

RCPsych NI Response to Department of Health NI Draft Mental Health Strategy 2021-2031

1.0 Introduction

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families, and communities.

The College has approximately 440 members in Northern Ireland (including Doctors in training) who provide the backbone of the local Psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

This response is submitted on behalf of the Royal College of Psychiatrists in Northern Ireland Devolved Council following significant engagement with our members.

2.0 General Comments on the Strategy and the identified Themes:

We welcome this 10-year Mental Health Strategy for Northern Ireland and feel it is very timely. It is taking us forward from the successful developments that have flowed from the Bamford Review of Mental Health and Learning Disability. In particular it reinforces the principle of service development being focused on the needs of our Patients and their Carers and co-produced in conjunction with people with lived experience, Carers, the community and voluntary sector, the statutory sector and other organisations involved in the delivery of mental health services.

The structure of the Strategy into three themes provides a very useful and practical framework for the Strategy.

Theme 1 “Promoting wellbeing and resilience through prevention and early intervention”: is a very positive and welcome development. We know increasingly more about the importance of mental wellbeing and resilience and more specifically how these can be improved. Poor mental wellbeing can lead people to make bad choices in their lives, resort to alcohol and drugs, be vulnerable to abuse and for some to develop a mental disorder or mental illness. This theme also rightly focuses on positive mental health for children and their families. The early formative years are so important for children and much of this depends on the mental health of their parents/guardians. As important as it is to do everything to improve wellbeing, it does not prevent many people developing mental disorders and severe mental illness, which have in general a multifactorial aetiology.

Theme 2 “Providing the right support at the right time”: This is a good overall heading for the section on the delivery of mental health services. However, the title needs to be changed. Mental health services primarily provide “treatment”. as well as support. This needs to be acknowledged in the title of this section e.g. “Support, care and Treatment” or “Therapeutic interventions and support”. Treatment or therapeutic interventions would include talking therapies, psychological therapies, psychotherapy, medication, and other evidence-based therapies. It is important that there is recognition in this section of the range and

complexity of mental disorders across the age span. In child and adolescent services there are complex emotional and behavioural mental disorders needing a wide range of interventions including individual and family therapy. Common and severe mental disorders often emerge in young people and young adults. These include depression and anxiety as well as the development of severe and enduring mental illnesses such as schizophrenia, bipolar disorders, severe depressive disorders and eating disorders. These conditions can continue to emerge throughout the lifespan along with organic brain disorders including dementias and brain injuries. Patients with the more severe mental disorders utilise many of the inpatient, outpatient and supported housing resources. There seems to be little acknowledgment of the needs of Patients with severe and enduring mental illness.

It is important that the needs of those Patients with milder mental disorder (usually managed through outpatients or C&V sector) are not seen as in competition with those who have severe mental illness. The interventions should be proportionate to the need and evidence base, but both groups and the full range of illnesses need to be recognised.

Patients with a learning disability, especially a severe learning disability, and their families need expert support and interventions. This Patient group are also more likely than the rest of the population to develop a mental illness which needs expert assessment to identify and treat.

We feel there should be a better “fleshing out” of the types and range of clinical need in this section so it is more understandable how the Strategy will meet the needs of the Patient groups rather than in general terms. There need to be pathways for some specific illnesses including those mentioned. An integrated approach is also required considering the social determinants of mental health including housing, accommodation, education and the environment.

Theme 3 “New Ways of Working”: Looking to how mental health care systems may develop as well as the data, outcomes etc to support this is very refreshing. There is a need for further development in innovation and research on mental health in Northern Ireland as recognised under this theme. This will help stimulate the conversation around this subject.

We have focussed our response on specific key areas and whilst we have not used the template provided, we have referred to the relevant sections.

3.0 Comment on mental disorders and their aetiologies:

There is a need for an agreed understanding around what is meant by mental wellbeing, common mental disorder, severe mental illness, learning disability, emotional and conduct disorders etc.... Many mental disorders have complex aetiologies which include social, psychological and biological dimensions. It is important that all of these dimensions are recognised as contributing to mental disorders. The delivery of care and treatment for Patients is best provided through a multidisciplinary team where all three needs are met. The relative impact of the range of aetiologies varies among the mental disorders and from person to person. The biological dimension is significant in Patients with a severe mental illness. The Strategy does not appear to give as much weight to the biological aetiologies, especially of the more severe mental disorders/mental illnesses, as it does for the social and psychological aetiologies. The lack of recognition of

the biological dimension contributes to misunderstandings about mental disorders and the important role of medication in the treatment of some mental illnesses.

The Strategy seems to indicate a shift towards primary care and GP Federations. However, there needs to be emphasis on the important input of clinical teams and services for those with severe mental illness. Consideration needs to be given to how integration could be achieved between primary and secondary care services to achieve the best outcomes for Patients.

4.0 Vision for the future (pages 13-14)

The vision needs to be more aspirational and inspirational. Most of all it needs to really grasp the nettle of culture change i.e. public and services joint ownership of and responsibility for mental health /ill health in Northern Ireland.

We welcome the DoH's increased inclusion of Clinicians as part of the overall Co-production ethos, especially in the work so far on the Strategy.

The seven principles on page 14 could be improved by including timely access to assessments and treatment. There is also no mention of a rights base. It appears in the vision and elsewhere but should be in the principles. Equity of physical health care, in particular for Patients with a severe mental illness and learning disability, where there is often an earlier mortality of 15 to 20 years, should be a principle. There needs to be recognition of the needs not only of the User but also the Carer.

We need to do more to reduce the stigma not just of depression/ anxiety/ stress, but also of severe mental illness – schizophrenia, bipolar disorder, personality disorder, OCD, eating disorders etc.

5.0 Theme 1 – Promoting wellbeing and resilience through prevention and early intervention.

Promotion, early intervention and prevention

Please see the general comments on this theme in section 2.0

5.1 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 disproportionately affected by mental ill health which often struggle to access early intervention services.

We broadly agree with this important action point but would draw attention to our points earlier regarding severe and enduring mental illness and the need to include care and treatment as an integral part of any action plan. Early intervention, especially for those with psychosis, should be provided through a multi-disciplinary Early Intervention team. The reference to the mental wellbeing and mental health of students is welcome as this is often under recognised. However, mental health service provision needs to continue to adjust to the mobile and transitory nature of the student population. The Strategy needs to include a commitment to and appropriate resourcing for university student wellbeing services and student mental health services. This will be discussed further in 8.5 below. The importance attached to Adverse Childhood

Experiences (ACEs) and their impact on the mental health of adults is welcomed and the need for the appropriate training of staff.

5.2 ACTION 2. Expand talking therapy hubs to ensure a 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.

An ethos of health promotion and early intervention is clearly appropriate. However, we have a number of concerns in relation to the narrative and action point.

The absence of detail on issues such as 'embedding psychological therapies' in primary and secondary care means that commentary is difficult to make - other than keeping in mind the staffing, resource and training implications. A more developed sense of a dynamic but stepped care structure would be important. There is an over focus on 'access' which risks losing sight of the question: access to what?

Changes to services must be evidence-based and planned to take account of their impact on the existing and future workforce.

Improved access to psychological therapy is acknowledged as a need and we support this. With the introduction of this innovation, it will be important to monitor and assess the impact on referrals to secondary care and the evaluation of the Talking therapy hubs as they develop.

A meaningful expansion of the hubs should not only be the geographical one which is referred to in the Strategy. The range of therapies should also be expanded to include a higher level of therapy for common mental disorders, including the cognitive-behavioural therapies and the insight orientated and creative psychotherapies.

We recommend that this mixed economy of provision should be reflected in the planning or reconfiguration of networked mental health services across the entire developmental spectrum from infancy to old age. These services need to be available to the population across Northern Ireland. A regionally equitable approach is required. Such development will require investment in training in psychotherapy practice and research.

These services are available to General Practitioners in many parts of England under the NHS Improving Access to Psychological Therapies (IAPT) service. The Minister in his introduction highlighted this Action as one of the most important four. He envisaged the development of the Talking therapy Hubs and of Multi-Disciplinary Teams (MDTs) with mental health workers that would enable GPs to take on extra responsibilities. However, GPs have made it clear that the roll out of the MDTs will not mean they will take on extra responsibilities. The intent here needs to be clarified. Secondary care mental health services do not currently have the resources to treat all those who are ill and who present to mental health services.

Promoting children and their families' positive mental health

- 5.3 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.

This is welcome. An important factor in achieving this would be the good mental health of parents, especially with young children. The parents need access to help, support and, if necessary, treatment. School teaching staff need to be aware of when and where to access advice if they become concerned about a child.

Promoting wellbeing, prevention and early intervention is absolutely vital. If we do not get this right, people are more likely to have chronic difficulties which take longer and are more costly to treat, will be associated with increased likelihood of other physical or mental health comorbidities developing and will have a greater impact on functioning. A significant consequence of not getting this right, apart from the preventable distress for the person affected, is that mental health services become overwhelmed, so are unable to function effectively.

Specifically, when considering perinatal mental health for example, the evidence could not be clearer. If we focus on wellbeing and prevention and intervene effectively and quickly when problems arise, the outcomes in the short and longer term are better for Mother, Baby and the rest of the family.

Universal prevention services should recognise that patterns leading to negative developmental outcomes can become established during the child's early years, often before a diagnosis of learning disability is made. Parenting programmes should be able to address the types of difficulties associated with developmental delay and specialist mental health services should work collaboratively with early years services to provide advice, consultation, training and joint working. It is very positive that the Strategy recognises that specialist parenting programmes should be made available to children with developmental delay who present with "behavioural challenges".

- 5.4 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 disabilities, ASD and learning disabilities. This must include help and support for parents and families.

We welcome the emphasis on ensuring equal access to Child and Adolescent Mental Health Service (CAMHS) for vulnerable children and young people.

Children & Young People with a Learning Disability: The current inequalities must be addressed to arrest the lack of progress in this area. We know from epidemiological studies that children and young people with a learning disability are at least four times more likely than their non-disabled peers to have a mental

health condition or a concern about their emotional wellbeing and behaviour requiring access to specialist, multidisciplinary and therapeutic intervention.

The Strategy recognises that CAMHS should be inclusive of children with learning disabilities. More is needed. Children and young people with a learning disability should have equal access to specialist and intensive CAMHS, including step-up and-down from the regional inpatient service. Specialist teams, often called Intellectual Disability (ID) CAMHS teams in other parts of the UK and Ireland, should be part of a comprehensive and integrated CAMHS service model for Northern Ireland. CAMHS should be able to offer evidenced-based, clinically effective interventions in line with The National Institute for Health and Care Excellence (NICE) and other relevant guidance and to demonstrate quality-of-life outcomes. As well as meeting the needs of children and young people with identifiable mental health conditions, these teams will often see children and young people presenting with behaviours of concern, such as self-injury, which are associated with distress and risk of harm. Whilst initial assessment and advice might be offered within schools or community paediatric services, CAMHS should be able to offer specialist support and intervention when children and young people present with more severe or complex behavioural difficulties (e.g. chronic anxiety, trauma, unrecognised Attention Deficit Hyperactivity Disorder (ADHD)) and require specialist, multidisciplinary assessment in addition to an analysis of their behaviour. Practitioners must have specialist skills and training and the service should also develop a highly networked approach, working within well-defined and collaborative care pathways including education, social care, and other specialist health services.

Children and young people with learning disability should be able to receive timely access to treatment in the community when possible and in hospital when necessary. Any future re configuration of inpatient beds should specifically consider the current provision in the Iveagh Unit. There is a need for intensive community-based treatment to prevent admission to hospital, greater integration between existing inpatient services and access to Psychiatric Intensive Care Unit (PICU) and low secure mental health beds for young people with learning disability. The planned development of an Acute CAMHS Network should include CAMHS for children with learning disability and progress alongside the development of specialist community-based services aimed at preventing late, complex presentations and improving long-term outcomes.

Building on the foundation of the CAMHS Service Model and CAMHS care pathway, children and young people with learning disability should have equal access to the “full range of services that should help them flourish” from prevention through to inpatient services, with an urgent need to ensure access to comprehensive and integrated community based CAMHS.

Autism/ADHD: Services for diagnosis and treatment of neurodevelopmental disorders including autism and ADHD are not adequately developed or funded and this needs to be addressed, as mainstream mental health services are not equipped to meet the needs of these populations. There is an increasing number of young people who have had ADHD treatment commenced in childhood being transferred to adult mental services for the management of their ADHD as well as co morbid mental disorders. Their service needs as adults should be reviewed and a service model developed. There are currently long waiting lists for young people who need an assessment of autism. There should be a scoping exercise for the needs of the

population and what resources will be needed. There should be ongoing education for mental health services about the nature and presentation of ADHD and autism.

6.0 Theme 2: Providing the right support at the right time.

Please see the general comments on this theme in section 2.0

Child and adolescent mental health

- 6.1 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.

This is welcome, but it is not clear if this will be an increase in funding or will this mean a pro-rata reduction in funding for adult mental health. How the 10% figure was reached in Action 5 is not explained. There needs to be assurance that the budget shift will not reduce the funding for other mental health services. Increased funding for CAMH Crisis Resolution Services must be for mental health services rather than services and interventions which might be expected to be available through other sources - for example through education and social care.

- 6.2 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.

The 'no wrong door' approach is welcome. The needs of vulnerable children including young people with mental health problems who enter the criminal justice system must be recognised - with investment and service development in this area leading to many benefits. The transition of looked after children to adulthood should have better developed support services.

The difficulties for young people in the transition from CAMHS to Adult services is well recognised in general – but there should be more discussion about alternative service models e.g. 16 to 25 years and youth services. The Royal College of Psychiatrists will be issuing a position statement on 0 to 25 years mental health services in the near future.

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

We welcome this inclusion but would reiterate earlier points regarding access for those with learning disability. This is an area where there needs to be consistency in the development of services across Northern Ireland.

Mental health and older people

- 6.4 ACTION 8.** Ensure adult mental health services cater for older people 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 need.

This should be revised to reflect the needs of older people, particularly those who have complex physical illness or frailty, being best met by specialist old age psychiatric services rather than generic ageless services (i.e. that access to *all* services should be based on *need* rather than chronological age). We therefore suggest an alternative wording, which would better reflect the position of the Royal College of Psychiatrists and the Strategic Advisory Panel.

Proposed *ACTION 8. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs-based rather than solely dependent on chronological age. The quality of care provided must be equal to those of other Service-Users and open to younger people when necessary.*

The Royal College of Psychiatrists believes the specialism of Old Age Psychiatry, delivered by an appropriately skilled multidisciplinary workforce provides the best outcomes for older and physically frailer people with functional illness and dementia (including younger onset dementia)¹.

In this case, “old age” is a term that covers needs that are usually (but not exclusively) associated with ageing as opposed to just an arbitrary “cut-off” at the traditional retirement age of 65 years. It is expected the specialty will follow global trends in the next ten years and be renamed Psychiatry of Ageing and Memory or similar. Good pathways of care are key and while these needs mostly coincide with age, sometimes they do not. Currently some services (such as psychology) tend to be concentrated in operational silos leading to unintentional discrimination and poorer outcomes. This arbitrary split at 65 has detrimental effects across the region - even affecting issues like Regulation and Quality Improvement Authority (RQIA) certification and funding options for older people, often to their disadvantage.

However, splitting Old Age Psychiatry into generic, ageless “functional” mental illness services and separate dementia services would ignore the high overlap in needs between these groups and possibly lead to new silos rather than deliver best outcomes. Much work has been done to harmonise the vision and standards in older peoples’ services across Trusts in recent years. The current wording could be interpreted as a call for generic services and if taken as such would have a retrograde effect on services in Northern Ireland compared to the rest of the UK.

Mental illness is common in older people and presents unique challenges. Successful care is heavily dependent on an infrastructure that can deliver home visits and cater to the needs of physiologically frail and often disabled people. The advisory panel and the College both identified a lack of access to psychological services (which traditionally are based in services oriented around the under 65s) as a core problem. This could be addressed by a statement of equality of provision based on need rather than chronological age - rather than the current call to stop a cut-off at 65.

The assessment and management of dementia is an increasingly complex and specialist field, often requiring careful co-operation between Psychiatry of Old Age, Care of the Elderly and Neurology services. Specialist Psychology assessment and support is central to high quality care, as is occupational, physiotherapy and speech and language therapy. It is anticipated that as the investigation and treatment

¹ [Old age psychiatry faculty news | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/news/2018/01/01/old-age-psychiatry-faculty-news/18010101.htm)

of dementia evolves, that the skill set of an old age Psychiatrist will be increasingly different from the general Psychiatrist - incorporating areas such as interpretation of neuroradiology, use of new biomarkers and the administration of novel treatments such as monoclonal antibodies. In dementia care, it is thought that intervention will shift in the next 10 years to those aged 55 and above. The increased ability to detect and manage dementia in younger people means that the best Old Age Psychiatry services are already managing people irrespective of their chronological age and should be supported to do so.

The demographics show how important it is to get this right. In the lifespan of the Strategy, 1 in 3 citizens will be what is traditionally thought of as “old”. This population will include people whose mental health needs will be most effectively met by specialist “old age” services. Rates of dementia will also increase in the next 10 years and 50% of those affected will have behavioural or psychological symptoms. A new Dementia Strategy which addresses these mental health needs is needed but dementia should also be specifically mentioned as a core area in the Mental Health Strategy as it is a major source of mental illness.

Community mental health

6.5 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.

The ideal of primary, secondary and Voluntary, Community and Social Enterprise (VCSE) services working in a seamless and integrated manner is a worthy aspiration. The role of the consultant Psychiatrist as a resource and support providing consultation and advice for GPs in managing Patients with mental illness may significantly enhance overall service effectiveness and Patient satisfaction and outcome. To deliver this effectively would require planning, involving close working between GPs and Psychiatrists in the design and development of systems. The classic work by Goldberg and Huxley on Pathways to Psychiatric Care², illustrated that small changes in referral patterns could have a major effect on demand for services throughout the system.

GPs have made it clear that the development of the MDTs will not impact on referrals to secondary care services and they will not be taking on extra responsibilities. Consideration should be given to involvement of a senior mental health professional alongside a GP to allow early combined decision making. The shift towards Primary Care is supposed to mean more treatment being available in primary care. The emphasis might usefully be shifted to conjoint design and perhaps shared ownership of these new clinical services. Caution, however, is needed and Community Psychiatry’s role needs to be maximised. Clarity is needed from Department of Health (DoH) around whether DoH are expecting GPs and VCSE organisations to take on more responsibilities in terms of MDTs, Talking Therapy hubs etc. The Department might consider taking on a central role in helping to build the relationships to ensure clarity of roles and enable Governance structures to be developed to deliver these fundamental changes in Service provision. There is the additional risk of a further reduction in the skill base of Trust mental health professionals if staff

² [Mental illness in the community: The Goldberg-Huxley model of the pathway to psychiatric care: Nordic Journal of Psychiatry: Vol 50, No sup37 \(tandfonline.com\)](https://doi.org/10.1192/bjp.1997.125.5.607)

transfer to these MDTs in General Practice in a disconnected way. There is a limited resource of qualified mental health professionals.

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

The ethos of a recovery model of service in fostering progress and recovery from mental illness with growth towards independence is important. It is also important that those who, by nature of their condition, will require longer term support or whose level of recovery and independence achieved is dependent on continued and reliable input from services, are not neglected and that specialist rehabilitation services which enable people to function at their best are resourced. This can include services for those suffering sequelae of acquired brain injury, alcohol related brain damage, long-term psychotic illness, learning disability and developmental disorders.

Rehabilitation in mental health is a whole system approach to recovery from mental ill health. It maximises an individual's quality of life and social inclusion by encouraging their skills and by promoting independence and autonomy in order to give them hope for the future, which leads to successful community living through appropriate support.

Rehabilitation is part of a family of services for people with psychosis. It forms part of a pathway to recovery for people with the most severe and complex illness.

Rehabilitation is a comprehensive biopsychosocial treatment aimed at the needs of people with complex psychosis who are at risk of being unable to achieve or sustain successful community living.

Around 10% of Service Users who present for the first time with psychosis will require rehabilitation because of the severe impact that their illness has on their daily lives.

Up to 20% of acute inpatient beds may be used by people whose needs are not acute or who may be considered 'delayed discharge.' The majority of these are people with a psychosis that is of a high severity and/or complexity requiring intensive rehabilitation treatment and support.

Acute hospital care is expensive. The inappropriate use of acute beds leads to chronic bed shortages and problems accessing acute beds for those who need them.

Frequent or prolonged admission to acute inpatient care can lead to a new form of institutionalisation and reduce the likelihood of meaningful recovery.

The costs to the service from the absence of a regional Strategy for Rehabilitation come in the form of high-cost placements and problems with acute bed management. The costs to the Patient come in the form of institutionalisation, poor recovery and social exclusion.

Rehabilitation is an effective intervention which substantially increases the likelihood of someone achieving a meaningful recovery and sustaining life in their home.

6.7 ACTION 11. Fully integrate community and voluntary sector in mental health service delivery across the lifespan.

This is important and we welcome this action. However, we would suggest that the Department includes the faith sector and recognises the valuable work that they do in relation to support and recovery. For example, often faith communities provide the first response to those who are bereaved and their families.

Psychological therapies

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

To embed psychological services into mainstream mental health services is welcome. The broad range of psychological therapies should be recognised.

It is also important that psychological services and psychological therapies are integrated into overall mental health provision. For example, those presenting in distress or to acute services often may require access to a psychologist or psychological therapist. Difficulty in accessing psychological therapies may have a significantly negative impact both on Patient well-being and the efficient functioning of mental health teams and the service they are able to provide. This includes acute mental health services and liaison services to the general hospital and accident and emergency departments.

6.9 ACTION 13. Develop and implement a comprehensive digital mental health model that provides digital delivery of psychological therapies at all steps of care considering Patient outcomes and access to digital technology.

There is scope for the development of digital mental health, but this has to be carefully evaluated.

There is a need to embrace technologies at every level of mental health provision from Patient-centred aspects such as mental health interventions provided by apps, virtual/video/telephone clinics and clinics that Patients can self-book slots within - to more service-related technological developments such as digital dictation input for both correspondence and Information Technology (IT) systems. What we have learned during the pandemic from Patients, is that while they value services being maintained virtually when this is essential, virtual interventions are not always a replacement for in person appointments. Clear definitions of when virtual appointments should be maintained need to be developed.

All tiers of mental health services should develop their version of hybrid services to incorporate the opportunities for digital and virtual working, but the focus should always be on clinical outcomes. Patient feedback and clinical outcomes should be central to any digital interventions. Much of the effectiveness of psychological treatment is about the therapeutic relationship. This must not be lost in the push towards a digital world.

The reality of digital poverty within Service Users of mental health services must be recognized and plans made to overcome or address this.

Physical healthcare and mental illness

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

We suggest that this Action needs reworded as follows:

Proposed ACTION 14: Develop an agreed framework between mental health services and primary care services for the physical health monitoring of Patients with a severe and enduring mental illness as well as other Patients with mental disorders and learning disability. The framework needs to include clarity on who is responsible for acting on abnormal results.

The document incorrectly states that the main responsibility for the monitoring of the physical health of Patients with severe and enduring mental illness lies with secondary care. This is not the case. The responsibility for this lies with the GP as is the case with any other Patient. It is expected that GPs carry out an annual physical health review and bloods for those Patients with a severe mental illness on their mental health register.

Patients with learning disability have an annual review with their GP, but arrangements for their health care need to be further enhanced. Both Patients with severe and enduring mental illness as well as learning disability have significantly shortened lifespans compared to the rest of the population.

Secondary care services do monitor limited aspects of the physical health of Patients on specific treatments such as Lithium, Clozapine, high dose antipsychotic medication and a number of other treatments.

However, there seem to be different interpretations of responsibilities for the physical health care of Patients with severe and enduring mental illness. This needs to be clarified as for those Patients who do not have severe and enduring mental illness. The mental health worker in the new GP MDTs, in conjunction with the community mental health team, needs to ensure that Patients with severe mental illness are recorded on the GP mental health registers.

If an abnormality is identified during the monitoring of a Patient by mental health services, the Psychiatrist will ask a Physician or the GP to assess the Patient, depending on the issue. However there is not universal agreement by GPs to act on this request. Psychiatrists are not the best placed to treat physical illness.

6.11 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.

This Action needs considered in relation to our commentary on Action 14 to ensure that there is a clear framework between primary and secondary care.

In-patient mental health services

- 6.12 ACTION 16.** Continue the capital works programme to ensure an up-to-date in-patient infrastructure. Also further 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.

People feel a lot better if seen in respectful facilities – so the mental health estate and the gross antiquity of some parts of it, need to be addressed. This in itself would be an eloquent statement of respect for mental health Patients and Staff. A Regional Rehabilitation service, for example, will require Inpatient Units.

There is a requirement for access to specialist residential and specialist inpatient services in line with what is often available in other parts of the UK. A regional evaluation of the need for inpatient services should be undertaken.

Staff and Patient safety require provision of appropriate facilities in which to see Patients. This is true across the health care estate including community, outpatient, acute settings and emergency departments, as well as within inpatient facilities.

- 6.13 ACTION 17.** Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care (either in hospital or in supported community living)

The emphasis on regional rehabilitation services is very welcome and we strongly support this. There is also a need for inpatient neurobehavioral rehabilitation services along with the range of community residential options, including intensively supported living facilities.

Patients with complex psychosis at risk of being unable to sustain successful community living may require community supported services approximating to those that would have been available in a hospital type setting. Placing Patients into sometimes inappropriate nursing and residential care home options can be detrimental for both the individual and other residents. It also has the potential to increase the likelihood of individuals being subjected to deprivation of liberty.

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

The Forensic Faculty of the Royal College of Psychiatrists NI has major concerns about the persisting and serious under provision of secure beds for mentally disordered offenders; Northern Ireland is not receiving parity of access compared with the rest of the UK. The terms of reference, as laid out in the 2006 Bamford Review, have not been delivered upon over the intervening years in a satisfactory manner. We welcome the inclusion of low secure services in the Mental Health Strategy and continue to request urgent review by commissioners of how forensic low secure services for adults can be made tangible and how this will integrate into the wider Strategy for forensic services in Northern Ireland.

Please refer to supporting information in Appendix 1.

Crisis services

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

This is welcome but may be difficult to achieve. The crisis service will be regional but also integrated with mental health services (which are clearly still Trust-based). Various models may need to be considered and evaluated.

Reference should be made to the Towards Zero Suicide care pathway which is currently being developed.

There is no mention of Liaison Psychiatry, even though evidence shows that a significant proportion of Patients in General Hospital have psychiatric morbidity and that a properly funded Liaison service can be cost effective. Please see point 8.4 on Liaison Psychiatry.

There are a number of successful Liaison Psychiatry models from other parts of the UK and these should be reviewed and evaluated for consideration. We are happy to assist DoH with examples of good practice.

Co-current mental health issues and substance use (Dual Diagnosis)

- 6.16** 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.

We support the approach to dual diagnosis care and other specialist services but there is very little about addictions/substance misuse which is a major gap in the Strategy.

Please see point 8.3 on Addiction Services.

Specialist Services

- 6.17** ACTION 21. Continue the rollout of perinatal mental health services and consider the feasibility of a mother and baby unit.

Regarding inpatient mental health services, development of a Mother and Baby Inpatient Unit (MBU) urgently needs to be a focus here, as this is a vital and core part of perinatal mental health services. This is clear within NICE, RQIA, RCPsych and Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE)³ reports. Without this, the new community perinatal services will be managing at times a higher level of risk in order to keep Mother and Baby together at home, as without an MBU, admission means separation of Mother from her Baby. This needs to be clearly outlined in the focus around inpatient mental health services. It is encouraging that a MBU is mentioned in paras 125 and 155.

Focusing on the development of perinatal services, this regional consistent approach has been central and will continue to be. It is vital that no matter where a Mother lives and no matter where she had her Baby,

³ [MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | NPEU\(ox.ac.uk\)](https://www.npeu.ox.ac.uk/mbrrace-uk)

that she gets the same standard and approach regarding her mental health if she needs to access perinatal mental health services. Safe and effective communication across Trust boundaries is also vital.

Regarding perinatal mental health, an overall increase in training of professional staff will be important so there can be training posts within these teams to upskill the future workforce and to improve understanding of the unique features/complexities and risks in the perinatal period across mental health staff.

The next stage of the perinatal team development will be having peer support workers as part of the team - this is a key part of any modern mental health service.

New perinatal teams will have to build in focus to capture data and outcomes in order to review how they are doing, but also to feed into further service development in perinatal – both in terms of the community teams and reinforcing the need for a MBU.

We strongly recommend the development of bespoke therapeutic services for infants in the early years up to age 6 and their parents. The enhancement of existing social care and educational provision and early years interventional programmes by the development of a core of Regionally accessible specialist psychotherapeutic resource should be strongly considered. The establishment of the MBU and perinatal service invites an opportunity for Northern Ireland to develop these services in an integrated way and in line with best practice and evidence.

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

This is welcome but there should not only be access to the treatments and interventions for first episode psychosis (including schizophrenia), but the development of Early Intervention teams for first episode psychosis across Northern Ireland. In addition, there should also be easy access to evidence-based treatments for first episode bipolar disorder, severe depression and severe Obsessive-Compulsive Disorders.

We suggest an amended wording:

Proposed ACTION 22. Ensure access to evidence-based treatments and interventions for people presenting with a first episode psychosis and develop first episode psychosis teams across Northern Ireland. There should also be mental health practitioners with skills in evidence-based treatments for other mental disorders such as bipolar disorder, severe depression and severe Obsessive-Compulsive Disorders.

6.19 ACTION 23. Create a personality disorder managed care network, with an integrated care pathway to specific personality disorder services.

We would suggest the narrative is changed to the wording below with an emphasis that there is a need for financial support to further develop these services in line with these suggestions:

159: *Up to 50% of those attending psychiatric outpatient clinics, 50% of those in psychiatric inpatient services and 80% of the prison population, meet the criteria for a personality disorder. 45% of those presenting to Emergency Departments with self-harm have a personality disorder and 9-10% of those with a personality disorder die by suicide (RCPsych, 2020)⁴. The ethos of the 'Personality Disorder a Diagnosis of Inclusion' Strategy (DoH, 2010) will be retained and people considered to have a personality disorder will have access to mental health services in a way that is equitable with all other Patients who access treatment.*

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

161: *Increasing day treatment services for personality disorder and the provision of therapeutically informed supported accommodation will be explored to provide local alternatives to specialist inpatient treatment of personality disorder.*

We suggest the Action is changed to the following wording:

Proposed ACTION 23. *Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network to co-ordinate and plan the further development of interventions available to treat personality disorder in Northern Ireland.*

There is a strong need for a regionalised approach and, like CAMHS and Forensic, a managed care network would help develop this.

We welcome the recognition that the absence of tier four services for people diagnosed with personality disorder needs to be addressed to avoid the historical and ongoing movement of Patients, often with the most severe disturbance, to England and Scotland at significant cost and more importantly disruption to family life etc. Alongside exploring this through an options appraisal, amelioration could come from enhancing day treatment and supported accommodations for personality disorder to allow provision of the highest level and quality of outpatient treatment to be provided locally - as tier 4 services are being considered.

It is important that the Strategy reflects that the majority of Patients with personality disorder are currently managed within existing community mental health teams and many do not progress to specialist personality disorder teams due to co-morbidity, poor engagement etc. It is important that any resource provided to improve the quality of care for Patients with personality disorder is distributed in such a way as to ensure all Patients have access to this - and that specialist training and support in the management of personality disorder is provided within community mental health teams

⁴ [ps01_20.pdf \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/ps01_20.pdf)

6.20 ACTION 24. Develop a dedicated eating disorder service that is fully funded and has sufficient staffing resource.

We would suggest the narrative is changed to the wording below :

162: *Northern Ireland has a regional network for the provision of services for people with an eating disorder. Outcomes for Patients with eating disorder in Northern Ireland could be improved. In particular, the evidence base suggests that early intervention is key. This means supporting services to offer specialist treatment to all eating disorder presentations, including mild to moderate cases, without delay. The treatment of Binge eating disorder remains under a separate pathway.*

163: *We will provide further investment so that eating disorder services can achieve optimum staffing levels and skill mix to deliver effective care across the pathways. In practice this will include additional medical, nursing, dietetic, psychology, occupational therapy and social work staff both working in the community and providing in-reach to medical and mental health wards.*

164: *Additional investment will allow for the development of intensive day treatment facilities in line with NICE guidance.*

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

7.0 Theme 3: New ways of working

A regional mental health service

Please see the general comments on this Theme in section 2.0

7.1 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.

We agree with this aspiration and this approach. We agree that administrative change disrupts and the focus should instead be on equality of access to quality services – on more Regional co-ordination, collaboration - rather than administrative changes.

Our suggested starting point for improved working in services would be a form of Regional oversight inclusive of Senior Clinicians.

Clinician leadership in any new Regional structure will be vital. Clinicians and Operational Managers need to work together on this in a trusting relationship, aiming towards achievable goals led by evidence and some constructively considered experience.

In terms of the Perinatal service just announced, the Public Health Agency will provide oversight to ensure that this Regional service is similar or the same in each Trust – and that each Trust will be joined up. This

may in time provide a useful template for getting Regionalisation right, given its commencement at a time when the Minister is advocating a single mental health service approach. Eating Disorders currently offer another worthwhile example of emerging Regionalisation.

Fundamentally, there must be a mechanism to ensure compliance by Trusts to standard ways of working and service provision – otherwise how will it actually happen in practice in mental health services across the board? The mechanism must have the ability to ensure that all Trusts follow the regionally agreed pathway and must not become another layer of bureaucracy.

Regionalisation must be linked to Workforce planning as well.

Problems will have to be overcome along the way – some are obvious, some less so – such as custom and practice, subtle and not so subtle differences from Trust to Trust.

Primary care is the gatekeeper and there are five Trusts which receive referrals. Therefore, closer working with primary care is essential. Lack of coordination between the Trusts and the GP Federations would hamper this. Clinicians working at either end of a disconnected system in primary and secondary care impairs service efficacy.

We need better integration also of mental and physical healthcare. The two are inextricably linked but our systems for planning, commissioning and provision of services treat them as separate and we end up in unhelpful silos.

Equality of access to quality standardised services, regardless of address etc is key – but some services cannot be based in all five Trusts as some areas will have such a small Patient cohort. To avoid the risk of centring too many services in Belfast, we need a hub and spoke services approach.

We will continue to work with DoH on the scoping of this action point, but we feel that it will need to be re-worded to ensure that it has the maximum effect.

Workforce for the future

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

We welcome that the vacancy rates in Psychiatry posts have been recognised.

We would draw attention to the RCPsych Workforce Census⁵ of Psychiatry posts every two years, the last of which was in 2019 (the workforce census for 2021 is currently being undertaken). When Psychiatry posts are being looked at, they have to include 1) Consultants and 2) Specialty doctors. One also has to look at both the vacancies and the locum posts, together. The latter are temporary posts, generally vacant posts which because of the key role of the Psychiatrist, have to be filled (sometimes by locum agencies, trainees, specialty doctors or other sources), otherwise an inpatient or community service cannot function. In consultant posts (2019 census) there were 9 full time and 2 part time posts vacant but there were also 24 full time and 7 part time posts filled by locums. These figures for vacant and locum Psychiatry posts

⁵ [Our workforce census \(rcpsych.ac.uk\)](http://ourworkforcecensus.rcpsych.ac.uk)

represent 22% of the consultant workforce. Regarding Specialty Doctors, there were 5 full time and 2 part time posts vacant and 6 full time and 2 part time posts as locums. This figure for vacant and locum is about 30% of the Specialty Doctors. A comprehensive review of workforce is crucial for all professions in mental health services. This will need to look at identifying issues with current workforce, training, supply and retention, as well as the proposed expansion and modernisation of the workforce identified through the Strategy.

The high Locum use leads to problems in fulfilling Mental Health (NI) Order 1986 duties. Psychiatry in recent years has also been unable to find sufficient Member time to fulfil the requirements of Trust Panels, RQIA and Northern Ireland Judicial Appointments Commission (NIJAC), all of which points to the need for more Psychiatrists as a matter of some urgency.

Considering the existing Psychiatry workforce pressures, the additional requirements as a consequence of the Mental Capacity Act (NI) 2016 and RQIA/NIJAC roles, Psychiatry requires a longer-term expansion by urgent provision of increased training places.

There is a massive workforce issue in learning disability Psychiatry and expansion of numbers is essential in order to meet the mental health needs for this specific population.

We highlight the need for workforce planning to take into consideration the serious need for Consultant Psychiatry posts that can address the shortfall of resource in areas of complexity such as CAMHS and Forensic Psychiatry. There are currently no dual child and adolescent medical psychotherapy, or dual forensic and medical psychotherapy training posts in NI, despite the growing demand within these areas. Consultant Psychiatrists with this training would be well placed to take forward and develop services for Patients who have significant complexity, morbidity and risk.

Regarding perinatal mental health, an overall increase in training numbers will be important, so there can be training posts within these teams to upskill the future workforce and to improve understanding of the unique features/complexities and risks in the perinatal period across mental health staff.

There is very limited reference to the wellbeing of healthcare staff in the Strategy. This is surprising given the considerable pressures faced by staff during the COVID-19 pandemic. Prioritising wellbeing of staff is an essential part of ensuring a culture that is compassionate and Patient centred.

We understand that a survey about psychological safety for staff is planned. Such safety is needed but cannot be achieved within a punitive culture. A just and learning culture is essential. Psychological safety for staff is needed to ensure compassionate care.

Pharmacy: This is another vital aspect of workforce for mental health services to effectively work. The Pharmacists have a central role but are not even mentioned in the Strategy. We are under resourced for Pharmacy compared to Acute medical services. Mental health pharmacists greatly enhance the quality of medical treatment for Patients.

It should also be added that workforce also needs to include administrative support, advocacy, VCSE workforce and other specialities, as well as Clinicians. A narrow approach to Workforce planning will not be helpful. The mental health service is made up of a lot of elements – each vital.

We strongly endorse the workforce review commitment.

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

We welcome the introduction of a peer support model and would suggest that this needs to include both Patient and Carer peer support. The Carer role in promoting and maintaining recovery needs to be acknowledged and given due support.

Data and outcomes

7.4 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.

This should be a data and outcomes framework that has Quality Improvement Methodologies at its heart. There should be an overall emphasis on the utilization of Quality Improvement as a methodology to create continuous data driven improvement across Northern Ireland mental health services, similar to how East London Foundation Trust has so successfully managed this.

It is important that there is accurate data collection and data analytics to better inform service development.

Innovation and research

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

We welcome this inclusion and would highlight the need to develop a robust research Strategy and the need to ensure that there is parity of funding. There will need to be discussions with academic staff of all professional backgrounds and the wider mental health community.

8.0 What we believe is missing:

8.1 Learning Disability

We understand that learning disability is not singled out in the Strategy on the basis that if a person has learning disability and a mental disorder/illness then they simply need equal access to mental health services. However, this approach is flawed. Patients with a learning disability have very particular needs and there is a substantial prevalence of psychiatric comorbidities which can be by complicated by communication challenges; some literally do not have a voice.

Learning disability services should be an integral part of mental health services. It important that the Strategy recognises the specialist skills of professionals in learning disability services in the diagnosis and treatment of mental disorders in patients with a learning disability.

To suggest otherwise is to deny the particular coalescence/ co-morbidities which Psychiatry deals with among the learning disability population – hence the major concern. Ready access to condition specific care pathways for those with learning disabilities who have various mental illnesses must be an integral part of mental health services.

The apparent exclusion of learning disability from the Mental Health Strategy has met with widespread concern among Members and not just those working within learning disability services. This is significant. We believe it is important that the Strategy addresses the needs of the substantial number of people in Northern Ireland with a learning disability - and their Carers.

There is little comment on how to provide specialist assessment and treatment for adults in the community. We would suggest the actions outlined in Appendix 2 are included in order to ensure inclusivity for people with learning disability.

8.2 Neuropsychiatry

Neuropsychiatry services are at the interface between Neurology and Psychiatry. They provide assessment investigation of treatment for people with neurological disorders associated with cognitive, behavioural or psychiatric symptoms such as Parkinson’s disease, epilepsy and acquired brain injury, functional neurological symptoms such as dissociative seizures or conversion disorders and other neuropsychiatric conditions which may include sleep disorders or complex neurodevelopmental disorders.

As with other mental health specialties, services are delivered through multidisciplinary teams. A neuropsychiatry team would include consultant neuropsychiatrist, consultant neuropsychologist, clinical psychologist, psychological therapists, occupational therapists, speech and language therapy, social work, nurses with skills in mental health and neurological disorders, dieticians and neuro-physiotherapists. A neuropsychiatry service would work in conjunction with neurology, neurosurgery, neuroradiology, neurophysiology and other neuroscience services.

There is need for investment and development to provide a comprehensive regional service supported by a multidisciplinary team in line with expectations for services elsewhere.

A regional neuroscience Centre with inpatient neurology and neurosurgical services should have access to a liaison neuropsychiatry service with capacity for assessment of inpatients and joint specialist clinics with neurology for conditions where psychiatric comorbidity was high – eg epilepsy, movement disorder and Huntington’s disease. The need for investment in and further development of services across Northern Ireland for Huntington’s disease has been previously recognised and needs to be addressed in the Strategy.

A neuropsychiatry service should have access to inpatient beds. These could be in existing mental health facilities or neuroscience units. It has been estimated that for a population of 1 million there should be between 5 and 10 beds.

The care pathway for rehabilitation following brain injury should include access to inpatient neurobehavioral rehabilitation for individuals presenting with challenging behaviours and specialist

supported community residential facilities. The absence of these options can lead to delayed discharge or inappropriate placement.

Non-statutory and community services make an important contribution to the treatment and care of people with psychiatric and psychological difficulties due to neurological disorders including the sequelae of brain injury. Opportunities for specialist supported living, day treatment rehabilitation and structured activity and input from non-statutory services are important components of care provision.

It is important to note that whereas elsewhere in the UK, there may be access to specialist services including inpatient centres outside the NHS, this is generally not the situation in Northern Ireland.

There is an opportunity to invest to save as illustrated in the College Report on services for Alcohol Related Brain Damage⁶. Delivering the right service can lead to improved outcomes for Patients and reduce use of resources. The Report's message is 'Treatment, not just care'. This involves delivering rehabilitation to individuals to maximise recovery of independence and to support them through transitions and progress.

Likewise, with the longer-term treatment of individuals with sequelae of traumatic brain injury we need the range of dedicated, specialist services to continue rehabilitation and provide sufficient support to optimise independence.

For people with long term conditions, we need the community supports and rehabilitation services that allow them to continue to function at an optimal level. Some conditions do not necessarily get better. Basing funding for service provision on throughput will result in neglect of the needs of a significant number of people and hardship to them and their families.

Having the necessary range of specialist residential facilities available would increase the potential to deliver support and care in a less restrictive and more enabling manner.

The COVID pandemic has given rise to neuropsychiatric presentations. The nature and full extent of neurological and psychiatric complications is as yet unclear. Data is being gathered - eg Psychiatrists have been encouraged to report presentations for inclusion in the CoroNerve surveillance survey⁷.

8.3 Addiction Services

We like the approach to dual diagnosis care and other specialist services but there is very little about addictions/substance misuse which is a major gap.

Gambling addiction is not addressed in either this Strategy or the new Alcohol & Drugs Strategy. Neither Strategy team seems to feel it should be covered within their paper. Gambling Addiction is more common than suggested and is becoming increasingly more common with increased access via online betting. There is a case for both a Public Health Agency approach and specific treatment services. Such exist in England. Experts on the treatment of gambling addiction will only emerge if we have a service – and the

⁶ [Alcohol-related brain damage in Northern Ireland \(CR212 Apr 2018\) \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/pressandpublicaffairs/pressreleases/2018/04/20180420-alcohol-related-brain-damage-in-northern-ireland)

⁷ [CoroNerve surveillance survey | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/pressandpublicaffairs/pressreleases/2020/04/20200420-coronerve-surveillance-survey)

good news is that effective treatments can be made available. This issue must be fitted into the Mental Health Strategy in a real meaningful way. Apart from the proven need, it is an issue which is very topical in media and political circles - and must not be omitted at this stage.

The ONS/NISRA figures relating to alcohol specific deaths in Northern Ireland are alarming. Alcohol has been largely overlooked/ overshadowed by drugs in the Strategy. There is huge need for services for alcohol.

We repeat our call from our response to the DoH Draft Drug and Alcohol Strategy⁸ - for a regional plan for community-based assisted withdrawal services which would give greater access to all. Community-based withdrawal programmes and services have been proven to work, but not everyone has access to them. This needs to change. We need to focus on getting those who are addicted to alcohol better and reduce the alarming rise in deaths and self-harm. The Western Trust is the only one which currently offers community-detox services. It receives 400 enquiries across the region, per year.

8.4 Liaison Psychiatry

There is no mention of Liaison Psychiatry even though evidence shows that a significant proportion of Patients in General Hospital have psychiatric morbidity and that a properly funded Liaison service can be cost effective.

We would emphasise that comprehensive liaison services can improve the outcome for very many physical illnesses and help improve the outcome for Patients with somatoform disorders and medically unexplained symptoms, thus helping reduce the burden across many medical and surgical specialisms.

We would do well to take heed of what Plato said over 2000 years ago: 'The greatest mistake in the treatment of diseases is that there are Physicians for the body and Physicians for the soul, although the two cannot be separated'. This is the core of Liaison which is barely mentioned.

8.5 Student Mental Health Services

The needs of the student population attending the two universities in Northern Ireland is missing. Nearly half of school leavers go onto university and the student population is now more representative of the total population than ever. Many of these students are young (<25yrs). Between 16 years and 25 years is the peak time for the appearance of common and severe mental health conditions. Many students are living away from home for all or part of the academic term, are under pressure both financially and academically and are very mobile - moving between work placement, home and university. This results in challenges and concerns for students who need to be referred to mental health services. Specific student mental health services are needed, which have the flexibility, responsiveness and the culture to work with young adults - also to work in conjunction with the University Student Wellbeing services. Early intervention and services around this age can mitigate both severe and less severe mental illness (eg

⁸ [rcpsych-ni-stakeholder.pdf](https://www.rcpsych-ni-stakeholder.pdf)

anxiety, obsessional states). There should be a dedicated student mental health service working closely with the University Wellbeing Services.

Due to the impact of the Covid-19 pandemic on the student population, there has been an evident reduction in their mental wellbeing and it is important that University Wellbeing Services are enhanced to meet their needs.

8.6 Mental Capacity Act (NI) 2016 (MCA)

The sole reference to the MCA appears in relation to development of inpatient provision – yet this is a 10-year Strategy.

RCPsych NI supports the principles behind the legislation - and running two pieces of legislation, as is currently the case, is not viewed as in any way appropriate.

The MCA work also needs to be treated with the respect it deserves and therefore resourced in time terms across all affected disciplines of medicine with support from Trust leadership. This important legislation is designed to address issues relating to lack of capacity across health care and not just regarding the treatment of mental illness. The workload must be resourced across clinical practice and cannot be left to already pressed psychiatric services. Otherwise, resources in psychiatry will be diverted away from the provision of clinical services which will ultimately impact on access to treatment.

There should be a specific action on the MCA, including a clear timetable for the rest of its implementation.

The development of the Independent Advocacy Service – particularly for DoLS, awareness raising with the public and research on how the Act is delivering for people with mental illness should all be included within the Strategy.

A strong research evaluation framework should accompany the Act as it is introduced.

Funding for the MCA must not come out of mental health funding. This should also be clearly stated in the Strategy.

8.7 Sustainability

Worldwide we are facing a growing climate emergency. The carbon footprint of healthcare is significant and this includes mental health, so acting to reduce CO2 emissions is an important goal. In addition, we must acknowledge that the consequences of climate change will have significant and lasting effects on mental health worldwide.

An ethos of prevention and also recovery is at the centre of a sustainable approach to mental healthcare. Areas such as social prescribing, promotion of exercise and utilizing the positive effects of the natural environment, can both benefit mental health and form part of a sustainability agenda. Practising sustainably can and should form an integral part of an effective, person centred, future facing mental health service. Planning services in a sustainable way means using resources wisely and thinking about the effect that our resource use today will have in the future. A 10-year Mental Health Strategy cannot afford to ignore this.

Sustainability needs to be at the heart of the Strategy. Many principles underlying sustainability are also goals of an effective mental health service eg, prevention, wise use of resources, Service User involvement, recovery emphasis, recognizing the positive benefit of the natural world on mental health etc. Some of these are emphasised in the Draft document but it would be good to see them linked to a specified goal of a more sustainable service.

The College has a range of resources on sustainability in mental health care⁹.

8.8 Cross-departmental working

As Clinicians we see the benefits of non-statutory services in supporting the people we work with in the community. Whether this is access to support for alleviation of poverty, housing, employment or community outreach services, we all see the value of these services in our work. We would advocate that the Strategy takes a cross-departmental approach to work collaboratively to address the social determinants of mental health.

9.0 **Final Comment**

We trust that DoH will find our comments helpful and we are very happy to provide any further clarifications required and would be keen to participate in any Working Groups which may flow from the final version of the Strategy.

Dated: 26th March 2021



Dr Richard Wilson

Chair RCPsych NI & Vice President RCPsych

Contact Details: thomas.mckeever@rcpsych.ac.uk

⁹ [About sustainability in mental health care | Royal College of Psychiatrists \(rcpsych.ac.uk\)](#)

Appendix 1: (Section 6.14 additional information)

Despite the opening of 34 beds (29 male and 5 female) at the regional secure unit (Shannon Clinic) in 2005, Northern Ireland remains grossly under-provided for in terms of secure beds for adult mentally disordered offenders. Despite the Bamford Report of 2006, there remains no forensic low secure provision.

In England and Wales in 2013, there were 5.3 medium secure beds and 4.6 low secure beds per 100,000 population – this incorporates mental health and learning disability (NHS Commissioning Board, 2013). Accepting a current Northern Ireland population of 1.8 million, this would equate to a provision of 95 medium secure and 82 low secure beds, respectively.

In Scotland in 2017 there were 32 low secure wards (with 293 beds) and 14 medium secure wards (with 146 beds) spread between eight NHS Hospitals & two independent/private sector hospitals. Of these totals, learning disability accounted for 8 beds in medium secure and 63 beds in low secure. Of the totals, 9% of medium secure beds and 16% of low secure beds were occupied by female Patients. The Scottish population at that time was **5,424,800** (National Records of Scotland, 2017). This would indicate

Medium secure = 2.7 beds per 100,000

Low secure = 5.4 beds per 100,000

Low secure ID = 1.2 beds per 100,000

These ratios would equate to about 49 medium secure and 97 low secure beds (of which 22 would be learning disability) for Northern Ireland’s current population. It is also worth noting that the Forensic Network of Scotland recognised at that time (2017) that secure provision was still below the levels required to meet need. This led to major investment from the Scottish government through the expansion of the Rowanbank medium secure unit in Glasgow from 74 to 92 beds at a cost of around £9.8m and a Strategy from NHS Lothian to build a 23 bedded low secure unit to reduce the costs of expensive extra-contractual referrals to England.

This lack of secure beds leads to delays in admitting acutely ill prisoners from custody. The target of “admission within 14 days” is generally unmet. This continuing situation denies prisoners a standard of equal care compared with the civil population. There is also evidence of use of seclusion within prison for those waiting for treatment in hospital. The lack of step-down options from Shannon Clinic also creates delays in transferring and discharging Patients to community placements.

The needs of female mentally disordered offenders

Whilst the situation for male prisoners is unsatisfactory, it is even worse for females. Mental health problems are far more prevalent among women in prison than in the male prison population with up to 80% of women in prison having a diagnosable mental disorder. Mixed gender forensic services have raised concerns for many years in the UK, in particular issues around privacy for women Patients, access to appropriate psychotherapy and exposure to dangerous male Patients. Women who require gender specific secure care continue to have an unmet need. Shannon Clinic provides the only secure beds for female prisoners, but they number just five and are incorporated into a ward with seven forensic male Patients.

Therefore, so many years after the Bamford Report, the needs of mentally disordered female offenders remain un-addressed in Northern Ireland.

The gender-neutral model of care for secure services is not working well for women. Women in secure services have higher mortality rates, higher readmission rates and higher reconviction rates, particularly for arson. Violent incidents, not leading to conviction, are more likely for women.

Women with similar criminogenic needs as men are more likely to be treated at higher levels of security. Alternative models are currently being piloted in England.

The Women's Secure Blended Service is a new co-designed model of care to address the specific needs of women in secure mental health services. It aims to substantially reduce transitions for women by blending medium and low secure adult services in a single location and to improve the experience and outcomes, through a focus on relational security, attachment and trauma informed care and a psychologically informed environment.

This innovative model of care reduces the need for transitions between medium and low security levels for women by using a hybrid model.

These pilots will include independent evaluation to quantify cost savings and inform future commissioning decisions and the efficacy of blended provision.

The forensic managed clinical network advisory board will monitor the outcomes of these pilots of an evidence based, innovative, co- designed model of care for women - and consider commissioning secure services for women with gender sensitivity.

Appendix 2 (Section 8.1 additional information)

- Access to mainstream mental health services where appropriate, particularly for individuals with a mild learning disability and mental illness for specialist intervention. This will have to be facilitated by the local learning disability team.
- Establishment of responsive specialist mental health teams within learning disability services which have a coordinated access to assessment and treatment of a range of mental illness for people with Learning disabilities.
- Access to *adapted versions* of specialist psychological therapies that are applicable for individuals with a mild learning disability.
- Condition specific care pathways in adults with learning disabilities for various mental illness should be ingrained in the learning disability services and every Patient with a mental illness should have a mental health Action plan.
- There is an imminent need to reduce restrictive practices both in community and hospital - particularly needed is a Strategy on reduction in use of medications for control of behaviours such as Stopping Over Medication of People with a learning disability, Autism or both (STOMP) projects to reduce overuse of medications.
- Access to specialist pharmacists for providing specialist advice to the mental health team in learning disability in the community is needed. In light of severe co-morbid conditions whilst treating mental illness, we need access to medical Physicians who have an interest in learning disability in areas such as neurology and cardiology.
- Care pathways on out of hours access/Weekend basis for medications for individuals with learning disability who suffer from mental health crisis – must be established.
- Every learning disability team must have specialist mental health practitioner nurses and non-medical prescribers.
- The compatibility for individuals with learning disability in in-patient units will have to be reviewed and options created for catering for the in-patient needs if compatibility is an issue - as the population is very heterogeneous.
- We need step up secure care in learning disability if the needs cannot be met in generic learning disability in-patient units.
- We need pathways for aspirational zero-seclusion to be outlined.
- The current state of extremely limited access to inpatient learning disability specialist beds should cease and vision for future inpatient services for learning disability will have to be outlined.