perinatal mental health in Northern Ireland - A report on the perspectives of health visitors and midwives (Unite/CPTMA/The Royal College of Midwives).
[66] Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. and Adelaja, B (2014): The costs of perinatal mental health problems, page 3 (London School of Economics and Centre for Mental Health).
[67] Maternal Mental Health Alliance (2017): Northern Ireland Perinatal Mental Health is Everyone's Business, page 1.
[68] Guidelines And Implementation Network (2013): Is a perinatal in-patient unit needed in Northern Ireland?, Belfast: RQIA.

complexity of demand undermining the face to face time and continuity of care required for early recognition and response[69].

2.95 A further issue highlighted is the need for closer alignment between infant mental health and perinatal mental health practice[70].

2.96 The Commission therefore welcomes the commitment in the draft Strategy to the roll-out of specialist perinatal mental health services

2.97 The Commission **recommends**:

- Specialist perinatal mental health community teams are put in place in the 5 Health and Social Care Trusts;
- Development of a regional specialist mother and baby in-patient unit for Northern Ireland;
- Implementation of a strategy to ensure delivery of dedicated high quality training in perinatal mental health care for all health and social care professionals, including those working in the community and voluntary sector, involved in the care of women during pregnancy and post pregnancy.

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

2.98 The Commission welcomes the commitment from the Department to create a psychosis network to ensure early intervention psychosis care, access to evidence based treatments and interventions for people with psychosis.

2.99 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

[69] Cunningham, C., Galloway, S., Duggan, M. and Hamilton, S (20218): Time for action on perinatal mental health in Northern Ireland - A report on the perspectives of health visitors and midwives (Unite/CPTMA/The Royal College of Midwives).
[70] Ibid, page 7.

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

2.100 The Bamford Review reports on Forensic Services and Adult Mental Health Services both recommended the development of a dedicated personality disorder service in Northern Ireland[71] and a Personality Disorder Strategy was published in 2010[72].

2.101 The Personality Disorder Strategy noted that there was an increasing trend for people to require transfer to a range of specialist units in GB for specialist inpatient treatment not available within Northern Ireland, including specialist medium secure units for personality disordered offenders[73].

2.102 However, progress in creating a dedicated service has remained slow with the result that the recommendation appears again, over ten years on, in the current draft Mental Health Strategy.

2.103 The Commission, therefore, welcomes a renewed commitment to create a personality disorder service, with a tiered approach to creating regional pathways for treatment that will ultimately reduce the number of detained patients with emotionally unstable personality disorder that have to be transferred to GB for specialist treatment.

2.104 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 24. Create a regional eating disorder service.

[71] The Bamford Review of Mental Health and Learning Disability (2005): A Strategic Framework for Adult Mental Health, recommendations 121-124, page 121; The Bamford Review of Mental Health and Learning Disability (2006): Forensic Services, recommendations 145-149, page 140.
[72] Department of Health, Social Services and Public Safety (2010): Personality Disorder - A Strategy for Inclusion The Northern Ireland Personality Disorder Strategy.
[73] Ibid, page 33. The report notes that in in 2008/09 there were 15 people who received specialist treatment in GB at an overall cost of approximately £1.76M.

2.105 The Bamford Review noted that the Department had commenced work on the development of a four-tier eating disorder service with a focus on early intervention[74].

2.106 However, the Eating Disorders Association Northern Ireland has revealed that the planned amount of investment never came to fruition and that whilst there are specialist community eating disorder teams in each health trust for both children and adults, they are severely under resourced resulting in people not getting the early intervention that they require[75].

2.107 The Eating Disorders Association Northern Ireland has highlighted that existing Trust based services are stretched and under 'crippling pressure' and called for 'action to be taken to improve eating disorder services, including early intervention care, intensive treatment programmes, family support services and greater understanding both in the medical community and general public of what eating disorders are and how the conditions can be effectively treated[76]'.

2.108 The draft Mental Health Strategy notes that currently a number of patients travel to GB for specialist inpatient treatment, away from family and friends who can aid recovery.

2.109 The Commission welcomes the Department's commitment to provide further investment in 'additional nursing and dietetic staff to support the treatment and safe supervision of patients with an eating disorder in local mental health in-patient units, including the regional CAMHS unit and paediatric wards.'[77]

2.110 The Commission acknowledges the Department's consideration that 'additional support will allow all eating disorder presentations to be subject to immediate referrals and such referrals to be considered without delay.'[78]

2.111 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility,

---

[74] The Bamford Review of Mental Health and Learning Disability (2005): A Strategic Framework for Adult Mental Health, recommendations 100-102, page 110.
[75] Belfast Live (3 June 2018): Eating Disorders in Northern Ireland - Where to turn to for help?
[76] Eating Disorders Association NI (2020): Manifesto - Call for Action.
[77] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 163, page 46.
[78] Department of Health (2021): Mental Health Strategy 2021-2031 consultation draft, paragraph 164, page 46.

key actions to achieve the outcome sought, resource implications and a timetable for implementation.

Theme 3: New ways of working

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

2.112 The Commission welcomes the commitment to develop a regional mental health service that will remove variations in service availability and develop consistent care pathways, data collection, nomenclature and standards.

2.113 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility (e.g. the Department of Health Transformation Board), key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

2.114 The Commission notes the acknowledgment by the Department that 'for staff in mental health services, there appears to be an ever increasing demand, more complexity in presentation, and recruitment and retention challenges'.

2.115 We therefore welcome the commitment to employ more staff in Mental Health Services and to increase in the number of training places for mental health professionals, via the undertaking of a comprehensive workforce review, to focus on training, recruitment and retention needs and help create a workforce for the future.

2.116 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to resource implications and a timetable for implementation.

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

2.117 The Commission welcome the Department's commitment that going forward it will create clear roles and guidance for peer support workers and advocates and integrate peer support fully in the multi-disciplinary team.

2.118 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome of even coverage regarding peer support across the Trusts, resource implications and a timetable for implementation.

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

2.119 The Commission welcomes the Department's acknowledgment commitment, in the draft Strategy, that to ensure it has the right services that meet the needs of the population it must have data to measure outcomes.

2.120 There is clear evidence that groups belonging to Section 75 categories experience differential health outcomes. For example women are more likely to display signs of a possible mental health problem (21%) than men (16%)[70] and other research[71] in Northern Ireland has shown that the experiences of disabled women differ from those of disabled men or of women who are not disabled

2.121 The 2010 All Ireland Traveller Health Study highlighted that:

- a male Traveller men can expect to die 15.1 years before his non-Traveller counterpart;
- life expectancy of Traveller women is still 11.5 years lower than women in the general population[79];
- suicide rates are almost seven times higher for Traveller men than in the general population[80];
- mortality rates are considerably higher than the general population at all age ranges for both men and women[81].

[79] Kelleher, C. et al (2010): *All Ireland Traveller Health Study*, Table 37, page 94.
[80] Kelleher, C. et al (2010): *All Ireland Traveller Health Study*, page 94.
[81] Kelleher, C. et al (2010): *All Ireland Traveller Health Study*, pages 89-91.

2.122 The Commission **recommends** that outcome measures be tracked for ALL Section 75 grounds, discrete from any targeted actions aimed at advancing equality of opportunity for specific (e.g. currently disadvantaged) Section 75 groups. Such an approach would not only ensure that the outcome of targeted actions was tracked, but would provide a robust evidence base to assess equality of opportunity, compared to the population as a whole and to other equality groups.

2.123 It would also provide a firmer basis for the identification of future targeted actions, and for the fulfilment of the statutory equality and good relations duties.

2.124 The Department outlines that the Encompass programme, which will be replacing a number of existing software systems, will provides the opportunity to access a much richer pool of data and information to help inform and improve practice.

2.125 The Commission **recommends** that the Department explore how the Encompass system can be adapted to capture data relating to the S75 categories.

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

2.126 The Commission welcomes the commitment by the Department to increasing funding for mental health research and to the establishment of a centre of excellence which supports research and innovation.

2.127 However, the Commission **recommends** that greater clarity is provided in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

3 Section 75

3.1 **The Commission has provided Section 75 advice prior to consultation and will provide further advice on the consultation EQIA directly to the policymaker to ensure it is meaningful and informs the mental health strategy.**

4 Conclusion.

4.1 The Commission welcomes the publication by the Department of the draft Mental Health Strategy and is broadly supportive of its ethos, direction of travel and key actions.

4.2 However, we recommend that the Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

5 Summary of recommendations

Theme 1: Promoting wellbeing and resilience through prevention and early intervention

ACTION 1 Year on year health promotion plan.

5.1 The year-on-year mental health promotion action plan should incorporate targeted actions to include the Irish Traveller community.

5.2 The Department provide clarification on how the mental health and emotional well-being of children, including disabled children under the age of 16, will be appropriately assessed.

5.3 The Department should set out in the final Strategy how the following outcomes will be measured:

- Better interagency cooperation to promote wellbeing and resilience;
- Wider awareness of mental health within the health and social care sector outside the mental health profession;
- Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

ACTION 2 Expand talking therapy hubs to create NI-wide coverage]

5.4 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to

achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 3 Further promote positive social and emotional development throughput childhood

5.5 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 4 Promote enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities.

5.6 The Department should respond to the 2016 Concluding Observations of the Committee on the Rights of the Child by:

- putting in place systems to regularly collect comprehensive data on child mental health;
- rigorously investing in child and adolescent mental health services;
- and developing strategies with clear time frames, targets, measurable indicators, effective monitoring mechanisms and sufficient human, technical and financial resources.

Theme 2: Providing the right support at the right time

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

5.7 The Department of Health ensures that the provisions for CAMHS are adequate to ensure services support the mental health needs of all children and young people.

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

5.8 The final Strategy should identify the lead body with responsibility for co-ordinating implementation e.g. the CAMHS managed care network and partnership board; key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.9 The Department should ensure that effective processes are put in place to ensure the successful transition from youth to adult services.

5.10 The Department should strengthen its commitment that the expert panel review will inform policy direction and a way forward for emergency and crisis services for children and young people by committing to implementation of the panel's key recommendations.

5.11 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.12 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 9. Refocus and reorganise primary and secondary care mental health services around the GP Federations to

ensure a person centred approach, working with statutory and community and voluntary partners to create local pathways within a regional system.

5.13 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.14 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.15 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.16 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.17 The Department should take actions to raise awareness and uptake amongst older people of assistive technologies to access health, social care and well-being services.

5.18 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

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

5.19 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.20 The Department should provide further detail in the final Strategy provides of the extent to which the planned provision meets unmet need and that greater clarity is provided with regard to lead responsibility, key actions to achieve the outcome sought and a timetable for implementation.

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

5.21 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.22 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.23 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.24 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.25 The Department should ensure:

- That specialist perinatal mental health community teams are put in place in the 5 Health and Social Care Trusts;
- Development of a regional specialist mother and baby in-patient unit for Northern Ireland
- Implementation of a strategy to ensure delivery of dedicated high quality training in perinatal mental health care for all health and social care professionals, including those working in the community and voluntary sector, involved in the care of women during pregnancy and post pregnancy.

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

5.26 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.27 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

ACTION 24. Create a regional eating disorder service.

5.28 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

Theme 3: New ways of working

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

5.29 The Department should provide greater clarity in the final Strategy with regard to lead responsibility (e.g. the Department of Health Transformation Board), key actions to achieve the outcome sought, resource implications and a timetable for implementation.

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

5.30 The Department should provide greater clarity in the final Strategy with regard to resource implications and a timetable for implementation.

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

5.31 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome of even coverage regarding peer support across the Trusts, resource implications and a timetable for implementation.

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

5.32 The Department should ensure that outcome measures are tracked for ALL Section 75 grounds, discrete from any targeted actions aimed at advancing equality of opportunity for specific (e.g. currently disadvantaged) Section 75 groups.

5.33 The Department should explore how the Encompass system can be adapted to capture data relating to the S75 categories.

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

5.34 The Department should provide greater clarity in the final Strategy with regard to lead responsibility, key actions to achieve the outcome sought, resource implications and a timetable for implementation.

Other Actions

5.35 The Department should include as an action in the final Strategy the prohibition and withdrawal of practices of non-consensual electro-convulsive therapy on the basis of any form of impairment and put in place appropriate monitoring arrangements to ensure this outcome.