HOUSE OF COMMONS

Northern Ireland Affairs Committee

Oral evidence: Funding Priorities for 2018-19 Budget: Health, HC 1447

Wednesday 12 December 2018

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Watch the meeting

Members present: Dr Andrew Murrison (Chair); Mr Gregory Campbell; Maria Caulfield; Robert Goodwill; John Grogan; Lady Hermon; Nigel Mills; Ian Paisley.

Questions 265 - 311

Witnesses

I: David Babington, Chief Executive, Action Mental Health; Dr Gerry Lynch, Chair, Royal College of Psychiatrists in Northern Ireland and Vice-President, Royal College of Psychiatrists; Professor Peter McBride, Chief Executive, Inspire; Professor Nichola Rooney, Chair, British Psychological Society Northern Ireland.

Written evidence from witnesses:

- Action Mental Health
- Inspire

Examination of Witnesses

Witnesses: David Babington, Dr Gerry Lynch, Professor Peter McBride and Professor Nichola Rooney.

Q265 **Chair:** Good morning. Welcome to the Northern Ireland Affairs Select Committee and thank you for coming to see us today. As you will know, this Committee does not normally involve itself in matters to do with public policy in Northern Ireland because those matters are devolved. Things being what they are, we have interpreted our remit broadly and therefore are looking into health and education, in particular, in Northern Ireland at the moment. We will be producing reports on those subjects. I invite you to give us a very, very small pen picture of who you are and the main issues you think ought to bear upon our thinking as we compose our report on this important matter.

Dr Lynch: Thanks for the invitation. I am Dr Gerry Lynch. I am a consultant psychiatrist. I work in the Northern Health and Social Care Trust. I am also chair of the Northern Ireland division of the Royal College of Psychiatrists and vice-president of the Royal College of Psychiatrists in the UK. I have been working as a consultant psychiatrist since 1994 and I have seen a lot of good developments over the past number of years. The main issues are the lack of parity of esteem for mental health services, a relative underfunding of mental health services compared to acute services and the lack of a strategic direction for how we develop mental health services in future. Another issue is the mental capacity legislation, which is as yet not enacted, although it has been passed into statute.

Professor Rooney: Morning. Thank you for the invitation. I am here in my capacity as the chair of the Northern Ireland branch of the British Psychological Society. I am a clinical psychologist by background and I have worked in the health service for my whole career. I am also a non-executive director of the Public Health Agency and a professional adviser to RQIA, but my role here today is really around psychological therapies and psychological interventions. It will not be surprising to you that my concern is largely with access to psychological interventions. The British Psychological Society is the professional body for the family of psychology. As well as clinical psychology, we cover educational, forensic, occupational, counselling and academic psychology. For every version of psychology, this would be the professional body.

We have an opportunity to think across the lifespan and across services. Access to evidence-based psychological interventions generally is our concern. Within Northern Ireland, we have poorly developed psychological therapies. We have a psychological therapies strategy, which was launched in 2010 but has not been fully implemented. Compared to England, we have underfunding in relation to clinical psychology training numbers and posts. Not only does that affect the

delivery of psychological therapies by psychologists, but psychologists have an important governance and training role for other professions, so it has an impact there. That is the particular focus I will talk about today, with a particular interest also in children's mental health and in schools.

David Babington: Good morning. Thank you very much for the invitation. My position is as Action Mental Health chief executive. I have been in that post for eight years. Prior to that, I worked in the private sector. Action Mental Health is a local charity in Northern Ireland. This is our 55th anniversary. We have stayed true to our roots. We were started in Downpatrick as a recovery organisation helping people move out of institutions. We are very much a recovery organisation from our history. We have moved in recent years up to being more involved in resilience. We are now operating in a number of schools—about 150 this year—and we are doing a lot of outreach to the wider community, and building support and strategies to help them deal with the issues of mental health and wellbeing. We should be reaching about 30,000 this year.

In terms of today, we are very concerned about all the issues mentioned before, but particularly the prioritisation of mental health. Action Mental Health leads a consortium of eight other mental health charities in Northern Ireland, called Together For You. We have been lobbying very hard to make sure that mental health is prioritised. It is known as a Cinderella service, and no doubt we will be talking about this. One thing we have been promoting particularly is a mental health champion, making sure mental health has its rightful place and there is parity of esteem between mental health and physical health.

Professor McBride: Good morning. I am Peter McBride. Thank you again for the invitation to be here. I am the chief executive of Inspire. Inspire, like David's organisation, is a community-based organisation providing services for people with mental health problems. We also provide services for people with learning disabilities and addiction services, as well as workplace wellbeing services. I am also the chair of the Northern Ireland Council for Voluntary Action, a representative body for the voluntary sector in Northern Ireland. My concerns today are based on an analysis of the mental health situation in Northern Ireland, which is that there is differential prevalence. People in Northern Ireland experience 25% more mental health problems than people in England. There is a disproportionate burden on Northern Ireland in terms of mental health.

My organisation is a voluntary-sector organisation that provides community-based services. One of the simple things I would like to talk about today is that we are thinking about how to invert the pyramid on this at the moment. A lot of funding is focused on acute services, whereas a focus on prevention and support for people in the community as a way of helping people not end up in acute services—so prevention and mental health promotion—is a really important economic factor, apart from anything else, in the delivery of services.

There are three main anxieties that I have. The first is the absence of a mental health strategy. I think we are the only part of the UK that does not have a mental health strategy that we are all working to. The second is funding, obviously. Funding in Northern Ireland per capita for mental health is lower than the rest of the UK. We end up spending between 5% and 8% of our health budget on mental health services, compared to 12% or 13% in the rest of the UK. Lastly, and I would argue equally importantly, we face a serious workforce crisis in social care. The social care sector, which is providing a lot of that preventive work in the community, is really struggling to encourage people to work in it, to pay them properly and to value them properly.

Q266 **Chair:** The uniqueness of Northern Ireland is something we are particularly interested in on this Committee, for we are the Northern Ireland Affairs Select Committee. One thing that strikes one about Northern Ireland is the burden of mental ill health, which you have cited and which is unusual in many respects. You have all mentioned funding and, in various ways, parity of esteem. Dr Lynch, you began your remarks by stating that there is not yet that parity, and there is a big difference in funding in particular between mental health and physical health. Politicians here are very keen on articulating their desire to close the gap, but I am always left trying to work out how we will know when we have reached the point at which that gap has been closed. Do you think we will know when we have reached that point, and how far off are we?

Dr Lynch: One way of looking at that is to think about the overall burden that mental illness has on the general health of the population. WHO figures would say that 24% to 25% of the total morbidity in the population is because of mental health problems. A simplistic way of looking at that is to suggest that we should have that amount of money going towards mental health. I do not accept that we can read across like that, but I see an investment in mental health services as improving the overall wellbeing of the population.

For example, one issue of particular concern to us is the lower life expectancy of people who have severe and enduring mental illness. This is a problem throughout the UK, as you know. One way to measure an improvement might be to see whether the gap between the life expectancy of those with mental health problems and those without has improved or is at least improving. That would be one measurement. The other measurements would be a reduction in presentations with self-harm, a reduction in the suicide rate and an overall improvement in the mental health of those who have chronic physical conditions. I would see those as the main ways of trying to measure it.

Professor Rooney: When we are thinking of outcomes, we live in an age where we want immediate improvement and response. The outcomes we are talking about need long-term strategies. There is a wealth of information now about the impact of adverse childhood experiences. As

psychologists and mental health practitioners, we have been very aware of their impact on mental ill health in terms of suicide levels, drug misuse, early pregnancy and all the measures we have for poor mental health outcomes. We are much more acutely aware now of the impact on physical health, such as the increased likelihood of developing cardiovascular disease and cancer.

In a way, we need to implement strategies early and have early intervention to see long-term outcomes, and we need to be patient with that, but there needs to be a long-term strategy. We may need to put money in from some departments that will benefit others in the long-term. We need to be realistic about having a long-term view. It is not going to be a quick fix to simply put money into mental health and think we are going to solve the problems of health inequalities. It has to be a long-term view.

David Babington: In terms of achieving parity, as an organisation and, indeed, within Together For You, we have benchmarked ourselves against the other devolved nations—Scotland and Wales—as well as England and Ireland, to see what they are doing. There, you can see there is energy, passion and an aspiration to achieve parity. That comes from having the political will, the strategy and, clearly, the resources in place. In Northern Ireland, we are on a downward trajectory in terms of budget. It has been falling for mental health, as a proportion of the overall health budget, down to 6%. In all the other devolved nations it is going up and they have recognised that. Even across the border in Ireland, they have now made a commitment to get to somewhere like 10%. In terms of achieving parity, there are a whole range of benchmarks and outcomes, and we can look at figures, but political will is needed to make sure we achieve more and get closer to that parity.

Q267 **Chair:** I am no further forward on my original point, which is how we know financially when we are at a sweet point in the balance between physical and mental health. An intermediate outcome might very well be at least approximating the increases in neighbouring jurisdictions and parts of the United Kingdom. We are slipping back in Northern Ireland. That is what you are saying.

David Babington: Effectively, yes, but that is against the fact that Northern Ireland's prevalence of mental health is greater than any of the neighbouring devolved nations, to put that in context.

Professor McBride: A good starting point would be equality: an equal proportion for Northern Ireland in terms of mental health services, and divided up as it is in the rest of the UK. The measurements on this are difficult. It is easier to measure acute services and the number of people who take up hospital beds. Mental illness by its nature is a progressive illness. People will start with symptoms of malaise, minor depression, which then can escalate. The challenging thing is how you capture the information at the early stages. I get feedback from our service users on issues like waiting lists for GPs or waiting for access to psychological

therapies. There is a significant challenge in getting early intervention with people to stop the progression of the illness and allow them to get support in the community so they do not end up using expensive acute services. That is very difficult to measure. It is much more difficult to measure than hospital beds, yet it is one of the most significant things that would reduce the financial burden of mental illness on the country.

Dr Lynch: In the UK, the Royal College of Psychiatrists is aspiring to a proportion of 13% of the health budget going on mental health services. In Northern Ireland, we often read about UK or GB-wide initiatives such as have been announced in England, but there is no read-across then. When you see the Health Secretary announcing increased expenditure, say on mental health triage or mental health crisis services, there is often an expectation that that will read across to Northern Ireland, but because of the way things work, in terms of Barnett consequentials, while the money may come to Northern Ireland, it does not mean that expenditure will be on the same services.

Q268 **Ian Paisley:** Thank you for coming in and giving us your views today. In terms of the overall direction of mental health services as set out in the Bamford review, are we all on the same page on that matter? Do you have concerns or do you disagree with any elements of where Bamford is?

Professor McBride: The original ambition of Bamford, which has been reflected in Bengoa—there have been various iterations of this since Bamford—was the ambition for what Bengoa now describes as a shift left: the enhancement of community-based services, services in people's own homes, as I said before, to help prevent them ending up in acute services. My answer to that is no; we have not achieved that. There have been significant hurdles in the way of seeing that transition and the development of community support so that acute services are not overburdened.

David Babington: Bamford was remarkable. The prioritisation of mental health and learning disability that it set down was absolutely right. The institutions were not completely emptied, but they were nearly emptied. Most people are now out in the community, but the support of the community was not there. The big thing is the cultural change. People were talking about mental health. People were saying, "Yes, we are going to do this", but unfortunately since then it has drifted. We have already talked about how there is no strategy in place to make sure it is really thought through in the long-term. Bamford was great.

We are talking about all the problems in the system. There are many, many people out there, day to day, in the mental health sector doing amazing jobs—social care workers, CPNs and all the trusts, which we interact with on a daily basis. Given all the problems we have talked about, it is remarkable that they achieve what they do.

Professor Rooney: Yes, absolutely. Bamford had its time. It raised the issue of psychological therapies, access to them, implementing the NICE guidelines and the shift to the community. We have not had the publication of the review of Bamford and we await that. It is certainly time now to look to the future. Sometimes we focus on mental illness as a deficit model. It is time to focus on promoting resilience, a population approach to coping and to wellbeing, rather than pathologising what is sometimes a normal response to very difficult situations. That would be my aim to move forward: that we have a wellbeing approach and some leadership around that area.

Q269 **Ian Paisley:** That costs money, as you have already identified.

Dr Lynch: The Bamford review process began in 2002. It needs to be refreshed. As Nicky has said, the evaluation report has not as yet been published. The time has come to build on Bamford and its many achievements. There are some things that Bamford has not achieved: improving access to specialist services and psychological therapies, for example. They were all there as part of Bamford. We would like to see the publication of the evaluation report and develop, in a way, a strategy similar to the one they have in Scotland or, in England, the five-year forward view, which builds on Bamford but refreshes it and looks forward, because, as I say, the strategy for Bamford began as far back as 2002.

Q270 **Ian Paisley:** It is a huge agenda, obviously. If, for some reason, let us say, an extra £50 million was delivered to this sector of health care, to mental health needs, how would you allocate that to make the difference or to start to make the difference?

Professor Rooney: I would start with early intervention. We know enough now to know that we will always be on the back foot if we are just looking at outcomes further down the line. On infant mental health, the perinatal mental health strategy has to be implemented, which needs ministerial sign off. Better access to psychological therapies is required. Intervening early will have a greater bang for the buck. That has been proven by economists and research.

Professor McBride: I agree with Nichola on early intervention, but also early intervention in the sense of intervening early when adults start to present with mental health problems. This means increasing access to psychological therapies, allowing people at a very early stage in their experience of illness to get help and support. There is lots of evidence to show that the longer it takes for them to get access to someone to help them, the more likely it is that they will become more unwell and end up needing to use acute services. With children and young people, there is lots of emerging evidence to show that if you intervene early it helps prevent the disease developing into adult life, but early intervention with adults who are presenting is also important.

Q271 **Ian Paisley:** Have you made any calculation on what the additional £50 million would do? We are talking about additional money that has actually

been secured for this. What would it do to address this parity gap of 5% spending in Northern Ireland versus 12%, I think you said, in the rest of the UK? Is it a drop in the ocean or will it make a significant difference?

David Babington: When you talk about the £50 million, you are talking about the confidence and supply money?

Ian Paisley: Yes.

David Babington: That is £10 million every year for five years and, from what we have seen so far, the vast majority of it is going to inescapable pressures. It is not going to anything new. We talk about new money and new resources. Before we start talking about new projects, doing new things and going off in different directions, we need to get the day-to-day job right. I speak to colleagues in the third sector and the statutory sector, and interact with community mental health teams on a daily basis.

Q272 **Ian Paisley:** Sorry, are you consulted on that spend? Do you get any say? Do you give any professional direction or anything?

David Babington: No. The first I saw of it was in the public domain, on BBC News; that is when I knew this was where it had gone. Since then, I have been on the Department of Health's mental health plan project board. There, very helpfully, officials have told me more details of exactly where it has gone. There has been £10 million spent this year. There will be £10 million next year. It may not be spent on the same thing next year. They are all stop gaps. There is no recurrent funding. When you talk about extra money or new money coming in, it needs to be recurrent funding. It needs to be thought through. We need to get the day job done properly now before we start going off in new directions.

Professor McBride: In the absence of a mental health strategy, it is very hard to create a narrative around why that money should not be spent on what is easily presented as a critical situation in the acute sector. As David said, most of that money went into acute services. Very little came into prevention, mental health promotion or community-based support because there is an immediate crisis in acute services, whereas the benefit of the kind of services we offer we see two, three, four years down the line.

Professor Rooney: I agree. The non-recurrent nature makes it very difficult to use this money in a way that is transformative. Even in terms of training, there are very few programmes that train people in less than a year that would make substantial changes. A lot of money has gone towards cost pressures for previous ministerial agreements, but there is very little opportunity for innovation and change. One is always conscious of the need to spend the money wisely and not just spend the money. The non-recurrent nature makes it very difficult.

Dr Lynch: We have talked a bit about the underfunding of mental health services but, within mental health, there is a relative underspend in child

and adolescent mental health services. If there were to be recurrent money, I would like to see an expansion in child and adolescent mental health services and in early intervention for those with serious injury and mental illness. For example, in England, Scotland and Wales, there are early intervention psychosis services. Our services are very limited in that regard and for perinatal mental health. That is where I would see the money spent but it needs to be, as Peter said, recurrent expenditure.

Ian Paisley: That is fascinating. Thank you very much.

Q273 **John Grogan:** You have already mentioned suicide rates, which are pretty high in Northern Ireland. What are the factors behind that and what could be done?

Dr Lynch: It is really very distressing. The issue is that they are the highest suicide rates in the UK, in these islands. It is hard to say because there is a bit of lag in the collection of figures, but they are probably increasing, rather than decreasing as they are in GB. It is very difficult to determine the causes for that. It is a very complex phenomenon. Siobhan O'Neill, a colleague from University of Ulster, has done research into the transgenerational effect of the Troubles, the conflict and how it can be passed on from generation to generation. We have higher rates of substance misuse compared to other countries. The National Confidential Inquiry has pointed out that that may be a factor in the high rates of suicide.

As you know, the Protect Life 2 strategy has not yet been fully implemented. We are not really in a position to drive forward in the absence of a strategy. That does not mean to say we are not trying to develop services that will tackle the problem. One of the initiatives I am involved in is the Towards Zero Suicide initiative, which interestingly and almost uniquely brings all the trusts from Northern Ireland together to tackle that problem on a jurisdiction-wide basis. The trusts are co-ordinating their efforts. In the absence of a strategy, we need to begin to develop the services that that strategy is implementing, and that would be one of them, as well as support for families, improving how we manage patients who present with a mental health crisis, improving our access to substance misuse and co-ordinating mental health services much better than they are currently co-ordinated.

Professor Rooney: We cannot think of Northern Ireland without thinking of the legacy of the Troubles. We know much more now about the neuropsychological pathways that transmit trauma to the next generation. It is not simply about an environmental or behavioural issue. Resilience I have mentioned. There was a desensitisation to living with the trauma but we are now seeing the fallout from that. That makes us unique in the UK. Substance misuse plays a very large part in our self-harm presentations. We need to look to that. A majority of people who kill themselves in Northern Ireland have no contact with mental health services. We need to be very careful to place the solving of the problem of suicide at the door of mental health. It is cross-departmental. It is

about austerity, deprivation, parenting. Every Department in Government has to be involved in suicide prevention. Protect Life 2 has a focus on that. That is what we are largely missing. In relation to that, I would reiterate that alongside this we need some sort of strategy to promote resilience, wellbeing, coping and understanding psychological presentations. We are different, and we need a strategy.

David Babington: I would not disagree with anything that has been said. Suicide is a complex area and you have to be very careful in using statistics, but all the statistics show that Northern Ireland has the worst suicide rate in the United Kingdom and, indeed, the British Isles. The other areas have managed to, as I call it, turn the curve and get a downward trajectory. We have not achieved that. There is a lot of work going on. Dr Michael McBride has talked about £7 million or £8 million going into all the work of the current Protect Life. That is great, but clearly it is not working. Protect Life 2 is on the shelf, so we need a new or refreshed approach with resources behind it to make sure it happens and delivers for our citizens.

It is a difficult one. As we have heard, it is cross-community, as well as from the issue of deprivation and the trauma of the Troubles. We would really like to see people rolling up their sleeves and getting together. In Scotland, for instance, they have got a taskforce on suicide together. Everyone rolled up their sleeves and got round the table. All the agencies said, "Right, we are going to do this". Given our suicide rate, that is what we need. We need real energy, passion and focus to make sure we really do deliver. Protect Life 2 could give us the focus to be able to really make an impact on these horrible suicide rates.

Professor McBride: There are two things I would say about this. I would reiterate what Nicky has said. One of the confusions is around the historic link between suicide and mental health. When I was growing up, there was a perception that those who completed suicide would have been seeing a psychiatrist or might be in care. That is absolutely not the case now. For many people who complete suicide, there is no contact with any mental health services at all.

Secondly, Northern Ireland is a complex society, post-conflict. There are obvious impacts of the Troubles on those who were directly affected. I would certainly argue that, when you look at the burden of mental illness in Northern Ireland, there is a clear link with the past. There is a third section, which is how that legacy has affected the whole society, of which many of the people who complete suicide are a part. We do not fully understand what that legacy looks like. It affects how we are able to make peace. It affects our relationships with one another. There are lots of things about our society that are different to the rest of the UK because of the conflict that we had. It starts to manifest itself then in these ways. I am also very clear that we do not really understand the mechanisms for that. The research is just at the beginning of this, rather than well through it.

Q274 **Lady Hermon:** We are all very grateful indeed to all of you for coming over to give us evidence. There are some very serious issues. All of them are very serious issues this morning. Could I pick up on the reply about the extra funding that was announced? You said the first you heard about it was on the news. That suggests there is not a particularly close working relationship with the Department of Health in Northern Ireland. Am I right? I am shocked if that is the case.

Professor McBride: David and I both work in the voluntary sector, the community sector, and it is fair to say there is not a joined-up approach.

Q275 **Lady Hermon:** We are such a small jurisdiction and we still cannot join up really critical services?

Professor McBride: It is very difficult. My experience—the others will speak for themselves—is that we are the low-hanging fruit. In the statutory sector, if there is a cut to funding or a challenge on funding, one of the easy hits is to reduce funding to our sector. We are treated slightly differently in that way even though, over the years, there has been a significant increase in the volume and the importance of the work that is carried out by the community sector. In the absence of a strategy that clearly articulates the role of our sector, because most social care in Northern Ireland is delivered by the third sector, the importance of that service provision in supporting people so they do not end up in hospital cannot be overstated. It is significantly important, yet I would argue that our sector is the one that gets hit first when there is a funding cut.

That is difficult because there is an aspiration on all our parts to work meaningfully in partnership together with the statutory sector to really make a difference. But we are in difficult times. I have huge sympathy for my colleagues in the statutory sector given the challenges they are facing. They are making really invidious choices about funding, but on the ground my experience is that we get hit first.

David Babington: I must say I would agree with Peter that we are the low-hanging fruit. In times of austerity, we are not classed as core services. I have been in meetings recently where they have said quite openly that they are now more protective of their core services, that they are reducing and that we are on the outside, in the outer ring, and that therefore, if cuts are going to happen, they are probably going to be to us. I know that we have wonderful counselling. Our New Life Counselling is working in the hardest areas—west Belfast, north Belfast. They delivered 2,000 free sessions last year to people in really hard-to-reach areas. That is just not sustainable. We have told them we just cannot keep on doing this, because it cannot be funded. For a lot of the counselling—no doubt Nichola knows all the details of this—I know the rates being paid, for instance, in the community and voluntary sector, are hardly 50% of what would be required for a sustainable service. There are going to be more problems with counselling organisations being able to deliver this out in the community and voluntary sector. This is all work that can prevent suicide, help build resilience and provide early

intervention. In terms of our part in the decision-making process about where the effort and prioritisation are going, I am afraid we are just not at the table.

Q276 **Lady Hermon:** The essential services that both of your organisations provide, for people who are feeling very vulnerable indeed, you describe as low-hanging fruit when it comes to budget cuts. Have you suffered budget cuts?

Professor McBride: Yes.

Q277 **Lady Hermon:** How large and significant have those been?

Professor McBride: We saw a 5% cut in our funding from Supporting People, which is one of the funding streams. I will give you an example of this in terms of our staff. Our staff are paid the national living wage. We have young people who come to us as their first career. They will be recruited by us, go through training, get maybe a couple of years' experience and then almost invariably go into the local health trust for a job because they are better paid and have better pensions. We have done all the training. We have given them the experience, but it is really hard for us to hold on to them because we cannot match what the trust does.

Q278 **Lady Hermon:** At the present time, you are haemorrhaging staff?

Professor McBride: Yes, really significantly. That puts a burden of cost on us in terms of agency use. It makes it very difficult in terms of staff morale. It is a really serious challenge to the quality of our services.

Q279 **Lady Hermon:** In the meantime, mental health services will suffer?

David Babington: Yes. In most cases, we are now not able to achieve the cost of living at all. I remember that, in one of the trusts, we had a cut nine years ago and there has never been any increase or recognition that we had that cut. Effectively, in real terms we have been taking the hit on that for that number of years. I mentioned counselling, where in particular they are driving down the costs, because a lot of counselling is contracted out. Of course, it goes to the lowest-cost provider, and quality might get jeopardised. It is gradually putting organisations out of business in terms of counselling.

Professor Rooney: All health services in Northern Ireland have been subject to service improvement, as I think it is called. We have had to rationalise budgets and provide our services in a smarter way. That has been in trusts as well. There have been reductions in budgets. There have been some developments and changes. We are in a situation where there is transformation. At least 20% of clinical psychology posts are vacant in Northern Ireland. As I said, I have training figures I can leave with you here, which in comparison to the rest of the UK are considerably lower. We are a small profession that punches above our weight. We try as best we can to get involved with strategy through the trusts. We often hear of things after the event. We do not have a chief psychologist. For

every other profession—medicine, nursing, AHP, social work—there is a chief officer who can ensure that their profession is involved. We do not have that. We are asking for that. We are often not at the table to influence psychological thinking around organisations.

Q280 **Lady Hermon:** Why is it so hard to recruit? Why do you have so many vacancies?

Professor Rooney: We often get over 250 applications for 11 places in Northern Ireland; it was cut back to seven. It is really around commissioning. We are asking for an increase in training figures. With the advent of NICE, highlighting the importance of psychological interventions, we are aware that posts will be coming, probably through perinatal mental health when it is signed off. We are robbing Peter to pay Paul: people are moving across services because we do not have enough training places. As I say, we do not have a voice at the strategic table to influence this. We train other people. We give away our skills. We want to do that. We want to supervise and help with quality in other professions, but we do not have that important voice. When it comes to the strategy development, we are often lacking. We shout, we knock and we are brought into particular pieces of work, but we do not have the overall strategic voice that is required.

Q281 **Lady Hermon:** Are you saying that not one of you has a regular engagement with the Department of Health?

Professor Rooney: We do in different ways. It is whether or not it is strategic. There are things like the advisory committees. Psychologists sit on those. They are all the medical ones. There is no joined-up work where we all come together often.

Q282 **Lady Hermon:** There is a theme across Government that there should be parity of esteem—to use that phrase—between mental health and physical health services. You are saying that might be the theme, but in practice not one of you has been invited to be engaged at the top table, if there is such a thing, or around any table, at the Department of Health.

Professor Rooney: We are for some things.

Q283 **Lady Hermon:** In other words, you are picked at random to come in but it is not consistent. How are we to achieve this parity for mental health services if you are not engaged on a regular, ongoing basis? How can that be achieved?

Dr Lynch: It goes back to your question about decision-making. It goes back to the Donaldson report a few years ago. Liam Donaldson, the former CMO of England, did a report in which he pointed out that, for a small jurisdiction, in commissioning, who actually makes the decision and who is providing leadership can be a bit hard to determine. Then you will remember that Simon Hamilton, when he was Health Minister, made a decision to abolish the Health and Social Care Board because we had the Public Health Agency, the Health and Social Care Board, the department

and five trusts. Finding out who is providing leadership in terms of making decisions about mental health can be difficult. The problem is somewhat compounded by the fact that we are an integrated trust. For example, in England you would have a mental health trust that is responsible; you can follow the decision-making and follow the money in some respects, whereas because we are part of a large acute health and social care trust, sometimes it can be difficult to get the voice of mental health heard, because we are not a specific mental health trust. Trying to decipher who is making decisions can be difficult. Since I have taken up the chair of the Royal College, I have sought meetings with the Department of Health.

Q284 **Lady Hermon:** You have sought meetings. Have you had meetings?

Dr Lynch: Yes, I have had meetings.

Lady Hermon: Thank goodness for that.

Dr Lynch: As Nichola says, they are really on an ad hoc basis and we do not have a clear mental health strategy that provides clear leadership. When we heard about the extra funding coming to Northern Ireland, we sought a meeting with the Civil Service and produced what we thought the priorities were, but it was done at short notice because clearly things had moved on quite quickly. It is really about clear decision-making and clear lines of decision-making in terms of mental health. That is what is missing.

Q285 **Lady Hermon:** In the continuing absence of a functioning Assembly, with no expectation of that changing any time soon, who within the Department is giving leadership and vision towards improving key mental health provision in Northern Ireland? Can you identify a single individual? Is there someone within the Department?

Professor McBride: I do not believe there is a single individual. There are individuals who are showing leadership. There is a kind of inevitability about this in the absence of a strategy. In the absence of a strategy, £10 million comes in through the confidence and supply, people will scrabble around and it will go shore up where there is perceived to be the biggest crisis. The issue of leadership is also difficult, because there are people responsible for different bits of the organisation. As my colleague said, there are five health trusts, each of which has a mental health unit, so there is a director, assistant directors and commissioners. We are dealing with five of those in a small country with a population of less than 2 million people. In the absence of a strategy, people will inevitably look after their own interests and try to shore up the holes that are there. I cannot stress this enough. There is a huge need for us to create a strategy, on which we all agree, that we can work towards. That would allow each of us to fulfil our responsibilities, recognising that we will all have to make concessions, perhaps start collaborating, and work genuinely in partnership together to achieve the vision of that strategy.

In the absence of that, we all end up fighting for our own corner and sometimes fighting with each other.

Q286 **Lady Hermon:** In the absence of a Minister for Health in Northern Ireland, we have no strategy?

Professor McBride: That is right.

Q287 **Lady Hermon:** Therefore, people have suffered?

Professor McBride: Yes. That absence of the Health Minister who would champion the cause of mental health services is really sorely missed.

David Babington: The Department of Health has launched a new mental health plan consultation and I am on the project board for it. This is for a plan; it is not for a strategy, and it is limited to five years. It is very modest in its ambitions, and it is unlikely to get recurrent funding from what I hear so far. That is in its early stages. There is no strategy but there is what I would call a rather modest and unambitious plan.

Lady Hermon: Sorry, unambitious? Oh dear.

David Babington: From the words I have heard so far on the resourcing behind it and recurrent funding, there is very little that is firm on that. To be fair to some of the officials in the Department of Health, they have done this on the basis they know there is no Assembly. It is frustration on their part, to be fair. They felt they had to do something.

Q288 **Lady Hermon:** What is the timescale for the completion of the plan?

David Babington: The draft plan should be in place this time next year.

Lady Hermon: This time next year there will be a draft plan.

David Babington: Yes.

Professor Rooney: There are a number of very good, very skilled and very caring leading professionals in Northern Ireland throughout the bodies—PHA, the board, the Department and the trusts—who are actively working to improve and promote mental health services. There is no question about that. On the ground, people work closely together to support each other and support services. What you are hearing is that the lack of an overall strategy, clear leadership and a voice at the table can sometimes hamper progress.

Q289 **Lady Hermon:** It is deeply concerning, to put it mildly. Can I come to a point—well, several points—that I have written down? Dr Lynch—sorry to be so formal; I will go to Gerry if that is all right—we have the mental capacity legislation, but was I right in hearing you say that it had not in fact been implemented?

Dr Lynch: Yes, you are right. This is a concern. Currently, we use the Mental Health (Northern Ireland) Order, which dates back to 1986. You may be aware that in England there has recently been a review of mental health legislation. We do not have any capacity legislation at all. That is a

concern. For people who are not mentally ill but lack capacity to make decisions, in Great Britain there is the Mental Capacity Act. That provides the legislative framework for managing those who lack capacity. We do not have capacity legislation at all.

Q290 **Lady Hermon:** Could I interrupt? Reflecting on my own case where my late husband was diagnosed with Alzheimer's, for those in Northern Ireland who have dementia or Alzheimer's, what is the prevailing current legislation for mental capacity?

Dr Lynch: There is no legislation. As professionals, we try to work under the best practice from England, Scotland and Wales, given the guidance of the courts, for example the Cheshire West and Bournewood decisions. We are acting without a legislative framework for managing patients, such as your late husband, in terms of decision-making. It is about best interests and going to courts on individual occasions if you have to, but we lack capacity legislation. The Bamford review brought forward very, very innovative fusion legislation, as it is called, which combined mental health and capacity legislation into a single mental capacity Act.

Q291 **Lady Hermon:** That was taken through Stormont.

Dr Lynch: It was taken through Stormont and it was passed in May 2016. It is great to be part of such an innovative piece of legislation, because it is seen to be cutting edge and best in keeping with human rights, et cetera, that you combine this legislation. A lot of work went into it. It has been passed. It was passed in May 2016. As far as I can tell, there is a lot of work to be done in terms of regulations, code of practice, et cetera for it to be introduced. The code of practice was meant to have started a consultation process earlier this year. That has not started yet. We are still left with old mental health legislation and no capacity legislation. The Department is still saying this will be introduced in 2020, but the code of practice consultation, which will have to be gone through, has been delayed.

Q292 **Lady Hermon:** How would you describe that situation, apart from unfortunate?

Dr Lynch: We are vulnerable. Patients are vulnerable because there is no legal framework. Services are vulnerable to challenge through courts, et cetera, because we are using legislation that is not in keeping with contemporary human rights practice. In the absence of capacity legislation, we are essentially acting outwith any formal legal framework for patients without capacity.

Q293 **Lady Hermon:** That is really, really worrying. That has been flagged up to the Permanent Secretary, presumably.

Dr Lynch: Yes, absolutely. We have had meetings with departmental officials. In practice, this means a lot of changes for how we work—a lot of training, a lot of work on code of practice regulations—but it seems to

be slipping. I presume that is due to the absence of a Minister who can sign off on the code of practice to go out to consultation.

Q294 **Lady Hermon:** It takes my breath away on that one. I must allow colleagues to come in here, but could I come to Nichola? Bearing in mind that, last week and over previous weeks, we have taken a considerable amount of evidence from principals in schools who have talked to us about their concerns over children coming into school and mental health issues that they have highlighted to us, could you say something more about the problems you see in supporting children who may be presenting with identifiable mental health issues that are not being addressed at the present time?

Professor Rooney: Again, this is a very complex area. The issue of improving mental health and psychological wellbeing in schools is a priority not only for the Northern Ireland British Psychological Society but for the British Psychological Society in the UK. I have recently been doing what we call roadshows, which are free events for the public to bring psychology to society. I have been doing some roadshows on building resilience in children and young people in schools. These events inevitably are oversubscribed, and the audience is generally packed with teachers who are extremely concerned about the situation they feel they are being left in to manage mental health crises in schools.

Lady Hermon: For which they are not trained but are doing their very best to support the children.

Professor Rooney: The children and young people's strategy for Northern Ireland would also support cross-agency working. We are supporting the need for better partnership working between health and education. There are some projects going ahead, and pockets of very good practice, but there are wide areas within schools where the teachers are not trained to deal with the presentations. They feel that the children fall between stools. If they take them to A&E or CAMHS, they are told they are not severe enough and they do not have a mental illness. If they go to primary healthcare hubs, they are told they are too risky because they are self-harming. They have limited access to educational psychology, because there are, in one school, 1,600 people, five hours of educational psychology and only 15 children allowed to be statemented. They are choosing, in very difficult circumstances, who should have access to these services.

We are calling for a review and a health and wellbeing strategy that supports coping in children, better training for teachers, in teacher training as well as supporting them when they are in schools, and co-ordination. A lot of this is about partnerships with parents and community groups. We know that one of the best indicators for academic performance is parental expectation, which perhaps explains some of the difficulties we have in Northern Ireland within some of our communities.

We have a lot of knowledge about things that work, but it is very difficult to get an agreed strategy. Schools use whatever bits of budgets they have to buy in whatever they can get, and there is not an overall strategy of evidence-based approaches.

David Babington: With respect to our organisation, I mentioned in my introduction that we are working in 150 schools. Back in 2002, we started working in secondary schools in the Portadown area and we have now grown that to become a regional service. However, it is more or less self-funded now. It is free to the schools themselves. We are working not just in secondary schools but also primary schools, and we have developed and have had evaluated a programme for primary schools with the Royal College and one of the trusts. We find that demand for the type of course that Nichola has just been talking about is overwhelming. We cannot meet demand. We are in 150 schools this year and there are nearly 1,000 schools in Northern Ireland, including special schools.

The teachers recognise the issues there. The important thing is to have a complete package, putting the teachers themselves first, then the children and then the parents and carers.

Q295 **Lady Hermon:** Sorry to break you off; I am just very interested. When you are talking about the course, is this about building resilience? Is it about dealing with social media? Is it doing all of that?

David Babington: It is giving them the coping strategies to deal with today's ups and downs. As an example, it may be going in at the right time of year to make sure they are properly prepared to deal with exam stress, or it may be social media. The key thing we do is to go in with the teachers first to find out what particular issues there may be in the school. There may be a particular issue about eating disorders or something. The great thing is that we can be the canary in the coalmine. We can go in there with our trained trainers. At primary school you have to be very careful about the language you use. It is not so much about mental health but more about wellbeing, what makes you happy, what makes you sad. Our trainers can then pick up particular issues.

Generally, in every single class we go to, an issue comes out as a result of the workshops we are holding. Then we can signpost them to the relevant services, whether it is social services or even involving the police, but we can also provide support to the parents to deal with those things. There is no formal support from Government at the moment for the services in schools, and we have to turn to the private sector. We have some wonderful corporate partners such as Danske Bank at the moment, and they are providing the funding for these courses to be run.

Professor McBride: There is a burgeoning problem in schools. We see our young people starting to suffer in a way they have not suffered before. We need to be able to provide the services that have been described, but we also need to understand what is going on. What has changed? What is different for young people now from the way it was 10

or 20 years ago, when this kind of support was neither available nor perhaps needed? There is a piece of thinking and work to be done in Northern Ireland to really understand what is happening to the younger generation coming through and how support can be provided even before they reach school, where they are starting to act out some of these behaviours. The roots of this go back further.

Professor Rooney: We need to put psychological health and wellbeing at the centre of every school system. Sometimes that gets lost or is set aside as we strive to monitor our academic targets. Increasingly, self-harming children are very difficult for teachers to cope with, and this is often being acted out in the school environment. Teachers need support and training, and there needs to be better joined-up working between health and education, and CAMHS services and education services.

Lady Hermon: That is a message we have heard previously.

Q296 **Mr Campbell:** In a couple of months' time, it will be 25 years since the ceasefires. I still get, on a regular basis, quite a number of serving and former police officers, and other security services, who are either looking for assistance or displaying signs of mental health issues. That is simply what I get as a constituency MP. How prevalent is that across each of your experiences?

Professor McBride: My organisation provides services into and across the security forces—that is serving and retired police officers as well as army veterans. Those are specialist services around trauma. We are seeing an increase in that, which is not a surprise. A lot of the evidence shows that, as time goes on after a ceasefire happens, people only in the latter years start to feel confident about talking about that, when they feel safe enough to do it. There is certainly a need in our country to provide those people with specialist trauma services and specialist support services to deal with what they have been through.

David Babington: I would agree with Peter. Specialist services are absolutely essential. Like him, we provide services for ex-servicemen, but they are mixed in with our other recovery clients so they are not specialist services. There is a need for some specialist services there as well. I know that at the moment the Armed Forces Covenant Fund Trust has opened applications for people to come in and make bids for specialist funds. Peter and I will certainly be making bids for that. I worry about some of the specialist, or allegedly specialist, services, where people just keep on going round and round the wheel, going to them year after year. I am not sure they are really achieving their aim. Bringing a bit of order to that in terms of quality would be important as well.

Professor Rooney: When I was a young psychologist, we were trained for free in EMDR by Vietnam War veterans who came from America. It is interesting that we are in this situation now where we are finding our own security forces presenting in this way. As for psychological services, within the police force, there is a police centre of psychological

interventions, which deals with this a lot. In lots of psychological services through the trauma centres there is no differentiation made between the occupations of the people who present to them. It is probably the same for you, but we would see them in the course of normal treatments, as we did even during the Troubles, when you recorded everyone as working in the Civil Service. I know that the police service has a clinical psychologist as part of its team but, as regards specialist services, we do not have any particularly for the security forces.

Dr Lynch: Members of the security forces present a very high rate of morbidity because of the traumas they have suffered and they will present with lots of difficulties. Substance misuse, for example, is quite closely linked with post-traumatic stress disorder. It is a question of making sure they get the right service. They are seen within generic services. There is also the Combat Stress organisation with Dr Daly, who is a psychiatrist involved in that, and there is the regional trauma network. We need to be much more focused on how we deal with trauma because, as Peter said, the fact that it has been 25 years does not mean that this has gone away; in fact, in some respects, it is much more apparent now among victims and survivors of trauma.

Q297 **Mr Campbell:** I do not expect any of you to make any comment on the political implications of the next question but, in the past couple of years, I have had instances of former members of the security services who have come under the ambit of the reopening of investigations. As I say, I do not expect you to make any political comment, but over the past two years it has happened to a considerable number of people, and the concern is that it may happen to others who have not had the knock on the door as yet. Have you noticed a spike in that period of time?

Professor McBride: I cannot say. I would need to go back and look at the numbers. Without any comment on the political side of it, it is completely understandable, when someone is presented again with the experiences they went through, that they re-experience their trauma. It is extremely important that, in that situation, they are provided with access to appropriate help and support. That is the humane and obvious thing to do.

One of the challenges that we face with people coming from very specific backgrounds, particularly security force backgrounds, is their help-seeking behaviour—who they feel confident and safe speaking to and getting help and support from. We have a responsibility as a society to take that into account, to make sure that the support provided is genuinely accessible to people in such a way that they choose to use it, and not just to make it available and hope that they do. There are subtleties and political nuances in this, which you understand as well as I do. It is really important that people get access to support, particularly at those times.

Q298 **Maria Caulfield:** To summarise, you have given us evidence today on the suicide strategy, funding decisions, how money is allocated to mental

health and the lack of a mental health taskforce compared to Scotland. Would you agree that all of that and all the challenges you face are really because of a lack of political leadership at the moment in Northern Ireland? Would you agree that that is an accurate reflection?

David Babington: I would certainly say it has not helped. However, even before 2016 and the collapse of the Assembly, mental health was still there. We had Bamford in 2007. It was a wonderful report. Expectations were raised but, since then, the budget has declined. We were really fighting to make sure that the voice of mental health was heard even when the Assembly was in place.

Speaking about the third sector, we hosted a mental health summit, the first ever in Northern Ireland, in May 2016, just before the election of 2016, to try to raise the issue of mental health, talk about a mental health champion, et cetera. We had some traction there, in that they recognised a mental health champion would be appropriate because of the special nature of the issues in Northern Ireland with respect to mental health. I suppose I am saying that the lack of the Assembly has probably worsened that now. There has been this void since then, and nothing has really happened or moved on, apart from this talk of a new mental health plan, which is very modest and unambitious.

Professor Rooney: We were talking about not having the chief psychologist role and how we influence change. As a professional body, we would write briefing papers, launch events and try to provide politicians with information and an evidence base. We still find ourselves writing papers on mental health in prisons and schools, and it is difficult to know what to do with them, who will listen and what difference that can make. We feel the lack of Ministers to approach. We saw the benefit, certainly in relation to perinatal mental health, of having a Minister who was prepared to support that and prioritise mental health. We feel the lack of it.

Dr Lynch: The last Health Minister talked about mental health as being a priority, but we were not able to work through what that means in practice because of the collapse of the Executive. It is a long-term problem. I do not think it will be quickly fixed. It is about a fragmentation of services, a lack of clear leadership and a lack of clear direction, as well as underfunding. It takes a Minister to really set that agenda. Translating mental health from a priority into practice really requires ministerial direction.

Professor McBride: I have been working in this field for over 25 years, and in the early part of my career mental health services were described as the Cinderella services. There was a general acceptance that we were the least funded and often the last on the list. Frankly, there was not a huge amount of anger around that. People accepted that, if there had been money around, it would have been nice to do it.

My view at the minute is that that view has changed. Politicians now recognise just how pervasive mental health issues are across all of society: in our schools, in our workplaces, in our children's lives, in our adult lives and in the lives of the elderly. Both society and our political representatives understand now just how important this is.

My point about Northern Ireland is that, with that understanding, there is now an impasse. Had we a Government now, there would be movement. We recognise there are challenges and funding limits, but there is a genuine will, both in the statutory services and in our sector, to do something about it. Without a Government, though, there is an inertia and a sense of paralysis, of not knowing what to do. Who is going to make a decision? Who will finally make the call? In Scotland, for example, they made mental health a priority a number of years ago and they are starting to see real benefits from that. We are in a position to do exactly the same with a bit of political leadership when that comes back.

Q299 **Maria Caulfield:** I have worked in the NHS in England and, without the mental health legislation, it is very difficult for healthcare professionals to make difficult decisions. I did not work in mental health but we looked after patients who lacked capacity, and that legislation has been really fundamental in ensuring patient safety above all else. Are there other examples of legislation that has not been introduced or implemented that you are concerned about in terms of mental health, which is sitting on a shelf until an Assembly is back up and running?

Dr Lynch: The main issue I am aware of is the mental capacity legislation. We have talked a bit about strategies rather than legislation—for example, Protect Life 2—plus the lack of a mental health strategy. Nichola, are you aware of other legislation in terms of children?

Professor Rooney: Capacity legislation does not apply to children, of course, so that is another conversation. It is really in relation to strategy and signing off. We have co-operation under the co-operation Act, which is meant to determine better partnership working, but we do not have the strategy to put those things in place. We are very poor on information generally. It is very hard to get good data on Northern Ireland in terms of our prevalence and our services. We tend to look to England, Scotland and Wales and then extrapolate and add 25%. We need a greater knowledge base and more research into what is happening in Northern Ireland, in order to understand it as well.

Maria Caulfield: You are not getting those figures through.

Professor Rooney: No, there is a dearth of information. It is very difficult. Whenever we search for information, it is extremely difficult to get it even in terms of mental health in prisons. Finding out what is happening in the Northern Ireland situation is always very difficult.

Dr Lynch: Mental health is provided by five different trusts and they all measure things in slightly different ways. Even their IT systems do not

talk to each other, so getting a coherent set of information for the jurisdiction is very difficult.

Professor Rooney: That means that measuring outcomes and change is very difficult.

David Babington: My understanding is that a wellbeing framework is being drafted, and that is awaiting ministerial approval, so it is on the list as well. That has all the upstream and resilience-building work that we have all been talking about. It should be prioritised as well, so it is another thing that really needs to be pushed through.

Q300 **Maria Caulfield:** To come back to suicide, you have talked about the Protect Life 2 strategy. We had the Chief Medical Officer here a couple of weeks ago, and the question was put to him whether the lack of that strategy being implemented was costing lives in Northern Ireland. What is your opinion?

Dr Lynch: Looking at cause and effect as far as suicide goes is very difficult. I would not want it to be said that we are just sitting and waiting for a strategy; we are taking active steps to use the best evidence to tackle the suicide rate. One example is the Towards Zero Suicide project, which I referred to. It is really about the message that it sends—that the strategy is there. As we have talked about, there is not the drive and leadership needed to really tackle this. I could not say for sure that the lack of the strategy is costing lives. Tackling suicide is a long-term and complex issue so the lack of that strategy sends the wrong message.

Q301 **Maria Caulfield:** Given that there is a lack of an Assembly and a lack of direction in trying to improve those suicide rates, do you think that lives are being lost in Northern Ireland as a result?

Professor Rooney: It is very difficult to attach it to the strategy. There is a huge amount of work going on, certainly among voluntary agencies in the community, to respond to suicide and try to provide services. That was happening with the first strategy and it is continuing to happen. Our suicide rates are increasing. Why is that? I do not think you can pin it on the strategy. I do not think we are sophisticated enough to even measure the outputs and outcomes of our strategies.

What we do not have in Northern Ireland, which you do have in Great Britain, is the behavioural change, dealing with people's mindset and their behaviours. There is very good work by The King's Fund. There is the Behavioural Insights Team. We need a much bigger conversation around why suicide is an outcome and why self-harm is an outcome. What are the coping strategies? Where is the health and wellbeing? We have to look to England and elsewhere to draw on that and I do not think that there is a voice. I am not sure that that appears in the strategy. There are other things that we need in the strategy if we are going to seriously decrease the rates of suicide.

David Babington: It is impossible to say that lives are being lost because of the lack of a strategy. Clearly, we want the new strategy because we have managed, as I said before, to turn the curve and get those rates going in a downward trajectory. But it may be that rates will start to go up with a new strategy. It is just impossible to say at this stage.

Q302 **Chair:** Can I ask about the strategy? We had some very good evidence from the Chief Medical Officer, but Chief Medical Officers tend to be cautious people and they do not want to be the subject of headlines. He was questioned specifically on the point of having a suicide prevention strategy and whether, in fact, the lack of that strategy was resulting in lives being lost. I asked him specifically whether lives would be lost if we failed to have a suicide prevention strategy, and I have to say he was delphic in his response to me on that occasion, which is perfectly understandable given the position that he occupies, but you can be a little more forthcoming. I put it to you that the purpose of a suicide prevention strategy is to save lives. It logically follows from that that, if you do not have a suicide prevention strategy, lives will be lost. I invite you to comment.

Professor McBride: A challenge that we all face is that we have had a suicide prevention strategy and very significant interventions in society around suicide, and yet the suicide rate continues to rise. There is perhaps a lack of confidence among us—I will let my colleagues speak for themselves—in properly understanding how to attribute causality. None of us are prepared to attribute causality to not having a strategy, but I would put it more basically than that. I am not sure we particularly understand the mechanisms by which the suicide rate in Northern Ireland is going up. We know that there are a multitude of factors involved in that, but I am not sure we know enough to say that, if we do A, B and C, it is going to bring it down. That has not been our experience to date.

A lot of what we are doing is based on evidence and best practice but, when you look at the suicide rate, it is not changing. It is therefore very difficult to make the kinds of attributions that you are asking us to make.

Q303 **Chair:** I am not asking you to; I am just inviting you to comment, really, because I am struggling with strategies. We have strategies for all sorts of things and there is no point having a strategy if it is not going to produce outcomes. Otherwise, we are wasting our time and public resources.

David Babington: There is a logic there that, if the current strategy is not working, we will learn from that strategy and hopefully things will get better. There is a logic there that, yes, hopefully it will turn the curve in reducing the numbers. It is very complicated. Take, for instance, welfare reform. Welfare reform and benefits changes are a massive issue for people with mental health issues. Universal credit is starting to be rolled out in Northern Ireland, and our clients are already so stressed and need guidance to address that. That could theoretically lead to increases as

well. There are so many different variables and factors involved in this that it is impossible to say categorically that lives would be saved by any strategy.

Q304 **Chair:** It is worth making the comment, since you mentioned universal credit, that the idea of universal credit is to get people into work, which is a positive thing for mental health.

Professor Rooney: Psychological interventions, from the Layard report in England, are perhaps a more fruitful and helpful intervention to get people into work.

Dr Lynch: As medics, we like to look at evidence, and the evidence of what works in suicide prevention is difficult to find. The old saying is that association is not causation. If you look at the evidence, things like having good services for people in crisis, producing personal safety plans for those in crisis, trying to tackle substance misuse, seem to have the greatest effect on the suicide rate in the short term. In the long term, as people here have said, it is about resilience building at an earlier stage to prevent people getting into crisis. It would be helpful to have a strategy but, insofar as the evidence guides us, we are already trying to put into place what appears to be the best evidence that we can find.

Q305 **Lady Hermon:** I want to follow up on a couple of things. In response to my colleague, there was evidence given that there seems to be no central place in which the data about mental health provision or those who suffer from mental ill health, which covers a very broad spectrum indeed, is kept in Northern Ireland. Am I right in thinking that, while the five health boards might have the data, they operate in silos? You are nodding your heads.

Professor McBride: That is fair to say, yes.

Professor Rooney: Some data is kept by NISRA on bed usage but, in terms of meaningful data, measurement and outcomes, services are organised differently in the trusts. It is very difficult to be comparative.

Q306 **Lady Hermon:** How can we match resources to need if we have no centralised data about the growing need for mental health services? How can that be allowed to happen?

Dr Lynch: In England, the mental health trusts are charged with delivering mental health services in a particular area. Because we have five different trusts with mental health being a part of each of those trusts, it seems that, over the years, those trusts have developed their own ways of gathering data. For example, for the Towards Zero Suicide initiative, the trusts gather the data about how many patients present in crisis in slightly different ways, so we are already in a position of trying to reconcile data.

There is some data gathered centrally but it mostly tends to be statistics on bed occupancy, et cetera. There is a lack of coherence in how services are organised across the five trusts.

Lady Hermon: Is that not a huge disadvantage?

Professor Rooney: Yes.

David Babington: Yes.

Lady Hermon: It is so blindingly obvious that I assumed it worked differently and there was centralised knowledge about the data. You are saying there is not.

Professor McBride: There is not. From a service provision point of view, it is extremely time consuming and difficult to engage with five different trusts that have five different processes. There has been talk in the past about the development of a single mental health trust for Northern Ireland. The size of the population and the structure there would fit with comparative sizes in the rest of the UK, and that is certainly something we should be thinking about.

Q307 **Lady Hermon:** You mentioned a mental health champion in the evidence earlier. If we were to have one, should there be a duty on the five trusts to provide that data? Is that what you see as part of the champion's role?

Professor McBride: David has been talking about the champion.

David Babington: The role of a champion would have to be determined. We provided evidence to the Assembly, before it collapsed, about what that champion might look like and might do. Making sure that there was a common pool or a common source for evidence is certainly one thing that the champion would be advocating for.

Professor McBride: The challenge with this is gathering the data. We had an experience recently of wanting to find out what the prevalence was for people presenting with mental illness in emergency departments and, as far as I understand it from my staff, it was not being recorded. It was difficult to get those numbers. When it is something as basic as that, it is really difficult to plan and develop services in the absence of data. For me, the issue is less about a mental health champion and more about co-ordination of services within the health service, based on evidence and based on data about need. The idea of a single mental health trust, or how you get the five different trusts to work together on common issues, is a really challenging question.

Professor Rooney: I have some good news about Northern Ireland.

Lady Hermon: Yes, please.

Professor Rooney: We have a self-harm registry, which the rest of the UK does not have. We have information around the number of people who present to ED after episodes of self-harm.

Q308 **Lady Hermon:** Will all hospitals record that?

Professor Rooney: Yes.

Q309 **Lady Hermon:** Is it held centrally?

Professor Rooney: It is held centrally. There are pockets of information. One of the interesting things about the programme for government was this focus on outcomes. As psychologists, we were very excited by that because we are very good at measuring outcomes and not just outputs, so we hope that that will be back in place. The gathering of information to help better plan our services would be greatly welcomed.

David Babington: We are very supportive of the single mental health trust proposal. However, given where we are, with all the changes, austerity, et cetera, we would be very concerned about introducing it now. We do not do change well in Northern Ireland, particularly within the public sector, and it could cause upheaval for a generation in terms of trying to get to it.

Q310 **Lady Hermon:** When—I am saying "when" rather than "if"—we have a Health Minister back in post, what should her or his priority be in terms of mental health improvement?

Professor McBride: The development of a mental health strategy.

David Babington: A mental health strategy that has recurrence and appropriately funded resources.

Lady Hermon: Yes, instead of the time-limited resources because you cannot plan.

Professor Rooney: I agree, but with a focus on early intervention and promoting psychological wellbeing and a model of optimism rather than learned helplessness.

Dr Lynch: It should be a strategy consistent with the English five-year forward view idea, which is rolled forward every five years. We would point to much better co-ordination between the five trusts that each provide mental health services in a small jurisdiction, which has led to confusion and duplication. We need much clearer leadership, a more consistent approach across the jurisdictions to the delivery of services, and a clear strategy with a rolling five-year forward view.

Lady Hermon: That is very helpful and really insightful.

Q311 **Chair:** That is extremely helpful, thank you. There is just one final question from me. We have heard loud and clear the need for more resources, but I wonder whether, within the budgets that you have, you can think of things that could be done to improve efficiency and therefore free up funds for frontline services. You have touched upon the various configurations within the five health boards, for example. Is there anything you can think of that could be done and has not already been done that might perhaps free funds up internally, rather than rely upon

more money being poured in at the top, as it were?

David Babington: I suppose that is a question that we have been trying to answer for the last seven or eight years since the financial crisis, certainly in our organisation, and we have got to rock bottom in terms of where we are. The trusts would probably say the same. We also need to look at—if I am allowed to say the "B" word—Brexit as well. There is potentially an impact there for a lot of organisations in the voluntary and community sector that are delivering health and wellbeing in mental health. There are 54 organisations delivering there and, very soon, there will be uncertainty about the future of that funding if it runs out in 2021 and 2022.

Chair: You said that was in relation to the "B" word.

David Babington: The European Social Fund supports a lot of organisations to deliver health and wellbeing in mental health in Northern Ireland. There are about 54 organisations using that money to deliver various services.

Chair: You will be looking for that money to be replaced from another source.

David Babington: The UK Shared Prosperity Fund is potentially the follow-on programme, but there is a great degree of uncertainty as to what shape or form that will take. Scotland and Wales have already shown a great degree of concern with respect to the direction of that potential UK Shared Prosperity Fund, because it is not focusing on the issue of what the sector can deliver in terms of social value. It is very much directed to the private sector and increasing productivity, et cetera. For the future, that is another thing. You talk about where we can make changes, but there is another big hurdle coming up in a couple of years with respect to the sector.

Professor McBride: There is a shared acknowledgement that the health service needs to transform, and it has been shown through Compton and, currently, the Bengoa report, which set out very clearly what could be done within the health services of Northern Ireland. It is with some frustration that we see that work being done in terms of thinking around it but then we do not see it happening. The need for transformation is clear and obvious. That may require a bit of investment at the start but it should allow for much more efficiency later on. We have on the table a plan for that in Bengoa and in other documents, and my wish and ambition is that we get on with that, really do it and see the health service properly transformed and working together for the betterment of our population.

Professor Rooney: I would be thinking structurally. There is some duplication that goes on. There had been a plan, for example, to look at the role of the PHA and the board, and that has been stalled. That has left people uncertain about the future and was not necessarily the most effective way of working. I would like to see that aspect of structural

reform looked at, rather than constantly looking at the frontline services, which have worked extremely hard at providing best practice services, promoting access to services as best they can and working with community and voluntary organisations. Morale in the health service is low. Staff support and keeping people in work are very important. The transformation feels like a very acute process, so more involvement of mental health in the vision for that would be helpful. Looking at the role of the board and the PHA would be useful.

Dr Lynch: Looking at it as a relatively small jurisdiction with 1.8 million people, especially in how we deliver specialist services, much closer regional co-ordination of services would lead to efficiencies, rather than each trust doing its own thing.

Chair: That is great, thank you. Thank you ever so much for being here today. The evidence you have provided has been extremely useful and very compelling, and will most certainly colour and inform the report when we come to write it. Thank you very much indeed.