Mental Health 2021-2031 Strategy

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Mental Health Strategy 2021-2031

Consultation Response Document

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Are you responding on behalf of an organisation?		**Yes**
Organisation	**Institute of Public Health in Ireland**	
Vision and Founding Principles		
Do you agree the vision set out will improve outcomes and quality of life for individuals with mental health needs in Northern Ireland? *"Our vision for Northern Ireland is a society which promotes emotional wellbeing and positive mental health for everyone across the lifespan, which supports recovery, and seeks to reduce stigma. We want a system that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice. We want a mental health system that breaks down barriers to put the individual and their needs right at the centre, respecting diversity, equality and human rights, to ensure people have access to the right help and treatment at the right time, and in the right place. And we aspire to have mental health services that are compassionate and able to recognise and address the effect of trauma, that are built on real evidence of what works, and which focus on improving quality of life and enabling people to achieve their potential".* Mostly Agree		
Please add any further comments you may have **IPH welcome for the Ten Year Strategy** IPH welcomes the opportunity to submit views on this 10 year strategy for mental health in Northern Ireland. We welcome the development of the draft Mental Health Strategy and its commitment to mental health improvement in the coming decade. Changing population health and addressing health inequalities takes time and we welcome the commitment to both a long-term strategy and annual action plans.		

Suggested change to the vision – shift in emphasis on tackling inequalities
We welcome the commitment to address inequalities within the vision of the draft Mental Health Strategy. However, we recommend that this include a commitment to reduce inequalities in mental health outcomes rather than solely in terms of equity of access to services. This will shift the emphasis from narrowing gaps in service responses to mental illness to also narrowing the gaps in the occurrence of mental ill-health.

Do you agree the founding principles set out provide a solid foundation upon which to progress change?

- *Meaningful and effective co-production and co-design at every stage.*
- *Person centred care and a whole life approach – a system that meets the needs of the person, rather than expecting the person to fit into a rigid system.*
- *Care that considers and acknowledges the impact of trauma – where staff have the appropriate knowledge and skills and are aware of the impact of trauma, particularly in the context of Northern Ireland.*
- *Choice – meaning choice in treatment to fit the needs and preferences of the person*
- *Early intervention, prevention and recovery as a key focus – all decisions should be made with this in mind.*
- *Evidence informed decisions - services and interventions built upon sound evidence of what works.*
- *The specific needs of particularly at risk groups of people, and the barriers they face in accessing mental health services, should be recognised and addressed.*

Mostly Agree

Please add any further comments you may have

Suggested clarification – processes to maintain fidelity to the principles
IPH welcomes the inclusion of strong principles within the draft Mental Health Strategy. However, the draft strategy does not make clear how fidelity to the principles will be monitored during implementation, or in other words, how these principles will be 'kept in mind' during operational decision making. For example, what processes are to be put in place to ensure that the principles are taken into account in commissioning, resourcing, research and evaluation? What are the opportunities for review and challenge when decisions diverge from the strategy principles? What is the scope for involvement of stakeholders in assessing the alignment of principles with delivery?

Suggested change to the principles - include proportionate universalism
Among people living in more deprived communities mental illness is more prevalent, more severe and more likely to be a driver of early death, as a result of either suicide or substance misuse or other causes (WHO, 2017). Inequalities in mental ill-health, self-harm and suicide are stark in Northern Ireland and they appear to be widening. With this issue in mind, we recommend a higher level commitment to tackle inequities in both the vision and principles of the strategy. We recommend greater emphasis on equity focussed measures at both strategic and operational level driven by an over-riding principle of proportionate universalism. In terms of the proposed principle on proportionate universalism, this could be made 'real' by linked actions. For example, commitments to convene an expert advisory group to make recommendations on equity focussed

measures, strategy commitments to conduct health equity audit of the strategy as part of a mid-term (5 year) or final review alongside periodic health equity audits of services and strategy actions.

Supporting evidence for inclusion of proportionate universalism in the principles – widening inequities in mental health outcomes in Northern Ireland

The gap between levels of life satisfaction in the most and least deprived is widening. In 2020 the hospital admission rate for self-harm was over three time higher among the most deprived communities compared to the least deprived. Between 2010 and 2018 there was a 41% decrease in the number of admissions in the most deprived communities compared to a 30% decrease in the least deprived communities (2010/11-2014/15 and 2013/14-2017/18) (Department of Health, 2020). Suicide is at least three times higher in the most deprived communities compared to the least deprived communities. Over the period 2012 to 2017, the suicide rate has been increasing in the most deprived areas (Department of Health, 2020). The standardised prescription rate for mood and anxiety is around 40% higher in the most deprived communities, with an increase in both the most and least deprived areas between 2014 and 2017.

Supporting evidence on translating a principle of proportionate universalism into action

We recommend that the Strategy makes a clear commitment for proportionate universalism in resource allocation for mental health promotion in order that additional resource be made available for mental health promotion in disadvantaged communities. An assessment of inequalities in mental health by Public Health England recognises the need to consider the following dimensions in addressing inequalities in mental health :

- wider social and environmental determinants of poor health, including poverty, unemployment, homelessness and incarceration
- stigma, discrimination, social isolation and exclusion
- smoking and poor diet
- lack of support to access health and preventative care
- diagnostic overshadowing – the misattribution of physical health symptoms to part of an existing mental health diagnosis, rather than a genuine physical health problem requiring treatment (Public Health England, 2018).

Addressing inequalities in mental health requires more than the allocation of services or staff in disadvantaged areas. Upstream policy changes are needed in domains like social welfare and affordable housing policy, minimum unit pricing of alcohol alongside more downstream actions investing in enhancing emotional literacy, debt advice, school-based programmes and development of a trauma-informed public services (Mental Health Foundation UK, 2019).

Suggested change – develop a more gender sensitive Mental Health Strategy

We welcome the priority for the continued rollout of specialist perinatal mental health services. However, we recommend a thorough approach to gender mainstreaming be applied in the strategy. This engagement must go beyond the presentation of data by gender and better recognise the deeper role of gender in determining mental health, mental illness and the interaction with health and social service supports.

The Equality Impact Assessment (EIA) that was conducted to inform the actions of the National Mental Health Strategy has concluded that there was no negative impact based on gender. Because women and men, boys and girls, have different life experiences and socio-economic realities to, the mental health symptoms they present with are also often

different, as are their pathways into services, and their treatment needs. Economic and social policies that cause sudden, disruptive, and severe changes to income, employment and social capital that cannot be controlled or avoided, significantly increase gender inequality and the rate of common mental disorders (WHO, 2020). Risk factors for common mental disorders that disproportionately affect women include domestic violence, sexual abuse, harassment, objectification, socioeconomic disadvantage, low income, income inequality, low or subordinate social status and rank, workplace environment, poor work-life balance, and unremitting responsibility for the care of others and multiple roles (WHO, 2020).

Supporting evidence for a more gender sensitive Mental Health Strategy

The World Health Organizations recognises that "In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ" (WHO, 2009).

Health Survey NI data shows that more females (21%) than males (18%) have a high GHQ12 score which could indicate a mental health problem (Health Survey NI, 2020). It is estimated that eating disorders affect around 1% of the population. Incidence is 10-12 times higher among females than males with women age between 15 and 25 at the highest risk (The Regulation and Quality Improvement Authority, 2015). Compared with other mental health conditions, eating disorders are a significant cause of death, with standardised mortality ratios five times the population average.

Patterns of mental ill-health among young people are a concern. There are significant issues for both boys and girls, but these are different. A gender sensitive response is needed in terms of both mental health promotion and service response, but none has been specified in the strategy. Young Persons Behaviour and Attitudes Survey 2019. Girls were more likely than boys to report feeling left out, alone, and having no-one to talk to (Department of Health, 2020). The Stirling Children's Wellbeing Scale and the Warwick-Edinburgh Scale showed that girls aged 8-12 years and 10-12 years have lower mean wellbeing scores than boys respectively (Department of Health, 2020). Girls were more likely than boys to compare themselves to others on social media, to monitor the number of likes/comments/shares their posts get, and to feel that their mood is impacted. Girls are more likely than males to be at risk of an eating disorder (22.9% vs 10.0%), have higher rates of self-injury (13.2% vs 5.5%) and suicidal thoughts or attempts (14.2% vs 10.0%), with girls aged 16-19 years having the highest rates of suicidal thoughts or attempts of any group (22.7%).

In 2015 the Central Statistics Office reported that women most affected by poverty and social exclusion are also at highest risk of poor physical and mental health, notably lone parents, women with a disability, Traveller women and older women living alone (Central Statistics Office, 2015) . Marginalised women including asylum seekers, homeless women, Roma women, LGBTQI+ women, and women with disabilities are also disproportionately impacted by poor mental health (NWC, 2020). Many of the risk factors for experiencing mental health difficulties - poverty, violence, low social status, responsibility for care of others – fall disproportionately on women. In 2016, 98% of those looking after the home/family were women (NWC, 2020). Caring responsibilities can have a negative impact on mental and physical health, and can lead to exhaustion, depression, injury and put women at a higher risk of illness (NWC, 2020). Many women's preferred interventions are talking therapies or counselling, while women report that mental health services generally tend to rely more on medication. (NWC, 2020)

Similarly, in relation to men's mental health the issues of suicide, substance misuse, addiction and gambling are more prevalent. Men are less likely to access psychological therapies than women, accounting for only 36% of referrals to NHS talking therapies (NHS, 2019). Men are also more likely to be compulsorily detained (or 'sectioned') for treatment than women (Crime Survey for England and Wales, 2015). Nearly three-quarters of adults who go missing and 87% of rough sleepers are men (Biehal et al. 2003; Mens Health Forum, 2020).

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

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have

Suggested change - a more defined status for mental health promotion

We welcome the commitments made in the draft strategy to enhance mental health services. However, service reform have limited capacity to drive changes in the mental health profile of the population, tackle inequities or reduce the incidence of mental illness. The draft strategy currently groups mental health promotion and early intervention together, under Theme 1 and the thematic actions. However, we recommend that these be addressed as distinct themes within the strategy. In the words of the World Health Organization

*"*Within a public health framework, the activities that can improve health include the promotion of health, the prevention of illness and disability, and the treatment and rehabilitation of those affected. These are different from one another, even though the actions and outcomes overlap. They are all required, are complementary, and one is no substitute for the other."(WHO, 2004).

Suggested change – clarity on the scope and understanding of mental health promotion in the Strategy

We would welcome a clearer definition and focus on mental health promotion within the strategy. This could enhance clarity and promote collective understanding on health promotion and disease prevention activity and support the identification of suitable outcomes and indicators. We view mental health promotion as a system level approach to enhance the mental and emotional wellbeing of the Northern Ireland population as whole. It employs intersectoral strategies to strengthen protective factors for mental health and enable access to resources and supportive environments to keep individuals and populations mentally healthy(Barry et al, 2013). Mental health promotion has also been defined as a means to foster individual competencies, resources, and psychological strengths, and to strengthen community assets to prevent mental disorder and enhance well-being and quality of life for people and communities. The creation of health and the prevention of disease are overlapping but not synonymous endeavours. Successful mental health promotion supports primary prevention which aims to reduce the incidence of mental illness but is also supports people to reach their potential, parent well, support the mental health of others and participate fully in life bringing broad returns across society.

Suggested change – protected resourcing for mental health promotion

The draft strategy recognises that mental health in Northern Ireland is under-funded compared to investments made in the rest of the UK and the Republic of Ireland,

estimated as 27% less than England and 20% less than Ireland. We welcome the commitment to increase resourcing as part of the Strategy. We recommend that a protected and ring-fenced budget be allocated to mental health promotion, separate from budgeting for early intervention or mental health service development.

Supporting evidence for priority and protected status for mental health promotion in the Strategy

Evidence supports a strong case for a public health approach to mental health improvement, as susceptibility to mental health problems is strongly influenced by the broader socio-economic context as well as individual risk factors. Mental health is also inextricably linked with physical health and co-morbidity –while mental wellbeing and resilience reduce risk factors and are strongly protective for physical health (Faculty of Public Health/Mental Health Foundation, 2016). The World Health Organization estimates that mental and neurological disorders account for 17% of years lived with disability in older adults, highlighting the importance of preventing, diagnosing and treating these problems early (WHO, 2017).

Suggested change – a framework for mental health promotion that recognises 'upstream' determinants of mental health

A framework for mental health promotion is recommended within the Strategy, incorporating systems thinking to look at the drivers of mental health and ill-health at policy level as well as to guide investment in interventions within service and community settings. Policy level 'levers' with the capacity to influence population mental health include changes in employment, social welfare or housing policy (Marmot, 2021). Similarly, changes to the supply and control of alcohol, tobacco, drugs and gambling are significant in determining both mental health at population level and the occurrence of mental illness (WHO, 2004). National and local level policies determine the assets available to foster mental health at community level.

Suggested change - a recognition of loneliness within the strategy

There is no mention of loneliness in the draft Strategy. Although loneliness is not a mental illness, there are significant associations with loneliness and mental ill-health, and loneliness can negatively impact on those with mental illness. Evidence suggests associations with depression and anxiety, non-communicable diseases (e.g. cardiovascular disease), harmful health behaviours (e.g. smoking), stress, sleep, cognition, frailty and premature mortality (Cacioppo et al, 2010, Prohaska et al 2020). Paradoxically, there is a concern that chronic loneliness can adversely affect one's ability to connect positively with others and to engage in interventions that could decrease loneliness.

Do you agree with the actions and outcomes set out under this theme?

ACTION 1. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach. The action plan must consider groups disproportionally affected by mental ill health which often struggle to access early intervention services.

ACTION 2. Expand talking therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team. This will expand the delivery of psychological therapies across Northern Ireland to improve the mental wellbeing of the population and prevent the establishment of mental disorders.

ACTION 3. Further promote positive social and emotional development throughout the period of childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

ACTION 4. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for the disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

Neither Agree nor Disagree

Please add any further comments you may have

Suggested change – a more developed approach to policy coherence
We welcome the recognition within the draft strategy of the interface with other government strategies and programmes. We welcome the commitment to work closely in the joint implementation of mental health and social inclusion strategy. We also strongly welcome the outcomes (point 33) of better interagency cooperation to promote wellbeing and resilience and wider awareness of how mental health can be impacted by everyday decisions and strategic policy directions outside the health sector.

However, it is not clear in the draft Strategy what additional processes will be put in place to achieve these outcomes and how co-ordination mechanisms will be enhanced.
We recommend that the Mental Health Strategy includes actions specific to enhancing policy coherence and a prioritised roadmap to enhance co-ordinated decision making across related policy areas.

Supporting evidence – options to enhance policy coherence
A significant challenge in the design and delivery of this strategy is likely to be maintaining policy coherence. Policy coherence is the systematic promotion of mutually reinforcing policies across government departments to create synergies towards achieving agreed objectives and to avoid or minimize negative spill-overs in other policy areas. (WHO, 2019). One option to address this in the process of policy design is to create a policy map of the areas of overlap and common outcomes and grade the relative importance of co-ordination in decision making. For example, strategies with a need for the highest level of policy coherence would include those policies focussed on suicide prevention and self-harm, alcohol and drugs. Other policies requiring a medium to high level of policy coherence could include those relating to social protection, chronic disease, children, domestic violence and criminal justice. Mechanisms to develop policy coherence can include shared governance and monitoring or the formation of specific advisory groups or partnerships to support the co-ordination role of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention and the Mental Health Champion. Another asset to policy coherence includes the development of clearly defined two-way communication channels between policy leads and the integration of mental health impact assessments into decision making in other policy areas.

Suggested change –commitment to mental health impact assessment of social welfare reform

Social protection policy and the operation of social welfare programmes and supports are very significant in terms of population mental health and the lived experience of those with mental illness. In this context, many jurisdictions are now seeking to consider the mental health impact of regulatory and policy changes to ensure that mental health is protected and that those with mental illness are not unduly disadvantaged (Canadian Mental Health Association, 2019) Social protection systems in the UK are currently undergoing a significant programme of reform. In light of the evidence on the mental health impact of the change in social protection in the rest of the UK (see next section for supporting evidence), a mental health impact assessment is recommended. More broadly, we recommend that the strategy recommend the inclusion of health impact assessment on major policy and legislative change in Northern Ireland, in particular where significant changes to the social protection system are being considered including the proposed roll out of Universal Credit.

Supporting evidence for a mental health impact assessment of social welfare reform

The five-week waiting period for UC alongside access difficulties for claimants and issues leading to elevated levels of claimant debt and rent arrears, sanctions punishments such as the removal of benefits, and difficulties accessing the online system are likely to be significant in Northern Ireland, in line with experiences in other regions of the UK (UK Parliament, 2019). A longitudinal controlled study linked 197 111 observations from 52 187 individuals of working age (16–64 years) in England, Wales, and Scotland between 2009 and 2018 with administrative data on the month when Universal Credit was introduced into the area in which each respondent lived. When the policy change was introduced, the prevalence of psychological distress started to increase among those eligible for UC, while the prevalence remained constant for people not affected by the change. It was estimated that between 2013 and 2018 the introduction of UC might have led to an additional 63 674 (95% CI 10 042–117 307) unemployed people experiencing psychological distress. Of these individuals, an estimate of 21 760 might reach the diagnostic threshold for depression. The study found that UC did not appear to have a negative impact on the physical health and found no evidence that the system was associated with more people entering employment, one of the benefit's key aims. The potential for psychological impact is substantial owing to the nature of policy implementation. Given the mounting evidence of substantial mental health harms related to UC, the study's co-author highlighted the need for government to conduct a robust HIA to all welfare reforms, including Universal Credit (Wickham et al., 2020) .

Suggested change – a more developed response to alcohol use within the strategy

The draft Strategy has a limited view on the interface between alcohol and mental health strategy. It does not recognise the role of alcohol as a determinant of population mental health, but only refers to alcohol use in the singular context of alcohol use among those with existing mental illness (page 43). While we strongly welcome the commitments within the draft Strategy under Section 143 to address co-current mental health issues and substance misuse issues, we invite a broader view of the opportunities for change. We recommend that the Mental Health Strategy formally recognise the full complexity of the relationship between alcohol and mental health and identify specific actions in that context, either under a new Theme or as distinct actions under the existing themes, with a focus on reducing alcohol-related mental ill-health as well as enhancing service responses. In keeping with the previous commentary on policy coherence, we recommend that the strategy make explicit the structures in place to support policy co-ordination and joint programme development with the Mental Health Strategy and the forthcoming

Substance Misuse Strategy. Specifically, we would welcome a recognition within the Mental Health Strategy of minimum unit pricing (MUP) as an evidence informed measure with the capacity to reduce harmful consumption and enhance mental health in the region. Based on a minimum price of 50p per unit of alcohol, the modelling study has been estimated 4 fewer deaths and 33 fewer hospital admissions per year by intentional self-harm because of MUP(Angus et al, 2014).

Supporting evidence for greater attention on alcohol and mental health
Alcohol use damages mental health at population level, increases the risk of development of some mental illness, amplifies inequalities in mental ill-health and independently increases the risk of self-harm and suicide. Higher risk alcohol use is endemic in the region - this reduces the chances of sustained recovery and shortens the lives of people with mental ill-health in Northern Ireland. Conversely, mental illness independently increases the risk of the occurrence of alcohol use disorders and alcohol-related harms (Campbell et al, 2019). In this way, a reciprocal causal relationship is considered to exist between alcohol and mental illness, each disorder increasing the risk for the other simultaneously and each amplifying the harms of the other condition (WHO, 2019).

Suggested change – evidence-informed selection of mental health 'programme level' interventions
Mental health promotion and prevention interventions, when implemented effectively, can reduce risk factors for mental disorders, enhance protective factors for good mental and physical health, and lead to lasting positive effects on a range of social and economic outcomes (Barry et al, 2013). We welcome the commitments made in the Draft Strategy under Theme 1, under Action 3 Promoting children and their families' positive mental health. These commitments include promotion of positive social and emotional development throughout the period of childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life. This work can build on the 'local' evidence on the impacts of Sure Start and link with commitments under the Early Years Strategy to maximise policy coherence (RSM McClure Watters Consulting, 2015; Education and Training Inspectorate, 2020).Based on suitable evidence of effectiveness, we welcome the acknowledgement within the draft strategy of the scope for mental health promotion within the workplace setting and in the context of unemployment. However, we would welcome the inclusion of actions to address the issues raised as well as outcomes to monitor progress.

Supporting evidence for selection of evidence-informed mental health promotion investments
A review of evidence of effectiveness for 'best buys' in mental health promotion suggested the following as priority investments (Barry et al, 2013):

• Promote infant (0-3 years) and maternal mental health through integrating mental health promotion and prevention into routine pre and postnatal care services and home visiting programmes
• Promote early child mental health development (3-6 years) through pre-school education
• Parenting and family strengthening for school-going children (3-16 years)
• Promote young people's (6-18 years) life skills and resilience through school-based interventions in primary and post-primary schools
• Promote the mental health and social wellbeing of adolescents and young people (12-18 years +) through out-of-school multicomponent interventions

The review (Barry et al, 2013) also found evidence of effectiveness for these interventions:

• Community empowerment interventions to promote mental health and reduce the risk of mental disorders for families in poverty and debt (see also section below on integrated debt advice)
• Training primary health care providers in opportunistic mental health promotion and prevention interventions for adults and older people
• Workplace policies and programmes to improve the mental health of working adults
• The implementation of policies and regulations on alcohol consumption
• Enhanced regulations restricting access to commonly used lethal means of suicide

The Faculty of Public Health UK highlight interventions including befriending services, peer support groups, community-based physical activity programmes, investing in mentally healthy environments, and reducing stigma (FPH/MHF, 2016).

The London School of Economics analysed the costs and economic payoffs of interventions focussed on mental health promotion, prevention, and early intervention with a view to supporting the NHS and other commissioners in assessing the case for investment (Knapp et al, 2011). In terms of mental health promotion, the review concluded that parenting programmes are cost -saving to the public sector, and to the NHS alone, over the long term, with the main benefits accruing to the NHS and criminal justice system. When the wider costs of crime are included, total gross savings over 25 years exceed the average cost of the intervention by a factor of around 8 to 1. In addition, high returns were expected from school-based programmes including those relating to bullying and from workplace interventions. These analyses informed the subsequent guidance from Public Health England publication on Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health (Public Health England, 2017). This focussed on eight different interventions including school based programmes to prevent bullying and initiatives to prevent depression in children and young people, workplace programmes to promote mental health and initiatives to help adults at risk of stress, anxiety and depression, group based social activities, including volunteering, to address loneliness, financial advice services for people with debt problems as well as initiatives focussed on people with known illness or mental distress.

Suggested change – Adopt and adapt the Prevention Concordat for Better Mental Health to guide local planning in mental health promotion in Northern Ireland

The evidence reviews cited in the section above informed the Prevention Concordat for Better Mental Health – a planning tool to support local planning to promote mental health, prevent mental ill-health and target mental health inequalities in England. (Public Health England, 2020). We recommend the development of clear guidance for local responses to mental health promotion, building on the learning from the PHE Prevention Concordat model, and adapted to the Northern Ireland context.

Suggested change – a more developed approach to physical activity within mental health promotion and disease management

We recommend a more comprehensive recognition of the role of physical activity within mental health promotion, resilience and disease prevention within the strategy. We welcome the recognition of physical activity within recovery plan for people with mental illness (item 118) and as one of various preventive measures that can be undertaken to promote healthy ageing (item 44). There is compelling evidence that meeting physical activity guidelines significantly reduces the risk of all-cause mortality, Alzheimer's disease,

and depression in older adults, and that even small increases in activity are beneficial to cognitive health and wellbeing (Cunningham et al, 2020). We recommend that the strategy actions under Theme 1 include a commitment for greater integration of physical activity into mental health promotion initiatives. This could take the form of enhanced investment in physical activity programmes in areas of poor mental health and the enhanced integration of mental health promotion and support within physical activity programmes.

Suggested change –a focus on promotion of mental health and resilience in the context of violence

We recommend that the mental health and violence interface be further addressed within the actions of the strategy under Themes 1 to 4. We would welcome a commitment to enhanced training for health and social care workers to identify and respond to the mental health consequences of domestic violence. Such activity could be actioned as part of greater policy coherence with the regions domestic violence and child protection strategies. We recommend that sufficient resources are allocated to ensure access to mental health services through women's shelters – for all women, independently of their legal status, disability status, sexual orientation, gender identity, sex characteristics, race or ethnic origin, age or religion. Men are one and a half times more likely to be victims of violent crime and make up most of the prison population where there are high rates of mental health problems and increasing rates of self-harm (Mens Health Forum, 2020).

Supporting evidence for a focus on mental health and resilience in the context of violence

The World Health Organization's World Report on Violence and Health reported that the repercussions that gender-based violence has on women can take a variety of forms including psychological and behavioural effects (alcohol and drug abuse, depression and anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic attacks, low self-esteem, posttraumatic stress disorder, psychosomatic disorders, suicidal and self-harming behaviour, insecurity in later relationships) as well as fatal effects (including suicide) (WHO, 2002). The correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following such violence, renders women the largest distinct group of people affected by this disorder. The complexity of violence related health outcomes increases when victimization is undetected and results in high and costly rates of utilisation of the health and mental health care system (WHO, 2020). Violence related mental health problems are poorly identified and women are reluctant to disclose a history of violent victimization unless asked about it directly.

In 2019/20 there were 3.56 thousand sexual offences recorded by the Police in Northern Ireland. The number of reported sexual offences has increased dramatically (Statista, 2021). During the 2019/20 fiscal year the Public Prosecution Service (PPS) received a total of 1,684 files involving a sexual offence representing an increase of 5.6% on 2018/19. There was a rise of 6.9% in the number of files received involving a rape offence, from 610 to 652 (PPS, 2020). Over one quarter (26%) of women in Ireland surveyed in 2014 reported having experienced physical and/or sexual violence by a partner or non-partner since the age of 15, whilst one in three women experienced severe psychological violence from a male partner (SAFE Ireland, 2015). Domestic violence and violence against women have significant detrimental effects on physical and mental health and wellbeing.

Suggested change – recognition of ageism as an obstacle to mental health

We recommend that tackling ageism in the workplace and enhanced support older workers to plan for retirement could be considered as good investments for mental health promotion (Centre for Ageing Better, 2019). WHO recommends that intergenerational and educational interventions to tackle ageism can benefit mental health and slow cognitive decline (WHO, 2021). The prevalence of ageism and negative views of later life are

significant in the psychological wellbeing of populations and in mental health (WHO, 2021). A review of 44 studies examining the relationship between ageism and mental health found evidence that ageism effected psychiatric conditions. In 16 studies, experiencing ageism was associated with:

- the onset of depression,
- the increase in depressive symptoms over time and
- lifetime depression.

The report showed that when older American veterans resisted negative age stereotypes, benefits were found in that they experienced less suicidal ideation, anxiety and post-traumatic stress disorder.

Suggested change – evaluation of Talking Therapy Hubs

The strategy has signalled an intention to expand the availability of talking therapy through local hubs to ensure complete coverage across Northern Ireland. However, it is not clear what evaluation data has been considered in the selection of this action, nor how the quality and impact of the intervention will be assessed. We recommend that formal evaluation of the effectiveness of talking therapy hubs focuses on patient mental health outcomes, patient satisfaction, effects on crisis service utilisation and the impact on referral rates. We recommend monitoring of waiting times for service access to talking therapy to ensure that waiting lists are not transferred from one source to another.

Supporting evidence for conducting an evaluation of the Talking Therapy Hubs

A systematic review by Bower et al (2011) found that counselling in primary care was associated with significantly better clinical effectiveness on mental health outcomes in the short-term and that patients were satisfied with counselling. It found however, that the intervention provided no additional advantage in the longer term, and that it did not seem to reduce overall healthcare costs. The review stated that some types of health care utilisation may be reduced but an explicit analysis of this was not performed. Talking therapy hubs should provide significant improvements to mental health outcomes in primary care and afford alternatives and adjuncts to other treatment options. The impact that they will afford on health care utilisation and cost is less clear.

Suggested change – inclusion of Foetal Alcohol Spectrum disorder

We recommend the inclusion of foetal alcohol spectrum disorder within Actions 3 and 4 of the strategy. Specifically, we would welcome actions which support compliance with the newly published NICE quality standard on prevention and management of the condition (NICE, 2021).

Theme 2: Providing the right support at the right time

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have:

This section puts a much stronger emphasis on addressing the mental health needs of children and adolescents than it does on services relating to older people and would benefit from a reframing of the language and outcomes to ensure mental health needs and well-being in older age groups are fully understood and addressed.

Do you agree with the actions and outcomes set out under this theme?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ACTION 24. Create a regional eating disorder service.

Mostly Agree

Please add any further comments you may have:

Suggested change –integrated debt advice as part of the 'right support at the right time'

The draft strategy refers to the issue of debt advice in point 37, page 18. We would welcome further commitments on inclusion of decent quality integrated debt advice within both mental health promotion and service investments under the strategy. We would welcome a commitment to include financial difficulty and debt as part of routine screening and assessment rather than as a 'subgroup' activity for communities or settings. We would welcome commitments to training for health and social care on appropriate discussion and referral for debt issues. We would also welcome a commitment to consider the extent and nature of financial difficulty and debt with community needs assessment on mental health promotion and allocation of services. This may entail service developments such as welfare advice on prescription and co-location of welfare rights advisors in NHS facilities. Success in this work will require co-ordination with commercial, community and third sector organisations in areas like welfare rights advice, employment support, food banks and credit unions. (Faculty of Public Health, 2021)

Supporting evidence for inclusion of integrated debt advice within mental health services

Debt is higher in Northern Ireland and likely to increase in the next few years. Debt is associated with poor mental health and worse outcomes for people with mental illness and financial stress reduces the potential for sustained recovery. Compared to the rest of the UK, Northern Ireland has the lowest median wage, highest economic inactivity rate, the greatest number of people on Personal Independence Payments (PIPs) and Disability Living Allowance (DLA) and the lowest proportion of people with savings over £100. Following the 2008 Global Financial Crash, Northern Ireland was impacted more than other UK regions, leaving 41% of households with a mortgage in negative equity in 2013 (The Consumer Council, 2018). In 2019 Northern Ireland had the highest level of reported new household indebtedness across the UK. Research by French and McKillop (2017) found that financial stress was associated with a 58% increase in the probability of having problems with anxiety or depression. The evidence base on the effectiveness of integrated debt advice within mental health services is admittedly immature. However, the issue appears to be with the overall absence of evidence and the low quality of the evidence available rather than evidence suggesting it produces no effect. An analysis modelling the costs of integrating debt advice into a UK mental health service concluded that the costs

of providing debt advice would be more than covered by diminished demand for physical health care associated with mental health problems and increased productivity (Acton, 2016). A comparison of practice on integrated debt advice in the UK suggested that while pockets of good practice exist, much more needs to be done to join up efforts and ensure financial difficulty is not a systemic barrier to recovery from mental health problems (Evans, 2018). Half of CCGs and NHS Trusts which provide mental health services in England either commission or work with an external organisation to provide a specialist support service for people experiencing both mental health problems and financial difficulties. Every Welsh Local Hospital Board report some form of specialist provision, as do 91% of Scottish Trusts and three-quarters of Trusts in Northern Ireland. The analysis also suggested that where specialist services are offered, few providers collect data on the number of people accessing these services, making it difficult to evaluate their effectiveness and hindering quality improvement within integrated services. (Clarke et al, 2016)

Suggested change – clarity on additional funding commitments
We welcome the commitment to increase funding for Child and Adolescent Mental Health services from 6.5-8.5% of the total mental health budget to 10%. However, we would welcome some further clarification on whether the extra funding will be additional to existing budget or drawn from within a set budget. Given the overall underspend in Northern Ireland at this time, additional allocation is assumed (RCPysch NI, 2021). Regarding item 92, the allocation of £1m per year to improve access to mental health in the primary care multi-disciplinary team appears inadequate in the context of mental health needs in the community.

Suggested change – reorientation of priorities on the old age psychiatry service
We do not support the Strategy proposals to remove the cut off in adult services at age 65 and remove the chronological age-defined access to old age psychiatric services. The proposal is concerning considering there is no commitment to increase resource for the old age psychiatric service. The draft Strategy provides no reassurance on how such a change would protect the current level of specialised service needed by a growing population of older people. There is a concern that this may effectively lead to a down-grading of the service at a time of rising patient numbers linked to population ageing. We note that there is no commitment to budget increases for old age psychiatry in contrast to the commitments made to the child and adolescent mental health service. It is unclear where the additional resource would come from to take on additional patients in the old age psychiatry service and whether this would have an overall negative effect on the level of service available to older patients.

This evidence of underdiagnosis and treatment of mental health problems in older age cited in the consultation report (85% receive no state treatment) reinforces the importance of a focus on old age psychiatric services to ensure mental health issues in older age are correctly diagnosed, treated and advocated for, and to prevent older people with mental illness falling between two stools, or being overlooked for appropriate treatment. It also underlines the need for a public health approach to improve community mental health and encourage early intervention and prevention measures.

We recommend that the strategy re-orients its approach to old age psychiatry by placing the needs of the older person first in deciding on strategy priorities. We recommend greater attention to ensuring resources, expertise and training are in place to meet the needs of the current and future older population. There is substantial evidence (as detailed in the section below) that older people are more likely to be overlooked,

underdiagnosed and under-referred for specialist management for mental health issues and we recommend that this form the focus of any recommendation within the Strategy.

Supporting evidence to reorient the proposals for old age psychiatry service
Mental health problems in older age are often underdiagnosed by healthcare professionals– indicating that more rather than less specialist services are important to identify mental health problems in this age group (WHO, 2017). Evidence shows that old age psychiatric services are better than general psychiatric services at meeting the needs of older adults with enduring mental illness. The UN/WHO's new Global Report on Ageism cites evidence that mental health professionals are often not adequately trained to diagnose and work with older patients (WHO, 2021). A study in British Journal of Psychiatry found significantly fewer unmet needs in patients attending specialist old age services (Abdul-Hamid et al, 2015). A WHO review (WHO, 2004) also concluded that the evidence favoured specialist old-age mental health services that could also provide education, training and preventive strategies. Retaining age-defined thresholds for old-age psychiatry may be a better model for ensuring older people receive appropriate care and expertise, and to ensure that old age psychiatry works across the spectrum of mental health need in older age, including preventive measures and early intervention, rather than solely at the extremes of clinical need which could be the consequences of this proposal. If the issue is about people moving between services as they age, e.g. turn 18 or 65 than this requires a pathway transition approach.

Suggested change – commitment to change management support and evaluation for the enhanced community and primary care service model
The strategy intends to reorganise primary and secondary care services around the GP Federations to ensure a person-centred approach, with primary care MDTs at the heart of this. Action 9 commits to co-design local pathways of care across primary and secondary care and employ evidence-based community services. It is envisioned that the primary care MDTs along with an increase in accessibility to talking therapies through new talking therapy hubs (Theme 1 Action 2) will lead to quicker service access, less referrals, reduced waiting lists and better outcomes for patients.

We welcome the Strategy commitment to develop primary care and community based services. However, it is not clear the extent to which evidence from the evaluation of pilot primary care mental health MDT projects to date has informed the roadmap for change. There is a lack of detail on how data on hospital admissions and waiting lists was taken into account and how changes will be monitored with service reforms. Formal monitoring and evaluation of the impact of pilot projects is a necessary priority. Dissemination of results is recommended to inform service continuation, further expansion and any necessary service improvements. The impact of the MDTs should ideally be assessed in terms of outcomes like mental health referrals and waiting lists, crisis service utilisation, and antidepressant prescribing in primary care. We recommend that a clear 'change pathway' is specified alongside a commitment to implement a well supported change management programme for service providers and users alike.

Supporting evidence – change management in service reform for mental health
Dayan & Heenan (2019) highlighted that formal evaluation of initiatives was relatively scarce and recommended a greater emphasis on monitoring of performance and learning. The report noted that a tender for evaluation of the MDTs in Londonderry/Derry and Down was opened in 2019, which appeared to have come well into the process and after the decision to roll-out widely. The Social Care Institute for Excellence (2018) highlighted that MDTs can encourage better co-ordination of care by fostering professional collaborations.

They pointed to evidence that whilst MDTs may improve outcomes in cancer services (Prades et al. 2014), primary care MDTs have not been shown to be effective in decreasing admissions for high-risk populations and may have limited effectiveness as a tool to reduce care utilisation (Stokes et al. 2016).
A survey conducted as part of the MDT evaluation in Dudley UK found that the majority of respondents felt that the MDT improved quality of care (91%) and improved patient outcomes (84%) (ICF & Strategy Unit, 2017). However, evaluation of the impact of the MDT found an increase in admissions to non-elective ambulatory care services following introduction of the MDT model, although the cause of this increase is unclear. Of note most patients added to this MDT register were over 64 (78%), which may indicate that the medical co-morbidities and increased demands of this older age group could dominate the focus of MDT work rather than mental health issues. A systematic review on the effects of on-site mental health workers (MHW) on the clinical behaviour of primary care providers (PCPs) found the MHWs reduced PCP consultations, psychotropic prescribing, and rates of mental health referral in the patients that they were managing. However, the differences were modest and inconsistent across studies. In controlled before and after studies on the addition of MHWs, the review found that there may be little or no difference in how PCPs prescribe drugs, with no consistent pattern to the impact of patient referrals in the wider patient population not attending the on-site mental health workers. (Harkness & Bower, 2009). It is noted that a contract for evaluation of primary care MDTs was awarded in Feb 2020 with a specified contract end date of Feb 2022. This may provide clarity on the effectiveness of the MDTs in Northern Ireland (Bidstats, 2020).

Suggested action - a focus on waiting lists for specialist/secondary care
We recommend that the strategy include a strategic focus on tackling mental health waiting lists alongside the commitments to reform the primary care and community based services. This may necessitate separate initiatives to support patients within pro-active management of waiting lists informed by perceived risk. Brief interventions may be integrated into waiting lists, along with the provision of information on additional supports and self-help material while waiting for secondary level mental health services.

Waiting lists for specialist assessment are unlikely to be resolved, at least in the short-term, by the service reform measures linked to MDTs and increased talking therapies within primary care. While the development of primary care services is welcomed, evidence does not support that this will result in a rapid reduction in referrals with the presence of on-site mental health workers, with some studies even showing an increase (Harkness & Bower, 2009).

Supporting evidence for a focus on waiting lists
Health service waiting lists in Northern Ireland far exceed other parts of the UK. (Dayan & Heenan, 2019). Waiting for access to mental health treatment can have consequences for both individual mental health and for mental health services. Research by the (Royal College of Psychiatrists, 2020) found that two-fifths of patients waiting for mental health services contact emergency or crisis services with 11% ending up in the Emergency Department. Further 'hidden' waiting lists may be created by the wait between first and second appointments. These can result in further delays to patient treatment with predictable consequences. A survey of 513 adults awaiting mental health services found that of those on hidden waiting lists, 23% wait more than 3 months for their second appointment with 11% waiting more than 6 months. 38% reported that they had contacted emergency or crisis serviced while waiting for their second appointment, while 39% reported a decline in their mental health.

Waiting lists and the availability of mental health services may also impact on antidepressant prescribing. A Mental Health Foundation (2005) survey of UK general practitioners found that 78% had prescribed antidepressants despite believing that there may have been a more appropriate alternative. 62% had prescribed because of a waiting list for the alternative, and 66% because a suitable alternative was not available. Inequalities are seen in antidepressant prescribing with prescription rates being 60% higher in the most deprived areas than the least deprived areas (Information Analysis Directorate, 2020). The increase in antidepressant prescribing has additional cost implications, with Northern Ireland spending an estimated £18.3m on antidepressants in 2020. This represents a significant increase from spending in 2019 of £11.3m (HSCNI, 2021).Dual-diagnosis mental health waiting lists may be particularly important in terms of mitigating against wider social and criminal justice impacts. In a small study of opioid-dependant individuals on treatment waiting lists in New Zealand, 87% of the individuals yielded an average of 16.4 criminal acts during the week before treatment with crimes including drug related crime (manufacture, cultivation, supply, importation), property crime, violence and prostitution (Adamson & Sellman, 1998). A larger longitudinal cohort study in Norway found that rates of criminal convictions for individuals on opioid treatment programmes reduced to less than half of waiting list levels (Bukten et al., 2012).

Suggested action - clarify commitment on crisis services

We welcome the stated intention to develop crisis services in Northern Ireland but note a lack of commitment to an end point or detailed actions. The strategy intends to create a regional crisis service to provide support for persons in mental health or suicidal crisis with effective crisis services meaning fewer people with mental health issues attending Emergency Departments. In this regard we note that a separate review of the mental health crisis response is awaited to inform further actions (action 19). Notwithstanding the ongoing work, we would recommend that the strategy commits to the provision of a crisis service for all age cohorts, across all Trusts and at all times.

Supporting evidence on crisis services

A review of emergency mental health services in Northern Ireland undertaken by the Regulation and Quality Improvement Authority (RIQA) in 2019 found that within adult mental health services Trusts had services to undertake crisis assessments 24 hours a day, 7 days a week. However, it reported difficulties with 24 hours a day, 7 days a week service for children and young people and older adults' services, with inconsistencies across Trusts (RIQA, 2019).

Suggested change – commitments to monitoring of CAMHS

We recommend that additional commitments are needed in terms of service management and evaluation into include a strategic focus on waiting times for access to CAMHS services, CAMHS acceptance rates and availability of CAMHS data. It is recommended that additional data be collected to inform future service improvements. This includes waiting times from referral to an acceptance decision and waiting times for a second review appointment in Step 3 CAMHS services. This may identify potential 'hidden' waiting lists within services. Additionally, data on the reasons for referrals not being accepted to Step 3 CAMHS should be collected as this may inform improvements in referrals to the service. At present a 9-week waiting time is recommended from acceptance of referral to Step 3 CAMHS to first appointment. The number of patients and the percentage waiting for longer than the recommended 9-week target are outlined in the below table and can be

seen to have been trending upwards to a significantly increased number (NICCY, 2021).It is likely that the Covid-19 pandemic will impact on this further.

Supporting evidence – monitoring of CAMHS

The total number of young people waiting for any CAMHS service on the 31st of March between 2017-2020 increased from 1056 to 1829 equating to a 73% increase. The breakdown of waiting lists for 2019 show the gross majority are waiting for access to Step 2 (48%) and Step 3 (48%) services (NICCY, 2021) These prolonged waiting times may impact on individual mental health outcomes, crisis service utilization and emergency department presentations. In addition, concerns have been raised regarding the time between first and review appointments creating 'hidden' waiting lists (Gregory, 2019). NICCY (2021) outlined that regionally the percentage of referrals not accepted to Step 3 CAMHS increased from 33% in 2013/14 to 42% in 2015/16, with data from 2016/17 onwards no longer available. Aggregate acceptance data is now collected relating to global referrals to CAMHS services which include Step 2 and 3 services, Crisis Services and Drug and Alcohol Mental Health services (DAMHS) and eating disorder services. Non acceptance rates in 2019/20 were 29%. Variation is seen between Trusts, with non-acceptance rates in 2019/20 ranging from 17% in the Western Trust to 37% in the Belfast and South Eastern Trust. Currently there is no regional monitoring of the reasons for referrals not being accepted which may provide guidance as to how referrals to CAMHS can be improved and appropriately made. Additionally, supports for young people not accepted by Step 3 CAMHS must be considered. Whilst progress has been made on the monitoring of CAMHS data, gaps exist on the public availability of this data.

Suggested change – enhanced focus on gambling and mental health

We recommend that the strategy better recognise and respond to the mental health impact of gambling in Northern Ireland. The draft strategy makes one reference to gambling, but there is no real recognition of how it contributes to mental ill health for either the user or family members. Given the scale of problem gambling in Northern Ireland and the impact on mental health (as set out in the evidence section below) we recommend that the Strategy include an action to deliver a specialised service for people with problem gambling alongside commitments on enhanced detection, referral and management across the service. We would encourage the Department to ensure services support both individuals and families affected by gambling addiction. We recommend that the Strategy commit to resource the roll-out of a training programme for health and social care workers to support enhanced identification of problem gambling, provide brief counselling interventions and pathways for referral. We recommend that the Strategy commit to enhanced monitoring of gambling behaviours, gambling-related harms and associated mental health impacts among both children and adults through government surveys and research.

Supporting evidence – enhanced focus on gambling and mental health

People in Northern Ireland are more likely to gamble than those in England and Wales. The prevalence rate of problem gambling in NI is the highest in the UK at 2.3% (Department for Communities, 2017). UK survey data found higher levels of problem gambling among individuals with anxiety and depressive disorders, obsessive compulsive disorder, phobias, panic disorder, eating disorder, psychosis, attention deficit hyperactivity disorder, post-traumatic stress disorder and substance dependency (Wardle 2015). Other UK surveys conclude that people who play online slots and casino games (as well as betting on sports online) are more likely to experience depressive symptoms, anxiety, alcohol and substance misuse and past year use of major illicit and psychotropic drugs, as well as self-harm as a result of gambling (Lloyd et al. 2010). In the UK, 14% of children

aged 11-16 have gambled in the past week, with around 55 000 reporting problems from their gambling behaviour. Over 8 in 10 young people said that gambling harms increase the risk of a peer experiencing depression and nearly three quarters said that they increase the risk of a peer experiencing anxiety (Royal Society for Public Health, 2019).

Gambling addiction is an under-recognised threat to mental health and interacts in complex ways with issues of alcohol and drug misuse, self-harm and suicide. John et al (2019) found that there are no reliable estimates of gambling-related suicide deaths at a population level in the United Kingdom and a lack of reporting and awareness in official reporting mechanisms such as inquests. It is estimated that 58% of problem gamblers had a substance use disorder and 38% had a mood or anxiety disorder (Loraines et al., 2011). Problem gamblers only bear a proportion of the mental health burden of gambling; other gamblers, as well as the family and friends of gamblers, can be affected in similar ways (Rogers, 2019).

There is a lack of routinely collected data on gambling prevalence and its impact on the mental health of the population in Northern Ireland. There is also a deficit of research on the mental health impacts of those experiencing gambling related harms in Northern Ireland. We recommend a greater focus on gambling as a research priority in this strategy.

Suggested change – Enhanced commitments on reducing tobacco-harms for people with mental ill-health

We welcome the draft strategy's recognition on the physical ill health and health inequalities faced by smokers with mental health difficulties or mental illness. We strongly welcome the commitment and leadership shown in setting a target for percentage reduction of smokers with mental illness. Given the evidence to support the two way relationship between smoking and mental ill-health, we support greater linkages between the Mental Health Strategy 2021-2031, Northern Ireland tobacco control policy and stop smoking programmes and services.

In particular, we recommend a focus of this work include training and development initiatives to support mental health service providers to engage effectively to identify smokers and support them to stop smoking (WHO 2020). In response to findings from the Midterm Review of the *Northern Ireland Ten Year Tobacco Control Strategy (2012-2022)* the Northern Ireland Department of Health published a recommendation to prioritise people with mental health conditions as an additional priority group for inclusion to the strategy. The recommendation calls for the formulation of a plan with short- and long-term targets to address prevalence rates for those with mental health conditions.

Supporting evidence - **Enhanced commitments on reducing tobacco-harms for people with mental ill-health**

In Northern Ireland, in 2018/19, Health Survey NI respondents with a high GHQ12 score were two and a half times more likely to report being a current smoker (33%) than those with a low score (13%) (Department of Health 2020).

People living with poor mental health are also more likely to be heavy smokers who smoke more than 15 cigarettes per day. Research conducted in the United States by Lê Cook et al. 2013 investigated the percentage of self-reported smokers among people with and without probable mental health conditions between 2004 and 2011. The findings showed that while the percentage of smokers without mental illness decreased from around 20% to just over 15%, the proportion of smokers among people with probable mental illness remained stable over the time period at around 28–29%. The percentage

difference between the two groups therefore widened. In Ireland, studies show that adults living with mental illness are around twice as likely to smoke tobacco as compared to the general population (Callaghan, 2014). Within the context of Covid-19, data from Ireland have demonstrated that smokers with mental ill health and those experiencing psychological distress were more likely to smoke more in the context of COVID-19 measures than other groups of smokers (CSO 2020). This implies that tobacco-control policies have not worked as effectively for people with mental health conditions, who represent both an important demographic for action on this health disparity (WHO 2020).

Data suggests that those with mental-ill health also express the same motivations and desire to stop smoking as the general population. However, they are less likely to report being offered advice or support to stop smoking (Currie et al. 2010). One Irish study found that only 6% of patients who smoked had smoking cessation advice clearly documented in their case notes (Burns et al. 2018; Ohakim et al 2015). A recent Cochrane review found that stopping smoking does not harm mental health recovery. Compared with people who continued to smoke, people who stopped smoking showed greater reductions in: anxiety; depression; and mixed anxiety and depression (Taylor et al 2021).

In Ireland, a national conversation café on the topic of Smoking, Mental Health and Recovery, took place in July 2019 and brought together over 70 stakeholders to address the topic of smoking, mental health, and recovery. This was the first ever nationally co-produced event with Mental Health Ireland, the health service executive (HSE) and Healthy Ireland. The event brought together a diverse range of stakeholders including mental health service users, services providers, supporters, and ex-smokers to contribute to a solution-focused plan. Holding a similar exercise in Northern Ireland could inform the targets for the action plan for reducing smoking among those with mental health challenges.

In 2012, the Irish HSE launched the National '*Tobacco Free Campus Policy*' which aimed to implement a tobacco free policy in all health and social care settings offered by the HSE. In 2016, a briefing report for front line staff was published titled "*Smoking Cessation and Mental Health: A briefing for front line staff*". This report was published to serve as a complementary resource to the Tobacco Free Campus Policy. It is a detailed and tailored resource produced for mental health services in recognition of the unique challenges arising from established practices and misconceptions around mental health and smoking.

Theme 3: New Ways of Working

Do you agree with the ethos and direction of travel set out under this theme?

Mostly Agree

Please add any further comments you may have

See comments under theme 1 on policy coherence

The 'new ways of working' focus exclusively on the re-organisation of service and make no mention of new ways of working on mental health promotion.

We would welcome clarify on how the principle of co-production will be actioned within the new ways of working.

Do you agree with the actions and outcomes set out under this theme?

Mostly Agree

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

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

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

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

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

Please add any further comments you may have

Suggested change – integration of existing academic centres on mental health
The focus on research and research funding is welcome but as there are already mental health research centres at both Ulster University (Bamford Centre) and Queen's University Belfast (Centre of Excellence for Public Health). It would seem more beneficial to enhance these existing groups and build collaboration both nationally and internationally, rather than establishing a separate new centre of excellence for mental health research.

Suggested change – commitment to North South working and cross-border issues
We recommend the inclusion of a commitment to North South cooperation on mental health strategy and service development and a defined focus on service planning and delivery for people living in the border region.

Prioritisation

If you had to prioritise the actions set out above, which top 5 actions would you take forward (with 1 being the most important to you, and 5 being the 5th most important to you)?

1	ACTION 1. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach. The action plan must consider groups disproportionally affected by mental ill health which often struggle to access early intervention services.
2	ACTION 3. Further promote positive social and emotional development throughout the period of childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.
3	ACTION 20. Create a managed care network, with experts in dual diagnosis supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

4	ACTION 9. Refocus and reorganise primary and secondary care mental health services around the GP Federations to ensure a person centred approach, working with statutory and community and voluntary partners to create local pathways within a regional system.
5	ACTION 22. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a psychosis network.

Finally, is there any one key action which you feel is missing from the draft Strategy?

Recommendations on suggested changes to the strategy and supporting evidence are included in the sections above.

Impact Assessments/Screenings

Do you agree with the outcome of the Impact Assessment screenings?

Mostly Agree

Please add any further comments you may have

Do you agree with the Equality Impact Assessment (EQIA)?

Mostly Agree

As mentioned in the EIA there are a number of mental health issues that disproportionally affect men and women. An omission from the EIA is the gender differences in self-harm and suicide. In 2018, the age standardised rate of death by suicide in Northern Ireland was 28.0 per 100,000 in men compared to 9.5 per 100,000 women. Although men are more likely to die by suicide, data from the Northern Ireland Registry of Self-Harm from 2012/12 to 2017/18 show a greater number of females presenting to E.Ds. In 2017/18, females accounted for 3139 ED attendances compared to 2968 males. Of the 6,107 individuals treated for 9,127 self-harm episodes between April 2017 and March 2018, one-third of presentations were due to repeat acts of self-harm. One in five self-harm patients made at least one presentation to the ED with self-harm within this period. The repetition rates are similar for males and females (Public Health Agency, 2019). A report based on data from 2005-2011 found that women were significantly more likely than men to have a recorded health condition at the time of suicide (75% vs. 67.8%, N = 1253) ($\chi 2 = 27.80$, $p = <.001$).

Please add any further comments you may have

Thank you for taking the time to respond to the consultation.

Please submit your completed response by **5pm on 26 March 2021** using the details below:

E-mail:

mentalhealthstrategy@health-ni.gov.uk

Hard copy to:

Department of Health
Adult Mental Health Unit
Room D4.26
Castle Buildings
Stormont
Belfast
BT4 3SQ

Please note: To allow for the full 12 week consultation period required, responses relating to the **EQIA** will be accepted after the close of the main consultation, but must be received by 5pm on Monday 12 April 2021.

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