Northern Ireland Assembly

Public Accounts Committee

# OFFICIAL REPORT (Hansard)

Inquiry into Mental Health Services in Northern Ireland:
Professor Siobhán O'Neill, Mental Health Champion

18 April 2024

# NORTHERN IRELAND ASSEMBLY

# Public Accounts Committee

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**Members present for all or part of the proceedings:**
Mr Daniel McCrossan (Chairperson)
Ms Cheryl Brownlee (Deputy Chairperson)
Mr Cathal Boylan
Mr Tom Buchanan
Mr Pádraig Delargy
Ms Diane Forsythe
Mr Colm Gildernew
Mr David Honeyford
Mr John Stewart

**Witnesses:**

| | |
|---|---|
| Mr Stuart Stevenson | Department of Finance |
| Professor Siobhán O'Neill | Mental Health Champion |
| Ms Dorinnia Carville | Northern Ireland Audit Office |
| Dr Nicole Bond | Office of the Mental Health Champion |

**The Chairperson (Mr McCrossan):** I welcome Professor Siobhán O'Neill, the mental health champion for Northern Ireland and Nicole Bond. We thank you both for being here today and appreciate your attendance. Also with us are Ms Dorinnia Carville, the Comptroller and Auditor General for Northern Ireland (C&AG); Colette Kane director of the Northern Ireland Audit Office; Mr Roger McCance, audit manager, Northern Ireland Audit Office; Mr Kyle Bingham, Assembly support officer, Northern Ireland Audit Office; Mr Damien Prenter, senior auditor, Northern Ireland Audit Office; and Miss Nikita White, auditor, Northern Ireland Audit Office. I take the opportunity to welcome Mr Stuart Stevenson, Treasury Officer of Accounts (TOA), who is in the Gallery.

Professor O'Neill, you are welcome to the Public Accounts Committee. We are excited about the session. We thank you for taking the time to be with us today to speak on this all-important issue. Can you outline your role as the mental health champion and brief the Committee before we go to some questions?

**Professor Siobhán O'Neill (Mental Health Champion):** Super. The office of the mental health champion is funded through all of the Departments; they all pay a little towards the budget for my office. I work with all of the Departments to highlight the priorities in relation to mental health and well-being, suicide prevention and resilience across the whole population. For the first three years, there was a lot of intense work with Health, Education and Justice, although I met most of the other Departments at the same time.

One of my key roles in the first year was to develop a 10-year mental health strategy. Prior to taking up the role, I worked for over 20 years as a professor of mental health sciences at Ulster University. During that time, I conducted research into mental health and suicide in the population and called for a 10-year mental health strategy. I reviewed all of the work that had been done around mental health and mental health reform, so I had been asking for the strategy and a programme for mental health in education. Those two actions were achieved: we developed a framework for education in the first year and then a mental health strategy. The other aspects of my role are around public communication, including media work and doing public work such as this, where I advise government publicly, and campaigns, where we focus on the evidence base for well-being.

That is a summary of what I have been up to for the past few years. It all comes from an academic perspective and looking at the evidence base. My research officer, Dr Nicole Bond, works in that area and has expertise in it.

**The Chairperson (Mr McCrossan):** Thank you very much. Members have a number of questions that they will put to you. We appreciate your taking the time to answer them. We have a full house of members. Pádraig is on via Zoom. Is there anything that you would like to add?

**Professor O'Neill:** No, I will just take the questions. If there is anything else that I want to say, I will say it at the end.

**The Chairperson (Mr McCrossan):** Over the past number of weeks since the Assembly returned and the Committee formed, we have reflected on quite a number of key areas that are important to the Northern Irish population. Mental health was a key theme that the Committee felt strongly about; we agreed unanimously that it is a core issue in each of our constituencies. It is something that needs to be dealt with. We appreciate your being here for our first session before we begin our inquiry next week.

What is the scale of the mental health challenge in Northern Ireland?

**Professor O'Neill:** We get prevalence figures from government surveys. In 2021-22, 21% of our population scored 4 or more in the General Health Questionnaire (GHQ12), which indicates probable mental illness. That is a crude enough measure. The scale is used in other jurisdictions. When we compare ourselves with other regions of the UK, we find that Scotland's figure is 22%, which is just a wee bit higher than ours. The most recent figures for England were around the same as ours. Nicole has analysed some of the data and found that it is coming in a bit lower. We are not the highest: we are similar to some of the other UK regions. Nonetheless, it is worrying. We need more recent data for England and Wales.

When it comes to severe mental illness, which includes people with schizophrenia, bipolar affective disorder and psychosis, and patients on lithium therapy, the prevalence rate is 9 per 100,000, which is similar to those of the other UK regions. We are not that different in terms of the prevalence. The differences are apparent in relation to the severity of the mental health difficulties and the complexity of the difficulties that we are talking about because of our history of trauma. My research has demonstrated that. We have more severe and enduring mental illness and more trauma-related mental health difficulties that are more complicated and more difficult to treat. We certainly need a robust mental health service to meet the needs of the population.

The current cost of poor mental health in Northern Ireland is £3·4 billion annually. The Mental Health Foundation and McDaid and Park came up with that figure. It does not include dementia. Much of that cost can be reduced. I am pleased that you have taken this as an issue that you are going to look at, because it comes at a significant cost. Much of it is preventable, and, of course, there is a moral imperative to reduce the suffering caused by poor mental health in our population.

**The Chairperson (Mr McCrossan):** What is important about what you have just said is that the prevalence here is similar to that in other jurisdictions. Have you any figures in relation to the rest of this island — the south of this island? Professor O'Neill, is your opinion that the services in Northern Ireland are inadequate and failing our population, particularly those who have severe mental health issues?

**Professor O'Neill:** On your first question, we do not have data on the Republic of Ireland to hand, but we will find it. Their suicide rates are somewhat similar to ours, although coded in a different way. I am involved in that work in the Republic, and I know that the suicide rates — if used as we classify suicide

— are very similar. Our suicide figures are similar to those in the other UK regions. In some years they are above Scotland's, and some years slightly below Scotland's, and our rates are normally a bit above England's, but they are not the highest.

Are we failing? We are spending less on mental health services per head of population than other regions, so that is a problem. There are figures for that, going back over the past 10 years. There has, therefore, been historic underinvestment in mental health services, and we continue to spend less than other regions, which is unacceptable, obviously. Furthermore, given the fact that our mental illnesses are more complex, we should, arguably, be spending more. Five years ago, our rates were much higher than those in other parts of the United Kingdom, but those regions have increased their numbers, whereas ours have stayed relatively stable, with the exception of the pandemic year, when the scores were higher. It is not that our rates were better, or that we were lying in the past, when we said that ours were the highest — we certainly had the highest — but other regions got worse, and our rates have stayed relatively stable.

We have a problem that needs to be sorted out. Every year that we do nothing about this, and continue to let the waiting lists sit and people suffer, is costing us. The cost to the families and communities of those unfulfilled lives is huge, and we need to be doing something about that.

There is also the cost of physical illness. That is an interesting one. When David McDaid spoke most recently in Northern Ireland, he said that poor mental health adds about 50% to the costs of physical healthcare. So, it is not just a cost for mental health services; poor mental health is making our physical health needs greater as well. Therefore we need to be investing in mental health and in preventing mental illness — that is the best value for money — but we also need to be treating the people who have mental health difficulties. Those are treatable illnesses. We would not accept it in any other part of health, so we should not accept it in mental health, especially when we have conditions for which there are treatments and we are not delivering those treatments. It is not good enough.

**The Chairperson (Mr McCrossan):** That is helpful. Where is the greatest challenge in mental health in Northern Ireland? Is there a particular location that is worse than others? Is it mostly young people? Is it mostly young men? Have you seen an upward trajectory in younger people? What information do you have around that?

**Professor O'Neill:** The costs are mostly due to depression. A lot of the cost is borne by the carers, because they are unable to work because they are caring. Something like 36% of those costs are carers. You have a lot of costs that come with a common mental illness. Obviously, the severe and enduring mental illnesses, such as schizophrenia, psychosis and bipolar — conditions for which people require hospitalisation — are costly. There are lower numbers, but it is very expensive to treat those individuals. There is strong evidence that early intervention in psychosis will make a huge difference and save you further down the line.

Of course, around three quarters of suicides are male and around a quarter are female, but, in our population surveys, more women than men screen positive for depression. It depends where you look, but certainly, again, the evidence shows us that in 50% of those cases, there will be evidence of mental illness by the time those persons are 14 years of age, and it goes up to 75% by their mid-20s. When you are thinking about preventing mental illness, getting in early and giving the person the best chance, you would direct your money towards those younger age groups.

We know that, especially in the early years — in the first three or four years of life — attachments and relationships in families are important, and that adversities in that period are very predictive of the development of mental illness throughout the lifespan. Childhood adversities — we sometimes call them adverse childhood experiences (ACEs) — and trauma in that period lead to mental illness later in life. We can, however, identify the symptoms by the age of 14, so you can see why education is such an important setting in which to be doing that work and identifying people who have the early signs of poor mental health so that they can get the treatments that they need.

**The Chairperson (Mr McCrossan):** OK, thank you. I am going to go to members. Does anyone want to follow up on what I have said, or are we happy enough to move on?

**Mr Gildernew:** I have one brief point to make. The figure for total referrals has remained around one fifth below pre-pandemic levels. What is your take on why that remains the case? Does it represent a

ticking time bomb, in that people are not coming forward? Is there a potential that people are not coming forward because there is so much of a waiting list that they are not confident of getting help?

**Professor O'Neill:** It is difficult to know. We do not have data on that. People may be talking more about their mental health and are disclosing poor mental health. It may be that people have come forward and are on those lists, or they may have lost faith in the system and may not be coming forward. I do not have the answer to that. We will go and have a look at it, and we will come back to you if we can find any data that helps us to understand it. It may just be that the need is not as great as it was. If more people come forward, it does plateau eventually, but we need to start treating all the people who are on the waiting lists right now. That is fundamental.

**Mr Honeyford:** Is it possible that outside charities are carrying a lot of that, rather than the professional health service?

**Professor O'Neill:** The non-statutory agencies? Yes. There is evidence that people are going to the community and voluntary sector (C&V) or the private sector. The mental health strategy has a vision for a single regional mental health service that includes the C&V sector, where you have data across all the sectors. At the moment, however, that data has not been collated across the C&V sector. You are right: through the pandemic, the C&V sector responded in a very agile way and was able to meet people's needs. We are now seeing that the funding has dropped off there and, again, that is a real problem.

**Mr Honeyford:** In my constituency, GPs refer patients straight to the community and voluntary sector. It is a free service for the health service, which is ironic.

Moving on, you are saying that we have greater and more complicated need and that the numbers of those in need or with trauma are increasing, yet the percentage funding here is significantly lower than that in GB or on the rest of the island. As mental health champion, do you have any indication of the level of funding that is needed? What level of funding should we be looking at?

**Professor O'Neill:** What we need is the transformation of the mental health service, as outlined in the mental health strategy. That strategy has a funding plan attached to it. Were you to implement that strategy, that would be your starting point. There are two sides to it: there is the strategy, which is the plan to transform the service and create a single regional service, and then there is what we are spending every year on mental health services.

What do we have in terms of expenditure? We spend £13 million every year on antidepressants. The total expenditure on mental health is £359 million, which is 6·8% of overall health and social care expenditure. If you look at other regions, other estimates will tell you that that should be around 10% or 11%, depending on how you calculate that. At the moment, 6·8% of the overall health budget is spent on mental health. You could estimate crudely that that needs to go up to about 10%. Then, however, you have to look at the overall budget and ask whether that is accurate.

Equally, with child and adolescent mental health services (CAMHS), the idea is that that would be 10% of your mental health budget, but, again, I would prefer those estimates to be based on need rather than just looking at what is spent in other regions. No matter what way you look at it, we are underspending on mental health services.

The strategy needs to be layered on top of that, because you need that extra money to transform the system to bring together all the trusts to create a regional service — to create the new services that we need in order to provide a functioning mental health service that meets the needs of the population. That is in the funding plan and, overall, would be a third more than what we are spending. Those are figures that we came up with a couple of years ago. We need to be spending a third more, but it would be worth it to transform the system.

In 2023-24, we needed £24·38 million to fund the strategy. That is what was in the funding plan, and what we spent was £5·5 million. In 2024-25, which is where we are now, we need £42·08 million for the strategy, and we do not know how much is going to be spent on it in reality. My concern is that it will be a lot less than that. In 2025-26, we need £61 million. It goes up every year. What we actually need is a three-year budget at least so that we can say, "This is what we're going to deliver on the strategy", showing how the investment will stack up, year on year, so that we can get where we want to be in 10 years' time. A total of £5·5 million every year is not going to cut it — it really is not.

We have been able to do a lot of great planning work. Now, we need to put in more money so that we can build on that. I can tell you more about what that should look like and where that money needs to be spent.

**Mr Honeyford:** I think I am right in saying that you said that in other areas of GB, when higher percentages were spent on mental health, there was a 50% drop in what was spent on physical health.

**Professor O'Neill:** Yes. Poor mental health adds 50% to the cost of physical healthcare.

**Mr Honeyford:** Right, OK.

**Professor O'Neill:** When helping people with physical health problems, supporting them with their mental health will reduce the cost to physical health.

**Mr Honeyford:** What of the other regions? They have spent more on mental health. What are the outcomes of that within the rest of the health service?

**Professor O'Neill:** I can give you some figures for that. It depends on how you spend it, obviously. For every £1 you put into workplace well-being, you get £2·37 back; for suicide prevention it is £39·11. Those are 2017 figures. Collaborative care for physical health problems is £1·52. If you invest, it depends on where you put your money. Anti-bullying in schools, £1·58; school social and emotional learning, £5·08. Obviously, by treating mental illness you are reducing the cost to mental health budgets, but if you invest now in other aspects of the system, you get your money back on that investment.

**Mr Honeyford:** Other reports show that we have patients staying much longer in hospital, which has a significant cost. Is that making the mental health problem worse? Is there a connection between the amount of time that people are spending and the mental health —? No?

**Professor O'Neill:** I would not say that. The waiting lists for psychological therapies are a real problem. We know that psychological therapies work. They are effective treatments, but if you have somebody waiting for two years on a treatment for any condition, whether physical or mental, they are going to deteriorate, particularly in terms of mental health. You do all the good work with them in hospital, doing the stabilisation piece, so you want them to move out into the community as soon as possible, get them back into the environment that they are going to be in, and you want to deliver the psychological therapy, and that is not happening.

Of course, there is also the social care that needs to be in place for some of those patients, and the services need to be there in the community. The delays in discharge are a real problem, but we have a huge problem with accessing psychological therapies. That is causing problems. People's mental health is getting worse. It is more costly, and we just do not have the staff to do it.

**Mr Stewart:** Professor O'Neill, I just want to thank you and your office for all the work that you are doing. It is a massive undertaking. We appreciate everything that you do.

You mentioned prevention, early intervention and, in particular, CAMHS. The last figure that we heard was that almost 3,000 children were waiting for mental health services in Northern Ireland, and that over half of them were waiting for more than nine weeks. Anecdotally, certainly, in my office, it feels as though that is increasing and that access, particularly by parents, is becoming increasingly difficult. From your experience, how difficult is that? What are your feelings on what the improvements could be?

**Professor O'Neill:** What we see on the ground is that children and young people are getting to a service later than they would have done in the past. I am thinking about eating disorders in particular. Young people are much more seriously ill by the time that they get help. When parents present early with a young person who is showing signs of anxiety or depression, or who is struggling, they cannot get help for that young person. The child is not eligible for child and adolescent mental health services because they have not developed a full-blown mental illness and their needs are not significant enough. They may be in that group of young people who, before the age of 14, are showing signs of poor mental health but have not met the criteria for a mental illness. It is almost as though, in that area of intervention — if you were looking at the stepped care model, it would be steps 1 and 2 — the

services are not there. That is why we need to have joined-up working with Education. We need to have new posts like the clinical associate psychologist (CAP) posts. Those posts are being delivered right now. We need to ensure that we have psychological well-being practitioners and CAPs working there to do the early-intervention work. We need therapy hubs to be operational and the multidisciplinary teams to work well so that young people who are showing signs of poor mental health can get treatment earlier.

As I say, a lot of the referrals that are going through to CAMHS are being bounced back because they are inappropriate referrals. That is a significant concern. When you have a young person, it is important that you get them help urgently. I would use the phrase "time-critical". You can prevent a problem from developing, but, if they have to wait, it will lead to poor outcomes for their education. They will struggle at school if they have poor mental health. They will struggle with their friendships and social development. It is absolutely vital that young people get the help that they need. That was one of the things about the Healthy Happy Minds programme of interventions that was working. Some great work is happening between Health and Education. There is just not enough of it. When children get the help that they need, they flourish. It is a game changer. It prevents problems further down the line.

**Mr Stewart:** That takes me to my next point. Thank you for that. There is a clear case for invest to save; the more that we put into this, ultimately, the more we save. The economic impact assessment of mental health in Northern Ireland is vast. If we can tackle the problem head-on as early as possible, the amount of money that could be saved is astronomical. To that end, do you think that the strategy is ambitious enough in tackling child and adolescent mental health issues? Is 10% of the budget enough, given how much of a game-changer that could be? My final question is this: where are the areas of best of practice that you have seen in the UK, on these islands or elsewhere that we could replicate, if possible, here to tackle children's mental health problems?

**Professor O'Neill:** As regards the adequacy of the mental health strategy, the strategy itself is excellent, but it is for a single Department, really. I want to see a Programme for Government that prioritises well-being and children's well-being and really focuses on that, because that is what we need. We need to improve the experience generally for children and young people in Northern Ireland. That is a Programme for Government issue. As a health strategy, it is excellent, but we need now to match it in the Programme for Government and focus on child poverty. Eliminating child poverty and adversities, deprivation and inequalities is key to the issue. That is one thing, but it is really impressive that we have such a strong Department of Health strategy to work from. We now need to operationalise and implement it.

You asked about child and adolescent mental health. We need a workforce that is able to meet the needs of our children and young people, and we do not have that. My fear is that, if we increase our expenditure on CAMHS to 10% of the health budget, what we would really be doing is taking people out of the C&V sector and out of other parts of the mental health service. In Northern Ireland, we have no commissioned child psychotherapy services. That is just not good enough. We need to train more practitioners to work with children and young people. That is why the CAP posts that I talked about are so impressive; they are about children and young people. We need a lot more of that. We need to be able to provide psychological therapies for children and young people and their families. We need to invest in support for parenting, because how parents and families work is part of this. It is never about therapy just for the child; it is about play therapies, arts therapies and therapies that work with whole families on the attachment issues that are the foundation of good mental health.

**Mr Gildernew:** I will pick up on the workforce issue, because it is key. I know from my time on the Health Committee this old truism in health: no staff, no services. I will focus on health, although I realise that there are also education and all sorts of other workforce issues. The workforce review has indicated that there are 2,000 vacancies and that 500 nurses are needed. There is a long tail to providing those places. With training places, it takes a minimum of three years, and you have all that education and training to support. You are currently robbing Peter to pay Paul. Statutory services are looking for staff, as are the private sector and the voluntary and community sector. Given those pressures — we have also seen significant underspend in some areas over years as a result of not having staff, and you cannot provide the service without them — are you satisfied, Professor, that the Department of Health is acting urgently enough to bring forward the planning and actions needed to get that workforce into place?

**Professor O'Neill:** The workforce review happened quickly, and such things do not cost a lot. It was one of the first things that happened on the statutory side. We need a community and voluntary sector

workforce review, but the statutory-sector review is available. There needs to be a 45% increase overall in the workforce for statutory services, and, if you look at the workforce review, you see the percentage increase that we need across professional groups. It was done very quickly, and it is a really strong document. It involved all the right professional bodies. Now we need an implementation plan for it, but we also need the commissioning of training places. The review will be out of date in a few years' time, so it is vital that we move to the next stage, which is the implementation plan and the commissioning of training places.

We need a lead psychological officer, a chief psychologist or someone whose job it is to scope out the psychological therapies — the non-pharmaceutical interventions — and look at who is able to work in the mental health service to deliver those therapies, whether they are psychologists, counsellors, psychological well-being practitioners (PWPs) or CAPs. It is about who is out there, where can we get them in and how quickly we can respond to meet the need for psychological therapies. That is where the gaps are. When we talk about long waiting lists, we are not talking about a waiting list for antidepressants: there is no waiting list for medication. There is a waiting list for counselling or psychotherapy, and that is what people want. I am not saying that everybody needs psychotherapy — not everybody does, and there are other really effective treatments — but people wait far too long to get anything that is not a medication, and that is a huge problem.

**Mr Gildernew:** Really, my question is this: is the Department doing enough to make sure that that starts to happen, to lift off from understanding the problem and move into addressing it?

**Professor O'Neill:** At an upcoming strategic reform board meeting, I will see the implementation plans for the strategy for the next year. The Department did all it could last year, with its budget and the instability that we had, but, now that we have more clarity on budgets, we should move more quickly. Come back to me in a month or six weeks, and I will be able to tell you what the implementation plan is for the coming year. It needs to be about workforce training places, and having somebody in that job whom you can go to and ask, "What is happening with our psychologists? What about the psychiatry vacancies?". We have vacancies across that system: 25% vacancies in psychiatry. We need that person in place and to get moving, but it is early days. I cannot say that they are not doing enough, Colm, but I will be able to tell you in a few months' time.

**Mr Boylan:** Siobhán and Nicole, you are welcome. You are very glowing about the strategy, so I want to stick to the strategy. It is a 35-action plan, across the board. It comes at a massive cost, which is unaffordable to the Department at the minute. As mental health champion, do you think that that strategy — bearing in mind the answers that you have given so far — is deliverable?

**Professor O'Neill:** It depends on budget, not even for the coming year, which I know will be a one-year budget, but for after that, when we will be looking at three-year budgets. When we get that first three-year budget, we will know how much of this can be delivered. Then, we will have to look at the strategy and think about what is doable. It is still too early to say. The fact is that we do not know what the budget will be. We have lost some time, in fairness. It is hard when you are in year 3 of a strategy and there has not been enough investment, but we can catch up. I am optimistic that we can catch up, on at least some of this. However, will we get to where we need to be in 10 years without three-year budgets after this year? Probably not.

**Mr Boylan:** OK. I want to focus on the strategy. We are delighted to start off with this inquiry, because it is most important. At the end of the process, we hope to be able to develop recommendations and work with the Department to deliver across the board.

Given the limited resources, from your perspective, what are the priority areas in the strategy?

**Professor O'Neill:** It will be no surprise to you that I think workforce has to be the priority. Getting a lead person in to develop the psychological therapies side of the workforce is fundamental. I would then go to the other end, which is crisis intervention services. The regional crisis intervention service model was developed and launched in the first couple of years of that strategy. Good progress has been made in mapping out what crisis services are there. The regional crisis intervention service is really a way of bringing together all the strands that deal with individuals in crisis: primary care out-of-hours, mental health liaison, the Ambulance Service, the police, rescue services and community services. It is really about creating a regional model that provides alternatives to emergency departments.

The really important piece of that is the C&V sector response for people who do not require a hospital admission or have a diagnosable mental illness for which they need mental health statutory services, but who need something. Scotland has a project called the Distress Brief Intervention (DBI). It provides 14 days of community and voluntary sector follow-up for people who are in crisis. It is suicide prevention care, problem-solving, working out what led to that point of crisis and helping that person get the care that they need. That is the missing piece of the puzzle that we do not have. We have multi-agency triage teams (MATTs), community navigators and crisis services that do de-escalation. It is the follow-up — the crisis service — that we do not have and which is a priority area for me.

Another priority is early intervention and prevention. We have a plan for early intervention and prevention that was developed in the past couple of years. We now need to move faster as we go through that plan. A lot of work has already been undertaken there.

The final priority is the creation of that regional mental health service. Again, we have the groundwork and a model. We now need to work with the C&V sector to make sure that it is part of the service. The head of the mental health service has been appointed. We need to get the head of the service to provide the regional collaborative board and set up that regional structure. That is fundamental.

None of those things, you will note, will cost a lot. We will not need the full amount that is in the funding plan for those priority actions. If we could get the full amount, I would be saying, "Let us do more of that". If you look at those four or five actions, depending on how you lay them out, that would be the best way to spend the money that we have, so that we get the best benefit, help the most people and save ourselves money down the line.

**Mr Boylan:** OK. This is my final question, Chair. The strategy is three years in, and there are seven years to go. Where are we on the scale?

**Professor O'Neill:** We have not spent what we needed to spend, so we are not as far forward as we should be, but we have some impressive plans. We have a regional outcomes framework. People ask me about data and outcomes. We have a framework that is good to go and will work really well in measuring people's experiences of services, the outcomes and how services are performing. We have the workforce review. We have the regional crisis intervention service. We are doing really well given the context, but people are not feeling the difference on the ground, and that is what worries me. We need more people on the ground delivering services and therapies.

**Mr Boylan:** That is what worries us as well, Siobhán, to be honest.

**Professor O'Neill:** I hope that you can help with that.

**Mr Boylan:** Thank you.

**Mr T Buchanan:** Thank you for being with us today. Accessing services and obtaining treatment are huge barriers facing mental health patients. As mental health champion, what are you hearing from the service users? What are you hearing about their experiences of those barriers? In what areas of service do you see particular problems that need to be addressed?

**Professor O'Neill:** That is a great question, because part of my job is to engage with people on the ground. They come to me all the time, and they are saying that the help is not there and that they are having difficulty navigating services. A lot of people will try to access services by going to their GP, and we must remember that primary care deals with a lot of this as well. Even as a starting point, getting a GP appointment can be difficult, as can getting a referral to adult mental health services or child and adolescent mental health services. The waiting list to be seen can be excessive. There are long waiting times, and then they may be assessed and told that their needs are too complex. They may have an addiction or be a substance user, and they may find that the services are not suitable for their needs for that reason. They may be neurodivergent or suspected to have ADHD, and there is no way, in some of our trusts, of having that diagnosed. That is a problem: there is literally no service for that. They may be sent to a service that is inadequate. Someone with an eating disorder may be sent to a hospital and admitted, but they do not get any sort of psychological care; it is purely physical care.

It depends on what you are talking about. We then have people who, when they get to the stage of getting services, are told, "You have mild depression. We are not the service for you", so they go back into the community and voluntary sector or they approach a C&V sector organisation themselves and find that they are on another waiting list. They may attempt to go private and then are looking through

lists from professional bodies and thinking, "How much is this going to cost?", or they may simply ask for a prescription — something to settle them — from the GP and choose that option. It is literally all over the place.

Some people receive excellent care; I have to say that. Such cases rarely make the news, because those people do not complain. I have heard of many cases of people with complex addiction and mental health problems who get excellent services, have turned their life around, are back working again and are fulfilling roles in families and being a parent in the way that they want to be. It is amazing when you see that. I go out and visit the different services, and I hear about the work that they do and the care that they provide, but just getting to the point where you can get the service that provides the treatment that you need can be a real difficulty. You often hear of suicides among people who get a lot worse. They end up needing hospitalisation, but they asked for help at an earlier stage and were not able to navigate the system and get the help that they needed.

Our services are doing their best, but there are significant gaps, and many of our most vulnerable people do not get the care that they deserve and need.

**Mr T Buchanan:** There are those who are waiting and are crying out for help. We get them in the office. They are not getting the help that is required, and the waiting lists continue to grow. What can be done to improve that situation?

**Professor O'Neill:** As I say, what we need is reform of the whole service through the mental health strategy. It is about the workforce, fundamentally. When we look at psychology, we see that there is a 30% vacancy rate across all the trusts, so we have one third fewer psychologists than we should have. Funding, in and of itself, will not solve that problem. We need to increase training. We need to make sure that our universities train enough people every year. We have 500-plus psychology graduates every year. We have around 21 places and 250 applicants for every place. In psychiatry,16·4% of consultant posts are vacant or unfilled, which is more than double the percentage — 7% — in the United Kingdom. The vacancies are a difficulty. Training is a problem.

When I say "the strategy", I do not mean setting up a new service per se, although we need new services too; I mean working from the ground up to set up the structures. We have the plans; now we need the structures, the training places and the people on the ground to deliver the care. The strategy is where it is at. We need more money for the services, but the strategy is the solution, as I see it. People with lived experience have worked on and put energy into the strategy. They have given their time and themselves to it, so we owe it to them to do it right.

**The Chairperson (Mr McCrossan):** This is an important area. I think that most MLAs in the Building would say, Professor O'Neill, that the obstacle faced by their constituents — yes, there are issues with treatment generally — is accessing the actual service. We often say, "There is help out there: just ask", but the criticism is that, when they go looking for the help, that help is not there; they cannot find the door. A&E is not the right place for people who are in that vulnerable state and who need help and assistance. Do you agree with that?

**Professor O'Neill:** It is for some of them. If someone has injured themselves or attempted suicide and needs a medical assessment or an assessment because they are showing signs of psychosis, they need to go to an emergency department or another safe place where they can get a psychiatry assessment. If someone needs to be admitted to hospital, the emergency department is the right place for them. However, there are so many people outside of that who are in crisis. That is where the regional crisis intervention service comes into play, because it provides those alternatives.

In many parts of Northern Ireland, there are alternatives. There are the multi-agency triage teams. There are community navigators who work in the emergency departments to help people find the right sources of help. There are community crisis services. There is Lifeline, the suicide prevention helpline, the number for which is 0808 808 8000. There are all those other services. It is really important that people present so that we can get them the help that they need, especially if they are in suicidal crisis, because that is a death that can be prevented. We need that whole regional crisis intervention service, including the C&V sector follow-up, the problem-solving and the 14 days of help, starting from the morning after. We need that in Northern Ireland. It is the bit that is not there.

In any society, an emergency department should be able to help someone who has attempted suicide and is in suicidal crisis. We need to provide them with that follow-up and treatment for their condition or problem-solving for whatever it is that has led them to that point of crisis. We need to recognise that

some crises are not related to a mental illness. People may feel very distressed, but they may not have a mental illness. Nevertheless, they still need support and help. Many of them have substance use difficulties and addictions that need to be dealt with as well.

**The Chairperson (Mr McCrossan):** There are a number of points in relation to your answer, which I appreciate, Professor O'Neill. If a young person or any person presents to our office and says that they are struggling with their mental health and cannot get access to their GP — remember, anyone's mental health can deteriorate in an instant, depending on the circumstances and challenges they face — we will ring mental health services in the town or constituency and be told, "They are not known to us. We cannot see them. Go to A&E". Even if that person is struggling with severe anxiety, we are told to send them in. Would you say that A&E at Altnagelvin, for instance, is not the best place for that individual, given that it is a difficult, busy environment where staff are overworked? We have touched on workforce already. I am aware of people who have sat in that state for two days, at least.

**Professor O'Neill:** Absolutely. Anxiety is not a condition that will be treated in an emergency department. Ideally, a multidisciplinary team in primary care would have a mental health worker who can see that person. Ideally, they would be able to get an appointment with a mental health worker. It does happen in many of the GP federations that someone who is struggling will get an appointment. It is not a 24-hour service, obviously, but the person is seen and gets an assessment. If a person has anxiety, it is about deciding whether treatment is required, what the treatment will be and where the person goes next, which can be a problem. An emergency department is probably not the best place for someone with anxiety, but it is for someone who is in significant distress, is hearing voices or has attempted suicide. It is good that you made the differentiation.

**The Chairperson (Mr McCrossan):** I will probe that, because it is important and is something that we hear about on a daily basis. If someone in that fragile state of mind presents at A&E on a Saturday because they have nowhere else to go, they can be sat in a waiting room surrounded by a huge number of people who may be intoxicated, severely ill or have dementia, and that can make their situation worse. Often, that person does not remain in A&E because the waiting times are so significant. How can we resolve that? If there is no physical injury, is A&E really the most appropriate place to send people who are in that vulnerable state?

**Professor O'Neill:** I agree that it is not. It can lead to an escalation in anxiety, because that is an anxiety-provoking environment. It can also lead to hopelessness, because the person feels, "This is where I go? There is nothing for me here. I have asked for help. I have done all the stuff that you told me to do, I have heeded the 'It's OK not to be OK' message, and this is what I get". That makes it worse, arguably, for some individuals. A&E is not the right place to go. The regional crisis intervention service model provides an alternative to get them out of A&E quickly. Ideally, that model will ensure that they do not go to A&E at all, and, instead, ring an agency such as Lifeline or, if they are in touch with the Ambulance Service, be brought somewhere else and be treated by the C&V sector services that we talked about. There are those alternatives.

There are also the high-street cafe models, the well-being cafes and crisis cafes, which operate as places where people can go when they are in a state of distress or crisis or feel that they need support. Ideally, it is about identifying the signs that something is about to escalate and getting the support early. Those models operate really effectively in various parts of Northern Ireland, and they are staffed by clinicians and professionals who really know what they are doing and can help people. We need that across Northern Ireland, which is why the regional crisis intervention service that I keep banging on about is so important. The work has been done on it, and other places are using that model. There are evaluations from other places that we can use to say, "This works well, and here is how and why it works well". That is what I am advocating for. We have the solution for some of it.

**The Chairperson (Mr McCrossan):** Thank you.

**Mr Boylan:** Siobhán, you keep talking about the workforce: how do we retain the people we have? Secondly, how do we encourage or incentivise people to come into the sector?

**Professor O'Neill:** The staff whom I have engaged with — there have been so many — are there because they want to be there. The majority of them could go into the private sector and find jobs elsewhere, but they are there because they want to be there and they want to help people. Retaining the staff is about giving them hope that we will change the system and make things better. They know that the strategy is there, but, often, they just do not believe that anything can happen, even when they are shown the models. I try to be optimistic when the staff talk to me, but that is all we need to do. The

staff have stuck it out this far; they want to help people and they find the work really rewarding, because that is what they do. Otherwise, they would have left. When it comes to attracting people into the mental health workforce, psychologists and psychiatrists tell me that there is no shortage of applicants for the positions that they have. It is not necessarily about attracting people into the workforce. I know that people can go elsewhere and they do. It is about increasing the number of training places. I meet psychology students all the time and have conversations with them. They want to work as part of the mental health workforce in any way at all by which they can get into it. They are prepared to do that. They have the commitment, passion and motivation to help people. That is what they have chosen as their career. Let us expand the number of training places so that we can get more people into the workforce and do the job of reforming the system so that we can use the people whom we have, the skills that we are creating and the people who are already out there. There are counsellors who cannot apply for jobs within the system, for example. A lot of task shifting and work needs to be done to scope out who is there and who wants to be involved in getting them in. There is all of that.

It has been a real joy to watch reform start to happen in perinatal mental health services. That has given people hope and optimism. We are finally seeing services in every trust. We still need the mother-and-baby unit, but the fact that the services are there is a sign that things can change. That is our spark of light and hope. We need to light more little fires across mental health, as somebody said the other day, as evidence of the change that is happening and that we are able to create. It will take money to do that, but it will be money well spent.

**Mr Boylan:** Thank you.

**Ms Forsythe:** Thank you very much for being here, Siobhán. I really appreciate the chance to have expert evidence ahead of such an important inquiry.

I want to speak specifically about data and outcomes. Reviews have highlighted that there is a lack of data to monitor the service activity, especially for measuring service effectiveness and user outcomes. In your role, for which you report that you work towards:

> *"improving the mental health of everyone throughout all aspects of life",*

how do you measure improvements, given that lack of data?

**Professor O'Neill:** The GHQ is an important government survey, but we need to do more in-depth work. In 2019, there was the childhood prevalence study, which was the first epidemiological study of mental health conditions and risk factors across our children and young people. That was an important study, and then the pandemic happened; all the prevalence rates that we had for things such as ADHD, disordered eating and eating disorders, mental illness, anxiety disorders and all that stuff was in there. That is our in-depth stuff. What got me into this work was doing the Northern Ireland study of health and stress in 2005, in which we looked at the prevalence of trauma, depression, psychoses and all those things. We need more of those epidemiological prevalence studies, and the government surveys are also useful.

The difficulty that we have with getting data from the Department of Health is that the trusts all collect data and their definitions are different. Journalists come to us and say, "We can't make head nor tail of it. We have asked about waiting lists, but we don't know what counts as the time that somebody goes on the waiting list. Is that at referral?". It is messy. There is a lot of data. We have the Administrative Data Research Centre (ADRC), which works to link datasets, and there are a lot of academics who are interested in analysing the data. We need to bring it together better.

One thing that was identified as an action in the mental health strategy was to develop a regional outcomes framework, and we have created that. It has not been launched. I do not think that it is publicly available. However, the plan is to bring together all the data. I will read directly from the framework. There are three pillars. There is access: numbers and waiting times. That is about how many people out there have mental health problems, what the waiting times are and who is trying to access services. Then there is acceptability, which is about patients' experience of care. That is important. People go through their treatments and come out the other end. Particularly in CAMHS, some of the evidence says that about a third of patients feel that they are no better when discharged. That is not good enough. That is about how well mental health services did for them and whether their needs were met. They are on a journey to recovery, which is more complex than just getting a

treatment. That is in our regional outcomes framework. Then we have effectiveness and efficacy, and that is where you get your symptom-level changes or your treatments.

The regional outcomes framework is there, and we need to implement it. It will be costly. We are also waiting on the Encompass system being embedded across all the trusts, because you need those mechanisms to be working, but that regional outcomes framework is the answer to a lot of the difficulties that we have around data at the minute. We were told about this yesterday, and we asked the Department of Health yesterday for some up-to-date information. It came back to us straight away about expenditure, proportions and all that stuff. Good data is available, but we need that regional outcomes framework so that we get data across access, acceptability and effectiveness. That is where we need to be.

We need to do more of those prevalence studies as well to work out where we sit, and we need a follow-up for the children and young people's one at least, so that we can find out, because my sense is that things have got a lot worse and that there is a lot of hidden poor mental health that we are not capturing. We need to design a service that meets the needs of people on the ground.

**Ms Forsythe:** The framework certainly seems to be, on paper, an answer to the way forward, but it is not where we are, unfortunately. In your annual report for 2022-23, you talk about providing advice on improvements and performance with the Department of Health and the trusts. You talked about the complexity of the data. Are all the trusts collating and measuring their data in the same way?

**Professor O'Neill:** It is difficult to know. We get this. It mainly comes from journalists who do FOIs with the trusts, and they then come to us for us to explain the information. I am looking at it and asking, "What question did you ask that generated these figures?". It is then difficult to compare. We can go back then and ask, "How do you define this and what counts as that?". People are being sent to different trusts for treatment, and that makes it even more complex because there could be double counting in the system as well. I am not saying that the trusts are doing anything wrong here, but what we need is that regional mental health service and the regional outcomes framework to make sure that everybody is doing everything in the same way. We can then start to make those comparisons. The trusts use different models, so the services are not the same in all the trusts. You could have a long waiting list in one trust, but that might mean that it is grouping together various groups that are separated out in a different trust. It is a nightmare at the minute, but we have the plan to solve it.

**Ms Forsythe:** That makes it seem even worse than what I had imagined it to be, to be perfectly honest. It is good to get the feel for what you are actually dealing with here.

**Professor O'Neill:** That is the theme of everything here.

**Ms Forsythe:** It is really good to get that clarity about you as a professional user, as the mental health champion. As a professor in the field, you are finding it this complicated to be able to put the data together and compare.

**Professor O'Neill:** I will tell you about something that we have done and will be launching soon. We have just done a population survey in which we asked how many people have tried to access mental health services, how long they have waited and where they have gone. We have gone about it the other way. I do not have the figures in front of me because we need to do the tables. We are presenting that data. Nicole has been working really hard on that. We have tried to circumvent it and find out ourselves what it is like on the ground for people. That is the sort of data that will be really useful to us.

**Ms Forsythe:** That is brilliant, and it is great that you are taking that initiative.

**Dr Nicole Bond (Office of the Mental Health Champion):** To add to what has been said about the framework, there is also a subgroup that focused on data and outcomes, and we sit on that subgroup. I think that there are about 100 members at this stage, but there is a smaller working group as well. It includes the people who create those population-level surveys, academics, people with lived experience and people from the C&V sector. It is about trying to get everybody into one room to decide how you record your data and what you need. We are looking at it from a mental health perspective, and we want the outcomes in the framework to be for that. However, they were not set up to measure that. The health population surveys have a wider remit than that, so we are picking sections out of them. It is about trying to identify what is already there. There is quite a lot of data, but

its disjointedness makes it difficult to put it together. Work is being done to try to hone that in to identify which markers we will use at a population level and which markers at a practice service delivery level people should be incorporating into those reports so that the wider public can get that insight. It is scary, but a lot of work is being done to try to figure out how to streamline it.

**Ms Forsythe:** Absolutely. If you have a whole lot of data but it is not available for meaningful analysis, you are not really using it effectively at all. We are talking about measuring the effectiveness of outcomes. I was going to ask you about regional disparity, but it sounds as though we are not even in a position to recognise whether parts of Northern Ireland are worse than others because the data is incomparable, which is very concerning. As a representative of a rural constituency, I certainly get the feeling from my constituents that they experience even more significant barriers, but there is no data to back up that case. I was also going to ask whether we are able to benchmark our service delivery and outcomes against other areas, but, again, I feel that you have answered that question, and we cannot do that because of the quality of the data. Elsewhere in the report, we are benchmarking against other parts of these islands when it comes to how much money is spent in Northern Ireland on mental health, but it is challenging if we cannot benchmark the outcomes against anywhere else.

I am almost afraid to ask any more questions. Do you know whether any data is held or collected by the Department or the trusts about how many direct referrals they make to voluntary and community sector organisations?

**Dr Bond:** There might be data there, but, again, it is not consistent. We worked with the children and young people's strategy team that was set up. The Children's Services Co-operation Act 2015 states that resources should be pooled for services that relate to children and young people. Departments can share those resources and identify when referrals are made. The C&V sector is listed as one of those organisations, but, obviously, there are so many of them that knowing how they access that is difficult. Work was being done to see whether that function has ever been used and how it would be used. We know how much of the services are commissioned. There is core funding to go into it, but, as one of the members highlighted, some of the trusts are using C&V sector resources because they are quite strong in certain areas. They know that people will be seen quicker and will get more place-based support. It is not consistent. We do not have a way forward, but part of the plan is to map where those resources are.

**Ms Forsythe:** That is particularly the case in rural areas. When we faced the cliff edge last year, the trust had literally nowhere else to refer those patients to in certain parts of Northern Ireland other than to the voluntary and community sector. Thousands of people are sitting on that cliff edge, so it is important to capture it. Thank you very much for your evidence today. I really appreciate it. It is really important.

**The Chairperson (Mr McCrossan):** Diane's questions point to a real problem with mental health services generally. If we do not have data to measure the level of the problem, how can we help to find a solution? Why is the data so poor, Professor O'Neill? In this day and age, when we collate and analyse everything, why, specifically around mental health services, is the data so poor?

**Professor O'Neill:** As Nicole said, the data collection systems in each of the trusts were not designed to provide the sort of evidence that we are looking for. The surveys have not been commissioned. Government surveys give us the general level of need, but we do not have enough of the population prevalence surveys to go into detail about how many people out there have the various different conditions. We need to do a lot more. We need to invest in research. We need to create a single regional mental health service and implement the regional outcomes framework. In a regional model, the data would be collected in a consistent way using the same definitions, and it would be available. Encompass would allow that to happen. However, the trusts were, essentially, working in isolation and set up their own systems to capture data to meet their needs. That data is helpful to them; it helps them to understand what they are doing. That is the legacy that we are dealing with, but we have the plan to change that.

**Dr Bond:** It is not unique to here. The Office for National Statistics met us a few months ago. There was a review of how mental health information was collected in England, Scotland and Wales, which have different dashboards and things. A lot of work preceded that to look at what administrative data already existed and how you could glean information from different existing systems that were set up for different purposes. We are grappling with the same thing here. It is not about creating an entirely new recording system; it is about taking what we already know and funnelling it into our mental health outcomes so that it feeds both.

**The Chairperson (Mr McCrossan):** Thank you.

**Mr Gildernew:** My question is on the data situation. You touched on it, Professor O'Neill, and I will pick up on the point about the Encompass system. We know that it has been developed at a huge cost, potentially £300 million. It is being trialled in the South Eastern Trust. Will that system include mental health data that we can use? If yes, will that help and how soon? If not, is that a terrible mistake that we need to rectify quickly?

**Professor O'Neill:** Looking at the regional outcomes framework, I see that the implementation of the Epic IT system under Encompass provides the opportunity to do that. I am not across what is happening on the ground with Encompass. I met them in the early stages — in the first few weeks and months — and said, "This is happening, and we need to be able to do this". They received that message loud and clear, but a lot of it was already designed at that stage. That is something that we will check and find out. I may be naive in assuming that, obviously, that will be the case. It must be. We will certainly check that. It should though.

**Mr Gildernew:** The Department will be here next week.

**Professor O'Neill:** Then that is a question that they can answer, because they are across the whole system.

**The Chairperson (Mr McCrossan):** We hope.

**Mr Delargy:** Siobhán and Nicole, can you hear me OK?

**Professor O'Neill:** Yes, loud and clear.

**Mr Delargy:** Thank you. We are doing a huge body of work, through the all-party group on mental health, around early interventions. Unsurprisingly, therefore, I want to touch on that topic. You have both already done a huge body of work on it, but I am keen to ask two specific questions. First, do you think that, at the minute, the Department of Health is putting enough priority on prevention services?

**Professor O'Neill:** By prevention services, do you mean interventions at an earlier stage?

**Mr Delargy:** Yes.

**Professor O'Neill:** That is a difficult one. Statutory mental health services mainly deal with steps 3 and 4, which is the moderate to severe end of things. The community and voluntary sector works across the entirety of the steps, but a lot of the funding has dried up. The C&V sector would have delivered a lot of the preventative work, and the funding streams have run out. The Department of Health will say that the one-year funding is the barrier there: where you do not have a three-year budget, you cannot provide three-year funding for the C&V sector organisations.

We had the mental health fund, but, again, the money has run out. That fund was about providing interventions to address the impact of the pandemic on mental health. It was a one-off pot of money, but, unfortunately, many C&V sector organisations were relying on that for their survival, and the money has now stopped. We have a problem. Investment in the community and voluntary sector is an issue. There is a finite pot of money, and, for the higher level and more severe mental illness, the statutory services are costly and are sucking up a lot of the money.

We need to be doing the earlier intervention. The work that is happening in schools is impressive. We just need to make sure that it happens in all schools. There are emotional well-being teams in schools. Health professionals from the Department of Health are working with schools to create an all-school approach to well-being and to work out what unique things are needed in each school to make things better. That is an example of good practice, and there is lots of work happening in communities, through those community structures, that we do not hear enough about.

In answer to your question, Pádraig, I am concerned about the C&V sector funding.

**Mr Delargy:** Thanks, Siobhán. Schools will do their own thing and will run different programmes, but we in the all-party group on mental health have found that there clearly needs to be a basic provision and a bare minimum of exactly what schools need to do. Some schools are leading the way. All

schools are trying their best in difficult circumstances, but we need to establish a baseline for what schools need to do.

My second question is on how that can be measured. I do not want to speak for other members, but I think that there is agreement across the room that early intervention is vital. How do we measure that? In the longer term, health outcomes will be seen over 10, 15 or 20 years, but how do we make sure that they are measurable in the short term? Do we use certain models? If we do it through schools, how do we measure that? One of the things that the Committee looks at is making sure that things are done as well as possible as we go along, rather than getting to an end stage before finding that something did or did not work. I am keen that we go through that process and evaluate as we go along. I am keen to hear your thoughts and any suggestions on how we measure that, quantitatively and qualitatively.

**Professor O'Neill:** In my view — paediatricians say this as well — we need child health records from birth right through. If we want to catch 50% of children by the age of 14, we need to measure health outcomes regularly. We need to look at the whole child; it is about their physical health and relationships as well. It is really important that we do that. The work of health visitors is fundamental to that, but we see cuts there: children are not getting face-to-face assessments when they are toddlers. That work is really important. There are key things that we can look for across childhood.

We do it well in the first three years; I know that, having gone through it as a mummy myself. The data is collected. There is that sort of oversight, but it falls off. There are opportunities in the education system to do it and do it well. We should be measuring child health outcomes at intervals, so that we can intervene early. We should also be vigilant in schools for signs of problems and get a link between education and health. Links are being developed, which is really good, but there is no substitute for measuring and recording health outcomes as we go. It will make a huge difference, because we will then be able to benchmark against other regions. We will have all the physical health stuff as well.

**Mr Delargy:** That is great —

**Professor O'Neill:** May Nicole come in on that as well? Sorry, Pádraig.

**Dr Bond:** You have heard me talk about this before. Continual evaluation processes have been built into the framework for schools. Two consultations are going on at the minute. One is asking schools what services they use, and the second is asking the C&V sector which services it provides to schools, in order to get a benchmark. The services that are set up in the emotional health and well-being framework are routinely monitored. They are asked how many young people they are reaching and whether there is satisfaction with the delivery of the service. The caveat is that a lot of those services are very young. Staff are only just in place. There were recruitment issues, again, because of budgeting concerns. That process is continual, however, and should be continual throughout the life of that framework, which is funded by DE and DOH.

Processes such as that, at a programme level, can tell you whether a service is value for money, whether people are using it and how it looks at a wider regional level. It is a regional framework, but they are departmental reports, which are put out so that people can see where the money is being spent on early intervention and prevention in the school setting. The question is whether we can use that framework in other settings. Again, that depends on the type of intervention that you are looking at and where your markers would be.

**Mr Delargy:** That is really useful. Thank you both for your answers and for your ongoing work.

**Ms Brownlee:** It has been fantastic to hear all this; thank you so much. A recent report suggested that access to early intervention in schools is variable. I am cautious about data — you may not have the information — but how widespread are those problems?

**Professor O'Neill:** In access to mental health services? The answer is that it is impossible to know. Parents, however, are saying that they cannot get help for their children or access to child and adolescent mental health services within the time limits. There are long waiting times, or they do not meet the criteria for CAMHS, so they do not fit in the boxes in the system. Parents will, then, go to other services in the community and voluntary sector — maybe not the right services, but they are getting something where they pay for support themselves or go to a private service. It is very difficult to know just what the state of play is.

We have been in receipt of the CAMHS data set from the Department of Health, because all of the data is collated there. Nicole is working on that, and we have looked at it together. There does not seem to be an increase in the waiting times for CAMHS generally: they remain too high, but there has not been an increase over the last couple of years, and they have remained stable.

The reports can be very concerning. We were talking to the Belfast Trust about its experiences with eating disorders. For the more serious cases needing hospitalisation, the change is very worrying, but we do not have the data for the other trusts, so it is hard to know.

**Ms Brownlee:** I am just thinking about school settings. Is there a way in which you can see the Department of Health and the Department of Education working better to deliver these services?

**Dr Bond:** If we look at the CAMHS data set, we see that, primarily, the majority of referrals to CAMHS come from GPs. When we speak to schools, their opinion is that they cannot refer to CAMHS but can identify when there is an issue that they cannot deal with. We cannot put that through, but we advise them to go through a GP and the medical route.

The team that produces that CAMHS data set will tell you that you can have a referral through education. I do not know whether you have ever seen a referral to CAMHS: it is time-intensive, and our teachers are under a lot of stress and have a lot of demands on their time. It is about figuring out a process whereby they can communicate better, and I know that the well-being in schools team having that link with the Department of Health, and with health professionals on the ground on the campus, enables those conversations to happen more fluently.

If it is the case that a young person has an issue, is definitely in crisis and is experiencing distress, CAMHS might tell you that it is not at a clinical level at which they should intervene. The school and that young person are still in a position where, if they cannot find support in their local community, or if they are in a rural area that is not well serviced or where local supports have lost funding recently and services have closed, they really are in a position where the school does not know what it can or cannot do. They often fear doing the wrong thing, as we all do with mental health. However, having that relationship with the health professionals means that you can have those conversations.

You should understand that teachers are very skilled. They deal with young people day and daily. They know how to support them, and they know when there is an issue. When it comes to mental health or anything health-related, however, they need that assurance from a health professional that their approach is OK and that they can support that child in their educational environment until such times as a service becomes available. If it is a case requiring clinical care, teachers want that clearly identified early on so that they are not left in a grey area where, as professionals, they do not understand whether they have done enough, the fear being that they have not. It is about those relationships and how they work, but there is positive movement in that. Where it works, it really works well.

**Ms Brownlee:** I appreciate that. You gave a fantastic presentation when reporting to an Education Committee meeting. You highlighted SEN provision and support, which is a huge issue. A particularly vulnerable group of people is not getting the support that it needs. I wanted to get your opinion on that. How can we move forward, and what is being done to support children with SEN and mental illness?

**Professor O'Neill:** It is important to say that the support that we give to children in education settings improves their mental health, because it is about emotional regulation and making sure that they are content and that the environment is not overstimulating and is meeting their needs. That is really what it is about. By providing educational support, you are supporting their mental health. The delays in getting the assessments and the lack of services, particularly around autism and ADHD, and the lack of awareness of neurodiversity generally, are a real problem too. We need to raise awareness across the education system, but we need more specialists because there is an increase in the numbers of children with those conditions.

Those children can be in mainstream education, of course, and they should be part of school communities. It is just that their needs need to be met, and, if they are, they will not develop mental illness. We are not talking about children who are mentally ill. Often, we are talking about neurodivergent children who need support so that they do not become mentally ill. When they become mentally ill, however, we do not have mental health services that meet their needs. I have had parents say to me, "My child has autism. Therefore, they can't get treatment, because the trust is saying, 'We

don't have anybody here who specialises in autism and in treating autistic people who have a mental health problem'". We do not have that expertise, and that is the difficulty that we are seeing.

If we expand the mental health workforce, we will have more people equipped to meet the needs of autistic people who have a mental illness or someone with ADHD who may be at risk of having a mental illness or who needs medication to manage their ADHD. There is a lot of work that needs to be done there. In the meantime, the rates are going up, and we do not know why. There are various theories, but we need to meet the needs of those young people so that they do not miss out on key years of their education.

**The Chairperson (Mr McCrossan):** Supporting children's mental health involves multiple Departments. Is there sufficient cooperation on that between, for instance, the Education, Justice and Communities Departments? Is there any evidence that the requirements of the Children's Services Co-operation Act 2015 are being met?

**Professor O'Neill:** I will start but then quickly pass you on to our expert on the Children's Services Co-operation Act.

Is enough being done? The framework was a game changer. We have Health and Education working together. I sit on steering committees where we have Health, Education and Justice sitting together, whether it is crisis services or children and young people. Whatever it is in the education framework, they are there, motivated and engaged and part of the decision-making process, so that does happen.

However, Education is clear that its goals are about education. When we are talking to Education officials about outcomes, they are thinking about qualifications as outcomes, and the mental health piece is different. Health is about treating mental illness. The piece in the middle is well-being. What is it? Where does it fit? That is why I am talking about a Programme for Government that really focuses on that. There is so much in Communities, such as housing, that is vital to mental health and well-being.

Departments work together, but, when it comes to budgets, they like to stay in lane because they cannot spend on something that is not an outcome, and that is fair enough. I totally get that, but it makes life more difficult when you are trying to fund something such as the framework. It cannot be a mental health outcome, because it is not about treating mental illness, but there is mental health in it, and it is funded through both Departments.

I worry when you have a situation where the budgets are limited. Departments will move back into their lanes and look at their outcomes and at what, strictly speaking, they have to deliver. That is a problem. It is also a problem with Justice, but Justice delivers a lot of mental health treatments that it feels that Health should pay for. However, Justice is delivering them because the needs there are huge. The majority of people in the care of the justice system, particularly in prison, have significant mental health problems resulting from trauma. That is what Justice is dealing with, and it pays for that through its budget.

**The Chairperson (Mr McCrossan):** Is it safe to say that the silo mentality of Departments is resulting in the requirements of the Children's Services Co-operation Act 2015 not being met?

**Dr Bond:** The legislation has incredible potential because it is cross-departmental, and it has that action whereby, for funding, it does not necessarily mean that the Department of Health does this project, the Department of Education does that project, and people stay in their lanes and have their own outcomes. It gives the legislative power to pool resources and ask, "What do our children and young people need? What services do we need to surround them with to meet that need? This is the joint pool of money that can accommodate that". The last time that our Executive sat, there was to be a report, but, obviously, in the interim, there was instability, and that was never produced. It would have looked at how often that power was utilised, how it functions through our Finance Department and whether there are mechanisms in place to facilitate that in a larger capacity.

Again, without that information, we do not know. It will be a unique document and has not been done before, so it might require specific procedures to be put in place — not extra money to do it, but a specific process of how you would go about sharing it so that it has departmental oversight from lots of different Departments. None of them could claim separate projects within it, if you know what I mean.

**The Chairperson (Mr McCrossan):** This Act is specifically to meet the needs of children, and I understand that. Multiple aspects of life can affect the child's mental health. However, if a child's mental health is poor as a result, for instance, of the cost-of-living crisis or deprivation, they will not perform well in school. So, that impacts on the output of education in schools. Really, if this Act is not being adhered to or its requirements met, the outcomes fail everywhere, so the cost of that is significant. That is my point.

**Dr Bond:** I note that the Department of Health, in its budget plan — it is the first time that I have seen it, although I have been in this position for only a number of years, so it may have been there before — has a detail that budgets might change if there are any demands on it from the Children's Services Co-operation Act and that pooling of resources. The acknowledgement is there that it can be used. I am not sure to what level it has already been used.

**The Chairperson (Mr McCrossan):** That is helpful, thank you. We go to Colm, John and then Cheryl.

**Mr Gildernew:** Our work here is nearly done

**A Member:** Go round the table again.

**The Chairperson (Mr McCrossan):** There is only Colm left.

**Mr Gildernew:** I want to build on your question, Chair, on work between Departments: are we doing enough between Departments? I go back to the Audit Office report, which identifies that one in six young people exhibits indications of an eating disorder. In relation to that type of service or need, are we working closely and cooperatively enough across the island? Months ago, I became aware that there was not a single inpatient bed for a young person with an eating disorder in the North. However, I became aware that there was some capacity in the South. Could we be cooperating better, and do we need to do so in some of these specialist services on an all-island basis?

**Professor O'Neill:** Yes, we could and need to cooperate better. It is the only way in which we can maximise what we have to benefit everybody. It is essential. I have regular engagement with Minister Butler, who is responsible for mental health in the South. We do this. The Shared Island unit is funding work: it is doing a digital mental health piece that I am involved with and leading on. That is looking at digital interventions on both sides of the border for young people, and officials are doing the work together. If you look at the two strategies, you see that the South's Sharing the Vision and our mental health strategy are similar. There is the potential for that working and, indeed, levering in funding. A lot of the PEACE PLUS moneys will, effectively, fund health interventions, mental health interventions and early intervention.

I sit on the monitoring committee and have advised on the direction of those projects. Yes, we are working cooperatively, and we need to do a lot more of it. We need to work smarter here to make sure that we have the services, particularly for conditions of low prevalence that need special services.

For eating disorders, it is good for the person to be located close to their family. The Maudsley model is the one we should be implementing, and that is, first of all, about nutrition. You stabilise the person's nutrition, and they may require a hospital bed for that, not in an eating disorder unit but just to get their weight back up. However, it is so important that you work with the families. You would not want people to travel too far for those inpatient services. Equally, we discussed this in relation to the mother-and-baby unit. Again, there are conditions where people need to be close to home and their families. It is a tricky one. We need to look at what we can do. I am having the conversations. You are pushing at an open door there with Minister Butler and the Government in the Republic. Let us get more of that, if we can.

**The Chairperson (Mr McCrossan):** OK. Members, are there any other questions?

**Mr Stewart:** It has been really useful, Chair.

**The Chairperson (Mr McCrossan):** You have been extremely patient. We really appreciate your being here and taking our questions. Is there anything else that we have not raised with you that you would like to raise with us?

**Professor O'Neill:** No. The only thing is that the rate of psychiatry vacancies is actually worse than 16·4%. The true consultant vacancy rate is 24·6%. That includes locum and vacant consultant posts. We will send you that data, but the 16·4% there is an underestimate. In psychology, there is a 30% vacancy rate. That is what we are dealing with. That is the only thing that I wanted to clarify. There is a lot there. I am happy to take questions as you go through your inquiry. Other things will come up, and you may want to ask our perspective on them. We can give you our view on those as well. Please, feel free to do that. It is really important that you are doing this work, and we are really happy and keen to be involved in shaping it.

**The Chairperson (Mr McCrossan):** Do you think that we are in a mental health crisis?

**Professor O'Neill:** I do not use the word "crisis", because I think that it creates more hopelessness and a sense of distress. When you look at the proportions, you see that they are similar to those of other regions. Things have got worse in the past number of years in those other regions as well. We have significant unmet need, the cost of which is £3·4 billion annually. That is preventable cost. It is preventable suffering. Suicides are preventable. We have 200 deaths every year. It is costing us £1·5 million. We are putting £10 million into our suicide prevention strategy. That is just not good enough. Whilst I do not use the word "crisis", it is just appalling that we are still in this situation when we have been talking about it for so long. I have been talking about it for so long as an academic. We have the plan, but we are not implementing it. That is just such a shame.

People have invested in that plan. People with mental illness who have had significant suffering and trauma in their lives have come and helped us to develop it. Community and voluntary sector services have worked and taken time out unpaid to develop it, and it is not being implemented fast enough because we cannot spend the money. We know that we will get that money back. There are few other areas where I can see the clear economic argument. When I listen to the radio, people are talking about spending on this and that. The economic argument for this is really strong, but we are not doing it. With children, we cannot buy that time back, so we need to do this, and we will get that investment back. We will see the difference in the economy.

**Ms Forsythe:** You referred a number of times to the regional outcomes framework for Northern Ireland. Is that a published document? I would like to have a copy of it to hand, whether it comes from you or the Department of Health. It would be good to get it —.

**Professor O'Neill:** I got my copy because I am part of the group that developed it.

**Ms Forsythe:** OK.

**Professor O'Neill:** I do not know whether it has been finalised or signed off. I am working from the last draft. That group produced it, but, of course, these things need to be scrutinised by a Minister and signed off. I do not know whether that has happened just yet. If it has, we will send it to you. We will keep a note of that. I can update you then on implementation as well. We will ask this question again. The document that I got was the last version of it.

**The Chairperson (Mr McCrossan):** Does the C&AG have any questions for Professor O'Neill?

**Ms Dorinnia Carville (Northern Ireland Audit Office):** No.

**The Chairperson (Mr McCrossan):** OK. Thank you.

Professor O'Neill, that was an extremely powerful contribution and a deep insight into a lot of the challenges that society faces. It is a hugely important inquiry that we are about to undertake. The evidence session today will have informed members of the reality. It has also put real focus on the solutions that are there, which I found really fascinating, and the fact that the Assembly and Departments need to take them up and implement them in people's interests. We appreciate that very much.

Does the TOA have any comments?

**Mr Stuart Stevenson (Department of Finance):** I have just have a couple of brief observations. From a finance perspective, this has been a helpful session, and I commend the witnesses and the Committee for that. From a financial perspective, a huge amount of energy and effort, of which

members of the Finance Committee will be aware, is going into the work on the 2024-25 Budget, but also into the longer-term sustainability piece. The Audit Office report and the witnesses' comments today have provided clear evidence to help to make a compelling argument for the funding need. That has been helpful as well.

The comments about multi-year Budgets were also helpful from a DOF perspective. In many respects, that is outside our control, but it is important to make the point about the importance of delivering on strategies; that is not lost on us. We cannot lose track of the impassioned comments around the potential savings, given the issue around sustainability. I think that there was a comment about the invest-to-save initiative, and this issue fits exactly into that agenda. That is an important takeaway for the Department of Finance as well.

The comments about the funding model for the mental health champion's office were also interesting. Given the likelihood of funding gaps as we move forward, it will be interesting to hear the Department's comments on that model next week and to see whether there is any potential for using that to help to eliminate the gap.

Those are the key takeaways for me.

**The Chairperson (Mr McCrossan):** Thank you, and thanks again to Professor O'Neill. Is there anything that you want to respond to?

**Professor O'Neill:** No. The £13 million on antidepressants is the cost that can be reduced. People say that they want psychological therapies: they want therapies, counselling and alternative interventions. There is research that shows that there are other models and that those are treatable illnesses. We need to do the work.

**The Chairperson (Mr McCrossan):** Thank you very much. Thank you for the important role that you play as a powerful voice and advocate for all those out there who battle every day and who seek that help and support. It is important that the Committee reassure the public that help is out there and that it is just about finding the right route to get that support.

Thanks to you, too, Nicole. We appreciate you both being here. This has been very informative and extremely helpful, and it has set us on a solid foundation for the inquiry that will begin next week. This is a huge issue for all people and all families across Northern Ireland. They will be happy to see the inquiry begin and will look forward to the outcome and the publication of the report on 20 June, which is the date that we are aiming for.

Thank you again, Professor O'Neill, and thank you, Nicole Bond, for being with us.

**Professor O'Neill:** Thank you.