Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Mental Health Awareness Week: Mr Robin Swann MLA, Minister of Health; Department of Health

13 May 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Mr Swann	Minister of Health
Dr Tomas Adell	Department of Health
Mr Peter Toogood	Department of Health

The Chairperson (Mr Gildernew): Members, it is Mental Health Awareness Week, and the briefing from the Minister this morning will focus on mental health issues. I advise members that the Minister will be joined by departmental officials. The Minister has advised that he will have to leave by 10.15 am to attend the Executive meeting, although officials will be able to remain, if required.

I welcome to our meeting Mr Robin Swann, the Minister of Health. Good morning, Minister.

Mr Swann (The Minister of Health): Good morning, Chair.

The Chairperson (Mr Gildernew): You are very welcome this morning. I also welcome Dr Tomas Adell, who is the head of the mental health and capacity unit in the Department of Health. Good morning, Tomas. Can you hear us OK?

Dr Tomas Adell (Department of Health): Good morning. I can hear you fine, yes.

The Chairperson (Mr Gildernew): Thank you. I also welcome Mr Peter Toogood, who is the director of mental health in the Department. Are you able to hear us OK, Peter?

The Committee Clerk: Sorry, Chair, but I do not think that Peter is on the call yet.

The Chairperson (Mr Gildernew): OK. If the Minister is content, we will go ahead. Peter can join in when he arrives on the call. Minister, do you want to give us your briefing?

Mr Swann: Certainly, Chair. My opening comments before we take questions will be a bit longer than the usual COVID update that I give.

Chair and Committee members, thank you all for inviting me to speak today about one of my top priorities and one of the most important aspects of my Department's remit: mental health. As you have already acknowledged, Chair, today's Executive meeting is slightly earlier than usual, so I will have to leave at around 10.15 am, but officials will stay on to allow the discussion to continue. I am also aware of the Committee's motion to be debated next week, and that debate on Mental Health Awareness Week will provide another welcome opportunity for us to come together to discuss further this very important issue.

Chair, given that, as you said, this week is Mental Health Awareness Week, it is entirely appropriate that we give the topic the platform and focus that it deserves, because it is hugely important that we use the opportunity to strive to reduce stigma associated with mental ill health, to improve support for those who need it and to secure the resources to ensure that we have a system that adequately cares for our community.

Before I begin the main part of the presentation, I would like to introduce Peter Toogood, although he has not yet joined the meeting. Peter is my Department's new director of mental health. He has recently joined us to take up what is a newly created post that will allow my Department to place an even greater focus on mental health and put it on a much more equal footing with physical health. It is a really significant step forward, as it provides a dedicated senior civil servant resource for mental health for the first time.

I am also joined by Tomas Adell, who is head of adult mental health policy and a key member of Peter's team. I know that the Committee knows Tomas well.

This morning, I will give you an overview of the work that my Department has been doing, and is planning to do, to improve outcomes for those who suffer from mental ill health. I will also speak about the challenges that are facing mental health services, not least because of the pandemic. Members will be aware that, in May last year, to mitigate and address the initial impact of the pandemic on our population's emotional well-being and mental health, I published a mental health COVID response plan. The plan set out a range of key actions that my Department and its agencies were taking forward to support our communities during the initial period of lockdown and beyond. Actions included the development of digital means of support, such as access to online stress control classes and the development of bereavement support resources, as well as the joint development of the COVID-19 well-being hub. That was done in conjunction with the Department for Communities and Inspire Wellbeing.

A range of other resources was developed, such as support for students joining the Health and Social Care (HSC) workforce early and support for children and young people. All those resources continue to be available for those who need them.

As we know, mental health services were under considerable pressure before the pandemic, and they are now experiencing unprecedented challenges. Inpatient services are under extreme pressure. Our mental health staff are hugely dedicated, caring, highly skilled and committed, but they are doing a very difficult job in increasingly difficult circumstances. An already difficult position has been compounded by the impact of the pandemic. Our trusts are reporting an increase in referrals as well as heightened acuity for patients. Trusts operate consistently above 100% bed occupancy levels in mental health inpatient units, and patients who are admitted are often much more seriously ill than would usually be expected.

It is really important that people understand what operating above 100% capacity means in that context. It simply means that additional pressures are placed on already hard-pressed staff, thus compromising their ability to provide the care and treatment that patients need. It means that there are people whose mental health needs are such that they need to be admitted to hospital, and people who are in crisis and who are seriously ill are being asked to sleep in armchairs and on sofas in hospital.

The statements that we all make about tackling the stigma attached to mental illness must feel a little hollow to people who find themselves in that situation. I must emphasise that this is not simply a problem caused by not having enough inpatient beds. Too often, the situation arises because beds

are having to be used for people who cannot be discharged, because of an absence of the community services that they need. It is highly likely that those pressures will continue as the mental health surge that we have all been anticipating begins to bite over the coming months. Indeed, evidence from other countries indicates that we are only at the beginning of that surge, as we are dealing with the knock-on effects of not just lockdown but the pandemic itself.

Even as our society is now beginning to take the first steps back to normality, the impact of the past year will have a lasting effect on our communities, on their mental health and on the services that support them. In particular, mental health inpatient bed pressures are likely to continue, but, to deal with those severe pressures in the short, medium and longer term, a number of key actions are being taken forward by my Department and its agencies. To deal with the inpatient bed issues in the short term, the Health and Social Care Board (HSCB) has established its regional bed-flow network. The group is meeting weekly and is looking at a number of options for increasing capacity in the short tem and the medium term. In the longer term, the provision of psychiatric, low-secure inpatient and mental health rehabilitation services is likely to have a positive impact on patient flow and bed capacity, as well as providing better outcomes for patients. I have recently approved the policy direction in both areas, and work can now start on developing detailed proposals.

A comprehensive review of crisis services has also recently been completed, and its outworkings have the potential to have a significant positive impact on people in crisis and on pressures on services in the longer term. Once my officials and I have had an opportunity to consider fully the recommendations, I will make a decision on the way forward and have the conversation with the Committee, Chair.

Those reviews and a number of others were commissioned as part of the mental health action plan that I published in May last year. I am pleased with the progress that has been made on its implementation, because most of the 38 actions are on target or have been substantially completed. Notable achievements to date include the creation of a mental health champion; the approval of the business case for, and the securing of, recurrent funding of £4·7 million for the development of a specialist perinatal mental health community service model; the establishment of the child and adolescent mental health services (CAMHS) and forensic managed care networks; and the launch of a mental health innovation fund. As I mentioned, reviews have been completed on crisis services and transitions from CAMHS to adult mental health services, eating disorder services, personality disorder services, psychiatric secure inpatient services and mental health rehabilitation services. The outworkings of —.

The Chairperson (Mr Gildernew): Sorry for cutting in, Minister, but you are breaking up at times. Can you do anything with your sound? We have been able to follow you so far, but the sound has dipped a bit. I am not sure whether there is any way in which to improve it. Apologies. Please go ahead.

Mr Swann: Thanks for that, Colm. It is important that you hear what I am saying. Is that any better?

The Chairperson (Mr Gildernew): Yes. That seems a little better.

Mr Swann: I will continue from where I left off. The outworkings of the reviews that have been completed will help inform future strategic policy. The completion of the actions represents a significant step forward for mental health in Northern Ireland.

The action plan also committed to developing a new 10-year strategy for mental health in Northern Ireland. That is the best way in which to address historical issues in mental health, to face up to and meet the increased demand caused by the pandemic and to put in place real and lasting change that will significantly improve mental health outcomes for people in Northern Ireland.

Committee members will be aware that I published the draft mental health strategy 2021-2031 for public consultation in December of last year. Following an intensive period of co-production, the consultation concluded at the end of March. In total, we had 428 responses to it. I was delighted with the level of interest and engagement that was generated by that work, and I am grateful to the large numbers of individuals and organisations that contributed to the process, both during the co-design phase and in response to the consultation. Their input is really valuable. The response to the consultation has been overwhelmingly positive, with over 82% of formal responses received being assessed as such. Many of the comments and suggestions received will be reflected in the final draft of the strategy.

The draft strategy sets out a number of actions for taking forward significant reform of mental health services. Its key aim is to ensure long-term improved outcomes for people's mental health, putting individuals and their needs at the centre. It focuses on the promotion of well-being across the lifespan and seeks to ensure consistency and equity of access and choice for those accessing mental health services and support. The strategy is my Department's long-term strategic plan to address the pressures on mental health inpatient beds, meet the increased needs created by the pandemic and put mental health on an equal footing with physical health in this country. I hope that it will bring us into line with mental health provision in other parts of the United Kingdom and, once fully implemented, ensure that Northern Ireland has a world-class mental health system of which to be proud. I hope to be in a position to publish the final strategy, alongside a funding plan setting out the resource requirements for implementing it, in the summer.

One of the other areas that I wish to mention in Mental Health Awareness Week is children and young people. The pandemic has had a significant impact on many children and young people. The loss of the daily structure that school attendance normally provides, alongside reduced social contacts and school support, could lead to a deterioration in mental health. The support that my Department put in place at the beginning of the pandemic provided valuable resources for our children and young people when they needed them most. In addition, my Department funds a number of community and voluntary organisations that continue to support young people during the pandemic. For example, the facilitating life and resilience education (FLARE) project from the Public Health Agency (PHA) aims to support young people who are struggling with mental ill health or suicide ideation or who have made suicide attempts.

Furthermore, my Department has worked collaboratively with the Department of Education on the development of the children and young people's emotional health and well-being in education framework, which was launched in February 2021. The framework comprises a range of initiatives that are aimed at delivering better mental health outcomes for children and young people. Given the impact of the pandemic, it will be especially important at this time. Some £5 million from the Department of Education and £1·5 million from my Department have been allocated to fund that plan. Some of its programmes have already commenced, such as the health and social care trust Text-a-Nurse service and the Education Authority Youth Service's resilience education assisting change to happen (REACH) programme. Others are pending business case approval, including new CAMHS and emotional well-being teams in the school service. That will involve the teams working directly with schools alongside other services.

Unfortunately, despite the great strides forward that we have made as a society in talking about mental health and the progress that has been made over the past year, I must also reflect the reality of the position that we are in with funding. As members will know, mental health services in Northern Ireland have historically been underfunded in comparison with those in other UK jurisdictions. Mental health in Northern Ireland receives between 25% and 30% less funding per capita than it does in England, despite many indications that mental health needs in this country are greater, not least because of the legacy of the Troubles. That equates to a funding gap of approximately £100 million to £150 million a year, which is a dire reflection of the low priority that we as a society and past Governments have afforded to mental health up until now. The particularly difficult funding position that my Department is currently facing does not make redressing that imbalance any easier or any more likely. Indeed, no funding has as yet been identified to support the implementation of the strategy.

The capital budget position also remains severely constrained. Without additional resources and a multi-year Budget settlement, my Department is unable to commence any significant new investments that will continue beyond this financial year. All of that limits my options, and our options, for addressing the current challenges that are facing the system and for implementing the strategic improvements that are greatly needed and that have been so long sought by our communities. Full implementation of the strategy, which all stakeholders are fully in support of, will require significant investment in order to achieve what we want and what our society deserves. It will require full support from the Executive and across Assembly parties. We absolutely must now walk the walk. If we are truly serious about making mental health a priority, as so many of us in government, in the Assembly and on the Committee genuinely want to do, we have to do our utmost to get the resources in place to do that.

In the meantime, Chair, I assure you that I will continue to work to make resources available where I can and to make the strongest case possible to my Executive colleagues for a significant increase in funding for mental health. A key element of that will be the funding plan that I will publish alongside the final mental health strategy. That will set out more clearly the funding requirements needed to see that

strategy implemented, as I mentioned. The figures will be significant, but now is not the time to bury our heads in the sand. We have seen the needs of our communities increase during the past year. We know that the situation is unlikely to improve significantly. We are building on a shaky foundation of years and years of underinvestment. Now is the time for action. I trust that the Committee will be supportive of all attempts to secure additional resources to achieve our strategies and aims and to improve mental health outcomes for all in Northern Ireland.

As I said, I will continue to work hard to secure whatever resources I can for mental health in my Department. One of the most significant actions that I have taken in recent weeks was to establish a £10 million mental health support fund, which will provide grants to charity organisations that provide interventions to improve the population's mental health. I fully recognise the hugely important role that our community and voluntary sector plays in supporting our community's mental health. The sector provides much-needed advice and well-being support as well as commissioned services as part of the stepped care model. I also recognise —.

The Chairperson (Mr Gildernew): Sorry, Minister, but I am really conscious of time. I want to get to some questions, so I wonder whether we can —.

Mr Swann: I am coming to a close, Chair. As I said, mental health is an important issue for me, for my Department and for the Committee, given the work that it has done, which I acknowledge. I have come to the Committee regularly, on a monthly basis, but that has been to talk about the COVID response. I therefore welcome this full engagement on another policy area on which we can work strongly together.

As I was saying, we all recognise the hugely important role that the community and voluntary sector plays. I also recognise that organisations in the sector have come under incredible pressure during the pandemic, as they seek to support more people with fewer resources and in a hugely difficult circumstance. In recognition of that, the new mental health support fund will equip charities, enable them to provide a wide range of support services for people with mental ill health and help ensure that those who need to access mental health support services in the community can continue to do so. The fund is expected to open formally in the next few months and will be accessible through the Community Foundation's website.

In conclusion, I thank the Committee for its focus on mental health today. I know that we share the same frustrations about the current pressures on services and the same desire to make things better. I trust that members are reassured, and assured, today of the scale of my and my Department's ambition. I emphasise the point that, without sustained, recurrent funding, we will be limited in what we can achieve jointly. In recent weeks, my Department's director of finance has given you a stark assessment of the budgetary situation that our health service faces. That situation is concerning. We have, of course, many serious problems in health and social care. Those problems cannot be fixed by long-term funding alone, but, equally, they cannot be fixed without it.

I reiterate my complete commitment to improving mental health services and outcomes for all the people of Northern Ireland. There are many challenges on the road ahead, but I am determined to continue to strive to ensure that all those who need help can access it when they need it and to give the people of this country a mental health system of which they can be proud.

Chair, thank you for the time to make the statement this morning. It was important to set out the full case on what is a very important issue.

The Chairperson (Mr Gildernew): OK. Thank you, Minister.

I will start with a quick round of questions for the Minister from each member. We will then have another round of questions. Members can tailor their questions in that regard, while remaining conscious of the time restrictions this morning.

Minister, I welcome the direction and the commitments. I am concerned about one thing in the action plan, objective 13, which is about building a stronger mental health workforce. This week, we have met the mental health policy group and with workforce and community-sector representatives. The most basic and fundamental building block of the action plan will be the workforce. None of this can be delivered without it. I am concerned to see in the action plan that, for that objective, the costs and the timeline for a review are still to be scoped, yet there will still be a significant lead-in time for recruiting

and training that workforce. Can you tell me how that can be prioritised? What planning will be needed for a mental health workforce?

Mr Swann: Chair, I will let officials pick up on those specifics when they address the Committee. We have seen the depletion of the workforce across the health service over the past 10 years, and that has affected all sectors equally. The 300 nurses that come on board each year are in a number of specialties, so you are right to say that the investment takes time to complete. There is no workforce ready and waiting for us to put out a job advert. The number of trusts that have advertised key positions over the past number of weeks, since the start of the new financial year, has indicated that. The desire is there to fill the positions, but it is a question of having appropriate scope and time for training, because we have not been investing in that workforce. That is why we were where we were last year, with concerns being raised by our trade union colleagues as well. It was about that long-term challenge, but also about succession planning, because, without that continued recruitment process, it has been hard to put that succession plan in place. I am sure that Peter and Tomas can pick up on those specific actions in more detail later.

The Chairperson (Mr Gildernew): OK, yes. I will go back to them on that.

Mrs Cameron: Minister, I thank you and your team for being here this morning. I know that you do not have much time. I want to ask you specifically about any progress that has been made towards a regional approach to bed management. I am also wondering whether you want to answer as to whether or not there is a case for reforming the trust model in Northern Ireland. I ask that on the back of how well the trusts have all worked together through COVID; it has been very impressive. Given the very small population that we have, is there a case for reforming that trust model and making it better? Also, have you made any progress on that regional approach to the bed management issue?

Mr Swann: Thank you, Pam, and my sincere apologies for having to go — the Executive meeting is earlier this morning than it usually is — because I would have liked more time to talk about this.

The Health and Social Care Board already has a manager in place to look at the regional bed model, because one of the learnings that came out of COVID was management of that system. As I said in my opening address, we are looking at over 100% occupancy of our mental health beds over the weekends — mostly at weekends, but over the pandemic as well. That is where we looked at that approach. Again, that is where we saw a regional coming together, with the five trusts beginning to work as one, especially in supporting the likes of mental health and other specialities.

Regarding a longer look at the trusts and their functions, I do not want to get into party policy, but the Ulster Unionist Party has always said that we should have one trust across Northern Ireland. This is only for future scoping or discussion, but we may look at having a single mental health trust that covers the entirety of Northern Ireland, so that we can look at a regional approach to the standardisation of service and provision and remove some of the challenges of the past. There has been a postcode approach, unfortunately, to some of the service models that we have looked at.

In the longer term, there is no departmental direction at this time for a single trust. As I said, that is something that we have put forward as a party policy, but the regionalisation approach has really been embedded through the pandemic. It has worked well for us, and we want to build on it, because we have now moved from that silo mentality that we have seen in the past, which has been challenging.

Mrs Cameron: Thank you.

Ms Hunter: Thank you, Minister and panel, for being here this morning. Minister, when you speak, we can definitely tell that you have real passion about this subject. That is most welcome.

My question this morning refers to the work of community crisis intervention services. These services are always in high demand, and yet they often struggle to get crucial funding. Have you had any recent conversations in your Department about longer and more sustainable funding? I know that the one based in the north-west does exceptional work.

Mr Swann: No, Cara. In relation to crisis services, the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services, and that one in 10 in distress actually ended up in emergency departments. It is not the service model that we want to provide, especially for mental health. Early intervention prevents that, and that is where our crisis service comes in. Recognising the need to improve the mental health crisis response in Northern

Ireland, one of the actions — I think that it was action 8.4 — in the mental health action plan centres on the reconfiguration of mental health crisis services. We agreed to prioritise that, because providing a better crisis response is seen as key to unlocking the ability of the entire system to respond better, if you can get that part to work. With regard to the financing models of crisis *[Inaudible owing to poor sound quality]* I was up in the north-west with Tomas on Friday looking at work being done by the Western Health and Social Care Trust. There is also an opportunity for many of those organisations that have been providing a crisis response without core funding to apply for the new mental health support fund that I recently announced. There is £10 million there that will be handled through the Community Foundation response. They can look for additional supports there. The core challenges of my Department through funding are something that I have rehearsed. Committee members are well aware of it and alive to the challenges that it places on us.

The Chairperson (Mr Gildernew): Minister, your sound was dipping a wee bit again towards the end of that answer.

Ms Ní Chuilín: Good morning, Minister. You are responsible for making bids and for your own budget. While the budget is not what it needs to be, it is your decision on the level of money that goes to mental health. I want to make that point. It is a postcode lottery, particularly if you live in north and west Belfast, when it comes to mental health services. Recently, our accident and emergency almost reached crisis point. A lot of those people, albeit older people, are struggling with mental health. Given the fact that there is nowhere for people to go who are in mental health crisis and, indeed, who suffer with addictions, how can this figure be reduced?

The last thing that I will say, Minister, is that we had a presentation from your officials last week on health inequalities, and it was about stats. There was no policy on it. Unless you get to grips with and address the current health and mental health inequalities, we are going to have this same conversation for evermore, unfortunately.

Mr Swann: Carál, on your last point about health and mental health inequalities, you know as well as I do that this is not just Health. It is about a whole-system approach and about Communities. You and I worked together when you were Minister for Communities. This is about how we improve people's position in life. Health inequalities come about because of poor housing, lack of access to education and poor job opportunities. When we talk about health inequalities, those stats that we measure are the outcomes of that lack of investment and action in other areas. The Programme for Government is where we start to address those. As a health service, unfortunately, we are left to pick up the end of those inequalities. When it comes to the additional pressures on our A&Es, because of those inequalities that are systemic throughout postcodes in certain areas, that is where we see additional pressures. That is where we have to put support mechanisms in, again, in crisis response in the voluntary and community sector so that we get that early interaction. I met a number of the north and west Belfast organisations a couple of weeks ago about the work that they are doing and the further work that they can do to get the early interventions in. Hopefully, the £10 million that we are announcing will help them to do that. Carál, we should not be relying on the community and voluntary services to do it. However, if they can help us get over this crisis in the next two to three years, so that we can get the mental health action plan and strategy into place so that the core health service functions are there to support people, that is what we need them to do. This is about partnership, co-production and co-working.

Ms Flynn: Minister, thank you for the briefing. Following on from some of Carál's points, I am a wee bit disappointed at today's briefing. When we spoke to the officials about the mental health strategy the other week, they said that it was difficult to achieve any certainty on the plans. That was disappointing then, but I am even more disheartened this morning. I completely appreciate all the work on perinatal services and the £10 million, but it is all a drop in the ocean. This morning, in your own words, you have said that your options are limited and that it is going to be difficult to address the imbalance with mental and physical health. Basically, you have said that there is no funding. While we have all these great initiatives that are being progressed — the crisis review, Protect Life 2, the 10-year strategy and, more specifically, the substance use strategy — I am just really worried that we have got to this point and are not going to be able to push any of that any further because of funding. I accept that your budget is tight. However, Minister, at a previous Health Committee meeting, you gave a commitment to increasing the amount of spend from your budget on mental health. The officials were not able to confirm that with me two weeks ago either, and I am waiting to hear the percentage figure that will be spent on mental health in the most recent budget. At last week's health inequality briefing, the biggest health inequality was drug- and alcohol-related deaths, and I accept that that goes

right across the board. To be honest, I am worried. In your current budget, what will you actually spend on mental health, particularly on the substance use strategy and the mental health strategy?

Mr Swann: The substance use strategy and the mental health strategy have not been published yet. As I said, we will put fully costed proposals against those. Again, as I said, my budget is already £100 million to £150 million short. As my officials have briefed, we have a standstill flat-cash budget. Therefore, to give the additional funding to mental health, we have to strip it away from somewhere else. Those are the decisions that we have to make in the Department. That is why we bring forward these strategies and these implementation plans to show the cost-benefit analysis. You will understand that it is hard for me to put a monetary figure on what we want to do and what we know we need to do. Unfortunately, that is the system that we are in. I have to make bids and I have to prove it. That is where we will get to. Where I have been able to allocate money, we have, with regard to the perinatal regional approach. We want a mother-and-baby unit. I need a business case to do that, and we are working on that.

Órlaithí, it is about the building blocks of this. You and I have met and talked about mental health; I know that we are both coming from the same place. I have been open and honest in my statement about the financial challenges that we are facing to do the work that we want to do. We are trying to set out the evidence base so that I can convince other Ministers that this is where money needs to be focused. It is a challenging budget; Conor Murphy will tell you that as well. I received a flat-cash budget, and we have to progress that where we can, but also make a bid for recurrent funding, because that is when we start to see the long-term strategic change that we need. While the £10 million sounds like a lot, it is a drop in the ocean in the support for the voluntary and community sector. However, it is another avenue that we are utilising, because it is there, it needs funding and it can support and help us achieve the goals that we want to achieve.

The Chairperson (Mr Gildernew): I recognise members' frustration with the amount of time that we have with the Minister on this very important issue this morning. It is regrettable. We asked for an earlier start in light of the Executive meeting start time. However, that was not possible, so we are dealing with a very tight time frame. I appreciate members' adherence to that time frame.

Ms Bradshaw: Good morning, Minister. Thank you for coming this morning. I want to focus on the eating disorders review. Obviously, during COVID, a lot of people put on weight, but we also know that there are a lot of pupils who started manifesting restricted eating. Some of my constituents' children ended up at the acute end of that. To what degree does the review in the draft strategy look at overeating as well as restrictive and binge eating? We know that obesity puts pressure on the rest of the health service. To what degree are you engaging with the schools on the pastel highlighter children who could end up with anorexia?

Lastly, Minister, in the Queen's Speech, the Queen indicated that legislation could come forward in Westminster around putting calories on restaurant menus. To what degree is your Department thinking of introducing that in Northern Ireland?

Mr Swann: Thank you, Paula. On the last point, I heard that in the Queen's speech too. The Food Standards Agency usually takes the lead on such issues; I do not have a more up-to-date briefing on that.

On the specific school provision, we have done joint work with the Department of Education on the £6·5 million fund that we have specifically invested in schools jointly for the mental health support programme. We know that we need to make that intervention and make sure that the support services are there as well.

I am trying to find the specific update on the work on eating disorders — apologies, I cannot find it. Tomas, will you cover that when I come off? I do not have it to hand, Paula, even though I know that I have it in this pack. It is about the balance of being able to provide those supports, not just, as you rightly indicated, for those who are under-eating but for those who are overeating. There are challenges that come from that, so there is support that we can give to young people and their parents. Doing that in educational settings is of more benefit, because it is about getting the first-door approach that we want to be able to achieve so that people can get support where they are and when they need it.

Ms Bradshaw: Thank you, Minister.

Mr Carroll: Minister, we heard from you today and we heard from officials last week that the budget is bad, is not good enough and, going on what you have stated, will not cover the mental health pressures or deliver the service that you want to see. You have an interest in mental health, and I do not doubt that, but I am really concerned that the budget is not fit for purpose. What has been done, specifically and politically, by you, your officials and other Executive Ministers to challenge that? We were in, and have still to come out of, an unprecedented period, and to have a budget that stands still and continues as normal is simply unacceptable and is a slap in the face for everybody who has been through the pandemic. I want to know what is being done to challenge this terrible budget.

Mr Swann: Gerry, as we sometimes say, you and I are on the same page on this. I have been making that argument about the budget that has been supplied to Health overall. We were told that we were getting a flat-cash budget, which is challenging for us. One of the biggest expenses that we have is our workforce, so it makes the transformation pieces, the new initiatives and the new strategies all the more challenging. That is why we have to make the case, which is what setting out the action plan and the mental health strategy is about. We will bring forward a fully costed action plan so that my ministerial colleagues can see what it costs to do. Then, it is about seeing whether the political will is there around the Executive table and in the Assembly to support that. It is easy for individual Ministers to look to their own budgets without being challenged to see where the greater good is. That is where the Programme for Government should come in, with us, as an Executive and an Assembly, coming together to do it.

Mr Chambers: Minister, it would be great if we could provide you with a magic wand to overcome the funding shortfalls to enable you to do all that you would like to do. On this particular issue, has your Department recorded increased instances of mental health issues in the community during COVID? If so, has that been the case across all age groups? As we come out of the pandemic, could any of these new mental health issues begin to resolve themselves without professional intervention? Thank you.

Mr Swann: Thanks, Alan. Yes, we are seeing an increase across all age groups, and we are also seeing an increase in acuity across many age groups. As regards what more we can do, it is not about individuals solving that themselves, but about us empowering them and empowering community and voluntary organisations to provide those interventions. That is why it is important to engage with the Department of Education to support them. It is important that we work with the community and voluntary sector to empower it as well. As we come out of the pandemic, we need every available body to assist us. Over the past 14 months, dedicated people out there have committed their own time and that of their organisations. It is about how we now work alongside them so that, when we work through our mental health action plan and strategy, we can actually get to a better place.

I want Northern Ireland to be a model of mental health best practice across the United Kingdom and these islands, but I want that for our people. We need the strategy and action plan to set out that direction of travel. I need the support of the Assembly and the Executive to get there. I need funding support as well. We have got the buy-in from the people of Northern Ireland. They know what needs to be done. We are setting out a road map and a direction in the strategy and action plan as to how we think that we can get there. That is why the consultation and the feedback that we got were specifically important.

The Chairperson (Mr Gildernew): Thank you, Minister. Just before I wrap it up there, I see that Peter has joined us. Do you want to introduce Peter, and then I will come back to you, Minister?

Mr Swann: Yes, Colm. Peter Toogood is our new director of mental health. As I said in my opening comments, that is a new position in the Department. It is the first time that we have had a civil servant at that level dealing specifically with mental health. It shows our commitment and that it is a genuine approach and piece of work.

Chair, I apologise: you said that you had asked for an earlier start. I actually had a briefing with the Chief Medical Officer prior to this meeting to update me before I go into the Executive meeting. I wanted to spend more time with you on the issue, because it is something on which we have had a good working relationship with the Committee. There is a joint will and, I think, a joint approach, and we can really make a difference here.

The Chairperson (Mr Gildernew): Thanks for that, Minister. Before you go, I want to acknowledge the decision last week to not extend the children's regulations. The Committee had expressed a number of concerns, and I know that the sector had expressed a number of concerns around that. I

just want to acknowledge that; it is a good example of where consultations are carried out, listened to and actioned. That is welcome. It also came up last night in our meeting with young people on mental health as a key issue for them. It was good to be able to tell them that the system is going back to the one that had been in place before — not that it was perfect, but it was certainly better than the curtailed system that has been in place throughout COVID.

Thank you for attending this morning, Minister. It is regrettable for us all that our time has been disrupted. It is a massive issue for you, us and the sector out there, and one that we really need to get to grips with. We will see how we get on with the officials. If there are outstanding questions, maybe members can put those through to you.

Mr Swann: Chair, that is no problem. I apologise. I know that, in our four-weekly schedule, I was meant to be in front of you again next week to give the usual presentation. However, I thought that, as this is Mental Health Awareness Week, it was useful that we actually did this today, because I know that it is where the Committee's focus is. As we come out of the pandemic, the more engagement that we get with regard to the delivery of the services that we are meant to be concentrating on, the more that I appreciate that engagement.

Sorry, Chair: I have just one final point. I have actually found the response for Paula. I approved the inclusion of the policy on eating disorder service provision across Northern Ireland, which has been examined by the Health and Social Care Board. That policy direction is included in the final, unpublished mental health strategy for 2021-2031. It is actually the development of a detailed business case with regard to eating disorders as well.

I will leave Tomas and Peter to follow up on the detail of that, Chair, but if there are further questions, we are happy to come back and re-engage on this issue, because it is a large piece of work. As I said, we will be able to engage next Tuesday, I think, when the Committee motion on mental health comes to the House. Thank you for that.

The Chairperson (Mr Gildernew): OK. Thank you, Minister. We will let you go. Good luck and take care in the time ahead. All the best.

I will pick up again, Tomas and Peter, on the workforce issue that I was asking the Minister about. First of all, having a workforce and the people in place is key. Then, there is a lead time involved in workforce, and planning is required. I am disappointed in section 13 of the strategy, on the workforce plan, because these things are still to be scoped and the timeline for the review is to be scoped. There is very little detail, and nothing else can fall into place until the workforce is in place. I would like some detail on what planning is taking place on that.

I also notice a reference in that section to:

> *"Consideration of alternative methods of working and alternative workforce."*

What does that "alternative workforce" refer to, where might it exist and how might it be mobilised? I am not sure who wants to lead off on that.

Dr Adell: I guess that that will be me, Chair. Thank you very much. I can start with the question about the alternative workforce first, because that is the easiest to answer straight away. We believe that the traditional mental health workforce is hugely important. Psychiatrists, psychologists, social workers and nurses are, absolutely, a key part of our mental health workforce. There are, however, other people who provide really good mental health interventions, such as counsellors and interactive therapists, including art therapy, music therapy and so on. That alternative workforce has often not been considered part of the core mental health workforce. We want to make sure that those people are considered to be part of the core mental health workforce and to bring them into the bigger picture of workforce planning when we talk about the mental health workforce. It is about making sure that we use all available resources, not just what is traditionally seen as the medical or social care model of mental health but the bigger picture. That is what we mean by that. We have clarified that further in the mental health strategy to make it explicit what we are talking about so that there are no misunderstandings. We are not looking to undermine the existing workforce. We are looking at enhancing the workforce overall.

As I say, the workforce review is key. Unless we know how many people we need to do the work, it is really hard to plan ahead. It takes time to plan. It takes seven years to train a psychiatrist. A

psychologist spends six years at university, at least. These things are not quick fixes, but, having said that, it is important that we get it right. We should not rush through the workforce review just to have something on the books. It must be a good workforce review. To that extent, we have been planning what the workforce review would look like and how we can get that done. We see that as a priority, but I need the resources to do that. We cannot do it in-house in the Department because we need help and support from professionals and people who understand how services are delivered on the ground. Until we get that resourcing, it is very difficult for us to carry out that review. We see it as a priority, and I hope that we can start that later this year.

The Chairperson (Mr Gildernew): That is disappointing, Tomas. I know that a review should be good, should be done properly and not rushed, but the problems have been known for quite some time. I am surprised that we are only now getting to the point of saying, "Let us do this properly". That is disappointing, given that, as you pointed out, some of the disciplines and professions require six years of training. That is a concern. Obviously, we cannot go back and redo it, but there is a trend in that we are very good at reporting what the problems are, but actually putting specific plans in place and implementing those plans to address the problems is the bit of the picture that is not happening to the degree that many people would like. I will, maybe, come back with further questions on that later. I do not know how this fits in with the larger workforce review that Charlotte McArdle was doing. Charlotte is the Chief Nursing Officer. Was that workforce review simply on nursing? Was mental health not taken into account as part of that?

Dr Adell: I cannot speak on the detail of Charlotte's workforce review, but I know that mental health nursing was definitely part of it. There has been work ongoing, but we just do not have a comprehensive workforce review on mental health as a whole that demonstrates how the whole workforce joins together. It is not that work has been standing still. There has been work ongoing. Our social work colleagues in the Department are looking at social work in mental health services. Charlotte has been looking at mental health nursing and the need for it in the future. However, we need to bring together a comprehensive mental health workforce review, so that we can see how all these professions work together as a whole and how we can properly resource the system in the future.

Your disappointment over why it has not been done in the past, I can only share with you. I cannot say anything else. It is frustrating.

The Chairperson (Mr Gildernew): I declare an interest, in that I have worked as a social worker, including in the crisis response teams. It is deeply frustrating, and it is now a matter of urgency that we start recruiting the workforce and getting it in place. This is a 10-year strategy, and we are going to be more than halfway through it before the right people are in place, if we do not start to action that.

I will open the meeting to members' questions.

Mrs Cameron: Thank you, panel. Can you tell us a bit more about the mental health strategy going forward? What role will technology have in it? I am thinking in particular of the Encompass programme, and the significant issue that you have with different computer systems in trusts, with different actions in relation to coding and gathering the data that you require.

Dr Adell: We all know the frustrations of having different computer systems across the trusts. It is something that I believe that we all share. Encompass will certainly help us in mental health. It will help us to have comparative, shareable information between community mental health services, inpatient mental health services and across the trusts. Good understandable data and good outcomes measurements are really important to assessing what we are doing and how we can do it better. That is specifically mentioned in the strategy as one of the actions, to have a clear outcomes framework. That hinges on having a data system that works across trusts and within them. Encompass will help us to do that.

I just want to make it clear that that is not the only thing that we are doing when it comes to technology and mental health. We are also looking at how technology can help and support professionals to do the work more effectively. That requires being able to share data easily, and Encompass will help us to do that when a patient moves between trusts, which is very common in mental health, as we all know. It also includes developing, for example, online CBT or other, similar online treatment methods. This is not a replacement of existing methods, but it is an additional support for people, where it is helpful. All this technology and these online methods will help us become a better, more responsive service as a whole.

Mr Peter Toogood (Department of Health): I will add to that. The key thing is to find out how ways of working better and working digitally can complement face-to-face working. That came through in the consultation. I just want to emphasise what Thomas said: this is not about replacing face-to-face intervention; it is about complementing, adding to and improving. Specific refinements that we propose to make in the final strategy reflect that. It is really about building on a lot of the good stuff that happened over the past year that has been forced on us as part of the pandemic. We are trying to develop that further and exploit it in a more normal operating context.

Mrs Cameron: I appreciate that, thank you. We absolutely need a balance in how things operate as we go forward, from pre-pandemic working. It is good to take the good bits that have worked well, build upon them and use them. However, I would like to see provision being rolled out as quickly as physically possible.

Have you any comment about GP access or GP provision of talking therapies? Can you update us on that this morning?

Dr Adell: It is absolutely vital that GPs are able to deploy talking therapies, counselling or other therapies, as a form of mental health support, as in step 1 and step 2 of the stepped care model. Counselling services are available at many, but not all, GPs. Work is under way in the Health and Social Care Board to try to encourage further uptake of counselling services. Similarly, we have talking therapy hubs, which are currently run by the trusts. One action in the mental health action plan is to shift the focus of talking therapy hubs towards primary care so that they become part of the GP toolkit in their delivery of mental health services. That will go hand in hand with the development and roll-out of further mental health workers in primary care multidisciplinary teams (MDTs). It is all about helping people to get quick access to mental health services when and where they need them. Some of those things are not easy because they require structural change. We are actively working on that to make sure that it is available to GPs in high numbers.

Mrs Cameron: That is great. May I come back on that? I just want to reiterate the importance of physical GP access in the first place in order to access any of the services that are available. Obviously, there are great difficulties because it is not streamlined across the board and across GP practices, and some people, especially those with mental health issues, have even greater difficulty getting in contact with their GP, let alone seeing them. I hope that there is some work going on to address the particular issues with access to GPs. Thank you.

Ms Bradshaw: This is a request to Tomas: can you, in slower time, tell me what the Minister said about the policy direction? Can I get a wee bit more detail on that? I have a separate question for Peter. Thank you.

Dr Adell: The Health and Social Care Board has done a review of eating disorders, together with the Regional Eating Disorder Network Group, which consists of service users, clinicians, carers, the community and voluntary sector and trust and board representatives. They came up with a service proposal for a way forward that would enhance eating disorder services across Northern Ireland through the provision of additional medical, nursing, dietetic, psychology, occupational therapy and social work staff. It will provide in-reach from community work into inpatient settings, where we have eating disorder patients in mental health wards. It will also expand those other therapies and other allied health professional interventions in eating disorder services. That is a very short summary of a large paper. It provides a number of options that the Minister has approved for a future policy direction. It will massively improve eating disorder services and will ensure that we are compliant with NICE guidelines and similar. It will also make sure that we can provide good pathways for all people with eating disorders.

Exactly how those services are developed and delivered will depend on what are the best clinical outcomes. It will cover all kinds of eating disorders. We have asked the board to develop a detailed business case for us so that we can consider funding for that, which, obviously, we have to do as part of the process. The mental health strategy will reflect the work of the Regional Eating Disorder Network Group, which has done fantastic work to produce that for us.

Ms Bradshaw: Thank you, Tomas. I appreciate that it is still in draft and developmental format, but at what stage can the Committee get a more substantive paper on that? Will it be when the Minister has signed off on it? In advance of that, is there anything that we can get on the thinking? There is plenty of brilliant stuff going on there. A number of constituents are keen to feed into that, and they will be delighted to hear that that is the direction of travel.

Dr Adell: I am sure that we can provide something in more detail in writing to you. If you write to the Department, I am sure that we can provide that in writing, as long as you give me a few days to summarise all that for you. That is not a problem.

Ms Bradshaw: Brilliant. Thank you so much.

My second question is to Peter. You mentioned the length of time that it takes for people to become specialists. I am particularly concerned about victims and survivors of not just the Troubles but the mother-and-baby homes — those who have been through forced adoption and had children taken away from them — historical clerical child sexual abuse and others, who require a very intricate conversation with somebody who really understands what they have been through and the support that they need. Do you feel that there are enough of those specialists in Northern Ireland? If not, what is being done to put those people in place?

Mr Toogood: Paula, if you do not mind, I will probably defer to Tomas again for a substantive response to that. I am still very much reading into the brief and am not long in post, so I would not want to give you incorrect information.

Tomas, is that something that you could respond to?

Dr Adell: Absolutely. We have a really good, dedicated workforce in Northern Ireland for those areas. We have really good staff carrying out really good work in the statutory sector and the community and voluntary sector. I do not want to take anything away from that but it is accepted that we need more.

The levels of people with trauma-related mental health problems in Northern Ireland are significant, whatever the trauma. We need to make sure that we have a workforce that is trauma-informed and expert in how to help people with that kind of trauma. There are some recommendations in the strategy on research and helping Northern Ireland to become better at doing those things and pulling that together. That will help to ensure that we have the right training for people, so it is an ongoing issue.

It is important to say that people who have severe needs can definitely get the help and support that they need in Northern Ireland. That support is there. No one will be turned away if they have severe needs, and there are specialists for those people. I want to make it very clear that we should not scare people away from seeking help.

Ms Bradshaw: OK, thank you very much. Again, if we can be kept up to date with the policy review that you mentioned, Tomas, we would really appreciate it.

Ms Hunter: Thank you, panel. Last night, we had a fantastic conversation with young people about barriers to accessing mental health support and how we could improve them. One thing that was mentioned was that, if you live in a rural area, it is that bit more difficult to get counselling and access to medication.

Off the back of that, what conversations or engagements is the Department having with groups such as the Rural Community Network to identify need and the impact in rural areas? In my constituency, we have had conversations with constituents in areas such as rural Limavady, and if you do not have access to a car, for example, getting access to your GP can be difficult. As we move more towards utilising technology to get in contact with GPs, there are fears that rural communities are being left behind due to broadband issues. Any clarity on that would be helpful.

Dr Adell: First of all, access to mental health services should not depend on where you live. That is something that we are very clear on. We want to have an equity of service across Northern Ireland with local service delivery. That means that it is delivered differently depending on the setting so that it matches the need of the population. That is absolutely key for us going forward.

We have engaged quite extensively with a large number of people, over the last 18 months to two years, about the mental health action plan and mental health strategy. That includes groups from rural communities. I met a number of them personally, and they have taken part in our reference group work and in our co-production work on the mental health strategy and action plan. Those groups have been considered. We are very aware of them, and that is definitely something that we want to work on and reflect in the practical outcomes of the strategy.

Ms Hunter: Thank you, Tomas. Just off the back of that, are you looking at any innovative initiatives, such as social prescribing, to engage with people in rural communities? I welcome your comments because sometimes people in rural communities can be left behind, and it is good to hear that their first-hand comments and opinions have been included.

Dr Adell: Social prescribing is a great thing. It is very helpful to people, especially those on steps 1 and 2 of the stepped care model or to people who need support even prior to that. That is not for just rural communities; that is across the board. It will look different in urban and rural settings but it is something that needs to be available across the board.

We really want to make sure that services are catering for communities. A service in the centre of Belfast might be a drop-in centre. In a rural community, that would not be practicable. It would mean people would probably have to travel, as the professionals would have to travel to the people who need the help. It is about building that into the details of the service delivery and implementation from the very beginning so that it is not an afterthought but part of the delivery of the service model in the first place. We are putting those kinds of considerations as a requirement when developing the services that are coming forward in the mental health strategy. We are trying to ensure that that balance is not lost.

Ms Hunter: Thank you.

Ms Flynn: My first question is for Tomas. The Minister referred in his briefing to the crisis review. I assume that the Minister is now considering the recommendations in that review. I was told, in response to an Assembly question that I asked a couple of months ago, that the intention was to have it published by April. Do you have a timeline for when we can see the findings and recommendations of that review?

Dr Adell: The review was received in the Department a few weeks ago. It is currently sitting with me. The delay is with me, so blame me and not the Minister. I am working my way through it as quickly as possible. It is a more comprehensive review than we anticipated, which is brilliant, but it is taking me a bit longer to make sure that we can provide accurate commentary on the review to the Minister. My hope, barring any unforeseen circumstances, is to get it to the Minister shortly, by which I mean weeks rather than months. I do not want to promise a date, considering that we are all under significant pressure and are working very hard.

Ms Flynn: That is no problem, Tomas. I am glad to hear that it is more comprehensive than you expected because, as you said, you would rather have that. That is a good thing.

I am due to meet the Minister when you have completed the substance use consultation responses. He has agreed to hold a meeting with me, so, hopefully, that might chime with the crisis review, and we can get a fuller conversation on both those issues.

Secondly, you and I spoke at one of the previous mental health all-party groups (APGs), and I had requested to the Minister that the Department needed to carry out a full needs analysis for poor mental health, mental health crisis and drug and alcohol addiction. The Minister referred to the prevalence study that was carried out around children and young people, but he said to me, in response to an Assembly question in October that, under the mental health action plan, action 15.2 calls for a prevalence study for adults. Is that being carried out by the Department? Has that been done? Do you have any update on that?

Dr Adell: We have not carried out the prevalence study among adults. We looked at it last year, and it has been on my desk quite a bit. At this point, we struggle to get value for money for that kind of study. Significant academic research shows us the needs in adult mental health and across substance use and diagnosis as well. That data already exists and provides us with a fairly good indication of need, and we think that the costs to develop a prevalence study for adult mental health could be better used to provide the services, as we have more academic research among adults. That does not exist to the

same extent among children, so there is a slightly different need. The children's prevalence study gives very good evidence about the prevalence among children and how much that is carried on to adults. So, it gives us a good basis to work on.

So, at this point, we are not progressing the prevalence study for adults simply because we have the information in other areas, and we can use the money better to deliver services. It is something that we will consider going forward. If we think that it would help us, I would definitely put that proposal forward, but, at this point, I am not sure that it would, considering the cost of doing that.

Ms Flynn: OK. That is fair enough, Tomas. Thanks for that update.

Finally, Peter, it is nice to meet you, via StarLeaf for the moment. I am conscious that the Minister said that this is a new post that you have taken up as director of mental health. Will you explain a bit more about your role, who you will engage with and what your position entails? I would love to organise a separate meeting, outside of the Committee, just to chat with you in a bit more detail around all that.

Mr Toogood: Yes, Órlaithí, no problem at all. I am delighted to be here, and I will be delighted to have a chat with you about this. Yes, it is a newly created role, and it covers all aspects of mental health, which is adults and children, and the implementation of the Mental Capacity Act. The domestic violence and sexual violence aspects, as they fall within the DOH remit, fall under me as well, so I have four strands to my remit.

To be honest, I am genuinely excited about getting stuck into the role. I was in the Department of Health a number of years ago, albeit in a different capacity. I have spent the past four or five years in TEO, the last year of which working on COVID-related matters and the Executive's response to that. Through that work, I have really seen the importance of mental health and the emerging issues that need to be resolved. I am personally passionate about making things happen. I am not one for talking; I want to see things happen on the ground. Hopefully, that chimes with you on the Committee. I have a strong finance background, so I am very keen about and acutely aware of the challenges around health funding. I will be looking at any way possible to get money into the mental health arena and to try to be as innovative and as imaginative as possible in that regard.

I am in post only a couple of weeks, but I am struck by the need to join everything up across government. We have talked about that already in saying that there are so many determinants and so many features that impact on mental health across many Departments. Again, through my previous role, I have made some really good contacts across Departments, and I want to exploit that in my current role to make sure that we are all joined up. The need to be better joined up across government comes through strongly in the consultation on the draft mental health strategy, and I would like to give priority to that. I have already had this conversation with Tomas many times in the past couple of weeks. To me, *[Inaudible owing to poor sound quality]* so important is about doing everything through the patient or the citizen's perspective, not through the system and not through an organisation. That is challenging, and I have already seen challenges in that regard, but I would like to embed that as we go forward. Órlaithí, I am delighted to meet you, and I would be delighted to have a chat with you outside this on how we take things forward.

Ms Flynn: That is brilliant, Peter. I wish you all the best in your new role. Hopefully, it will go a long way to achieving that parity between mental and physical health. Thank you.

The Chairperson (Mr Gildernew): Thank you, Órlaithí. Peter, it is good to meet you, as Órlaithí said. It is also good to see that sense of commitment to the role. That does come across, and that will be useful. What you said about the need to involve the individual and the citizen is interesting. We absolutely need to do that, and there is also a strong potential in the community and a need to involve communities as well as individuals in the community. That is all interesting stuff for the future. Those are interesting considerations.

Ms Ní Chuilín: Go raibh maith agat, a Chathaoirligh. Thank you, Chairman. Thank you, Tomas and Peter. Peter, I welcome you to your new role. To repeat what other members have said, it is very important to give mental health this status through a post such as yours.

Tomas, in your commentary, you said that the Department was keen that GPs also took on board, through primary care, talking therapies. Can you clarify that that is in addition to the talking therapies in the community and voluntary sector? You will be aware of the #123GP campaign to get GPs better equipped to deal with mental health problems.

My second question is on the care pathways and, indeed, the Children's Commissioner's report on mental health services, 'Still Waiting'. First, the length of time that it takes to fill these much-needed posts is alarming but not surprising. The indications from my constituency work are that the demand for CAMHS and, indeed, adult mental health services has increased. I want to get a sense of those.

My last question is to Peter. When the Health and Social Care Board is dissolved, will you sit on any of the new management arrangements to ensure that mental health is given the same status and priority across all trust areas? At the minute, each of us feels that it is a bit of a postcode lottery. I accept that no one wants that to be the case.

Those are my questions. Thank you.

Dr Adell: Counselling is key. I have much sympathy for the #123GP campaign. We need to ensure that GPs are equipped to deal with mental health problems.

Talking therapy hubs are funded by the trusts and often delivered by the community and voluntary sector through contracts. We want to get to a position where there is stronger working between GPs and the community and voluntary sector. They should not be in opposition but should be partners in delivery with the really good voluntary work that they do and through the statutory funding that comes through the talking therapy hubs. That is an additional resource for GPs in that it is about putting existing resources in the most appropriate place so that they can be accessed more easily. It is not a competition. Putting the community and voluntary sector in with GPs should enhance overall provision rather than taking anything away from anyone. Sorry if I was not clear on that earlier. I want to make it very clear that the community and voluntary sector is a partner in the delivery and that it is absolutely key.

On your question about increasing the staff in post and NICCY's 'Still Waiting' report, we know the challenges. I am not shying away from those. We need to do everything that we can to ensure that the workforce is available, that posts are attractive and that we have the right banding levels so that the right people will be interested. We are working actively with the board and the trusts to make sure that that is the case.

I can only assure you that we are doing the very best that we can, but it is difficult to get staff to fill posts, particularly in some areas of Northern Ireland. The west is a very good example of that. We have a lot of vacancies in the west. It is not that those in the Western Trust are not trying really hard to fill those posts; it is just that we do not have a big enough workforce. That brings me back to the workforce review. We need to have that in place so that we know how many staff we need to train, how we can incentivise them to come from other jurisdictions and so on. That work is ongoing.

Ms Ní Chuilín: And my question about the Health and Social Care Board?

Mr Toogood: Carál, you are right: when that organisation ceases to exist, a lot of the key personnel will still exist. One of the key focuses that I have had over the past couple of weeks has been in starting to develop those relationships. In many ways, Brendan Whittle, the new director of mental health on the board, who has recently taken up post, will ensure that we are on the same page and that I understand exactly what is going on there as well.

You can be assured that I will be an advocate for mental health in the Department and will make sure that it is prominent there. Again, I will develop relationships internally with the key senior folk in the Department, such as Sharon Gallagher, who is in post and will retain responsibility for the board. It is about developing relationships so that they understand exactly where we are coming from in the *[Inaudible owing to poor sound quality]* possible way that will maximise every effort so that we can get funding and resource into that area.

The Chairperson (Mr Gildernew): I have a question. It might be for Tomas, but I am not sure who can deal with it. It is about gambling addiction services. A number of years ago, prior to COVID-19, I was at an event in the Long Gallery and was taken aback when it was identified that one in 10 suicides — it was possibly a higher number — was linked to gambling addiction. Tomas or Peter, are there any commissioned gambling addiction services? Are there any plans to develop those further?

Dr Adell: Peter, I do not know if you want to answer, but I will begin. There are no specific gambling addiction services. All trusts have generic addiction services that deal with addictions of various kinds,

including gambling addiction. Gambling addiction is a very serious thing, and I am not, in any way, trying to minimise it. It is important to distinguish between addiction related to gambling and problem gambling because they have fundamentally different sources. The reasons for and ways to deal with them are different. People who have a gambling addiction should receive appropriate addiction services, which we provide.

We do not have any statistics across services on gambling addiction or on services for people who have a gambling addiction in Northern Ireland. The Committee has highlighted that as something that we could improve on. Services are available for those who have a gambling addiction.

We have to look at what causes problem gambling. That is often not addiction but relates to the social determinants that sit behind gambling. Gambling needs to be considered in relation to society as a whole. If people are gambling because they have financial problems, the response is probably about not mental health or addiction but how we cope with difficult financial situations. There is a fine line between the two, but it is important that we do not put into mental health or addiction services people who do not need that help and support because that will not help them. It is about getting the right service response. In saying that, I do not minimise the impact that gambling has on people.

The Chairperson (Mr Gildernew): What services are commissioned for the people who, according to your argument, have a gambling addiction?

Dr Adell: In all trusts, there are generic addiction services within mental health services. They will help and support those with addictions. They are not specific gambling addiction services but exist for people with any addiction. People with a gambling addiction are treated in those services. On top of that, there are mental health services for people whose struggle with addiction leads to poor mental health. Mental health services will provide help and support for those people. There are a lot of people in our generic mental health services for whom addiction is the cause of their mental ill health. We provide help and support for those people.

The Chairperson (Mr Gildernew): I have worked with addictions in my role as a social worker. I recognise what you say. With those comorbidities of addiction and mental and, indeed, physical health issues, the lack of addiction services often becomes a barrier to the other services. If the addiction is not addressed, the mental health access is not available. It is fundamental.

Gambling is a specific issue. I am not entirely convinced that a generic service best meets those needs. That might be worth considering. It is a major and growing issue, and it has grown during the pandemic, alongside a host of other physical and mental health issues. It merits a further look. Peter, do you have anything on that issue?

Mr Toogood: I have nothing to add to what Tomas said. We need be aware of it and to consider it.

The Chairperson (Mr Gildernew): Thank you very much, gentlemen, for joining our meeting and for taking questions from members. There is a commitment to forward some specific pieces of information, which the Committee will look forward to receiving. For now, good morning and thank you for attending.