Northern Ireland Assembly

Public Accounts Committee

Report on Mental Health Services in Northern Ireland

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Report: NIA 39/22-27 Public Accounts Committee

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Powers and Membership

Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance or of any junior minister appointed to the Department of Finance.

Membership

The Committee has 9 members, including a Chairperson and Deputy Chairperson, and a quorum of five members. The membership of the Committee is as follows:

- Mr Daniel McCrossan MLA (Chairperson)
- Ms Cheryl Brownlee MLA (Deputy Chairperson)
- Mr Cathal Boylan MLA
- Mr Tom Buchanan MLA
- Mr Pádraig Delargy MLA
- Ms Diane Forsythe MLA
- Mr Colm Gildernew MLA
- Mr David Honeyford MLA
- Mr John Stewart MLA[1]

[1]With effect from 5 March 2024 Mr John Stewart replaced Mr Robbie Butler

List of Abbreviations and Acronyms used in this Report

the Assembly:	the Northern Ireland Assembly
C&AG:	Comptroller and Auditor General
CAMHS	Child and Adolescent Mental Health Services
the Committee:	Public Accounts Committee (PAC)
NIAO	Northern Ireland Audit Office
PSNI	Police Service of Northern Ireland

Executive Summary

1. The Public Accounts Committee (the Committee) met on 11, 18, and 25 April, 2 and 30 May and 6 and 13 June 2024 to consider the Northern Ireland Audit Office's (NIAO) report "Mental Health Services in Northern Ireland". The main witnesses were:

    - Mr Peter May, Department of Health
    - Mr Peter Toogood, Department of Health
    - Mr Brendan Whittle, Department of Health
    - Dr Petra Corr, Northern Health & Social Care Trust
    - Prof Siobhan O'Neill, Mental Health Champion
    - Ms Dorinnia Carville, Northern Ireland Audit Office
    - Mr Stuart Stevenson, Department of Finance.

2. Mental health remains one of the greatest health issues affecting Northern Ireland, impacting many of the most vulnerable in society. Its cost is conservatively estimated at £3.4 billion annually, with the majority of costs associated with four main conditions – anxiety, depression, bipolar disorder and schizophrenia. Many mental health conditions are preventable, and therefore the financial cost to society can be reduced. We also have a moral imperative to reduce the suffering caused by poor mental health in our population. However, there are significant gaps in services and many of our most vulnerable people do not get the care that they deserve and need.

3. There is an accepted need for transformation in mental health and broad agreement on the form that transformation should take, as identified in the 10-year mental health strategy published in June 2021. However, the costs associated with the strategy, at some £1.2 billion, are significant and it was acknowledged that the level of additional funding necessary for full implementation was not available from within Department of Health resources,

with the Minister calling for action across the Executive to prioritise mental health in future budgets.

4. Alarmingly, despite the stated priority of mental health, the additional funding anticipated has not been forthcoming. While to date the Department has allocated approximately £10 million towards the strategy, this represents a significant shortfall against the almost £35 million estimated to be necessary over the period to 2023-24. Progress in the implementation of the strategy to date has been disappointing, and mainly focussed on preparatory and enabling activities, the impact of which will not be felt by users.

5. In 2024-25, based on its plans, funding for the implementation of the strategy would be expected to grow to £42 million. The Department has, however, signalled that given its proposed budget, funding available for the strategy will continue to be the subject of competing priorities. There is real concern that, should the shortfall in funding continue beyond 2024-25, the strategy (and the necessary transformation of services) will not be delivered within its 10-year timeframe and a danger that it will become outdated. The anticipated 3-year budget commencing 2025-26, therefore, represents a key milestone in the overall deliverability of the strategy, at which time the Committee believes it may be necessary to reconsider what is reasonably achievable.

6. It is a truism within healthcare that without the workforce there can be no services. Evidence provided to us highlighted concerns around the inadequacy of the mental health workforce, particularly in relation to Child and Adolescent Mental Health Services (CAMHS) and psychological therapies. As a result, mental health services have been unable to adequately meet the needs of those seeking support.

7. The importance of workforce in achieving the desired transformation in services is recognised in the mental health strategy, which committed to a comprehensive workforce review. However, the review's findings, published in July 2023, are hugely concerning. Providing the future services envisaged in the strategy, would require overall growth in staff numbers within statutory services of almost 50 per cent (representing almost 2,000 whole-time equivalent staff). Within this, the CAMHS workforce would need to double.

8. The Mental Health Champion identified workforce as the number one priority in mental health, specifically the need for the Department to now move to develop plans to deliver the growth necessary to meet peoples' needs, through the commissioning of additional training places. In particular, she highlighted the need to grow the CAMHS and therapies workforces, and specifically noted the lack of commissioned psychotherapy services for children and young people. Concerningly for the Committee, the Department has conceded that the number of training places is not on a trajectory to address its workforce problems and that the scale of workforce expansion necessary cannot be delivered without additional funding. It also accepts, however, that without substantive workforce growth services users will not feel any impact in services.

9. Despite the worrying levels of mental ill health in Northern Ireland, and growing complexity in presentations, there is a long history of underfunding in mental health. Evidence indicates that we spend significantly less per capita, and as a share of the overall health budget, on mental health than the rest of the United Kingdom. Greater health needs in Northern Ireland, a number of competing priorities and resultant pressures on health budgets, has meant the Department has not spent a greater share of its budget on mental health.

10. However, there are compelling economic arguments for spending more on mental health, reflecting the potential to reduce costs to society, reduce the associated costs of physical healthcare, and particularly the reduction in the burden of mental illness in later life through early intervention via CAMHS. There is also clear research evidence of the cost effectiveness of particular interventions.

11. Data in mental health is limited and overwhelmingly focused on activity being undertaken, rather than on the impact services are making for patients. While welcoming the progress that the Department is now beginning to make, and specifically the design of an outcomes framework, obtaining better and fuller data remains some way off, and is dependent on the successful implementation of the new Encompass system. Once available, however, it will be important for the Department to start to use the information received to improve the effectiveness of services. In supporting transparency and accountability, it is also important that mental health performance data should be published.

12. The Committee heard that the Department had developed the new mental health strategy despite having little data on the outcomes of services for patients, no strategic data on the workforce needed within the statutory sector and limited data on services in the voluntary and community sector. Whilst the Committee acknowledges work has now begun in each of these important areas, the baseline from which the Department has started has been incredibly low.

13. As a result of a lack of capacity in, and lower levels of acceptance into, CAMHS, many children and young people are getting to mental health services later than they would have done in the past. As a result, a young person's condition can worsen significantly l by the time they get help.

14. There is clear evidence that early intervention and early support has clinical benefits and can prevent lengthy and expensive treatment in the long term. Regrettably, however, the Committee heard concerns raised around timely access to CAMHS, particular lack of early intervention provision. Waiting for people to get sicker or to fall into crisis before they are offered treatment, however, is not an acceptable approach.

15. The number of people waiting to access mental health services continues to increase to unacceptable levels. Latest figures, for December 2023, record a total of just over 17,500 people awaiting a first appointment. Within this, psychological therapies represent a disproportionate share, with around 6,500 people waiting to access services. Alongside this, performance against waiting time targets has also continued to deteriorate. Worryingly, around three-quarters of those on psychological therapies waiting lists, as of December 2023, had been waiting longer than the 13-week target time. As a result, service users and their families feel that they cannot get the help that they need. Without timely treatment, however, peoples' conditions will deteriorate, becoming more difficult and costly to treat.

16. The Department told us, however, that waiting lists fundamentally reflect the demand-capacity gap in mental health services, accentuated by the COVID-related increase in acuity in presentation which, in taking longer to treat, has impacted negatively on case turnover. Nevertheless, in acknowledging that

waiting lists are too long, and with limited opportunity for increased productivity, the Department suggests that little can be done to reduce waiting lists and improve waiting times without additional investment in the workforce. However, its current financial position means that it is difficult to deliver the enhancements necessary to help address waiting lists.

17. As a consequence of poor access to mental health services, people are turning to Emergency Departments in search of help, although the Committee has concerns that, as busy and challenging environments, Emergency Departments are not an appropriate place for many people with mental health issues. While there are few alternatives available, the Department highlighted an ongoing pilot at the Western Health and Social Care Trust to provide a separate and safe space for individuals attending the emergency Department with mental health issues.

18. The Committee believe that addressing issues early can often result in better value for money and better solutions. The importance of prevention and early intervention is clear when the impact of poor mental health is considered. This impact, and the associated financial cost, falls not only on the Health service, but right across the public sector, and especially in the Education and Justice sectors. Schools have a particularly important role in supporting the mental health of children and young people and, while welcoming the joint development of an Emotional Health and Wellbeing Framework with the Department for Education, we recognise that more needs to be done to increase partnership working between the two departments. Similarly, given the cost and resource drain for the PSNI in responding to incidents of people in crisis, there is a need for improved collaboration between the Departments and Agencies to ensure better services for those in mental health crisis.

19. The Committee recognises the essential role played by the voluntary and community sector in providing a wide range of mental health services to those in need in their communities. However, precarious funding has real impact for the sector and those who rely upon it in terms of delivery of services, employment of staff and ability to plan for the long term. As a result, the Committee is hugely concerned about the potential impact of any withdrawal of mental health services from the voluntary and community sector, although it is

encouraged by the Department's recognition that it needs to improve how it works with the sector, to make best use of its knowledge, expertise and experience.

20. We also heard about a number of gaps in services, including services in areas such dual diagnosis, eating disorders and services for those who have Special Educational Needs (SEN) or are neurodivergent. These gaps raise concern about the future demand that will fall on mental health services as a result of those who are not currently receiving treatment. Gaps in services need to be planned for now, before the challenges build to the stage at which they are unsustainable.

21. The Committee is disappointed in the degree of progress achieved in the implementation of the strategy to date. Without urgent action, the deliverability of the strategy and the necessary transformation of services remains at risk. Lack of progress also jeopardises the goodwill and enthusiasm of stakeholders, who have invested considerable energy in the development of the strategy. As a strategy agreed by the Executive as a whole, the Committee calls on both the new Executive and the Department to give greater priority to mental health in order to support the timely and successful implementation of the strategy.

Summary of Recommendations

Recommendation 1

22. **The Committee recommends that the Department takes this opportunity to review the deliverability of the strategy. Where necessary, it should develop revised plans and timescales for the transformation of mental health services, to ensure maximum progress as soon as possible. As part of this, the Department should develop actions plans focused on actions that are deliverable and publish performance against these actions annually.**

Recommendation 2

23. **As a critical enabler of the mental health strategy and in addressing mental health needs, there is a clear need to grow the mental health workforce. Now, already three years into the strategy, is the time to invest. Otherwise, given the time lag between recruitment to training and introduction to the workforce, the envisaged transformation of services is unlikely to be achievable.**

24. **The Department needs to urgently implement the recommendations of the mental health workforce review, developing plans for the required expansion of the workforce within 6 months. This should include setting out how and over what timescale it intends to do this, together with the estimated cost of doing so. This should include the identification and cost estimate of the future number of training places needed.**

Recommendation 3

25. **There are significant levels of mental health need in Northern Ireland, and despite being a stated priority, mental health continues to be underfunded. Alongside the moral imperative to reduce suffering, there are clear economic arguments to increase funding levels. More funding for mental health represents an 'invest to save' opportunity in terms of reducing the impact on wider society, together with its potential to reduce**

future demand for (and cost of) services in both mental health and physical healthcare.

26. **The Committee recognises the benefits of multi-year budgets in facilitating effective long-term planning and development. However, even in the absence of these budgets, the Committee recommends that the Department outlines how it can increase the mental health budget by setting out a target and timeframe over which to grown funding towards the 10-11 per cent suggested by the Mental Health Champion.**

27. **The Department should also set out how it intends to grow the CAMHS budget towards a 10 per cent share of the overall mental health budget.**

Recommendation 4

28. **In light of the importance of data on the outcomes of mental health services in demonstrating value for money, the Committee expects to be updated on the progress in collecting outcome data in 12 months' time. At that stage, we expect all Trusts to be able to provide full, consistent and reliable information on mental health services and outcomes in a format that allows for effective regional comparability.**

Recommendation 5

29. **The Committee recommends that the Department reviews and considers how best to use the data it will collect to improve the services it provides. This should be commenced now so that it is completed when Encompass is fully rolled out.**

Recommendation 6

30. **Alongside providing a roadmap of how and when it intends to roll out the newly developed outcomes framework, the Committee believes that it is essential that the Department outlines how it will publish mental health data to bring transparency to the services.**

Recommendation 7

31. **We recommend that the Department engage with CAMHS services to identify common areas and themes around failed referrals and any other barriers to access appropriate support. This information should be used to inform and improve the quality and number of referrals.**

Recommendation 8

32. **The Committee recommends that the Department carries out a review within 12 months to examine whether it is providing sufficient, early support to those children in need. It should put a strong focus on providing additional support to those in need to prevent conditions escalating and ultimately becoming more challenging to treat.**

Recommendation 9

33. **Waiting lists and waiting times in mental health services are unacceptable, and are contributing to increased acuity in presentation, making conditions harder and more costly to treat. While there is a general need to reduce the numbers on waiting lists and improve performance against waiting times, there is particular need to address the numbers waiting for psychological therapies.**

34. **We recommend, therefore, that the Department develops an action plan setting out how it intends to address waiting lists in mental health. The Committee views the need to improve waiting lists as so urgent, that the Department should report back to the Committee in 6 months' time on its progress in reducing waiting lists.**

Recommendation 10

35. **The Department should urgently implement planned regional crisis services. In addition, the Department should learn lessons from pilot schemes including the Western Trust pilot, and Multi Agency Triage Teams, with the aim of providing alternative safe places within Emergency Departments and improved access to crisis services across the region as a matter of urgency.**

Recommendation 11

36. **The Committee expects better and stronger collaboration across government. In this case, it is clear that the mental health needs of children in Northern Ireland will only be addressed through genuine partnership working between Health and Education. We recommend that the Department builds on the work it has undertaken to date and increase collaboration with the Department of Education to support emotional wellbeing.**

Recommendation 12

37. **The Committee recommends that the Department and PSNI speed up consideration of proposals and bring forward an appropriate model that ensures those in mental health crisis can be seen by the most appropriate professional. We firmly believe that better services can be delivered by better collaboration.**

Recommendation 13

38. **The Committee recommends that the Department reviews its reliance on the voluntary and community sector. It should know how many referrals there are to, and from, that sector; how many people are reliant on the services carried out by the voluntary and community sector; and the value of those services provided. It should use this to engage with and carry out a review of how best to provide greater funding certainty to this sector.**

Recommendation 14

39. **The Committee expects that the Department reassesses its engagement with the voluntary and community sector. As part of this, the Department should set out more clearly how it intends to improve engagement with the voluntary and community sector. It is crucial that any barriers to having a more mature conversation are overcome and the expertise that exists is fully harnessed.**

Recommendation 15

40. **The Committee expects that the Department's review of the deliverability of the strategy also incorporates an identification of key gaps in services, including regional disparities across Northern Ireland. The Department should begin to plan now for addressing key gaps, rather than allow these challenges to build to a stage at which they are unsustainable. The Department's review should consider areas where working with health services across the island could result in better outcomes for patients.**

Recommendation 16

41. **The Committee recommends that the Department urgently implement services for those with co-occurring mental health and substance use issues. It is not acceptable that the pace of change in this area is so slow.**

Introduction

42. The Public Accounts Committee (the Committee) met on 11, 18, and 25 April, 2 and 30 May and 6 and 13 June 2024 to consider the Northern Ireland Audit Office's (NIAO) report "Mental Health Services in Northern Ireland". The main witnesses were:

- Mr Peter May, Department of Health
- Mr Peter Toogood, Department of Health
- Mr Brendan Whittle, Department of Health
- Dr Petra Corr, Northern Health & Social Care Trust
- Prof Siobhan O'Neill, Mental Health Champion
- Ms Dorinnia Carville, Northern Ireland Audit Office
- Mr Stuart Stevenson, Department of Finance.

Background

43. Mental health remains one of the greatest health issues affecting Northern Ireland, impacting many of the most vulnerable in society. The prevalence of mental health issues among the population is significant, with latest health survey results (2022-23) indicating that around a fifth of adults show indications of probable mental health problems. Prevalence levels are also significant among children and young people, with 1 in 8 meeting the criteria for anxiety and depression, 25 per cent higher than comparable rates in England. As highlighted in the Mental Health Champion's evidence to the Committee, what sets Northern Ireland apart from the rest of the United Kingdom is the severity and complexity of mental health difficulties because of our history of trauma, resulting in cases which are more difficult to treat.

44. Mental ill-health also has a high cost. The London School of Economics and the Mental Health Foundation, in 2022, conservatively estimated the overall cost of poor mental health in Northern Ireland at £3.4 billion annually. The majority of

these estimated costs are associated with four main conditions – anxiety (22 per cent), depression (20 per cent), bipolar disorder (16 per cent) and schizophrenia (8 per cent). Within the overall estimate, the cost of specialist mental health care services represents only a relatively small part, at around 12 per cent.

45. Many mental health issues are preventable, and therefore the financial cost to society can be reduced. There is also a moral imperative to reduce the suffering caused by poor mental health in our population. However, as many on the Committee understand through the experience of their constituents (and confirmed in the Mental Health Champion's evidence), there are significant gaps in services and many of our most vulnerable people do not get the care that they deserve and need.

While an overarching mental health strategy is now in place, implementation to date has been disappointing and its impact is yet to be felt by users

46. Past reviews in mental health criticised the lack of an overarching strategy. The restoration of the Executive in January 2020 saw a renewed focus on mental health, which culminated in the launch of a 10-year strategy for mental health in June 2021. The strategy, which covers the period 2021 to 2031 and which was agreed by the Executive as a whole, identifies a new vision for the future of mental health and sets out 35 key, high-level actions for the development and transformation of services. Five 'standout' actions are identified:

- creating an action plan for promoting mental health through early intervention and prevention;
- increasing the share of funding for CAMHS to 10 per cent of that provided in adult mental health;
- changing the structure of service deliver, refocusing and reorganising more towards community-based services, centred around GPs and primary care teams;

- improving the integration of the voluntary and community sector in service delivery; and

- ensuring consistency in service delivery and development by developing a regional mental health service across the five Trusts.

47. The costs to implement the mental health strategy are substantial. The funding plan published alongside the mental health strategy estimates the total cost of its actions at £1.2 billion over the 10 years to 2031, over and above the on-going costs of maintaining current services. This includes capital costs associated with the construction of three new inpatient units of £287 million, and revenue costs related to the development and implementation of new and improved services of £920 million. Whilst low in the early years, revenue costs increase to £158 million per annum by 2031-32 as new services are fully implemented.

48. From the outset, however, it was acknowledged that the level of additional funding necessary for full implementation was not available from within departmental resources without severe implications for existing services, and in launching the strategy in June 2021 the Minister of Health called for collective action across the Executive to prioritise mental health in future budgetary processes.

49. The Committee was alarmed to uncover, however, that the strategy has not been funded to the level required. While the Executive's draft budget for 2022-23 to 2024-25 did indicate full provision for these early years, this was never approved, and the funding has not materialised. To date, the Department has allocated just over £10 million towards the delivery of the strategy. This is some £24 million below the amount estimated to be needed over the first three years of the strategy. The funding shortfall in 2023-24 alone totalled almost £19 million, with the Department investing only £5.5 million towards the implementation of the strategy, against an estimated need of £23m. The Department acknowledged that it has not been able to fund the strategy to the levels envisaged, but the Permanent Secretary stressed that this this did not reflect a lack of priority towards mental health. Rather the very serious financial challenges faced by the Department.

50. In line with the funding plan, funding towards the implementation of the strategy would be expected to increase to around £42 million in 2024-25. However, whilst the level of funding available remains to be finalised, the Permanent Secretary has signalled that, given the Department's proposed budget, funding will remain 'incredibly constrained' in 2024-25.

51. As a result of its inability to adequately fund the strategy, progress in implementation has not matched original expectations. The Committee has strong concerns that, three years into a ten-year strategy, delivery has been slow and the impact for those who need support has been marginal. Many actions to date have been preparatory or enabling. Whilst this is important, in developing services, ultimately there must be a focus on delivery. A strategy should not be a goal in itself.

52. The Department told us that delivery has started against 20 of the 35 actions set out in the strategy. In particular, it highlighted the establishment of community perinatal mental health services, the development of a three-year early intervention and prevention action plan, publication of a mental health workforce review, the completion of a review on how it engages with the voluntary and community sector and finalisation of a regional mental health outcomes framework. Nevertheless, the Department acknowledges that, while work to date has mainly been focussed on important preparatory and enabling activities, users will not yet feel any impact in terms of services.

53. Despite the disappointing progress to date, the Department accepts the urgent need to transform services and, as confirmed by the Mental Health Champion, there is broad agreement among stakeholders that the strategy represents the correct direction of travel (or the 'North Star' as the Permanent Secretary put it). The Department also stressed that co-production of annual delivery plans with stakeholders ensures activity is focused in the right, priority areas, making best use of available resources.

54. However, we note the concern expressed by both the Department and the Mental Health Champion that, should the shortfall in funding continue beyond 2024-25, it will become less likely that the strategy will be achieved within its 10-

year timeframe. The (anticipated) 3-year budget commencing 2025-26 was identified as a key milestone in terms of the overall deliverability of the strategy.

55. The Committee is disappointed in the degree of progress achieved in the implementation of the strategy to date. Without urgent action, the deliverability of the strategy and the necessary transformation of services remains at risk. Lack of progress also jeopardises the goodwill and enthusiasm of stakeholders, who have invested considerable energy in the development of the strategy. As a strategy agreed by the Executive as a whole, the Committee calls on both the new Executive and the Department to give greater priority to mental health in order to support the timely and successful implementation of the strategy.

56. There is a danger that, through continued failure to progress and change happening too slowly, the strategy will become outdated. The Committee recognises the next budget cycle as a key milestone.

The Committee recommends that the Department takes this opportunity to review the deliverability of the strategy. Where necessary, it should develop revised plans and timescales for the transformation of mental health services, to ensure maximum progress as soon as possible. As part of this, the Department should develop actions plans focused on actions that are deliverable and publish performance against these actions annually.

Workforce is a major concern and critical to the transformation of services

57. It is a truism within healthcare that without the workforce there can be no services. Evidence provided to us highlighted concerns around the current mental health workforce, particularly in relation to Child and Adolescent Mental Health Services (CAMHS), and psychological therapies (inc. the lack of commissioned psychotherapy services in CAMHS). This is illustrated in the significant vacancy levels across professions, for instance the 11 per cent vacancy rates in mental health nursing highlighted in the NIAO report and the 25 per cent consultant psychiatry and 30 per cent psychologist vacancy rates

identified by the Mental Health Champion. As a result, services are unable to adequately meet the needs of those seeking support.

58. The Committee are pleased that the importance of workforce in achieving the desired transformation in mental health services is recognised by the mental health strategy, which committed to a comprehensive review of the workforce. We are, however, hugely concerned by the review's findings. The review identifies the need for substantial growth in the number of staff in mental health – almost 50 per cent overall (and incorporating a doubling of staff in CAMHS). This represents an increase of almost 2,000 whole-time equivalent staff over the next ten years (including over 500 nursing staff). More concerningly, this only reflects the statutory sector and does not assess capacity or need within the voluntary and community sector.

59. The Mental Health Champion identified workforce as her number one priority in mental health, indicating that expansion in the workforce is integral to the transformation of services and would also facilitate the development of additional specialisms and fill gaps in services in areas such dual diagnosis, eating disorders and services for those with SEN or neurodivergence. She also highlighted the importance of the appointment of a Chief Psychologist to lead development in psychological therapies. While welcoming the speedy delivery of the workforce review, the Mental Health Champion highlighted the need to now move on to develop plans to deliver the workforce growth necessary to meet people needs, in particular through the commissioning of additional training places.

60. The Department also acknowledged the importance of the workforce in transforming services, noting the priority to be given to it in next year's (2024-25) strategy delivery plans – in the further development of the regional mental health service, in work to better understand the capacity and capability of the voluntary and community sector towards maximising its contribution to services, and exploring options around what the psychological therapies workforce should look like. Specifically, with regard to the regional mental health service, the Department noted the recent appointment of a head of service to lead and oversee development. The Department also highlighted the investment of around £2 million in CAMHS, to alleviate pressures (particularly within the

regional inpatient unit) and enhance services, increasing the workforce by 38 whole-time equivalents.

61. The Committee's concerns around workforce numbers were exacerbated by the Department's evidence. The Department identified a total of just over 20 clinical psychology doctorate places in 2024-25 and 165 mental health nursing places, a decrease from 2023-24. Whilst the Department acknowledged that the number of training places is not on a trajectory to address its workforce problems, the Committee is clear that the success or otherwise of the strategy is reliant on the sustainable growth of the mental health workforce.

62. While recognising its inability to grow the workforce as a key constraint in the desired transformation of services, the Department told us that the scale of workforce expansion necessary cannot be delivered without additional funding, although it also accepted that without substantive growth service users will not feel any difference. Importantly for the Committee, even if the Department now received the necessary funding, the time lag between commissioning training places and having skilled, qualified staff available means that improvement is potentially years away.

As a critical enabler of the mental health strategy and in addressing mental health needs, there is a clear need to grow the mental health workforce. Now, already three years into the strategy, is the time to invest. Otherwise, given the time lag between recruitment to training and introduction to the workforce, the envisaged transformation of services is unlikely to be achievable.

The Department needs to urgently implement the recommendations of the mental health workforce review, developing plans for the required expansion of the workforce within 6 months. This should include setting out how and over what timescale it intends to do this, together with the estimated cost of doing so. This should include the identification and cost estimate of the future number of training places needed.

There are compelling economic arguments for spending more on mental health but significant

improvements to outcomes measurement are required before they do so

63. In 2023-24, the Department invested around £388 million in mental health services, amounting to around 7 per cent of the overall health budget and just over £200 per person in Northern Ireland. Within the £388 million, CAMHS accounted for approximately £30 million and around 8 per cent of the mental health budget. At this level, CAMHS funding continues to fall short of the 10 per cent share of the mental health budget advocated by the Department.

64. Despite the worrying levels of mental health need in Northern Ireland, and growing complexity in presentations, there is a long history of underfunding in mental health in comparison with elsewhere. Evidence indicates that we spend significantly less per capita, and as a share of the overall health budget, on mental health than the rest of the United Kingdom.

65. When asked about the reason for this, the Permanent Secretary indicated that this reflected a low starting base and the fact that Northern Ireland has been attempting to catch up during a period of constrained finances. The ability of other jurisdictions to spend proportionately more on mental health, according to the Department, reflects, at least in part, lower levels of health need. Greater health needs in Northern Ireland (as identified by the Fiscal Council), a number of competing priorities and resultant pressures on health budgets, has meant the Department has not spent a greater share of its budget on mental health. In indicating that the Department would like to spend more on mental health, and whilst its budget remains to be finalised, the Permanent Secretary signalled that the difficult financial situation is set to continue in 2024-25 and is again likely to restrict its ability to do so. The Department also highlighted that single year budgets also impact its ability to plan to effect longer term change and expressed its hope for a return to three-year budgets going forward.

66. However, as compellingly argued by Professor O'Neill, alongside the moral imperative to reduce suffering, there is an economic argument to spend more on mental health. Poor mental health places huge costs on wider society, conservatively estimated at £3.4 billion per annum. Action to reduce the impact of poor mental health, therefore, represents savings to society. In addition, poor

mental health also adds to physical health needs – adding approximately 50 per cent to the costs of physical health care. More spent on mental health has potential to reduce pressures in healthcare costs.

67. The Mental Health Champion also highlighted that in 50 per cent of cases, there will be evidence of mental health disorders by the time a person reaches 14 years of age. CAMHS, therefore, plays a key role in reducing the burden of mental illness in later life. Despite this, funding for CAMHS, at an estimated 8 per cent of the mental health budget, is some 20 per cent (around £8 million) below what the Department believes it should be (and set as an aspiration in the mental health strategy). The Mental Health Champion also highlighted evidence from research on the cost effectiveness of particular interventions, for instance the cost-benefit of social and emotional learning in schools is estimated at around 1 to 5 i.e. every £1 spent results in a return of over £5. For every pound put into workforce well-being, generates a return of over £2, while suicide prevention generates a return of over £39.

68. When asked what the correct level of funding should be, the Mental Health Champion suggested that mental health services should account for between 10 and 11 per cent of the health budget. In addition, she indicated that the cost of transformation (as set out in the strategy funding plan) would need to be layered on top of this. In terms of the recognised need to increase the mental health budget, the Committee also asked the Permanent Secretary whether the Department had considered setting a specific target for the share of funding allocated towards mental health. The Permanent Secretary, however, stated that this would be a matter for the Minister to determine.

There are significant levels of mental health need in Northern Ireland, and despite being a stated priority, mental health continues to be underfunded. Alongside the moral imperative to reduce suffering, there are clear economic arguments to increase funding levels. More funding for mental health represents an 'invest to save' opportunity in terms of reducing the impact on wider society, together with its potential to reduce future demand for (and cost of) services in both mental health and physical healthcare.

The Committee recognises the benefits of multi-year budgets in facilitating effective long-term planning and development. However, even in the absence of these budgets, the Committee recommends that the Department outlines how it can increase the mental health budget by setting out a target and timeframe over which to grown funding towards the 10-11 per cent suggested by the Mental Health Champion.

The Department should also set out how it intends to grow the CAMHS budget towards a 10 per cent share of the overall mental health budget.

Data on mental health services has been extremely poor, this is unacceptable, and needs to be improved urgently

69. Whilst additional investment in mental health services is undoubtedly required, this must be underpinned by better data and a better understanding of what impact services are having on those in need. Urgent action in this area is required to demonstrate that spend provides good value for money.

70. Poor quality and incomplete data has been a persistent theme in many Public Account Committees inquiries but it is especially important given the scale of investment and the importance of mental health services. Evidence heard by the Committee outlined a situation where the data held by the Department is limited and overwhelmingly focused on the activity being undertaken, rather than on the impact services are making for patients. The Committee welcomes the progress that the Department is now beginning to make around data, and specifically the design of the outcome's framework, but has significant concerns about the length of time it has taken to get here, and the very low base from which the Department has started.

71. The Committee heard from the Mental Health Champion that variations in data is "a nightmare" – it is disjointed and inconsistent. Other stakeholders have told the Committee even where data exists, access to that data is incredibly challenging. Given the poor quality of the data, the Committee is concerned that the Department has developed a ten-year, billion-pound strategy based on information that is at best deeply flawed or incomplete.

72. As long ago as 2016, the Bengoa report, 'Systems not Structures', outlined that the Department must move towards a process of paying for value and not only paying for activity. Yet now, in 2024, the Committee was still being told that plans to develop information systems which would provide detail around the value of services to the patient were not yet implemented.

73. The Committee expect that there should be a wider focus amongst public bodies on the importance of data and on using this to measure not just what public services are doing, but what their impact is. It is not enough to rely solely on collecting activity data – to assess value for money bodies must consider the outcomes of their actions. More widely, the Committee is clear that a lack of data on public services cannot be used as a means of avoiding accountability. We expect that where public money is spent, bodies must consider how to effectively measure what they are getting for that spend.

74. The Committee has been told that implementation of the outcome's framework will be the key to better and fuller data. However, the Committee also notes that it is dependent on the successful implementation of the new Encompass system and therefore full implementation remains some distance away. Evidence provided by the Department stated that the issues to date which prevented giving basic waiting list data were "snagging". The Committee view the implementation of an appropriate dataset as so important, that it expects an update on this in twelve months' time.

In light of the importance of data on the outcomes of mental health services in demonstrating value for money, the Committee expects to be updated on the progress in collecting outcome data in 12 months' time. At that stage, we expect all Trusts to provide full, consistent and reliable information on mental health services and outcomes in a format that allows for effective regional comparability.

75. Data should not be an aim in itself. Whilst the Committee are clear that the effectiveness of mental health services cannot be judged on the current data – waiting times – when the Department does begin to receive reliable information on the effectiveness of services for patients, this must be used to improve. The

Committee agrees with the Permanent Secretary's observation that the implementation of Encompass will not solve all the issues with data.

The Committee recommends that the Department reviews and considers how best to use the data it will collect to improve the services it provides. This should be commenced now so that it is completed when Encompass is fully rolled out.

76. Poor quality data on outcomes for Trust services has been compounded by the fact that voluntary and community Groups have told the Committee that they are expected to have better and more complete data that has to be submitted as part of the Department's monitoring and oversight. Whilst it will be important to incorporate the voluntary and community sector into the outcomes framework in the longer term, the Committee do not believe that this prevents the Department considering what information it needs from its partners in the voluntary and community sector.

77. To support transparency and accountability, the Committee believe that data on the performance of mental health services should be published. We note the Scottish government's commitment to developing a mental health dashboard and consider this to be a template for the Department to develop a publishable dataset that demonstrates performance against a set of indicators.

Alongside providing a roadmap of how and when it intends to roll out the newly developed outcomes framework, the Committee believes that it is essential that the Department outlines how it will publish mental health data to bring transparency to the services.

Better access to CAMHS services is needed to tackle mental health issues early

78. The Mental Health Champion provided evidence to the Committee that in many cases, children and young people are getting to mental health services later than they would have done in the past. As a result, this can lead to a deterioration in the person's condition, compounded by the lack of intervention, whilst waiting for a referral In the Committee's view, it is frankly unacceptable that even when parents present early with a young person who is showing signs

of anxiety or depression, or who is struggling, they cannot get timely help for that young person.

79. The Committee is clear that failing to treat those in need at an early stage leads not only to poorer health outcomes, but also to poorer outcomes for their education. They will struggle at school if they have poor mental health. They will struggle with their friendships and social development. Late treatment results in poorer outcomes and higher costs for public services.

80. It was therefore hugely disappointing to hear that there is a lack of capacity in CAMHS, especially in comparison to other services. Whilst there is a target that children will be seen within a nine-week period, the lack of capacity has led to more than 1,100 cases breaching this target.

81. The Committee also heard that there are lower levels of acceptance into the CAMHS service. Around 69 per cent of referrals are accepted, lower than adult mental health services where around 84 per cent of referrals are accepted. The Permanent Secretary told us that the Department would like to reduce the numbers of cases that do not meet the threshold, and the Committee agree that this is an important area to improve.

We recommend that the Department engage with CAMHS services to identify common areas and themes around failed referrals and any other barriers to access appropriate support. This information should be used to inform and improve the quality and number of referrals.

82. The Committee is also concerned by the regional variation in acceptances into the CAMHS service. Whilst the Committee heard that all five Trusts operate the same, regionally agreed criteria there is significant variation in acceptance rates between Trusts. In the Western Trust, 82 per cent of referrals are accepted whilst in the Belfast and South-Eastern Trust areas, only 70 per cent are accepted. In the Committee's view, it is important that the variations are investigated and where appropriate challenged, to ensure a postcode lottery of services doesn't develop.

83. The number of referrals into CAMHS that are not accepted is clearly a cause for concern, especially when the Committee heard evidence that the levels of

acuity are increasing and treatment, as a result, is frequently taking longer. The Committee heard that the percentage of eating disorder admissions to the general adolescent inpatient unit has nearly tripled in the last five years. Likewise, some children are now presenting with psychosis. The number of young people presenting at Emergency Departments who require mental health services is now rapidly increasing. Whilst the Department told the Committee that it did not accept that the numbers presenting at Emergency Departments reflected failures in the CAMHS service, it was unable to provide data on the numbers who had previously been in contact with those services.

84. The Committee is not convinced that waiting until people get sicker or allowing them to fall into a crisis before they are offered treatment is the most appropriate approach. There is clear evidence that early intervention and early support has clinical benefits and can prevent lengthy and expensive treatment in the long term. We echo the comments of the Mental Health Champion, who raised concerns around timely access to CAMHS, particularly the lack of early intervention provision. She noted that there are no commissioned child psychotherapy services in Northern Ireland and as a consequence, children and young people present later to services with much more serious mental health problems.

The Committee recommends that the Department carries out a review within 12 months to examine whether it is providing sufficient, early support to those children in need. It should put a strong focus on providing additional support to those in need to prevent conditions escalating and ultimately becoming more challenging to treat.

Waiting lists in mental health are too long and action is needed urgently

85. The Mental Health Champion told us that service users and their families feel that they cannot get the help they need and that they are having difficulty navigating services. She noted that a lot of people will try to access services by going to their GP. However, getting a GP appointment can be difficult, as too can getting a referral to services. Even where people get a referral, waiting lists are excessive, and there is the potential that they are assessed and told that,

because their needs are too complex, current services cannot cater for them. In acknowledging that some people do get excellent service, including those with complex needs, the Mental Health Champion indicated that getting to the point where people can get the services they need can be a real difficulty, and that, because of significant gaps in services, many of the most vulnerable people do not get the care they deserve and need.

86. All members of the Committee have experience of their constituents' difficulties in accessing mental health services. One example provided to the Committee illustrates the unacceptable position people now find themselves in. This identified a Trust response, with regard to a referral to its community mental health team, stating:

"…regrettably the current waiting list from the date the referral was received is approximately 5 years…".

87. The number of people waiting to access mental health services, however, continues to increase. The NIAO report noted that waiting lists increased substantially in the years prior to the pandemic, to just under 13,500 by March 2019, reflecting considerable increased demand for services. Despite reduced levels of referrals to services during and immediately after the pandemic, waiting lists continued to grow, reaching a total of almost 16,000 by March 2022. Latest figures, for December 2023, record a total of just over 17,500 people awaiting a first appointment. Within this, psychological therapies represent a disproportionate share, with around 6,500 people waiting to access services.

88. Alongside the recorded increase in waiting lists, performance against 9 and 13-week waiting time targets for access to mental health services, the key measure of services according to the Permanent Secretary, has also continued to deteriorate. At December 2023, almost three-fifths of those on waiting lists (over 10,000 people) had been on a mental health waiting list for longer than the 9 and 13- week maximum target time. Performance in psychological therapies was particularly poor, with around three-quarters of those waiting (almost 5,000 people) having waited for more than 13 weeks.

89. The Mental Health Champion identified waiting lists in psychological therapies as a huge problem. She told us that despite evidence that these therapies work, not enough is being delivered. As a result, waiting lists have increased and people wait a long time for treatment. Without timely treatment, however, peoples' conditions will deteriorate and become more difficult to address.

90. The Department told us that waiting lists reflect the demand-capacity gap in mental health services. In particular, it highlighted increased acuity in presentations post pandemic, as a consequence of which individuals need even more treatment, which takes longer and means that there is not the same case turnover as would otherwise be possible. This, it indicated, has impacted substantially on waiting lists and waiting times in recent years. The Department did, however, stress that this recent increase in waiting lists and waiting times has occurred despite notable increases in service activity. Activity levels in adult mental health, it told us, are up by around 15 per cent on 2019-20 levels in both adult mental health and psychological therapy services. Nevertheless, it accepts that it is not meeting needs and that doing so represents a challenge going forward.

Waiting lists and waiting times in mental health services are unacceptable, and are contributing to increased acuity in presentation, making conditions harder and more costly to treat. While there is a general need to reduce the numbers on waiting lists and improve performance against waiting times, there is particular need to address the numbers waiting for psychological therapies.

We recommend, therefore, that the Department develops an action plan setting out how it intends to address waiting lists in mental health. The Committee views the need to improve waiting lists as so urgent, that the Department should report back in 6 months' time on its progress in reducing waiting lists.

As a result of a lack of crisis services, those in need are forced to attend Emergency Departments

91. In acknowledging that waiting lists are too long, the Permanent Secretary admitted that productivity can only be stretched so far and that little can be done to reduce waiting lists and improve waiting times without additional investment in the workforce. Competing finances, however, means that it is difficult to deliver the enhancements necessary to help address waiting lists.

92. The Committee understands that, as a consequence of poor access and long waiting lists, people are turning to Emergency Departments in search of help. We are concerned, however, that Emergency Departments, as busy and challenging environments, are not the right place for many of those presenting with mental health issues. Unfortunately, as identified by the Mental Health Champion, few alternatives are available and what is available is not universal across Trusts (nor available 24/7). For this reason, both the Department and the Mental Health Champion pointed to the development of regional crisis services as a key priority going forward. It was also noted that consistency in service provision across the Trusts should be improved through the implementation of the Regional Mental Health Service, which is a key enabler within the mental health strategy.

93. The Department also highlighted an ongoing pilot project at the Western Health and Social Care Trust to provide a separate and safe space for individuals attending the Emergency Department with mental health issues.

The Department should urgently implement planned regional crisis services. In addition, the Department should learn lessons from pilot schemes including the Western Trust pilot and Multi Agency Triage Teams, with the aim of providing alternative safe places within Emergency Departments and improved access to appropriate crisis care across the region as a matter of urgency.

Early Intervention and collaboration across government are key in managing future demands on mental health services

94. The Committee welcomes the Mental Health Champion's evidence that more needs to be done in terms of early intervention and prevention. The Committee believe that addressing issues early can often result in better value for money and better solutions. Preventing mental health problems developing and reducing their severity where they do arise, suggests that there is a clear 'invest to save' rationale given that greater severity equates to more costly interventions.

95. The Department noted that the development of an action plan for early intervention and prevention is a key deliverable under the mental health strategy (a stand-out action). A three-year plan (2022-2025) has been developed and is being implemented, and managed through the PHA, with some £1m allocated to support its delivery in 2023-24. The plan includes scoping of what early intervention activity is undertaken across all sectors.

96. The importance of prevention and early intervention is clear when the Committee considers the impact of poor mental health. This impact, and the associated financial cost, falls not only on the Health service, but right across the public sector. The Committee heard especially of the impact on the Justice and Education sector.

97. The Committee heard from the Mental Health Champion that schools have a particularly important role in supporting the mental health of children and young people. Evidence from elsewhere in the United Kingdom provided by the All Party Group on Mental Health, demonstrates that the cost of a referral to CAMHS far exceeds the costs of support delivered in schools. This in turn can generate millions of pounds in lifetime benefits, the Committee sought information from the Department on the lifetime cost benefit of therapeutic services delivered in schools, and counselling delivered in primary schools, however the Department advised in a letter to the Committee that this information is not held. The Department, however indicated that it is undertaking significant projects with Education, highlighting the joint development of an

Emotional Health and Wellbeing Framework, and associated joint funding (£4-5m from Education and £1.5m from Health annually). We welcome this as a start, but also agree with the Permanent Secretary's acknowledgement that more can be done in this area.

The Committee expects better and stronger collaboration across government. In this case, it is clear that the mental health needs of children in Northern Ireland will only be addressed through genuine partnership working between Health and Education. We recommend that the Department builds on the work it has undertaken to date and increase collaboration with the Department of Education to support emotional wellbeing.

98. The Committee also notes its concern around the pressures that mental health issues place on policing. Whilst there will always be cases where the police have to be involved in responding to someone in mental health crisis, the PSNI have publicly stated that they attended more than 22,000 call outs relating to mental health last year. In the Committee's view, police involvement to this extent – and the associated cost – reflects gaps elsewhere in the system that are being filled by police officers. This doesn't result in savings for the public sector and is unlikely to produce the best outcomes for those in need.

99. The Committee was pleased to hear that the Department is now working with the police around proposals for a 'right care, right person' model. Again however, this is an area where work appears to be only commencing. Whilst the Committee accept that it is important to get this right, that should not be used as an excuse for inaction.

The Committee recommends that the Department and PSNI speed up consideration of proposals and bring forward an appropriate model that ensures those in mental health crisis can be seen by the most appropriate professional. We firmly believe that better services can be delivered by better collaboration.

The voluntary and community sector play a vital role in providing mental health services and more engagement is needed with this sector

100. The Committee recognises the essential and highly valued role that the voluntary and community sector plays in providing many mental health services to those in need in their communities. Despite relying on this sector to provide much needed services, the Committee is concerned that they often appear to be the first port of call when funding cuts are required.

101. The precarious nature of this funding has real impacts for the sector and those who rely on it – from the delivery of services and the employment of staff to the ability to plan for the long term. Whilst the Committee recognises and regrets the lack of long-term budgets for departments in Northern Ireland, we believe it is important that the Department consider how more certainty can be provided for the funding it receives, such as outline funding plans. We hope this will provide more certainty to both those organisations receiving funding, and those service users who are reliant on the services provided.

102. The Committee heard that the Department does not currently hold data around the number of referrals to and from the voluntary and community sector. In our view, this is a significant oversight. Without this data, the Department cannot possibly know the numbers receiving support outside the Health and Social Care sector and therefore the risk to the HSC if these services are no longer provided.

The Committee recommends that the Department reviews its reliance on the voluntary and community sector. It should know how many referrals there are to, and from, that sector; how many people are reliant on the services carried out by the voluntary and community sector; and the value of those services provided. This information should be used to engage with and carry out a review of how best to provide greater funding certainty to this sector.

103. The Committee is hugely concerned about the potential impact of any withdrawal of mental health services from the voluntary and community sector. Despite a perception amongst the voluntary and community sector that a

significant amount of information is requested by the Department, it was disappointing to note that the Department was unable to provide details on the level of referrals to the voluntary and community sector, given the large number of organisations involved.

104. We are encouraged to hear that the Department recognises that the way in which it engages can be improved and that it intends to improve how it works with the voluntary and community sector. In our view, it is essential that their knowledge, expertise and experience is harnessed in attempts to tackle the serious issue in this area. We echo the Department's evidence that the way in which it engages with this sector must mature.

The Committee expects that the Department reassesses its engagement with the voluntary and community sector. As part of this, the Department should set out more clearly how it intends to improve engagement with the voluntary and community sector. It is crucial that any barriers to having a more mature conversation are overcome and the expertise that exists is fully harnessed.

There are a number of gaps in services and the Department needs to plan now for how they can be addressed

105. The Committee also heard about a number of gaps in services. Concerningly, those gaps also included services for those who had a dual diagnosis of mental health and addiction issues. This Committee's predecessor considered these issues in a previous mandate, and it is concerning that the development and implementation of these services has been slow. The Committee now welcomes the Permanent Secretary's assurance that this is an important issue, and the Department is now looking to join up various services. However, the Committee firmly believes that there is no excuse for services provided to the public being disjointed – even more so when they both fall under the umbrella of a single government department.

106. The Committee heard about a number of gaps in services from the Mental Health Champion. Amongst those most important, are services for those who are neurodivergent. The Committee is concerned about the future demands that

will fall on mental health services as a result of those who are not currently receiving treatment.

The Committee expects that the Department's review of the deliverability of the strategy also incorporates an identification of key gaps in services, including regional disparities across Northen Ireland. The Department should begin to plan now for addressing key gaps, rather than allow these challenges to build to a stage at which they are unsustainable. The Department's review should consider areas where working with health services across the island could result in better outcomes for patients.

107. This Committee undertook an inquiry in 2021 into Addiction Services. At that time, the Department told us that the issue of dual diagnosis was one of those issues that were raised repeatedly at the time of the implementation of the previous substance misuse strategy. Despite the time that has passed, and the lack of services for those with co-occurring mental health and substance use issues, evidence provided to the Committee was that only now has recruitment commenced for the appointment of a co-occurring mental health and substance use project manager. The Committee is left with a strong impression that the Department has not demonstrated the necessary urgency in addressing many of these challenges.

The Committee recommends that the Department urgently implement services for those with co-occurring mental health and substance use issues. It is not acceptable that the pace of change in this area is so slow.

Links to Appendices

Appendix 1: Minutes of Proceedings

View Minutes of Proceedings of Committee meetings related to the report

Appendix 2: Minutes of Evidence

View Minutes of Evidence from evidence sessions related to the report

Appendix 3: Correspondence

View correspondence issued and received related to the report

Appendix 4: Other Documents

View other documents related to the report

Appendix 5: List of Witnesses that gave evidence to the Committee

- **Mr Peter May,** Department of Health
- **Mr Peter Toogood,** Department of Health
- **Mr Brendan Whittle,** Department of Health
- **Dr Petra Corr,** Northern Health & Social Care Trust
- **Prof Siobhan O'Neill,** Mental Health Champion
- **Ms Dorinnia Carville,** Northern Ireland Audit Office
- **Mr Stuart Stevenson,** Department of Finance

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