Programme for Government

Delivery Plan: Indicator 6

This is a live document which will develop and evolve throughout the engagement process. Please check back regularly for updates.

Indicator:

% population with GHQ12 scores ≥4 (signifying possible mental health problem)

This indicator is a primary indicator for:

Outcome 4: We enjoy long, healthy, active lives

Outcome 8: We care for others and we help those in need

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If you have any comments on how to improve the plan to turn the curve please contact: ops@health-ni.gov.uk

17/11/2016

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1. INTRODUCTION

This indicator seeks to drive improvement in the general mental health of people in the North. In the Department of Health, this is primarily about delivering good quality mental health services when they are needed, but under the Programme for Government we need to think about how we can support and promote mental health in the population as a whole, through prevention, early intervention and, where necessary, appropriate treatment and care.

This delivery plan describes how we will deliver new and expanded services in a range of areas as well as focusing on earlier intervention in schools and in particular with looked after children.

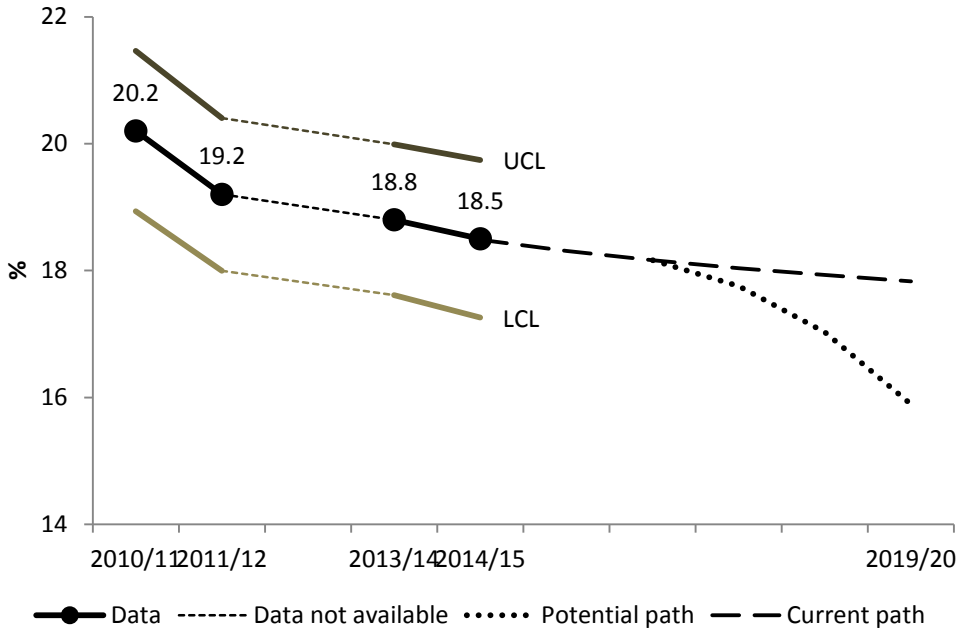
The challenge is considerable. In general terms, people here have worse mental health than in other comparable jurisdictions. We therefore need to recognise that any improvement in well being will require sustained, coordinated and continuous effort and investment.

Service development is costly and with limited resources there will be a need to focus on developing interventions that will have the greatest impact.

2. BASELINE POSITION

GHQ-12

Fig 1 - % of respondents with a GHQ-12 score of 4 or greater



Source: Health Survey Northern Ireland, Department of Health[1]

This graph shows:

- The historic data available for the lead measure associated with this indicator;
- The projected forward trajectory if no change is made (Business As Usual);
- The targeted trajectory to be achieved through implementation of the delivery plan (Turning the Curve).

The 12-item General Health Questionnaire (GHQ-12) is a widely used and validated measure of mental health. It is used to detect psychiatric disorder in the general population and within community or non-psychiatric clinical settings such as primary care or general medical out-patients. It assesses the respondent's current state and asks if that differs from his or her usual state. It is therefore sensitive to short-term

[1] UCL- Upper Confidence Limit LCL – Lower Confidence Limit
The potential path indicates the shift that would be needed to make a statistically significant change to Mental Health in the North.

psychiatric disorders but not to long-standing attributes of the respondent. GHQ-12 has been used consistently since 2010/11 in the Health Survey Northern Ireland (HSNI). A score of 4 or more on GHQ-12 indicates possible psychological disturbance or mental ill health.

Between 2010/11 and 2014/15, there was no real change in the proportion of the population that scored 4 or more on the GHQ-12. The dotted line (potential path) in fig. 1 above shows one of the many potential routes whereby sufficient progress is made to achieve a statistically significant reduction in the proportion of the population with potential mental health problems by 2019/20.

3. THE STORY BEHIND THE BASELINE

Policy context

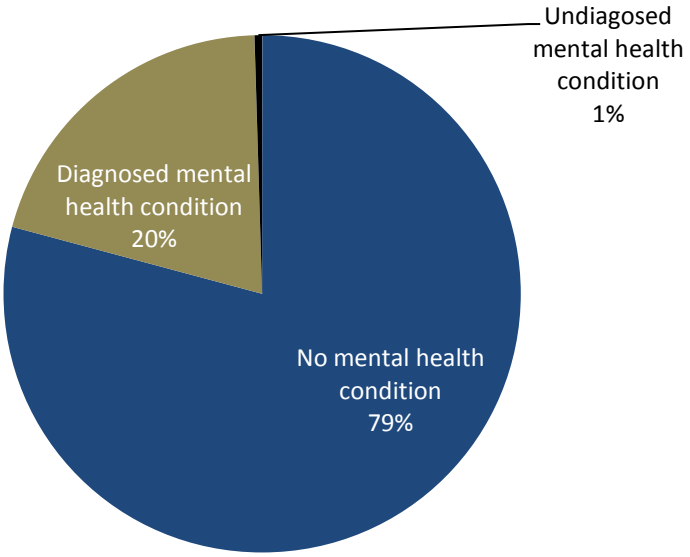
The Bamford Review (2005) is the policy basis for most of the recent mental health policy and service developments. It called for:

- the enhancement of community and primary care services to meet mental health needs;
- the development of alternatives to inpatient care for people experiencing mental health crises, including home treatment services;
- better access to psychological therapies.
- services to promote recovery and provide assertive community treatment for those who have the highest levels of disability and greatest vulnerability; and
- new capacity legislation.

It is estimated that **one in four people** will suffer from a medically identified mental illness during their lifetime. Mental ill-health costs an estimated 3-4% of GDP, mainly through loss of productivity, cost of healthcare and social security benefits.

In line with Bamford recommendations, the focus in the last number of years in terms of mental health service development has been on early intervention, home treatment services and the development of psychological therapy services.

Fig. 2 - GHQ respondents scoring 4 or higher 2014/15

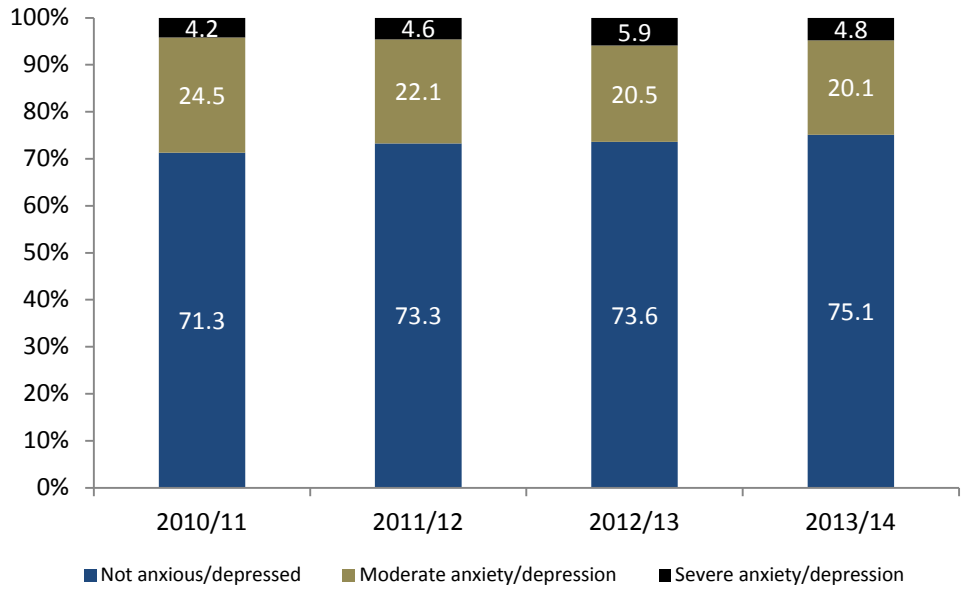


Source: Health Survey Northern Ireland, Department of Health

Respondents to the HSNI were asked whether they had a diagnosed mental health condition. A fifth of those that scored highly (i.e. 4 or more) on GHQ-12 had a diagnosed mental health condition which compares with 2% of those that scored less than 4.

Self-assessed anxiety/depression levels

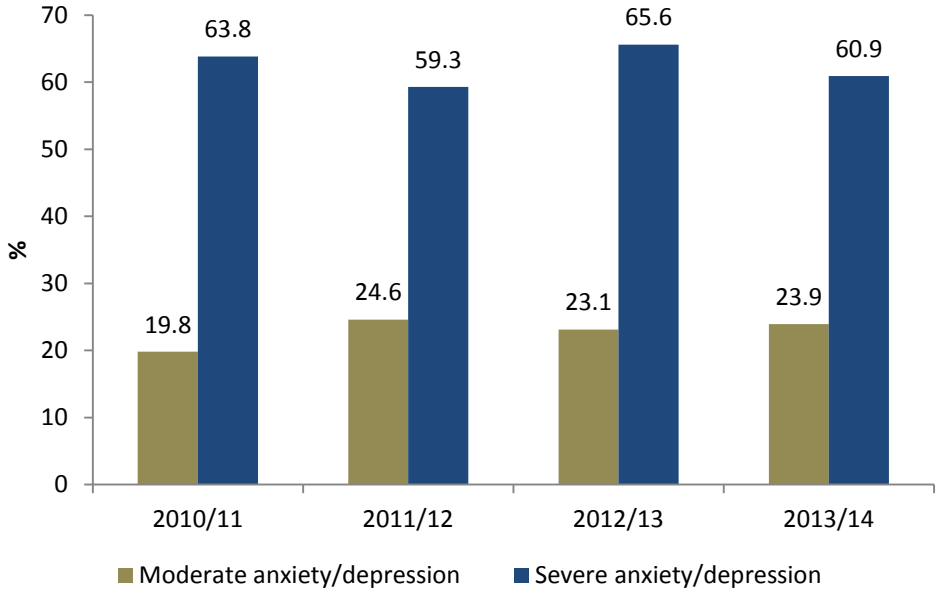
Fig 3a – Self assessed anxiety/depression levels



Source: Health Survey Northern Ireland, Department of Health

Respondents to the HSNI were asked to gauge their own anxiety/depression levels (as either none, moderate or severe). Fig 3a above shows that around three-quarters in each year reported as not having anxiety/depression compared with between 4-6% reporting severe levels. When asked whether they were receiving treatment (see fig. 3b below), generally more than three-fifths of those that were severely anxious/depressed stated they were receiving treatment for a psychological health problem (such as anxiety or depression). This compared with almost a quarter of those that had judged themselves to be moderately anxious/depressed.

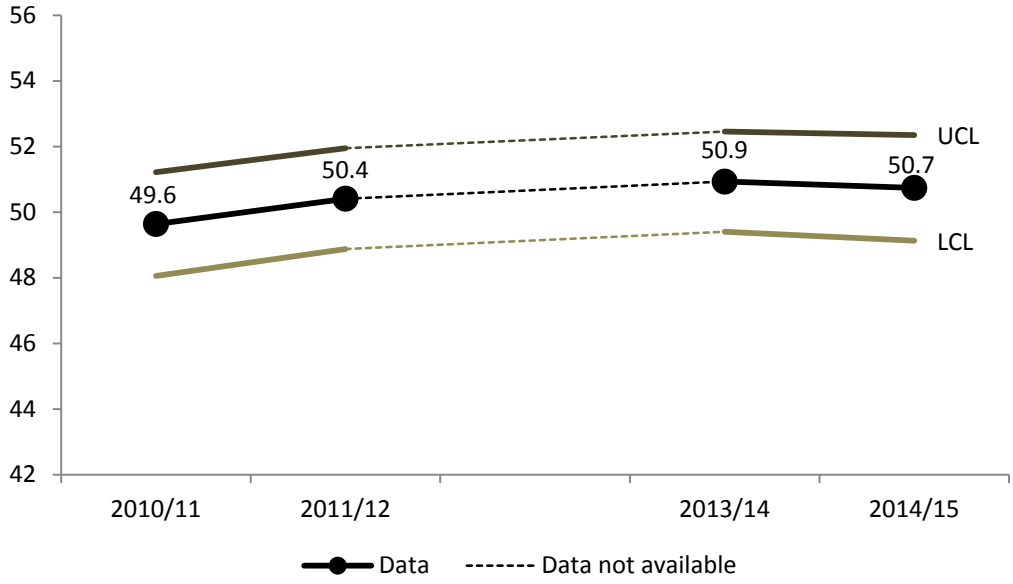
Fig 3b – Self assessed moderate or severe anxiety/depression levels by treatment status



Source: Health Survey Northern Ireland, Department of Health

Mental Well-being

Fig. 3 - Warwick Edinburgh Well-Being Score (WEWBS)



Source: Health Survey Northern Ireland, Department of Health

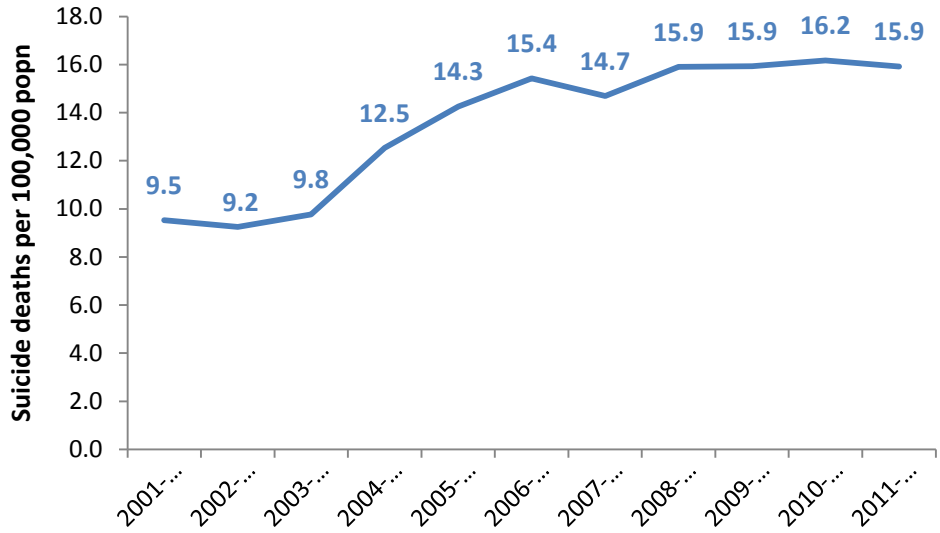
The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) is a scale of 14 positively worded items, with five response categories, for assessing a population´s mental wellbeing. A respondent can score between 14 and 70, with a higher score indicating a higher level of well-being. This short questionnaire has been included in HSNI regularly since 2010/11. The general average level of well-being within the NI population has remained similar over the period. This broadly reflects the same trend seen with the GHQ-12 measure.

Suicide and self-harm

Suicide

Suicide deaths in Northern Ireland are defined using the UK definition which includes deaths from Self-inflicted Injury (International Classification of Disease (ICD-10) codes X60-X84, Y87.0) as well as Events of Undetermined Intent (ICD-10 codes Y10-Y34, Y87.2). Data for three years have been aggregated in order to provide robust results.

Fig. 4 – Crude suicide rate per 100,000 population



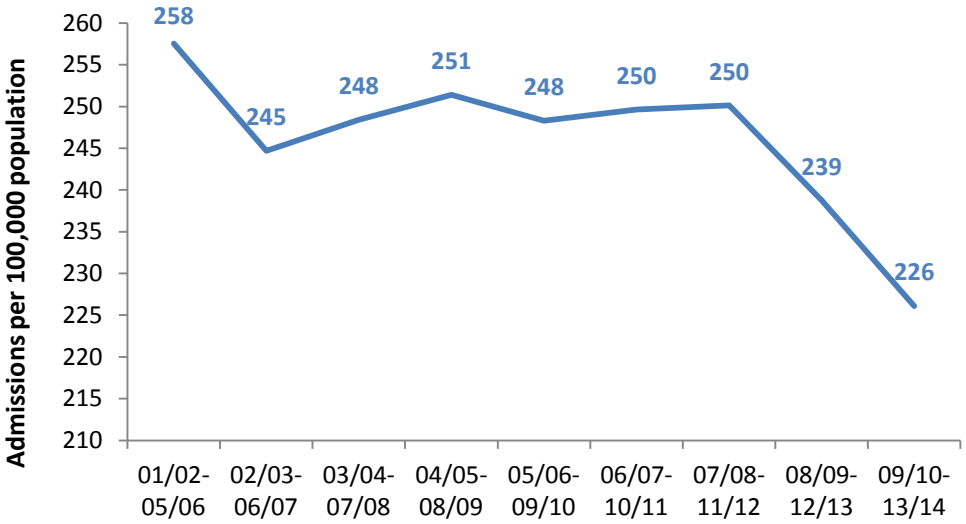
Source: Northern Ireland Health & Social Care Inequalities Monitoring System, Department of Health

In 2011-13, there were 15.9 deaths due to suicide per 100,000 population. Although the rate increased between 2002-04 and 2006-08, there has been no consistent direction of change in recent years with rates fluctuating between 2006-08 and 2011-13.

Standardised Admission Rate (SAR) for Self-harm

Data for five years have been aggregated to provide robust results and results are standardised to the 2013 European Standard Population. This indicator was developed to complement the suicide information. However it does not provide a complete picture of the problem of self-harm (or parasuicide) as in many instances, self-harm does not result in admission to hospital. Admissions for self-harm are classified using the ICD-10 codes X60-84 and Y87.0.

Fig. 5 – Self-harm hospital admission rate



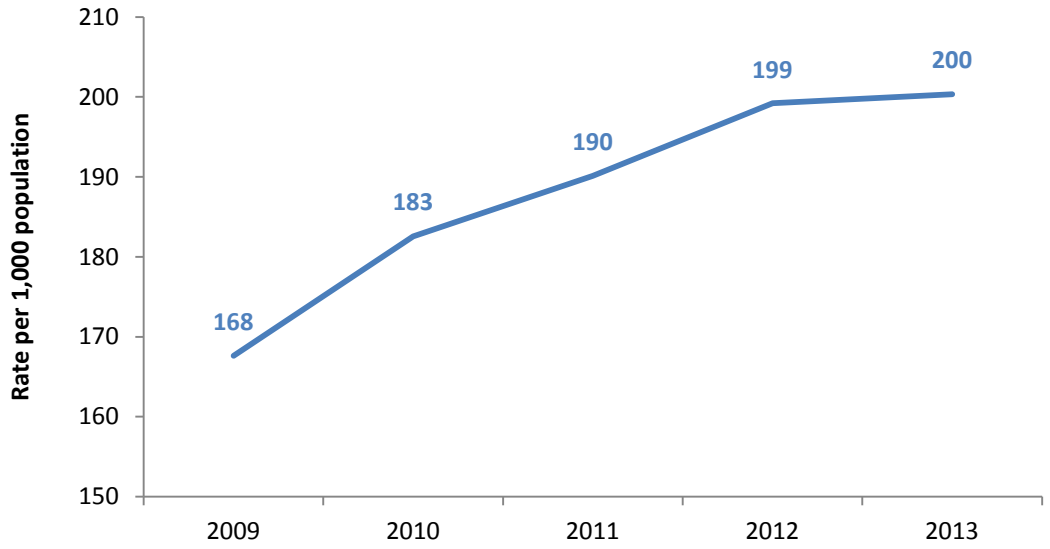
Source: Northern Ireland Health & Social Care Inequalities Monitoring System, Department of Health

In 2009/10-2013/14, there were 226 hospital admissions due to self-harm per 100,000 population. Despite fluctuation between 2002/03-2006/07 and 2007/08-2011/12, rates have decreased in the last nine years. Over the last three years, the self-harm admission rate decreased by a tenth from 250 to 226 admissions per 100,000 population.

Prescriptions for Mood & Anxiety disorders

The number of individuals suffering from mood or anxiety disorders is estimated using prescription data extracted from the Electronic Prescribing Eligibility System (EPES), which allows the calculation of age standardised rates (using the direct method and standardising to the 2013 ESP). Drugs included in Mood & Anxiety Disorders are coded 4.1.2 and 4.3 in the British National Formulary (BNF).

Fig. 6 – Standardised Prescription Rate for Mood & Anxiety disorders

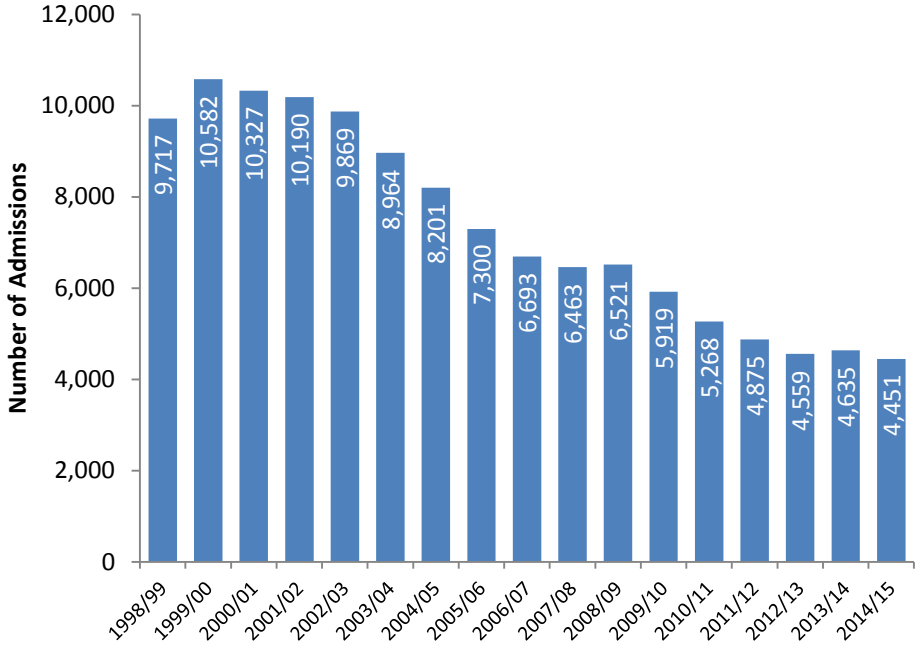


Source: Northern Ireland Health & Social Care Inequalities Monitoring System

The standardised prescription rate for mood and anxiety disorders increased consistently over the last five years from 168 to 200 prescriptions per 1,000 population.

Access

Fig. 7 - Inpatient Admissions within the Mental Illness Specialty



The number of inpatient admissions within Mental Illness specialties has declined generally in recent years from a high of 10,582 in 1999/00 to 4,451 in 2014/15.

Table 1 - Non-inpatient Mental Health Services (quarter ending March 31st)

	2014	2015	2016
New appointments booked for scheduled MHS	10,336	11,689	13,868
Review appointments booked for scheduled MHS	107,907	119,484	126,767
Unscheduled MHS contacts (new/review)	13,397	14,567	19,228

Source: Non-inpatient Mental Health (NIMH) return

There was an increase of more than a third for newly scheduled Mental Health Service appointments between March 2014 and March 2016. Similarly review appointments for scheduled Mental Health Services also rose over the same period from 107,907 to 126,767 (an increase of 17%). Between 2014 and 2016, there was a larger proportionate increase (44%) in unscheduled Mental Health Service contacts.

Expenditure

1. The total allocation to mental health in 2015/16 was in the order of £255m, to provide for community services (such as early intervention, crisis response, home treatment, day services, psychological therapies); specialist services such as those for eating disorders; and hospital services, for patients in need of acute inpatient admission. A further £700k was allocated to mental health organisations by way of grant funding, and £2.5m on Extra Contractual Referrals (transfers to hospitals in England or Scotland, where there is no equivalent service available here).

2. Whilst the overall allocation to mental health has increased from £200m per year since 2008 (following the Bamford Review), there is a widespread view that there has been historical underinvestment in mental health. Depending on the measure, mental health spending in the North equates to approximately 6% of the health budget (a similar figure to that in the South). The equivalent figure in England is 13%. To set these percentages in context, the Centre for Mental Health cites a figure that the "disease burden" of mental health on the NHS is 28%.[2]

3. Whilst there are clear needs and pressures, it is worth noting that the North was the only part of the UK to see an increase in spending on mental health by health Trusts in the last two years, with 1% additional spending in 14/15, and 2.6% in 15/16.

[2] https://www.centreformentalhealth.org.uk/parity-of-esteem

4. DELIVERY PARTNERS

The key delivery partners, and the particular roles in respect of the issues that the delivery plan will seek to address, are set out below.

The first Key Partner is the lead Department for this indicator – all other bodies, across sectors, that have a significant role to play in supporting delivery are identified here, and play an appropriate in development and implementation of the delivery plan.

Key Partner	**Their Role**
Department of Health	Policy direction, funding.
Health and Social Care Board/Public Health Agency	Commissioning, performance management, expert advice.
Health and Social Care Trusts	Service delivery
The Executive Office/Commissioner for Victims and Survivors/Victims and Survivors Service	Policy responsibility for voluntary and community elements of mental trauma service
Department of Justice	It is estimated that around 70% of people who come into contact with the criminal justice system have some form of mental health issue. There are a number of initiatives that can be progressed in relation to diversion of vulnerable individuals, and continuity of care, under the auspices of the Health in Criminal Justice strategy. The Departments of Health and Justice will also need to work together to implement the Mental Capacity Act (NI) 2016.
Department of Education	The promotion of positive mental health and of the emotional health and wellbeing has long been a central focus in our schools and is effective in reducing difficulties experienced by children and young people. The Department of Education has a number of 'preventative' programmes to educate our children on the risks to their emotional health and wellbeing, to assist parents and equip teachers to teach those sensitive subjects.

Department for Communities	Policy responsibility for welfare reform (includes elements of mental health funding)
Voluntary and community sector organisations: Action Mental Health ADD-NI Aware Defeat Depression CAUSE for Mental Health Cruse in Northern Ireland Eating Disorders Association Lighthouse Ltd Mindwise NIAMH The Samaritans Threshold Law Centre etc	Expert advice

5. PROPOSALS TO SHIFT THE CURVE?

1. Policy and strategy

Bamford action plan evaluation report, setting out gaps/needs.

Post-Bamford forward plan.

Official adoption of “parity of esteem” concept?

2. Increased funding

The Department has identified the need for at least £20m in additional annual investment in mental health services. Further funding will also be needed to action recommendations from the Bamford evaluation, and to implement the Mental Capacity Act. Prioritisation will be required to make best use of scarce resources.

3. Service developments, with clear outcome measures and improvement indicators, constantly monitored.

- Recommendations arising from the evaluation of the Bamford action plan, including more provision for carers, crisis support, education sector, more early intervention and prevention.
- Development of perinatal, eating disorder, mental trauma services.
- Further increases in psychological therapies provision .
- [Eventual input from public health side on wellbeing, suicide prevention, addictions, drug and alcohol misuse, etc].

6. WHAT WE PLAN TO DO

1. In the course of the evaluation, officials have engaged extensively with people with a mental illness and their families to listen to their direct experiences of services. We hosted a number of focus groups across the North of Ireland, in which 52 mental health service users and 80 family members / carers participated, as well as a range of voluntary sector organisations and support workers.

2. In addition, the HSC Board / PHA carried out an audit of Adult Mental Health Services, with a response rate of 665 questionnaires from service users and carers.

3. Since the draft PfG framework was published for consultation in May 2016, officials have engaged with the following organisations (primarily in the course of normal business, but using those opportunities to discuss their views on the draft framework and measurement tools):

   Law Centre
   UK National Preventive Mechanism
   The Together for You consortium of eight mental health organisations, led by Action Mental Health
   Mental Health Foundation
   Royal College of Psychiatrists
   Regional Eating Disorders Network Group
   Patient and Client Council
   Children's Law Centre

4. We have also discussed potential priorities with officials in other areas of DOH, DfC, DE and the HSC Board.

5. The emerging consensus is as follows:

(i) agreement on the need to improve mental health provision, building on Bamford reforms;
(ii) agreement on need for more funding to address historic underinvestment, allied with service and perhaps structural reform;
(iii) recognition of the need for focus on early intervention, including with Looked after Children (LAC);
(iv) recognition of extreme pressure on public finances, and need to combine clever, targeted investment, with savings from reform of existing services;
(v) recognition that definitively addressing all needs is a long-term project, that will take longer than one PfG period, and which will require prioritisation of limited resources; and
(vi) concern about the use of GHQ12 as the success measurement.

6. The issue with GHQ 12 is that it essentially measures potential prevalence of ill-health, and arguably does not exactly correlate with mental health generally, so that even if all the necessary mental health investment and reform could be made to happen, there would be no effect on GHQ12 as it is not the right measurement to use. We continue to discuss and consider potential alternatives.

7. In terms of overarching policy development, the following is emerging:

(i) An overarching aspiration to move towards parity of esteem between physical and mental health care, starting with initial investment in meeting the physical needs of people with mental health issues.
(ii) Improving CAMHS provision as part of cross-cutting Executive focus on the needs of vulnerable children and young people, investment in education, and diversion from contact with the criminal justice system.

8. The following proposed service developments are under detailed consideration:

(i) Development of a comprehensive regional perinatal mental health service, including mother and baby inpatient provision, potentially with an all-Ireland element.

(ii) Development of eating disorders service provision, potentially with an all-Ireland element.

(iii) Putting the provision of psychological therapies on a sure footing, by completing the roll-out of talking therapies hubs in each Trust area.

(iv) Fully implementing the Mental Capacity Act.

(v) Implementing a mental trauma service.

(vi) Improving personality disorders provision.

(vii) Developing a LAC support scheme

(viii) Consolidation of wellbeing and mental health services with Department of Education.

What?	**Who?**	**When?**
Set clear policy and strategic context	Department of Health	By 31 March 2017
Plan and bid for increased funding	Department of Health	PfG Period
Plan service developments	Department of Health, HSCB	TBC
Deliver service developments	HSCB, Trusts	TBC
Conduct workforce review?	Department of Health	TBC

7. PLANS FOR EVALUATION

Actions identified for implementation under this delivery plan will be evaluated for their success using an outcomes-focused approach. In addition to the core measure, we will use a range of HSC measurement systems to determine effectiveness as well as linking in with the measurement systems of other departments.

8. EQUALITY IMPACT

Services provided by the HSC are driven by clinical need and are available to all citizens equally. Any newly developed services or care pathways will be subject to the appropriate equality screening and consultation, as well as rural proofing and, where necessary, human rights impacts.

A copy of the screening is attached.

Equality Screening

PfG INDICATOR 6 –
IMPROVE MENTAL HEALTH

Part 1 – Policy scoping

Part 2 – Screening questions

Part 3 – Screening decision

Part 4 – Monitoring

Part 5 – Disability Duties

Part 6 – Human Rights

Part 7 – Approval and Authorisation

Part 1. Policy scoping

1.1 Information about the policy / decision

1.1.1 What is the name of the policy / decision?

PFG Indicator 6 – Improve mental health

1.1.2 Is this an existing, revised or a new policy / decision?

This is a new Programme for Government indicator and associated delivery plan, arising from Programme for Government 2016-21.

1.1.3 What is it trying to achieve? (intended aims/outcomes)

The intended outcome of Indicator 6 is to improve the general mental health of people in the North. For the Department of Health it is primarily about delivering good quality mental health services when they are needed and how people can be supported and mental health in the population as a whole can be promoted through prevention, early intervention and, where necessary, appropriate treatment and care.

Delivery partners include the Health and Social Care Board and Public Health Agency, the Health and Social Care Trusts, the Executive Office, Department of Justice, Department of Education, Department for Communities and voluntary and community sector organisations.

What are the PfG proposals to "shift the curve"?

The Bamford action plan evaluation will set out the gaps and needs in the mental

health services.
In addition there are a number of proposed service developments under detailed consideration:

(iii) Development of a comprehensive regional perinatal mental health service, including mother and baby inpatient provision, potentially with an all-Ireland element.
(iv) Development of eating disorders service provision, potentially with an all-Ireland element.
(v) Putting the provision of psychological therapies on a sure footing, by completing the roll-out of talking therapies hubs in each Trust area.
(vi) Fully implementing the Mental Capacity Act.
(vii) Implementing a mental trauma service.
(viii) Improving personality disorders provision.
(ix) Developing a Looked After Children support scheme
(x) Consolidation of wellbeing and mental health services with Department of Education.

The Department has identified the need for at least £20m in additional annual investment in mental health services. Further funding will be required to action recommendations from the Bamford evaluation and to implement the Mental Capacity Act.

1.1.4 If there are any Section 75 categories which might be expected to benefit from the intended policy, please explain how.

The delivery plan does not provide any detailed policy, project or service development proposals. These will follow in the normal course of business and separate equality screenings will be completed for these.

The impact screening exercise did not identify any adverse impact for any of the section 75 categories and did not identify any significant human rights impacts in the delivery plan. Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan are likely to be positive and will be dealt with, as appropriate, at the individual policy, project or service development level.

The proposed service developments that will be subject to further scrutiny includes a number of section 75 categories that might be expected to benefit from the intended policy. This includes age, gender, persons with disability and persons with dependents.

1.1.5 Who initiated or wrote the policy?

Mental Health and Capacity Unit in the Mental Health, Older People and Disability Directorate, Department of Health.

1.1.6 Who owns and who implements the policy?

Mental Health and Capacity Unit in the Mental Health, Older People and Disability Directorate owns the Delivery Plan, which is one of a set of indicators for Programme for Government which will be monitored by the NI Executive.

This indicator links to a number of other outcomes (outcomes 4, 6, 8, 11 and 14), and the SRO will work with other outcome owners (across NI departments) to deliver the plan and evaluate its success.

1.2 Implementation factors

Are there any factors which could contribute to/detract from the intended aim/outcome of the policy/decision? If yes, are they

Financial	x	Some actions in the Programme for Government Indicator 6 delivery plan will require resourcing. Some of the actions may be cost neutral or have low or no costs. Other actions may require a change to legislation in order to implement them. As such, their timescales will be subject to the NI Assembly legislative process. Some actions require support by Executive
Legislative	x	
Other	x	

	colleagues and as such are subject to political uncertainties.

1.3 Main stakeholders affected

Who are the internal and external stakeholders (actual or potential) that the policy will impact upon?

Staff	x
Service users	x
Other public sector organisations	x
Voluntary/community/trade unions	x
Other, please specify	

1.4 Other policies with a bearing on this policy / decision. If any:

Policy	**Owner(s) of the policy**
Looked After Children Strategy	Looked After Children and Adoption Policy Unit, Department of Health.
Voluntary and community elements of mental trauma service	The Executive Office/Commissioner for Victims and Survivors/Victims and Survivors Service
Implementation of the Mental Capacity Act (NI) 2016	Department of Health and the Department of Justice

'Preventative' programmes to educate our children on emotional health and wellbeing, to assist parents and equip teachers to teach those sensitive subjects	Department of Education
Welfare reform (includes elements of mental health funding)	Department for Communities
Protect Life 2	Health Improvement Branch, Department of Health

1.5 Available evidence

What evidence/information (both qualitative and quantitative*) have you gathered to inform this policy? Specify details for each of the Section 75 categories.

It is estimated that **one in four people** will suffer from a medically identified mental illness during their lifetime. Mental ill-health costs an estimated 3-4% of GDP, mainly through loss of productivity, cost of healthcare and social security benefits.

The 12-item General Health Questionnaire (GHQ-12) is a widely used and validated measure of mental health. It is used to detect psychiatric disorder in the general population and within community or non-psychiatric clinical settings such as primary care or general medical out-patients. It assesses the respondent's current state and asks if that differs from his or her usual state. GHQ-12 has been used consistently since 2010/11 in the Health Survey Northern Ireland (HSNI). A score of 4 or more on GHQ-12 indicates possible psychological disturbance or mental ill health.

Between 2010/11 and 2014/15, there was no real change in the proportion of the population that scored 4 or more on the GHQ-12. However, a fifth of those that scored highly (i.e. 4 or more) on GHQ-12 had a diagnosed mental health condition which compares with 2% of those that scored less than 4.

In 2009/10-2013/14, there were 226 hospital admissions due to self-harm per 100,000 population. Despite fluctuation between 2002/03-2006/07 and 2007/08-2011/12, rates have decreased in the last nine years. Over the last three years, the self-harm admission rate decreased by a tenth from 250 to 226 admissions per 100,000 population.

The number of individuals suffering from mood or anxiety disorders is estimated using prescription data extracted from the Electronic Prescribing Eligibility System (EPES), which allows the calculation of age standardised rates (using the direct method and standardising to the 2013 ESP). The standardised prescription rate for mood and anxiety disorders increased consistently over the last five years from 168 to 200 prescriptions per 1,000 population.

The number of inpatient admissions within Mental Illness specialties has declined generally in recent years from a high of 10,582 in 1999/00 to 4,451 in 2014/15

Section 75 category	Details of evidence/information
Religious belief	**Information on religious belief** can be found in the 2011 Census. One sixth (17 per cent) of the usually resident population on Census Day either had No Religion or Religion Not Stated. The figures for the main religions were: Catholic (41 per cent); Presbyterian (19 per cent); Church of Ireland (14 per cent); Methodist (3.0 per cent); Other Christian or Christian-related denominations (5.8 per cent); and Other Religions and Philosophies (0.8 per cent). Bringing together the information on Religion and Religion Brought up in, 45 per cent of the population were either Catholic or brought up as Catholic, while 48 per cent belonged to or were brought up in Protestant, Other Christian or Christian-related denominations. A further 0.9 per cent belonged to or had been brought up in Other Religions and Philosophies, while 5.6 per cent neither belonged to, nor had been brought up in, a religion. **As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact** on the grounds of religious belief has been identified. Mental ill health rates in the most deprived areas (30%) are twice that in the least deprived ares (15%). Suicide rates are also higher in the most deprived areas (29.9 deaths per 100,000 population) and is more than treble that in the least deprived areas (9.3 deaths per 100,000 population).

Political opinion	There is limited data available on **political opinion**, however data on the first preference votes per party in NI Assembly Elections 2016 can be used as proxy information: • DUP – 202,567 • Sinn Fein – 166,785 • UUP – 87,302 • SDLP – 83,364 • Alliance – 48,447 • Other – 105,845 **As health and social care services are available to everyone equally, on the basis of clinical need, no differential impact** on the grounds of political opinion has been identified.
Racial group	Based on **main ethnic group**, 98 per cent of people usually resident in the North on Census Day 2011 were White, 1.1 per cent (19,100) were Asian, 0.3 per cent (6,000) were Mixed, 0.2 per cent (3,600) were Black and 0.1 per cent (2,400) belonged to Other ethnic groups. Of the population 3.14% (aged 3 and over) considered a language other than English as their main language. It should also be noted that of the 98 per cent of people usually resident in North on Census Day 2011 who identified their ethnicity as White, almost 10 per cent (179,000) were born outside of the North. This includes 19,300 individuals from Poland, 7,250 from Lithuania, 4,000 from America, 3,800 from Germany and 1,650 from South Africa. The largest minority ethnic sub-groups in 2011 were Chinese (6,300 people; up from 4,100 in 2001), Indian (6,200; up from 1,600), and Other Asian (5,000; up from 200), each accounting for around 0.3 per cent of the usually resident population (Table DC2248NI). Including the 1,300 Irish Travellers, 1.8 per cent (32,400) of usual residents belonged to Minority Ethnic groups in 2011, more than double the proportion in 2001 (0.8 per cent). Although is expected that the number of people born outside of the North has increased significantly since the 2011 census, as **health and social care services are available to everyone equally, on the basis of clinical need, no differential impact** on the grounds of racial group has been identified. There is little data on how different ethnic groups have different rates and

	experiences of mental health problems in the North of Ireland. However, figure from England and Wales show that people from black and ethnic minority groups are more likely to be diagnosed with mental health problems, are • more likely to be diagnosed with mental ill health; • more likely to be admitted to hospital for mental health reasons; and • more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health These differences may be explained by a number of factors, including poverty and racism. It is important to note that these facts do not show direct correlation and that there may be other underlying reasons (such as social deprivation) as to why black and ethnic minority groups are more likely to suffer from mental ill health. It is also important to note that the racial profile of the North of Ireland is significantly different than in England and Wales meaning that the facts there may not be relevant here.
Age	The North's **average age** increased from 34 years to 37 years between the 2001 and 2011 Censuses. Over the same period, the share of the population represented by children aged under 16 years fell from 24 per cent to 21 per cent, while the proportion of people aged 65 years and over rose from 13 per cent to 15 per cent. Public Health Agency's report *Improving the Mental Health of Northern Ireland's Children and Young People: Priorities for Research (2011)* draws on the Bamford Review's acknowledgement that "very little epidemiological study of **child mental health** problems has been carried out in the North and the rates of many problems and disorders have to be extrapolated from British and international studies" (*A vision of a comprehensive child and adolescent mental health service*, *Bamford Review, 2006*). Compared with the 2001 Census, the number of people **aged 65 years and over** living in the North increased by 18 per cent (40,400) to 263,700 on Census Day 2011. Between 2002 and 2012, the number of people *aged 60-84* rose by 20%, while those *aged 85+* rose by 38%. In February 2007, the Alzheimer's Society published a major study on the social and economic impact of **dementia** in the UK. The research, commissioned through King's College London and the London School of

	Economics provides a detailed and robust picture of prevalence and economic impact of dementia in the UK. This report estimates that one in 14 people over 65 years of age and one in six people over 80 years of age have a form of dementia. A further report published by Alzheimer's Society: *Dementia 2013: The hidden voice of loneliness* indicates that 18,862 people in The North have dementia. **Mental health in-patients** can be broken down with the following age structure (as of 17 February 2016): • Under 18: 5.8%; • 19 – 44: 37.3%; • 45 – 64: 31.8%; and • 65 and over: 25.0% With the exception of those under 18 the spread of mental health in-patients are broadly proportionate to the general population. Of those patients **compulsory admitted** to hospital the spread is similar: • Under 18: 2.8%; • 18 – 44: 45.5%; • 45 – 64: 27.5%; and • 65 and over: 24.2% It is estimated that **eating disorders** affect about 1% of the population. Female teenagers have the highest rate of new cases of anorexia nervosa each year, at 51 per 100,000. The peak age onset is 13-18 and most cases develop between 13-25 years. However, an increasing number are now being reported among those under 10 years of age. Disproportionately high levels of mental health difficulties have been identified among **young people in the care system and those who have experienced abuse** (Teggart & Menary 2005, Mullan et al 2007). Disproportionate high levels of suicide have been identified in men between the ages of 20 and 50 thus affecting different age groups differently. Similar age related suicide links have not been identified for women.
Marital status	The 2011 Census data provides information on **marital status**. It showed that almost half (48 per cent) of people aged 16 years and over were married, and over a third (36 per cent) were single. Just over 1,200 people (0.1 per cent) were in registered same-sex civil partnerships in

<table>
<tr><td></td><td>March 2011. A further 9.4 per cent of usual residents were either separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8 per cent were either widowed or a surviving partner.

Recent research has indicated a correlation between marital status and suicide rates in The North (O'Reilly et al 2008, Corcoran Nagar 2009). Unmarried men over 55 and younger divorced men were shown to be at a higher risk than the population as a whole.</td></tr>
<tr><td>Sexual orientation</td><td>The 2012 Life and Times Survey interviewed 1204 adults to establish their sexual orientation. 98% of respondents identified themselves as Heterosexual/Straight, 1% as Gay/Lesbian, and 1% provided No answer/Refusal.

The DHSSPS Health Survey records:-

<table>
<tr><td></td><td>2012/13</td><td>2013/14</td></tr>
<tr><td>Heterosexual/Straight</td><td>93%</td><td>94%</td></tr>
<tr><td>Gay/Lesbian</td><td>1%</td><td>1%</td></tr>
<tr><td>Bisexual</td><td>2%</td><td>1%</td></tr>
<tr><td>Other</td><td>1%</td><td>1%</td></tr>
<tr><td>Not specified</td><td>3%</td><td>3%</td></tr>
</table>

0.09% of all usual residents aged 16 or over are in a registered same-sex partnership (Source: NI Census 2011).

In a systematic review of international research literature the National Institute for Mental Health in England (2007) found that levels of depression and anxiety disorders were higher in lesbian, gay and bisexual people. The risk of attempted suicide was over four times (4.28) greater in gay and bisexual men than in heterosexual men and almost doubled (1.87) in lesbian and bisexual women as compared with heterosexual women. Research conducted in England suggests that lesbian, gay and bisexual young people experience disproportionately high levels of bullying, distress and self-destructive behaviour (Rivers 2000).

As health and social care services are available to everyone</td></tr>
</table>

	equally, on the basis of clinical need, no significant differential impact on the grounds of sexual orientation has been identified.
Gender (Men and women generally)	The 2011 Census data showed that 49% of all usual residents in The North are male, with 51% of the population female. **Compulsory admission** to hospital for assessment of a mental disorder is evenly shared between men and women, with 50.5% of the admissions being women and 49.5% being men. No significant inequality is therefore present in these circumstances. It is estimated that **eating disorders** affect about 1% of the population. It is estimated that approximately 1 in 250 women and 1 in 2,000 men will experience anorexia nervosa at some point in their lives meaning that this will affect women at a significantly higher rate than men. About 10% of people diagnosed as having an eating disorder are men. However, these conditions often go undetected in male sufferers. Many men find it hard to ask for help, particularly when the doctor or counsellor does not recognise their symptoms. There are also a high proportion of treatment resistant cases within this client group, which can result in a high cost of treatment. **Perinatal mental health** disorders occur in up to 15% of all pregnancies. Given that there are approximately 25,000 births in the North of Ireland every year, this implies that there are around 3,750 cases of perinatal mental illness annually. One third of cases occur before birth, with two-thirds post-natally. Most cases are mild-to-moderate and can be managed in primary or community settings. Moderate-to-serious disorders that require secondary care intervention occur in relation to around 3% of pregnancies, implying approximately 750 cases annually. Severe/complex disorders requiring hospital admission occur in 0.4% of pregnancies, equating to approximately 100 admissions per year. Maternal death as a result of perinatal mental illness occurs in 3.7 of every 100,000 maternities. As perinatal mental health disorder affects during, or shortly after, pregnancy it has a disproportionate effect on women. It is clear there is a **gendered aspect to suicide** in the North of Ireland with men three times more likely to die by suicide than women, and males aged 20 to 50 having the highest suicide rate. There is also evidence that long accepted cultural perceptions of masculinity,

	characterised by competitiveness, risk-taking and enduring hardship without displaying feelings, impact negatively upon men's help-seeking behaviour. Males can be reluctant to disclose mental health concerns to their GP and often present with physical symptoms rather than mental health issues. **Suicide** rates among young trans persons is significant with reports that nearly half of all trans young persons have attempted suicide.
Disability (with or without)	In 2011, Census data showed that just over one in five of the usually resident population (21 per cent) had a long-term health problem or **disability** which limited their day-to-day activities. The most common long-term conditions among the usually resident population were: a mobility or dexterity problem (11 per cent); long-term pain or discomfort (10 per cent); shortness of breath or difficulty breathing (8.7 per cent); chronic illness (6.5 per cent); and an emotional, psychological or mental health condition (5.8 per cent). If a mental illness has a substantial, adverse and long-term effect on the ability to carry out normal day-to-day activities then it is likely to be covered by the Disability Discrimination Act. The Act also covers people who have had a disability in the past. The Act does not provide a list of impairments that are covered, but instead considers the effects of an impairment on a person. For example, someone with a mild form of depression with only minor effects may not be covered, while someone with severe depression with substantial effects on their daily life is likely to be considered as having a disability under the Act. Many people with a mental health condition do not think of themselves as having a 'disability' but in fact many mental ill healths are disabilities. This includes (but is not limited to) persons with dementia, depression, bi-polar disorder, obsessive compulsive disorder and schizophrenia. Any policy in relation to mental health will hence have an impact on those with a disability (as mental health issues often are disabilities). However, there is **no direct differential impact** on the grounds of disability.
Dependants (with or without)	In 2011, one-third (34 per cent) of households in The North contained **dependent children**, down from 36 per cent in 2001. Two-fifths (40 per cent) of households contained at least one person with a long-term health problem or disability; made up of those households with dependent children (9.2 per cent) and those with no dependent children

	(31 per cent). In March 2011, 5.8 per cent of households contained dependent children and no adults in employment.Although Davidson et al (2003) draw from the Acheson report on Inequalities in Health (1998) the particular relationship between caring for young children, poverty and poor mental health there is **no direct differential impact** on the grounds of having, or not having, dependants. 41% of all carers in the North of Ireland had a physical or mental health condition in 2012-13 and 63% of carers say they are at their mental health breaking point. 63% of carers also suffer from depression as a result of caring. However, the policies proposed does not have any direct differential impact on carers. See also above in gender in relation to perinatal mental health disorder.

1.6 Needs, experiences and priorities

Taking into account the information recorded in 1.1 to 1.5, what are the different needs, experiences and priorities of each of the following categories, in relation to the particular policy/decision? Specify details for each of the Section 75 categories

Any specific needs, experiences and priorities for individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

Section 75 category	Details of needs/experiences/priorities
Religious belief	No evidence of specific need has been identified
Political opinion	No evidence of specific need has been identified

Racial group	No evidence of specific need has been identified
Age	It is acknowledged that the existing framework relating to **children** is complex, encapsulating legislation such as the Children (NI) Order 1995, Mental Health (NI) Order 1986 and the Age of Majority Act, case law such as *Gillick* and the inherent jurisdiction of the court. Pending that review, the Department has also made clear its willingness to consider any proposal that results in children being better protected to mitigate against concerns raised. One of the potential outcomes in the delivery plan is developing a support scheme for **looked after children**. Although at the delivery plan level no specific needs, experiences and priorities have been identified in relation to young persons, research indicates this group is at increased vulnerability to mental health issues and suicide risk. **Eating disorders** usually has its onset in younger age and affect younger people to a greater extent. The priorities and needs are therefore higher among younger persons than among older persons. No direct differential impact has been identified in respect of **older persons**. However, fully implementing the **Mental Capacity Act** may indirectly affect more older people as the rate of dementia and other causes of loss of capacity are disproportionate among older people than in the population in large.
Marital status	Even though unmarried men are more likely to commit suicide there is **no differential impact** on the priorities and needs in relation to **marital status**.
Sexual orientation	No evidence of specific need has been identified
Gender (Men and women generally)	**Eating disorders** disproportionately affect more women than men. However, the disorders are often undetected among men and therefore represent an disproportionate cost to the health service. Development of policies, projects and service developments in the field of eating disorders will be informed by the facts and may as such be tailored towards its target group. Given the significant impact on perinatal mental health disorder on society

	as a large, and the mental well being of the population this indicator will continue to develop policy, projects and service developments to further the work on **perinatal mental health** services. Men are three times more likely to die by **suicide** than women. However, at the delivery plan level no specific needs, experiences and priorities have not been identified in relation to gender.
Disability (with or without)	No evidence of specific need has been identified.
Dependants (with or without)	No evidence of specific needs have been identified. See also above in gender in relation to perinatal mental health disorder.

Part 2. Screening questions

2.1 What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)		
Section 75 category	**Details of policy impact**	**Level of impact? minor/major/none**
Religious belief	None expected	None
Political opinion	None expected	None
Racial group	None expected	None
Age	The delivery plan is not expected to have any impact on this section 75 category. However, policies, projects and service developments to support the outcome of indicator 6 may have an impact on this category. The delivery plan notes that the Department is considering consolidation of wellbeing and mental health services with the Department of Education including a strategy in respect of Looked After Children. This may impact mostly persons of school age and therefore have a disproportionate impact on children under the age of 18. However, it is expected that this would be a positive impact. The delivery plan also notes work on implementing the Mental Capacity Act, developing eating disorder service provisions and developing a support scheme for looked after children. These may have an indirect differential impact on	Minor (positive)

	this section 75 category. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	
Marital status	None expected	None
Sexual orientation	None expected	None
Gender (Men and women generally)	The delivery plan is not expected to have any impact on this section 75 category. However, policies, projects and service developments to support the outcome of indicator 6 may have an impact on this category. The delivery plans note the consideration of development of a comprehensive regional perinatal mental health service, including mother and baby inpatient provision, potentially with an all-Ireland element. As this development is focussed on perinatal mental health it will impact on woman. However, it is expected that this would be a positive impact. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	Minor positive
Disability (with or without)	The delivery plan is not expected to have any impact on this section 75 category. However, policies, projects and service developments to support the outcome of	Minor positive

	indicator 6 may have an impact on this category. The delivery plan is aimed to deliver on the Programme for Government indicator 6 to improve the mental well being of the population. This will affect those with mental disabilities to a higher extent than those without. However, it is expected that this would be a positive impact and no differential impact can be identified at the time of the delivery plan development. Individual policies, projects and service developments may have an impact and individual impact screenings will be carried out at policy, project and service development level.	
Dependants (with or without)	The delivery plan is not expected to have any impact on this section 75 category. However, policies, projects and service developments to support the outcome of indicator 6 may have an impact on this category. The delivery plans note the consideration of development of a comprehensive regional perinatal mental health service, including mother and baby inpatient provision, potentially with an all-Ireland element. As this development is focussed on perinatal mental health it will impact on woman with dependants (mothers with young children). However, it is expected that this would be a positive impact. Individual policies, projects and service developments may have a major impact and individual impact screenings will be carried out at policy, project and service development level.	Minor positive

2.2 Are there opportunities to better promote equality of opportunity for people within the Section 75 equalities categories?		
Section 75 category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No. This is the best way we know of levelling the playing field for everyone. The delivery plan in itself is not expected to have any impact on any section 75 category. The individual policies, projects or service developments may have an impact, however, this is expected to be a positive impact. The positive impacts are related to age, gender, disability and dependents as noted above. Individual policies, projects and service developments may have a major impact and individual impact screenings will be carried out at policy, project and service development level.
Political opinion		
Racial group		
Age		
Marital status		
Sexual orientation		
Gender (Men and women generally)		
Disability (with or without)		
Dependants (with or without)		

2.3 To what extent is the policy likely to impact on good relations between people of different religious belief, political opinion or racial group? (minor/major/none)		
Good relations category	**Details of policy impact**	**Level of impact minor/major/none**
Religious belief	No expected impact on good relations	None
Political opinion	No expected impact on good relations	None
Racial group	No expected impact on good relations	None

2.4 Are there opportunities to better promote good relations between people of different religious belief, political opinion or racial group?		
Good relations category	If **Yes**, provide details	If **No**, provide reasons
Religious belief		No. The delivery plan offers limited potential to promote good relations between people of different religious belief as the main aim is to increase the mental well being of the population.
Political opinion		No. The delivery plan offers limited potential to promote good relations between

		people of different political opinion as the main aim is to increase the mental well being of the population.
Racial group		No. The delivery plan offers limited potential to promote good relations between people of different racial group as the main aim is to increase the mental well being of the population.

2.5 Additional considerations

Multiple identity

Provide details of data on the impact of the policy on people with multiple identities (e.g. minority ethnic people with a disability, women with a disability, young protestant men, young lesbian, gay or bisexual persons). Specify relevant Section 75 categories concerned.

The policies provide no no anticipated differential impacts on people with multiple identities.

However, in general men between 20-50 are more likely to commit suicide. Women between 20-40 are more likely to suffer from perinatal mental health. Young females are more likely to suffer from eating disorders. Young trans persons are more likely

to attempt suicide. Carers with disabled dependents are more likely to suffer mental ill health.

2.6 Was the original policy / decision changed in any way to address any adverse impacts identified either through the screening process or from consultation feedback. If so please provide details.

No adverse impacts have been identified in relation to the delivery plan. It was developed in consultation with key stakeholders to address areas where policies, projects and service developments could help increase the mental well being of the general population.

The delivery plan was not changed to address any adverse impacts and further work identifying any potential adverse impact will be carried out on the individual policies, projects and service developments when appropriate and applicable to do so.

Part 3. Screening decision

3.1 How would you summarise the impact of the policy / decision?

No impact		
Minor impact	x	Consider mitigation (3.4 – 3.5)
Major impact		

3.2 Do you consider that this policy / decision needs to be subjected to a full Equality Impact Assessment (EQIA)?

Yes - screened in	
No - screened out	x

3.3 Please explain your reason for making your decision at 3.2.

The intention of the delivery plan is to provide a high level framework for future policies, projects and service developments.

The impact screening exercise identified only minor positive and no negative impact for any of the section 75 categories and did not identify any major human rights impacts in the delivery plan. Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan are likely to be positive and will be dealt with, as appropriate, at the individual policy, project or service development level.

Mitigation

If you have concluded at 3.1 and 3.2 that the likely impact is '**minor**' and an equality impact assessment is not to be conducted, you must consider mitigation (or scope for further mitigation if some is already included as per 2.6) to lessen the severity of any equality impact, or the introduction of an alternative policy to better promote equality of opportunity or good relations.

3.4 Can the policy/decision be amended or changed or an alternative policy introduced to better promote equality of opportunity and/or good relations?

Yes	
No	x

3.5 If you responded "**Yes**", please give the **reasons** to support your decision, together with the proposed changes/amendments or alternative policy.

Part 4. Monitoring

Monitoring is an important part of policy development and implementation. Through monitoring it is possible to assess the impacts of the policy / decision both beneficial and adverse.

4.1 Please detail how you will monitor the effect of the policy / decision?

The implementation of the delivery plan will be monitored annually by the Department, in discussion with the Health and Social Care Board and our key stakeholders who have a vested interest in this policy.

The delivery plan will also be subject to evaluation to ensure it achieves its intended outcomes. Policies, projects and service developments identified for implementation under the delivery plan will be evaluated for their success using an outcomes-focused approach. In addition to the core measure, a range of HSC measurements systems will be used to determine effectiveness as well as linking in with the measurement systems of other Departments.

4.2 What data will you collect in the future in order to monitor the effect of the policy / decision?

The Department has access to a significant range of data which will enable us to monitor the effects of the implementation and outcomes of individual policies, projects and service developments.

The Department publishes the results from annual surveys and can disaggregate this information as required. In addition the Health and Social Care Board also provides half yearly statistics to the Department from the Trusts on delegated statutory functions, which are used to inform policy.

As individual policies, projects and service developments are evolved appropriate data will be identified to effectively monitor the outcomes.

Please note: For the purposes of the annual progress report to the Equality Commission you may later be asked about the monitoring you have done in relation to this policy and whether that has identified any equality issues.

Part 5. Disability Duties

5.1 Does the policy/decision in any way promote positive attitudes towards disabled people and/or encourage their participation in public life?

The main aim of the Programme for Government Indicator 6 is to improve mental health of the general population. This includes reducing the stigma for persons with mental disabilities and encouraging their participation in public life.

5.2 Is there an opportunity to better promote positive attitudes towards disabled people or encourage their participation in public life by making changes to the policy/decision or introducing additional measures?

No.

Part 6. Human Rights

6.1 Does the policy / decision affect anyone's Human Rights?

The impact screening exercise did not identify any positive or negative human rights impacts in the delivery plan. Individual policies, projects and service developments will likely have a human rights impact, in particular positive impact as the overall objective is to increase the mental well being of the population.

Any potential impacts of individual policies, projects or service developments undertaken to meet the outcomes in the delivery plan will be dealt with, as appropriate, at the individual policy, project or service development level.

ARTICLE	POSITIVE IMPACT	NEGATIVE IMPACT	NEUTRAL IMPACT
Article 2 – Right to life			x
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment			x
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour			x
Article 5 – Right to liberty & security of person			x
Article 6 – Right to a fair & public trial within a reasonable time			x
Article 7 – Right to freedom from retrospective criminal law & no punishment without law.			x
Article 8 – Right to respect for private & family life, home and correspondence.			x
Article 9 – Right to freedom of thought, conscience & religion			x
Article 10 – Right to freedom of expression			x
Article 11 – Right to freedom of assembly & association			x
Article 12 – Right to marry & found a family			x
Article 14 – Prohibition of discrimination in the			x

enjoyment of the convention rights			
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property			x
1st protocol Article 2 – Right of access to education			x

6.2 If you have identified a likely negative impact who is affected and how?

Not applicable.

At this stage we would recommend that you consult with your line manager to determine whether to seek legal advice and to refer to Human Rights Guidance to consider:

- *whether there is a law which allows you to interfere with or restrict rights*
- *whether this interference or restriction is necessary and proportionate*
- *what action would be required to reduce the level of interference or restriction in order to comply with the Human Rights Act (1998).*

6.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy/decision.

Not applicable.