Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Mental Health Resource Budget

28 September 2011

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Sam Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:
Mrs Christine Jendoubi)
Mr Colin McMinn) Department of Health, Social Services and Public Safety
Mr Peter Toogood)

The Chairperson:

I welcome Peter Toogood, Christine Jendoubi and Colin McMinn. We will begin with evidence from the witnesses and then open up the meeting for questions. As usual, anyone who wants to ask a question should indicate to me that they wish to do so. Fire away, Christine. Your colleagues have put you in the hot seat again.

Mrs Christine Jendoubi (Department of Health, Social Services and Public Safety):

I have a plan: if it is OK with you, Peter and I will jointly present the opening statement today.

The Chairperson:

That is great. We know what Peter looks like; we just do not know what he sounds like.

Mrs Jendoubi:

I imagine that you will hear quite a lot from him over the next few minutes. Peter will deal with the budget, and I will come in at the end with a bit on performance management.

Mr Peter Toogood (Department of Health, Social Services and Public Safety):

This is the bit you have all been waiting for — I do have a voice.

The Chairperson:

Do not disappoint us.

Mr Toogood:

I hope not to. As Christine said, I will talk about the financial aspects of the paper that we provided to you. A large proportion of my comments will be based on exhibit A, which, I presume, is the paper to which Colin referred. It details mental health expenditure across various items of expenditure. Colin prepared a revised paper, because the paper that we initially provided inadvertently omitted a line, which meant that the tables were not comparable. The paper that you have now links back to the programme of care analysis presented to the Committee on 7 September. As Colin outlined, the reconciling item — the difference between the papers — related to sub-commissioning funds, which is where one trust purchases from another.

I assure the Committee that that is the only difference between the two tables, and it does not affect any of the lines within the table. Accordingly, it will not distort any of the underlying messages or trends that I will highlight during my presentation. I must also highlight that the extent of the sub-commissioning element currently sits at around £1 million, which is less than 0·5% of the overall mental health expenditure of about £225 million. I recognise and apologise that it did not reconcile readily with the information previously provided in Colin's analysis.

First, I will focus my comments on the historical, or actual, expenditure. Secondly, I will talk

briefly about the planned expenditure as a separate item. As Julie Thompson outlined last week, it is not possible to directly compare historical and planned expenditure, as each are prepared on a different basis. I will not, therefore, rehearse the discussion that we had last week.

The Chairperson:

You have compared the two in that table.

Mr Toogood:

Granted, the table is set out like that, but we have not drawn variances or conclusions. We refer to it in the narrative, albeit I accept that we should have been more explicit. We make reference to the fact that they are prepared on different bases and are from different sources, but we should have been more explicit about their not being directly comparable. We do not draw any variances or conclusions from the comparisons, but I accept that the presentation could have been more explicit.

As Colin pointed out, the total spending on mental health increased by about 18% between 2006-07 and 2009-2010. Within that overall increase, I draw members' attention to the three key categories of expenditure highlighted in black lines in our table: hospital, community and personal social services (PSS). I highlight the fact that hospital spend increased by 12% over that period from £95 million to £107 million, whereas the community and PSS spend increased by a greater amount. The community spend increased by 45% to £59 million, and the PSS spend increased by 15%. As Julie said last week, we do not have actual expenditure figures for 2010-11, because they will not be available until the end of October.

What does that mean in practice? What do those figures tell us? The Bamford review of mental health and learning disability recommended that people with mental illness should be treated in the community unless there was a clear clinical reason not to do so. That requires a shift in funding from hospital services to community services. That is evident in the table's figures. Indeed, you will see that, although overall expenditure increased in 2009-2010, total hospital expenditure decreased by some 2%, and the other two lines increased.

That is emphasised because, at the time of the Bamford review, which was around 2004-05, the split in expenditure was about 60% on hospital services and 40% on the remaining community services. The hospital element of actual spend on mental health services in 2009-10

reduced to 48%, whereas the community aspect increased to 52%. Therefore, the current and actual expenditure reflect the policy intent and direction.

As regards trends in the table, members will see that the increase in community mental health expenditure has been driven largely by investment in community psychiatric nurses (CPNs) together with continued investment in other community services. That is a broad catch-all term for how it is presented here. It includes items such as community action teams, community grants, intensive care treatment teams and non-consultant hospital facilities.

In the PSS expenditure category, we note significant increases in nursing home care and social work. The broad category at the bottom called "Other PSS" includes items such as supported and other accommodation costs, grants to voluntary organisations, meals delivered to patients' homes and various grant aid.

That shift of resources into the community can be further demonstrated by the trend in inpatient admissions, which have fallen by 29% from 7,500 in 2005-06 to 5,300 in 2010-11. The table shows a corresponding increase in day cases in the same period from 2,500 to 3,000, which is an increase of 20%.

Papers provided to the Committee last week indicated a reduction in planned expenditure of some 1·3% between 2009-10 and 2010-11. Members will recall that that showed a reduction from £235 million to £232 million. As Julie explained, that was due to service developments not happening because of the budget cuts applied during that year. The table also shows that planned expenditure for 2011-12 increases to £235 million, which is an increase of around 1·5% from 2010-11.

In conclusion, last week, we mentioned that the Department's overall planned expenditure for 2011-12 was not ready. We committed to getting that to you as soon as possible, and we endeavoured to do so. You will note that we have provided the planned expenditure for mental health in 2011-12. Our reason for doing so is that it is, obviously, a subset of a larger document, namely the strategic resources framework. At the time that the briefing paper was completed, we were content that the mental health figures were in their final form. In good faith, we released that to the Committee to assist in providing an answer to the question that had been asked.

Those are the broad high-level comments that I want to make on finance. I will hand over to Christine, who will talk about performance management and service issues that relate to the analysis.

Mrs Jendoubi:

The Committee will be very much aware of the system that we now use for monitoring and holding the Health and Social Care Board (HSCB) to account on its spend in progressing the Minister's priorities right across the health service. Prior to 2009-2010, there was a budgetary control mechanism in the Department, which was closely involved in monitoring all lines of expenditure and the spend patterns across those lines. Since the creation of the new board under the review of public administration (RPA), the monitoring system has changed. The Department no longer exercises that close financial control over individual lines of spend.

We now allocate large block sums to the board and hold it to account by means of outcomes and targets, which are monitored through accountability reviews. We place the emphasis not on where the board puts each pound, but on patients' outcomes and whether the targets, which were set previously as priorities for action (PFAs) and are now in the commissioning plan direction, have been met.

The PFA targets for mental health that were in place for the past comprehensive spending review (CSR) period focused on areas such as reducing waiting times to access services; ensuring unplanned admissions to psychiatric hospitals were reduced; and ensuring that people who were ready for discharge following treatment were discharged within seven days of the decision that they could be discharged and that discharged patients who required continuing care were seen by community mental health services within seven days. Those targets have all been largely achieved. If the Committee wishes, we can provide further details on the number of patients involved in each.

The other key area of expenditure in mental health services over the past CSR period has been the resettlement of long-stay patients from mental health and, indeed, learning disability hospitals into the community. Over the CSR period, around £3·6 million a year was allocated by the Department for that purpose, and 185 patients were resettled during that period.

I will say just a word or two about the performance management arrangements for 2011-12

and subsequent years. The Committee is aware that a commissioning direction for 2011-12 was issued to the board on 24 June 2011. The direction sets initial priorities for 2011-12 and was issued to allow the board to meet its statutory obligation to develop a draft commissioning plan that will set out the details of the health and social care services that it proposes to commission for 2011-12. That direction was drawn up on the understanding that it was a necessary and transitional measure this year to enable the continued commissioning of services in line with statutory requirements. The Health and Social Care Board and the board of the Public Health Agency (PHA) approved the resultant draft commissioning plan at their respective board meetings on 30 June. The Committee took evidence from the Minister on the draft commissioning plan on, I think, 20 July. However, the commissioning plan is still not finalised. The Department has been in consultation with the HSCB and the PHA on various drafting aspects of the plan, which awaits the Minister's final approval within the coming weeks. Such a schedule is clearly not tenable for future years. This is a transitional year, in which there was a general election, and everything was pushed back accordingly.

Last week, Julie mentioned that we plan to have the commissioning plan for next year in place well in advance of the start of the next financial year. Indeed, we hope to have a draft available to the Committee early in the new year. We hope to have the plan and the concomitant budgetary arrangements in place well before the start of the next financial year. That is really all that we want to say at this juncture. Thank you very much. We are happy to take questions.

The Chairperson:

OK. Thanks, Christine and Peter. A couple of figures jumped out at me. Peter mentioned specialist nursing. Looking at the table in the briefing paper, I see that actual spend was £358,000 in 2006-07; £212,000 in 2007-08; £212,000 in 2008-09; and £126,000 in 2009-2010. That seems to be an awful drop in spend on specialist nursing. Also, the spend on district nursing and health visiting is down considerably. We expected to see the figures start to creep up for many areas under community expenditure, but instead they have gone the other way. Community psychiatric nursing bucks the trend, but the other figures cause some concern.

I am also concerned about the bottom line — the total expenditure on mental illness. If my sums are correct, the figure for planned expenditure in 2010-11, after subtracting the earmarked commissioning funds, is £216,737, 000 instead of £231,831,000. The figure of £234,802,000 for planned expenditure in 2011-12 equates to £222,228,000, which brings us back to the levels of

spend in 2008-09. I am not hearing that mental health is getting a better share of the budget or that we are getting the level of services that we need. In the other PSS that Peter talked about, the figure started out at £13,775, 000 and worked its way up to £20,337,000 and then £19,703,000 in the actual spend, but, in planned expenditure, it is pulled back to £15,000,000-odd. The planned expenditure on mental health is nowhere near the actual level shown for previous years.

That planned expenditure may change when the Minister's priorities are factored in. However, in the planned expenditure for 2010-11, it certainly looks as though the increase in hospital services stands at around 3·3%, whereas it is 2·8% for community services and only 0·9% for personal social services. That indicates that the main push is still spending on hospitals rather than in the community, even though the latter is the Minister's priority. Perhaps you could throw some light on that. It would be very helpful, because I find the figures to be at odds with the message that we are hearing.

Mr Toogood:

I will talk about the overall planned aspects of the latter part and refer some of the district nursing details to my policy colleagues. I do not want to go back into the whole issue of planned versus actual, but the figures are indicative, and the points that you raise are indicative of that dynamic. The earmarked funds that sit as a line item will be spent; it is just not possible, at the moment, to see where they will be spent across the lines. The figures of £232 million and £235 million are correct.

There are earmarked funds in the historical analysis; in the note, you will see extra contractual referrals and out-of-area treatments. Those are included in the actual expenditure and will be allocated across the line. It is proper to include those for the purposes of comparison and going forward, albeit that we cannot see exactly where they are at this stage of the analysis that has been presented. I will recap and explain the differences: the planned expenditure is for the whole health and social care system. It is representative only of our current funding, whereas our historical expenditure includes everything: the trusts spending money received from sources other than us or non-recurrent allocations that we give them in-year.

The Chairperson:

Will the earmarked commissioning funds be spent by the trusts? If not, who will spend those?

Mr Toogood:

I cannot give you an exact split, but my understanding is that they will be split between the trusts and the board, depending on the nature of what is required.

The Chairperson:

It would probably be helpful to get the exact split; it would be useful to see where that money is being spent.

Mr Toogood:

OK.

Mrs Jendoubi:

We can give you that only for the years for which we have actual spend.

The Chairperson:

For which years do you not have actual spend?

Mrs Jendoubi:

We have all the figures up to 2009-2010.

The Chairperson:

Does that mean that you have actual spend only for money that is planned to be spent as opposed to the money that was spent?

Mrs Jendoubi:

We have actual figures only for the historical expenditure columns. In the planned expenditure columns, it is not possible to know how the earmarked commissioning funds will be split over the different budget lines until the Minister sets his commissioning priorities and the board decides how it will have to allocate those earmarked commissioning funds to meet those priorities.

The Chairperson:

But that first line is for 2010-11. That money has been spent, because that is the last financial year.

Mrs Jendoubi:

The actual spend figures will not be in until the end of October.

Mr Toogood:

As we mentioned last week, we are waiting for that information, which will enable us to carry out a comparison on actual spend for 2009-2010. The trusts are due to provide us with that information at the end of October.

The Chairperson:

But you are bound to have an idea now of how that money has been spent.

Mrs Jendoubi:

If the Committee would like, we could ask the trusts for that information.

The Chairperson:

Do you even have a ballpark idea of who spent that money?

Mr Toogood:

I do not have that analysis to hand, Chair, but we can investigate.

The Chairperson:

Can you explain why the actual spend on specialist nurses went down from £358,000 to £126,000 in the space of four years?

Mr Colin McMinn (Department of Health, Social Services and Public Safety):

The second line of that analysis shows a growth in community psychiatric nursing. Community psychiatric nurses are the main constituent of our various community teams. I suspect that, as we increased the number of psychiatric nurses, the roles probably changed, too, and diminished the need for specialist nurses.

The Chairperson:

But the increase in community psychiatric nursing does not really tally either. I take your point, Colin, but the increase in spend on CPNs is not as big as the decrease in spend on other specialist nursing. The drop from £358,000 to £126,000 is far greater than the jump from £14,310,000 to

£18,242,000.

Mrs Jendoubi:

That is an increase of £4 million.

The Chairperson:

I meant in percentage terms. I am not that good at sums, and I am starting to calculate percentages. I hear what you are saying, but that is still a huge drop in spend on other specialist nursing, and the planned expenditure remains about the level of 2007-08 and 2008-09. I see that the expenditure on community psychiatric nursing has gone up slightly, but I am just making the point that, although you say that there is an increase, it is clear from the table that there has, in fact, been a drop. We are not seeing where the increase is actually being spent.

Mr McCarthy:

Given that there are no dedicated psychotherapy inpatient beds in Northern Ireland, will you explain what is meant by the figures of £1,203,000 and £1,187,000 in the table for inpatient psychotherapy?

Mr McMinn:

Psychotherapy is a component of a patient's inpatient care package. There will be medical, talking therapy and occupational health elements in that. There will be a range of inputs, and psychotherapy will be one of those inputs in the hospital setting, although you are right to say that there are no dedicated psychotherapy beds. Dedicated psychotherapy is mainly undertaken in the community on an outpatient basis.

Mr McCarthy:

Why are no figures given for outpatient psychotherapy services for the next two years?

The Chairperson:

Before we move on to that, Kieran, I am sorry for butting in, but there is no planned expenditure for community or outpatient psychotherapy at all.

Mr McCarthy:

That was my question.

Mr McMinn:

I cannot explain that, because those people are in post, and that expenditure is planned to continue. The policy direction is to maintain and, as far as possible, improve access to psychological therapies, whether in the hospital setting or in the community.

Mr McCarthy:

There is no figure given in the table that we have.

Mrs Jendoubi:

That is right. Can we come back to the Committee on that?

Mr McCarthy:

What moneys are going to be directed towards outpatient psychotherapy services in the future? Will that be in keeping with the 2010 psychological therapy strategy?

Mr McMinn:

I will just take a step back to talk about the increase across the mental health programme. The investment pattern for the last CSR period, which started in 2008-09, was that mental health was to get a significant injection in 2008-09. The next year was to be a steady-state year, after which there was an expected increase in 2010-11. That increase did not occur because of the external financial crisis. The amount of money that we were intending to invest that year was significantly reduced.

Mr McCarthy:

In 2008, Minister McGimpsey stated that £7 million per annum would be dedicated to psychotherapy, but that has been cut drastically. Is that what you are saying?

Mr McMinn:

That is what I am saying.

Mr McCarthy:

That is a big drop. Peter briefly mentioned home treatment teams. Why is there no mention of the home treatment teams, which are the way forward in delivering care to people in their

community? Linked to that, why is more money going into hospital services rather than community services?

Mr McMinn:

The expenditure of the different teams that are available in the community is not analysed by trusts. There are community teams and home treatment teams and some trusts have crisis response teams. Each trust calls those teams different things, but they are on the ground and they are expanding as resources become available.

Mrs Jendoubi:

They are included within that very large "Other Community" line that runs up to £35 million in 2009-2010.

Mr McCarthy:

That is useful information. Why are the figures for child and adolescent psychiatry outpatient services dropping so dramatically from £3·8 million to just over £1 million when we know that there is an increasing need for such services?

The Chairperson:

Kieran is saying that the actual spend in 2008-09 and 2009-2010 is over £3 million, but planned expenditure is one third of that or less.

Mr McCarthy:

Exactly. That is dramatic, when we know that there is an increasing need for such services.

Mr Toogood:

Again, I keep going back to the apparent difference between the numbers. It will be useful for members to see the analysis of 2010-11, which we will get at the end of October. It will show us truly where the money went.

Mr McCarthy:

Will you forward that when you get it?

Mr Toogood:

Absolutely.

The Chairperson:

Thank you, Kieran; that was very helpful.

Mr Wells:

I want to go back to the question that I asked earlier of the researcher. I am just trying to split the health element from the social care element and determine which is which. I presume that all the figures in the "Total Hospital" line come into what we would call health?

Mrs Jendoubi:

Yes.

Mr Wells:

Do any of the "community" lines also fall into health?

Mrs Jendoubi:

Yes.

Mr Wells:

What is the percentage split? I am asking that because protection is given to the health element of your budget but not to social care. I am trying to work out which are the most vulnerable aspects of the social care budget within mental health.

Mrs Jendoubi:

As a rule of thumb, anything that has a nursing tag under community expenditure would be regarded as health. That goes for allied health professionals (AHPs) as well. Under the "Total Expenditure-PSS" line — the personal social services — there is independent free nursing care. That is quite a small line. I am scared to use the emotive word "top-up", but it is the free £100 a week nursing element of nursing care home places. That would be regarded as health as well.

Mr Wells:

Residential home care is not regarded as part of health; it is regarded as social services.

Mrs Jendoubi:

That is correct.

Mr Wells:

In other words, do we know, roughly, what percentage of the mental health budget is health and therefore has a degree of protection because it comes under the same definition of health as in England and what percentage is within social care and therefore has to suffer the efficiency savings and reductions in expenditure that you have to make in order to meet your budget? Is it all up for grabs?

Mr Toogood:

Obviously, you are aware that the way in which the services are delivered here is different to how they are delivered in England because of the integrated nature of our services. To that extent, the health and social services split is not as clear and easy to work out. To try to pick out areas and say that they are protected over others is difficult because of the way in which we are configured here and the way in which services are delivered. It is not, therefore, as clear here as it is across the water.

The Chairperson:

Is any of it protected?

Mr Wells:

That was my next question.

Mr Toogood:

The budgets will be allocated in accordance with ministerial priorities. They will reflect what the Minister wants to do with the funding. Mental health is considered alongside all the other priorities and objectives that are outlined in the commissioning plan and the commissioning plan direction.

The Chairperson:

Christine is looking as confused as me. Is the Minister likely to prioritise health over social services? Is that what you are expecting?

Mrs Jendoubi:

I have had no indication of that whatsoever. It is very easy to say that non-elective care or urgent care needs to be prioritised. If you walk through a hospital door and you are bleeding, the hospital staff have to treat you, whereas with social care you might get an hour less of domiciliary care in the week, because it is easier to turn up and turn down social care as the money suits. Trusts have a statutory responsibility to live within their budgets, and they try to do that by making savings in areas that will have the least impact on patient health and safety. When they are trying to manage their budgets, I think it is easier for them to do that with the social care aspect than with the healthcare aspects. I am not aware of the trusts or the board having been given any direction by the Minister or anybody else that they are to safeguard health at the expense of social care. It is just easier to manage the budget for them that way.

Mr Wells:

That means that, without that direction, all of the mental health budget could be targeted for savings.

Mrs Jendoubi:

In theory, yes.

Mr Wells:

Therefore there is no direction. Then again, when we talk to the trusts, we may find, equally, that there has been no direction on elective surgery or cancer care and that, basically, everything has been thrown into the same pool. The budgetary element of health that is protected is a notional figure in there, but the savings can be found anywhere. Mental health has not been singled out for any particular treatment.

Mrs Jendoubi:

No.

Mr Wells:

The beauty of having a joint health and social care system is that it creates all sorts of savings and efficiencies, but the problem is that it is often very difficult to tease out what falls within social care and what falls within health. I know that this is complicated, but are we right in thinking that

the mental health element of that is less per head than it is in the rest of the UK? If it is less, by how much is it less? Is mental health the poor relation of health service provision in Northern Ireland?

Mr McCarthy:

Of course it is; it always was.

Mr Wells:

I know that Kieran has been going on about this since the Boer War. I understand that. He has been here for a long time raising the issue. What is the level of under-provision in mental health in comparison with the rest of the UK and the Irish Republic?

Mrs Jendoubi:

I do not have comparative figures of that nature. I have no hesitation in agreeing with you and Mr McCarthy when you say that it is underfunded in comparison with other health services, but I suspect that that is also the case in England. I suspect that Northern Ireland is not unique in that regard, but I do not have figures to back that up.

Mr Wells:

Am I right in saying that Northern Ireland is more underfunded than other devolved regions in the UK?

Mrs Jendoubi:

As an example, when the Bamford review was done, the mental health budget was about £200 million. We now have £224 million here. It was suggested that, to deliver the Bamford vision, it would take at least 10 years and a doubling of the mental health budget here.

Mr McCarthy:

I was at the launch of the Bamford review at the Stormont Hotel, and the figure was £300 million. It was quite clearly stated that to deliver the recommendations of the review in a 10-year period, the figure would have to be doubled to £600 million. I am sure we are not in better circumstances now. That was three or four years ago.

Mr McMinn:

It is difficult to make a direct comparison of per capita spend on mental health because we have an integrated service. There are different budgets to pull together across the water, because different organisations deliver social care and healthcare. It has been tried, but the figures produced from that are not reliable.

Mr Wells:

Even given the figures that you have provided, it is quite clear that the increase in funding among the various sectors happens faster in areas like maternity, acute services, learning disability and physical and sensory disability. They are all very deserving causes, but, if we look at the nine delivery modes, we can see that funding for them is increasing faster than funding for mental health. I appreciate that this is enormously difficult; you are comparing apples with oranges, and I can understand that. Not only is it enormously difficult because there is a different funding mechanism — they can add it to the rates and we cannot, and I accept that — but even your figures indicate that when the pie is being divided, mental health is getting less of an increase than the other services. Is that not a correct understanding of what is going on?

Mrs Jendoubi:

That is what the figures appear to show.

Mr Wells:

Funding for primary healthcare and adult community services is up by 76%, for acute services by 24·8% and for mental health by 18·2%. That indicates to me that mental health is lagging further behind, if we admit that it is already underfunded and that everything else is increasing faster. The figures for the longer period show a 47·8% increase for acute services and a 41% increase for learning disability, but, again, mental health is languishing down there at 30%. That indicates to me that we are losing pace faster and faster and falling behind the rest of the health service in Northern Ireland, yet, with an ageing population and the stresses of modern life, the demand is increasing much faster than resources.

The Chairperson:

We also have the awful blight of suicide in our society. We need to fund mental health services. I accept that they do not all come under that category, but more people die on this island from suicide every year than die in road traffic accidents. It has to be taken seriously.

Mr McMinn:

Part of the ongoing reform and modernisation of mental health services is happening through primary care services, early intervention and signposting people to voluntary organisations when they are in distress to try to ameliorate early conditions and prevent their situation from escalating into a crisis that requires inpatient services. On top of the statutory services that trusts provide, they buy a range of services from the voluntary sector, because that is a more efficient way of delivering some of the early-intervention psychotherapy.

The Chairperson:

But presumably that figure is in the other PSS line. It would be helpful to get details on that. I accept that the trusts contribute to community and voluntary sector organisations that do sterling work with that money, usually much more cost-effectively than the health service can. It would be helpful to extrapolate that line.

Mrs Jendoubi:

It is also in the "Other Community" line.

The Chairperson:

OK. I have that one marked as well, because I am looking for further information on it. It would be great if we could get that.

Mr Brady:

Thanks for the presentation. If I were being really cynical, I would think that you are saying that it is easier to take money out of the social care budget than the acute care budget. Is it true to say that the social care budget is regarded as a softer target and that people are less likely to kick against the fact that money has been taken out of that budget? For instance, cognitive behavioural therapy (CBT) is not yet readily available in Newry, even though it is recognised as one way to treat depression. If that therapy were available, there might be fewer people with mental health problems. So, that kind of flies in the face of what you are saying.

Mr McMinn:

CBT is recognised as an intervention that is approved by the National Institute for Health and Clinical Excellence (NICE). Computer-based CBT is available through every GP practice, again,

for folks who are able to go through those programmes. As I say, we launched a psychological therapy strategy, which, you are absolutely right, went out in June 2010. Unfortunately, however, there was a major hiccup, which was beyond our control, with the money that was going to underpin the development of our psychological therapy services in 2010-11.

Mr Brady:

With respect, do GPs really want to get involved in the long-term treatment of people with mental health problems? From my experience, gained over a long number of years, of dealing with people who present with mental health problems to their GPs, I know that there tends to be a referral mechanism, whereby the patient is sent to, for instance, the day hospital at Daisy Hill, which is non-residential. If, however, they have been referred to a residential hospital, they will be sent to Craigavon. It used to be St Luke's, but now it is Craigavon. Although numbers are increasing, there is less and less accessibility to treatments. So, I think that a balance has to be struck.

Mrs Jendoubi:

There is an issue around GPs' willingness to provide long-term care and primary care for people with mental health issues. I think that that has been coming out recently, even among surveys of GPs. As Colin mentioned, 'Beating the Blues', the computerised CBT service, has been available through all GP practices, but we have been disappointed with the low take-up.

The impression that we have been getting — again, I do not have the figures for this — is that GPs do not feel terribly comfortable dealing with mental health issues. They do not feel as equipped to respond to mental health issues as they do to physical health issues. That is something that we need to address as we go forward. Consistent with the direction of travel is the provision of services in the community. The first port of call for people who do not feel well, be it mentally or physically, is their doctor, so doctors have to be as well equipped as possible to be able to respond that.

Mr Brady:

I accept that, but I think that a lot of it is aspirational. In my experience of representing people at tribunals for over 30 years, many of whom presented with various ailments associated with mental health, I have rarely come across a case that has actually been dealt with by a GP and not been referred to a psychiatrist. I have certainly never heard of the programme that you

mentioned. Even in discussions with GPs, I have never heard of it. Maybe that is something that you need to look at again.

Mrs Jendoubi:

Yes, indeed.

The Chairperson:

I accept that you deal with finance, but do you know whether there is ongoing training for GPs? Is there ongoing training on any new developments to ensure that GPs are adequately equipped to deal with mental health problems? We know of lots of examples of people, especially women, being on tranquilisers for a second and third decade because their GPs did not know how to deal with them. The tablets were just fired into them, and they ended up spending half their life doped up on tranquilisers. That is not healthy. I know that some community providers in places such as north and west Belfast have tried to wean people off those drugs and to give them the support that they need in the community.

Mrs Jendoubi:

'Beating the Blues' was introduced to GP practices by means of a directed enhanced service (DES). It is being paid for by our esteemed colleagues in the Department for Social Development, for which we are exceptionally grateful. My understanding is that the DES included an element of training when the programme was made available. The money also covered the cost of the software licence. You cannot just go on the internet and do the 'Beating the Blues' programme; you have to be referred and have a password. I agree that it has been disappointing because of the take-up and the fact that GPs do not seem to be aware of the programme. They are all being paid to deliver it. That is something that we need to take up with the British Medical Council or the General Practitioners Committee.

Mr McCarthy:

I was a bit disappointed by your response to a question from Jim Wells about prioritisation. When Minister McGimpsey was in power, he said over and over again that his priority was mental health. That is easily said, but it is about sending the funding in the right direction. I do not know about the present Minister. Are you saying that you did not see anything coming through financially to bolster what Minister McGimpsey was saying?

Mrs Jendoubi:

We have had the increases in mental health finances that we have talked about, but there is a lot in what Mr Wells said earlier. If you start from a position that is further back, it is more difficult to catch up. Mr Poots has said that mental health is also a priority for him and that it would be the first place that he would put any additional money he was able to extract by way of efficiencies elsewhere in the system.

Mr McCarthy:

It is encouraging to hear that. Let us hope that he can get some.

The Chairperson:

The challenge is getting it out of the rest of the system. Can you imagine acute services letting go of anything? His job will be getting it off that area. That will be his biggest challenge.

We have another long session coming up, so, if nobody has any other questions, we can draw this session to a close. Thanks again to Colin, Christine and Peter. No doubt we will become very used to you over the next few months. We appreciate your attendance.