Northern Ireland Assembly

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Mental Health and the Treatment of Depression in Northern Ireland

This paper provides an overview of mental health in Northern Ireland and a comparative analysis of the cost of antidepressant prescribing and talking therapies in the treatment of depression. It also looks at the funding mechanisms for each of these treatments, and the cost implications for current and future care.

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Contents

1 Key Points

- People in Northern Ireland have worse mental health than those in the rest of the UK. Levels of depression, anxiety, eating disorders, self-harm, suicide and substance abuse and/or misuse are at historically high levels.
- Despite this, provision of mental health services in Northern Ireland accounts for a much smaller proportion of the overall health budget than in other jurisdictions.
- Antidepressant medication is the most prevalent treatment for depression in Northern Ireland. Prescribing of antidepressants has been increasing over time, however costs have been falling due to a range of cost containment strategies (from £25m in 2004 to £11m in 2019).
- The cost of antidepressant prescribing in Northern Ireland rose sharply in 2020 by approximately £7 million. This rise was due to supply-side shortages coupled with logistical challenges due to COVID-19. This pattern was seen across the UK; Prices have since stabilised.
- An alternative approach to treating depression is talking therapy. The National Institute for Health and Care Excellence (NICE) recommends a “menu of options” for treating depression. Talking therapies are recommended as ‘first-line’ treatment for mild to moderate depression.
- Talking therapies are not a substitute for antidepressants, but rather a complement to them, especially in the treatment of more severe depression.
- Talking therapies are available in Northern Ireland and can be accessed via GP practices, multidisciplinary teams (MDTs) and talking therapy/emotional wellbeing hubs. However, provision of this service is not uniform across all Trusts suggesting the existence of a ‘postcode lottery’.
- The new Mental Health strategy for Northern Ireland (2021-31) has such services at the forefront of the transformation agenda. Implementing this Strategy will cost £1.2bn over the next 10 years.
- This is a substantial investment. However, poor mental health has been estimated to cost the Northern Ireland economy £3.4bn per year.
- Unfortunately, implementation of the Strategy has been delayed as the draft budget was not agreed before the Executive was dissolved.

- Some commentators have linked poor access to talking therapies in Northern Ireland with rising antidepressant prescribing. However, the ‘NHS Talking Therapy’ programme has been available in England since 2008 yet antidepressant prescribing continues to rise.
- To support the mental health transformation agenda, there is a clear and pressing need to improve data around mental health services, to improve data accessibility and to develop an appropriate outcomes measurement framework.
- This will require significant investment. However, without knowing what works, for whom, under what conditions, it is impossible to know which services deliver meaningful clinical benefit for patients. Furthermore, data on the cost-effectiveness of services is crucial to support efficient commissioning decisions.

1.1 Introduction and context

The World Health Organisation defines good ‘mental health’ as “a state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. It affects how we think, feel, and act, and helps determine how we handle stress, relate to others, and make choices.[1]

Mental health is important at every stage of life, from childhood and adolescence through to adulthood. Mental health disorders cover a broad range of diagnoses such as developmental disorders, substance use disorders, depressive and anxiety disorders, schizophrenia and other psychotic disorders, and ranges in severity, from the mild and self-limited to chronic and functionally-debilitating disorders.[1]

Effective treatments are available for many mental health disorders, and if implemented with fidelity, treatment can decrease or eliminate symptoms, promote recovery, and reduce morbidity and mortality. However, people with mental health problems often fail to receive the same access to services or quality of care as people with other illnesses.[1]

More recently treatment of mental wellbeing, mental ill-health and mental illness has changed. The World Health Organisation (WHO) provides three main goals for the organisation of mental health services: to deinstitutionalise mental health care; to integrate mental health into general healthcare; and to develop community mental health services.[1]

While the exact cause of mental ill health is not known, a range of genetic, socioeconomic and environmental determinants are known to be linked to mental health. Evidence suggests that addressing these socioeconomic determinants and promoting social and economic equity can play a vital role in improving mental health

at both an individual and population level. Therefore, the costs and benefits of improving mental health have the potential to impact multiple sectors of the economy.

1.2 The state of mental health in Northern Ireland

Mental health is a crucial issue in Northern Ireland, where the prevalence and severity of mental health problems are higher than in other parts of the UK. According to the Mental Health Foundation[2], one in five adults in Northern Ireland has experienced a mental health problem, a rate 25% higher than in England and rates of depression are significantly higher than the rest of the United Kingdom with almost 1 in 5 of the population here receiving antidepressant medication during 2020/21. This translates to almost 24% of the female population and 14% of males.[3]

Suicide is also a major public health concern, with rates steadily rising since records began in 1970.[4] Three-hundred and eighteen deaths were registered in 2019, an increase of 19% from the previous year.[5] Self-harm rates are higher in Northern Ireland that other parts of the UK, with 5,237 hospital admissions in 2019/20,[6] and substance misuse is a significant problem.[7]

In addition, Northern Ireland has significantly higher rates of trauma-related disorders than other countries. The Ulster University reported that Northern Ireland had the highest rate of Post-Traumatic Stress Disorder (PTSD) in the world—ahead of war-hit regions in the Middle East, with violence as a distinctive cause in one in four cases.[8]

Levels of child, adolescent and maternal mental health problems in Northern Ireland are also concerning. According to the latest data from the Department of Health, in 2019/20, there were 10,636 referrals to Child and Adolescent Mental Health Services (CAMHS), an increase of 6.4% from the previous year, with an average waiting time of 10.4 weeks to first appointment.[9] In addition, 80% of women and families have no access to specialist perinatal mental health care in Northern Ireland.[10]

These high and rising figures have been attributed to a range of socioeconomic factors. Entering the pandemic, nearly 1 in 5 people in Northern Ireland lived in poverty, including 100,000 children. However, despite lagging significantly behind other parts of the UK with respect to earnings and employment rates, levels of deprivation in Northern Ireland have improved in recent years compared to other UK nations.[11] Deprivation (in this context) is measured by the index of multiple deprivation (IMD) which combines indicators of income, employment, health, education, crime, housing and living environment – all socioeconomic factors known to impact mental health.

The legacy of conflict is also cited as a contributory factor – not just for those who have lived through the conflict - but for those born post Good Friday Agreement who reside in deprived areas where violence, alcohol and drug misuse are prevalent.[12]

1.3 The cost of poor mental health in Northern Ireland

Understanding the humanistic and financial costs of the mental health crisis in Northern Ireland is fundamental, as left untreated, mental health disorders affect the well-being of children, adults, families and communities creating emotional costs as well as having economic ramifications. The health and social care system in Northern Ireland is under extreme pressure, a situation compounded by the COVID-19 pandemic and current cost of living crisis. Currently Mental health issues are the single largest cause of ill health and disability in the Northern Ireland population.[13]

Currently, mental health problems cost Northern Ireland £3.4 billion annually, most of which (65%) reflects the cost of informal care (£1.15 billion) and the cost of lost productivity associated with people living with mental health conditions (£1.07 billion). In addition, the cost of reduced quality of life due to mental ill-health was valued at £580 million.[14]

In the report, it was stressed that this was a conservative estimate as a wide range of costs were not included – relating to, for example, reduced performance at work because of mental health problems or the cost of health conditions which were caused or exacerbated by a mental health problem.

In addition to these costs, PTSD in Northern Ireland has been estimated to cost £173 million,[15] with the cost of substance misuse in excess of £1 billion.[16]

1.4 Provision of mental health services in Northern Ireland

The Department of Health in Northern Ireland has a statutory responsibility to promote an integrated system of health and social care designed to secure improvement in the physical and mental health of people in Northern Ireland.[17]

Within the UK, National Institute for Health and Care Excellence (NICE), a Non-Departmental Public Body, produces national guidance on the promotion of good health and the prevention and treatment of ill health, as well as responsibility for developing quality standards in social care.[18] As such they provide guidance on treatment for a range of mental health conditions.

NICE guidance is designed for use in England and, as such, does not automatically apply in Northern Ireland. The Department of Health established links with NICE in 2006 to ensure that Northern Ireland has access to up-to-date, independent, professional, evidence-based guidance on the value of healthcare interventions. When guidance is issued, the Department of Health initiates a review process to check for legal, policy and financial consequences related to its implementation. Such reviews are expected to be completed within 8 weeks from publication of guidance.

2 Policy context

Mental health policy direction in Northern Ireland has shifted over the last 20 years, from delivery of long-term care for mental health patients in hospitals, to community-based services with a focus on patient-centered care to promote health and wellbeing. Current mental health policy continues to be shaped and directed by the Bamford Review (2002);[19] an independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

The review produced 11 interlinked reports, with recommendations from the review taken forward by the NI Executive through two Action Plans (2009-2011 & 2012-2015). The Bamford Review envisioned a 10 to 15-year timescale for full implementation. Key recommendations related to promoting positive mental health; shifting services from a hospital to community setting; delivering specialist services and a fully trained workforce and a reform of mental health legislation through the introduction of the Mental Capacity Act (NI) 2016.[20] Despite significant reform, some commentators have pointed to the lack of (until recently) an overarching mental health strategy, and challenges relating to the lack of data relating to mental health services and issues around funding of services and access to those most in need.

Other documents which have driven change include 'You in Mind' (2014)[21] which was developed and implemented by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) to ensure consistency in service delivery. The pathway used a 5-step care model aimed to match patients' level of need with an appropriate level of support. In 2018 a similar pathway was launched for children and young people called 'Working Together: A Pathway for Children and Young People through CAMHS'.[22]

The importance of prevention, early intervention and provision of services in the community is stressed in the most recent 10-year plan for the delivery of healthcare services in Northern Ireland 'Health and Wellbeing 2026: Delivering Together'.[23] In the absence of an overarching Mental Health strategy an Executive Working Group

on Mental Wellbeing, Resilience and Suicide[24] was established in 2020, which was responsible for examining the progress of the implementation of Northern Ireland's suicide prevention strategy; Protect Life 2.[25]

2.1 Current mental health strategy

In May 2020, the Department of Health launched a Mental Health Action Plan as a precursor to the new 10-year Mental Health Strategy (2021-2031) which was published in 2022.[26] This approach aimed to deliver immediate improvement in services and had a remit to develop a new 10-year mental health strategy.

The new strategy aims to improve mental health outcomes for people in Northern Ireland, leading to strategic change and transformation over the next ten years. It was developed through an extensive process of co-production and stakeholder engagement, resulting in 35 actions setting out the strategic direction for mental health services over the next decade to ensure that the Northern Ireland population has access to the care and treatment they need, when they need it.

The action points aim to reduce waiting lists, by ensuring a good start in life; providing effective early support through primary care and accessible treatment, to prevent or delay the onset of more serious mental health problems; and ensure that people who are usually difficult to reach are targeted.

It proposes changing how mental health services are structured, with a greater focus on the community and GPs. This involves increasing the availability of therapy and provision of mental health support in primary care through the Multi-Disciplinary Team (MDT) programme which introduced mental health roles into General Practice. Through a holistic approach, it hopes to provide local populations with timely and accessible health and wellbeing support at the earliest stages. The Strategy also proposes a comprehensive workforce review designed to consider the existing workforce's needs and training, as well as the development of a new workforce.

2.2 Funding mental health services

Mental health has, in the past, been referred to as a 'Cinderella service' – both undervalued and underfunded, however, there is now a commitment to establish 'parity of esteem' between mental and physical health. In Northern Ireland, funding for mental health as a proportion of the health budget has remained relatively low at around 5.7% (2019/2020) despite the higher prevalence of need.[27]

This equates to just under £300 million being allocated to mental health from a total healthcare budget of £5.2 billion - approximately £160 per person. By comparison, NHS England spend 14.1% of their budget on mental health services, NHS Wales and NHS Scotland spend 11.1% and 7.1% respectively. Spending on mental health services in Ireland is of a similar magnitude to Northern Ireland at 6.2%.[28]

To match funding levels elsewhere in the UK would require a substantial investment. On the basis of per capita funding levels (2019/2020) the additional annual investment in mental health which would be needed is between £80 - £190 million.[29]

Low levels of investment has led to underfunded and understaffed mental health services and increasing waiting times. The number of people on mental health waiting lists has grown significantly since 2018 a problem compounded by a shortage of psychologists and psychiatrists in Northern Ireland.[30] There is also evidence that monies earmarked to address this situation have been diverted to address funding gaps in front line services.[31]

2.3 Funding the current mental health strategy in NI

To deliver all of the commitments within the new Mental Health Strategy will cost 1.2bn over the next 10 years.[32] However, the burden of mental health illness in Northern Ireland has been estimated at £3.4 billion *per annum.*[33] Therefore, this could

be viewed as a ‘spend to save’ initiative, with the potential for a significant positive return on investment across multiple sectors.

Full provision for implementation of the strategy was contained within the Executive’s draft budget for years 2022-23 to 2024-25. However, this budget was not agreed before the Executive dissolved in February 2022.

The Mental Health Champion (Professor Siobhan O’Neill) recently reported that full implementation of the strategy within the original timetable was unlikely. The funding plan set out a need for £9.59 million for 2022/23, but only £2.5 million was allocated by the Department of Health. Entering year 2 of the strategy (April 2023-2024), where £24.38 million is needed for full implementation, the Department of Health stated that they could not deliver the strategy within the existing budget.[34]

Meanwhile, preparatory activities and work towards key enabling actions have been started. This includes roll out of specialist perinatal mental health services; completion of a draft review report in relation to the development of a regional mental health service; establishment of a steering group; and commencement of work to develop an outcomes framework and implementation plan.

Against this transformation backdrop, the following sections will explore the clinical guidance, funding mechanisms and expenditure on two key treatments for depression (antidepressant prescribing and talking therapy).

3 Treatments for depression

Talking therapies and antidepressant medication are the main treatments for depression. The exact type of treatment depends on the severity and type of depression and whether the patient is a child, adolescent or adult. In the UK, the

National Institute for Health and Care Excellence (NICE) provides guidelines for the treatment of depression based on a stepped care approach, which involves providing different levels of treatment depending on the severity and duration of the depression.[35]

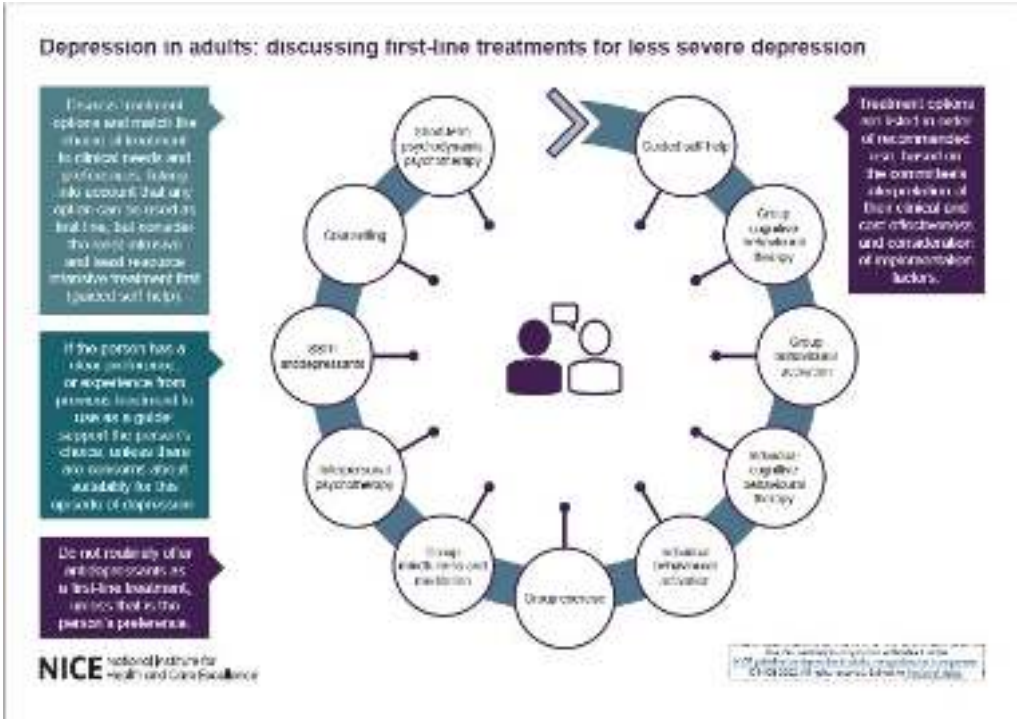
Talking therapies (such as cognitive behavioural therapy (CBT), counselling, interpersonal therapy, and psychodynamic psychotherapy) can help people with mild to moderate depression to understand and cope with their feelings, thoughts and behaviours. They can also be used for people with severe depression, sometimes in combination with medication.

Medication for depression includes antidepressants, which can help to balance the chemicals in the brain that affect mood and emotions. Antidepressants are usually prescribed for moderate to severe depression, but they can also be used for mild depression if talking therapies are not effective or available.

Different types of antidepressants are available, such as selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). The choice of antidepressant depends on the individual's symptoms, preferences and side-effects, with second generation antidepressants (SSRIs and SNRIs) being prescribed most frequently.

According to NICE Guidance, antidepressants should not be routinely prescribed for adults presenting with less severe depression unless it is the person’s preference (Figure 1), as, unlike talking therapies, antidepressant medication can be associated with side-effects, long-term usage or problems associated with withdrawal. Treatment options are listed in order of recommended use, starting with less intrusive and less resource intensive options and progressing through a range of alternatives.

Figure 1: NICE guidance for treating patients with less severe depression



For severe depression, a range of options are also provided in order of severity (Figure 2). NICE guidance is also available on the prevention of relapse, chronic depression, depression with personality disorder, or psychotic depression.

Overall, the choice of treatment for depression in adults is based on the severity of the problem, past experiences of treatment and the person's preference using the matched care model. In this model, treatment options are matched to the severity of symptoms (Figure 3).

Children and adolescents with depression should be offered a psychological therapy as the first-line treatment, such as CBT or interpersonal therapy. Antidepressants should only be used for young people with moderate to severe depression who do not respond to psychological therapy, or who have a high risk of suicide or self-harm. They should be closely monitored by a specialist and their parents or carers.

Figure 2: NICE guidance for treating patient with more severe depression

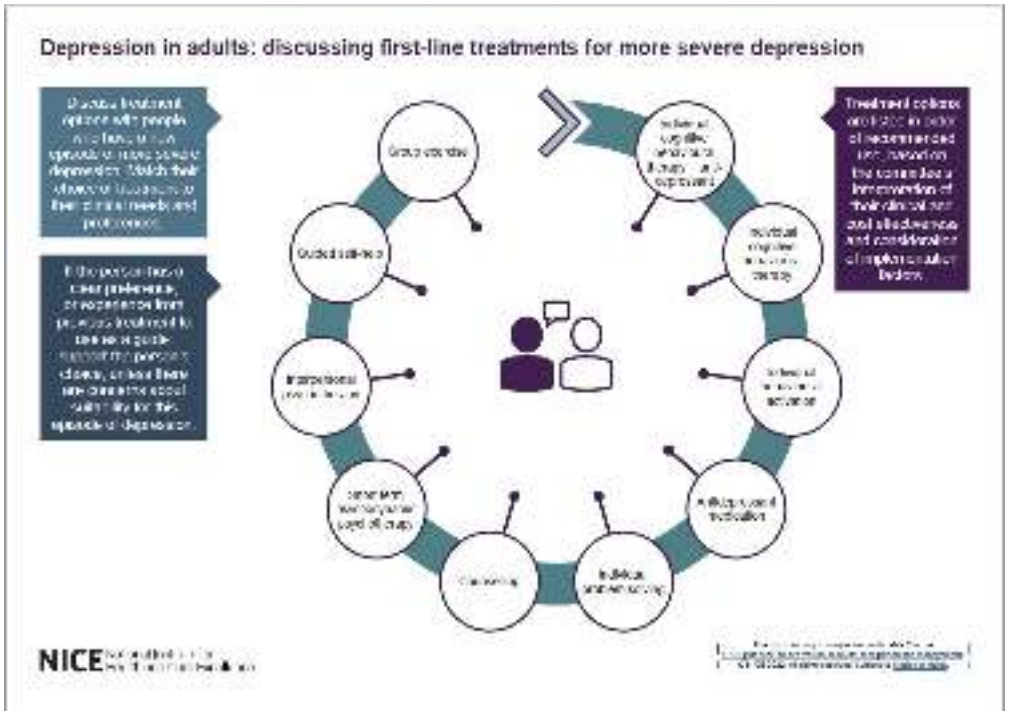
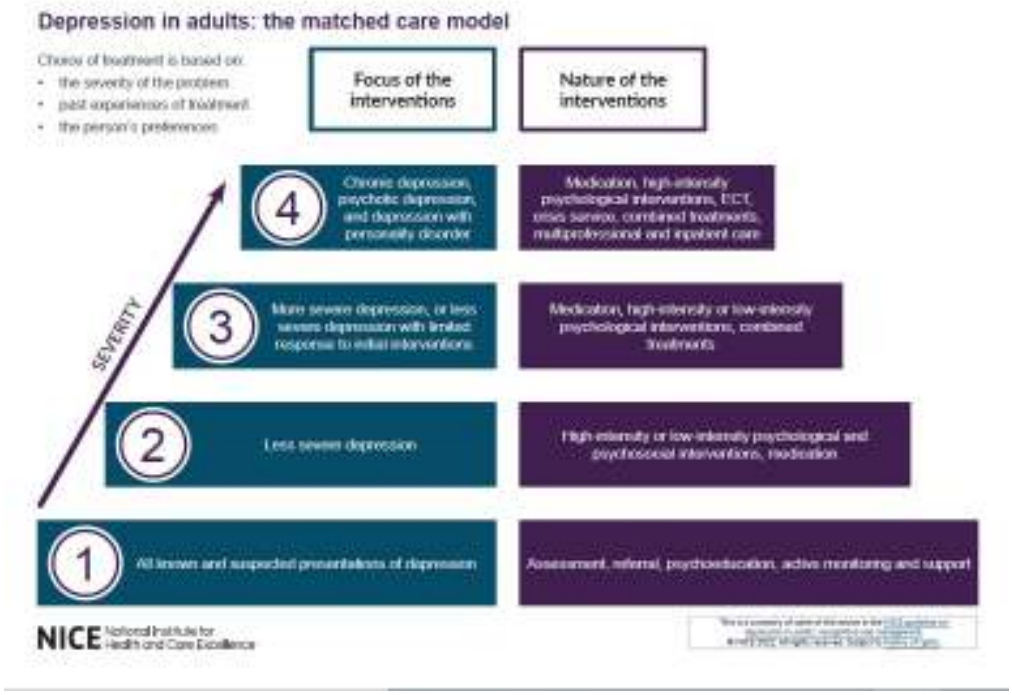


Figure 3: NICE guidance for depression in adults – the matched care model



3.1 Antidepressant usage in Northern Ireland

Antidepressant medication, such as selective serotonin reuptake inhibitors (SSRIs) revolutionised the treatment of depression, leading them to be the primary treatment option, however, this has led to a significant increase in antidepressant prescribing over time.

Northern Ireland has one of the world's highest rates for use of anti-depressants[36] with GPs in Northern Ireland prescribing on average two-and-a-half times more antidepressants than their English counterparts.[37] This high usage could suggest that socio-economic and geographical factors are affecting prescribing rates, or could be evidence of over-diagnosis of depression, or a rise in the number of patients on long-term antidepressant treatment to reduce relapse rates.[38]

There is also evidence that prescriptions for antidepressant medication, with or without diagnosis, are increasingly common for people managing chronic physical health conditions such as fibromyalgia, heart disease and diabetes.[39]

Northern Ireland also has the highest rate of repeat prescribing for antidepressants among the four UK nations[40] with almost 1 in 5 of the population in Northern Ireland receiving antidepressant medication in 2020/21.[41] These findings were attributed to several factors, such as the legacy of the Troubles, higher levels of deprivation and social isolation, and lower access to psychological therapies.[42]

3.2 The cost of antidepressant prescribing in Northern Ireland

Despite an increase in the number of prescription items dispensed (Figure 4), expenditure on antidepressants in Northern Ireland has almost halved in the past two decades (Figure 5; additional data in Table 1). In 2004, antidepressant prescribing cost almost £25 million compared to £12.3 million in 2022. The reason for this decline has been attributed to a range of cost containment measures which have been introduced to reduce costs whilst ensuring the quality and safety of prescribing (Box 1).

Box 1: Cost containment strategies:

- Regional formulary lists with preferred drugs for each therapeutic area based on clinical and cost-effectiveness evidence
- Establishment of regional prescribing support networks;
- Implementation of a generic substitution policy which allows pharmacists to dispense a less costly generic version of a drug
- Medicines optimisation quality framework – to improve patient outcomes and reduce waste and variation in prescribing

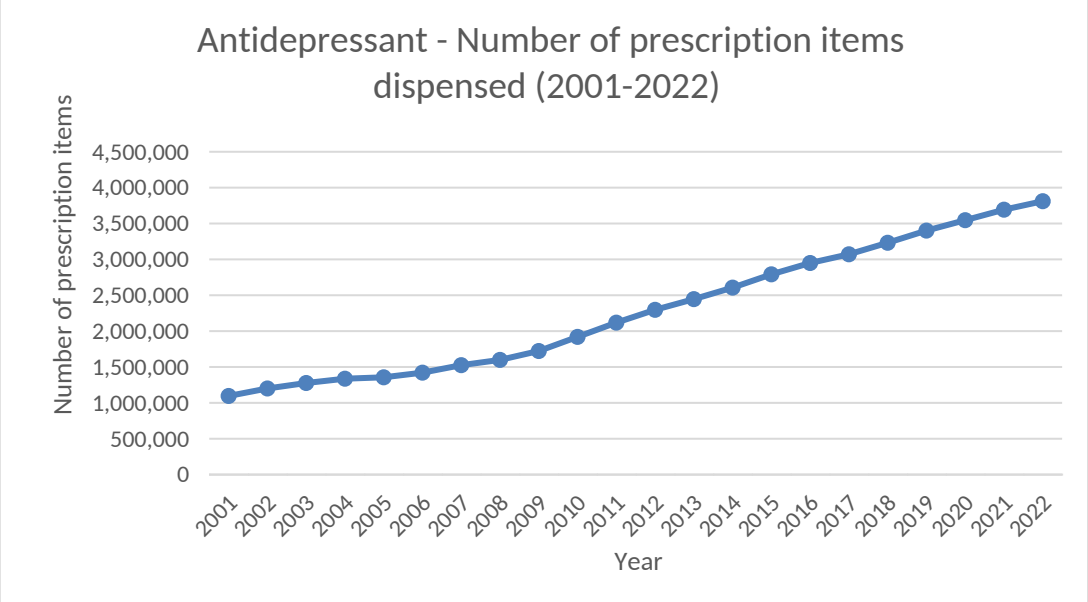


Figure 4: Number of antidepressant prescription items dispensed in Northern Ireland (2001-2022)

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

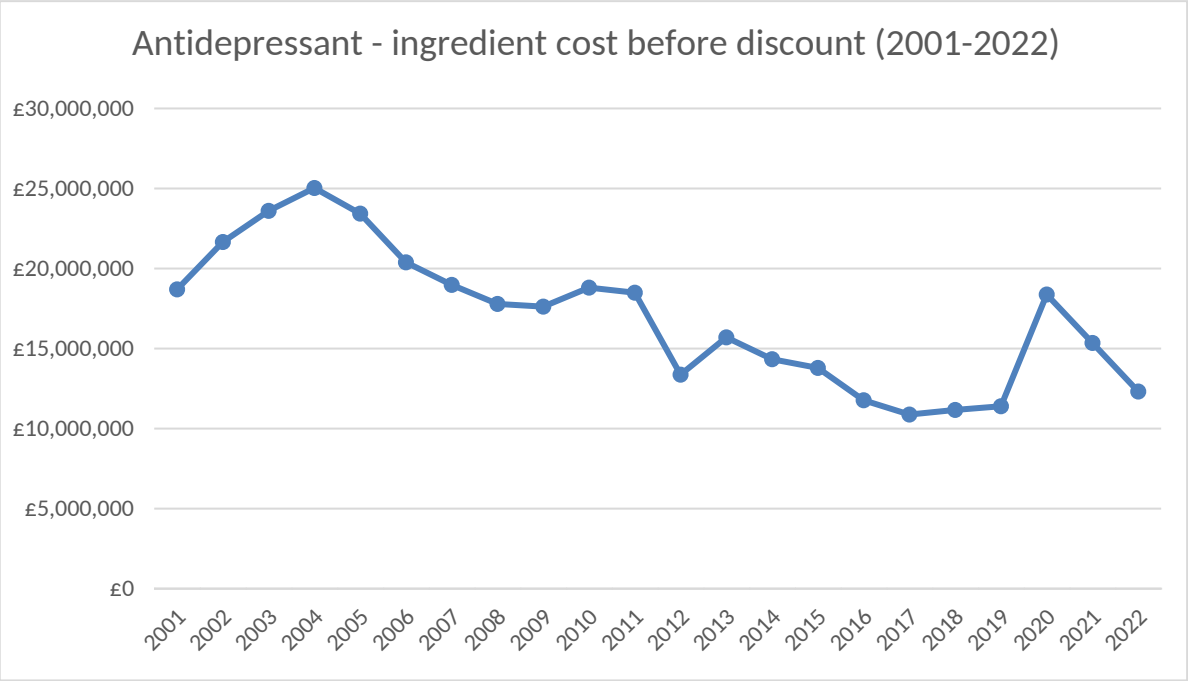


Figure 5: Expenditure on antidepressant medication over time

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

The BBC recently reported an alarming rise in the cost of antidepressant prescribing in Northern Ireland by almost £7m in just a year, with expenditure rising from £11.3m in 2019 to £18.3m in 2020.[43] However, when viewed over a longer timeframe, a less sinister story emerges.

The rise in expenditure was related to supply-side issues associated with the most frequently prescribed SSRI in Northern Ireland (sertraline). The shortage of a key compound used to manufacture the drug combined with logistical issues related to the COVID-19 pandemic resulted in a five-fold rise in the price of sertraline from £1.27 per pack of 28 in January 2020 to £6.46 in March 2020. However, the price of sertraline has since stabilised and stocks have returned to pre-pandemic levels.[44]

Table 1: Number of prescription items dispensed, total ingredient cost of antidepressant drugs and ingredient cost/prescription item in Northern Ireland from 2001-2022

Year	Number of prescription items	Ingredient cost (before discount)	Ingredient cost/prescription item
2001	1,096,255	£18,697,593	£17.06
2002	1,200,540	£21,657,019	£18.04
2003	1,276,880	£23,603,089	£18.48
2004	1,336,782	£25,031,553	£18.73
2005	1,356,284	£23,430,798	£17.28
2006	1,421,119	£20,386,966	£14.35
2007	1,525,497	£18,978,564	£12.44
2008	1,599,063	£17,788,364	£11.12
2009	1,722,746	£17,620,368	£10.23
2010	1,919,733	£18,806,959	£9.80
2011	2,118,159	£18,490,634	£8.73
2012	2,297,093	£13,368,984	£5.82
2013	2,445,986	£15,699,817	£6.42
2014	2,606,296	£14,334,644	£5.50
2015	2,791,622	£13,790,930	£4.94
2016	2,949,619	£11,770,330	£3.99
2017	3,071,021	£10,878,085	£3.54
2018	3,231,642	£11,166,087	£3.46
2019	3,401,306	£11,396,099	£3.35
2020	3,546,385	£18,376,333	£5.18
2021	3,692,922	£15,350,144	£4.16
2022	3,811,048	£12,315,720	£3.23

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

This upward trend in the number of prescription items dispensed can be seen across all 5 HSCTs (Figure 6) as can the temporary rise in the cost of prescribing arising from the supply-side issues (Figure 7).

Analysis of the data also suggests that cost containment measures have been particularly successful in relation to antidepressant prescribing (Figure 8) with the ingredient cost per prescription item for antidepressants falling from £18 per prescription item in 2002 to just over £3 in 2022

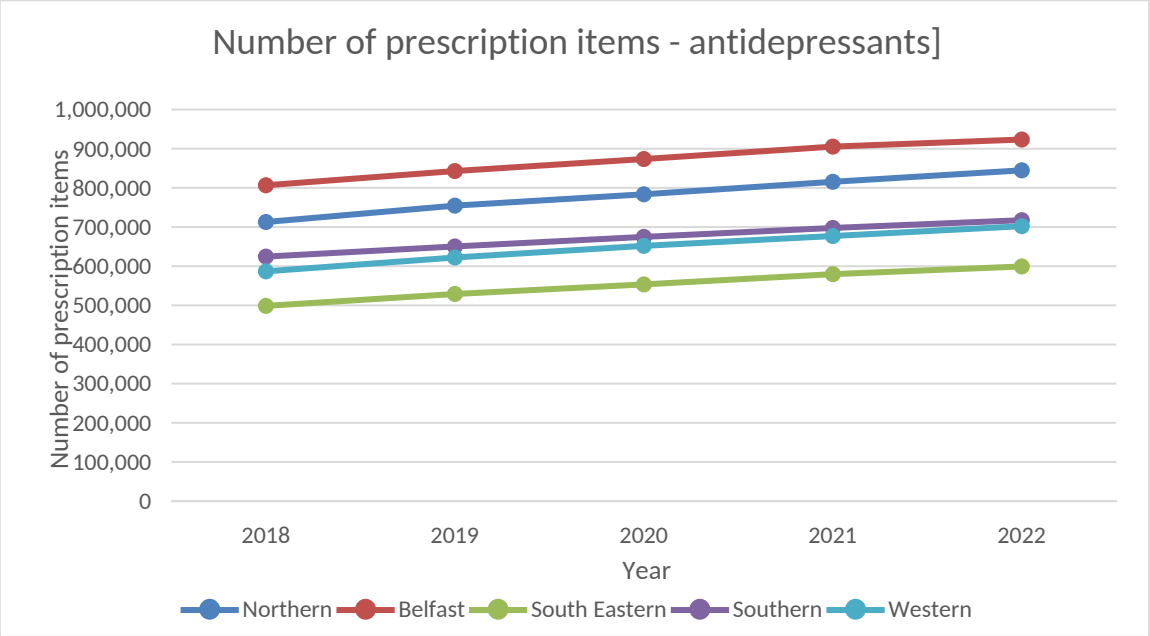


Figure 6: Number of antidepressant prescription items dispensed by Health and Social Care Trust (2001-2022)

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

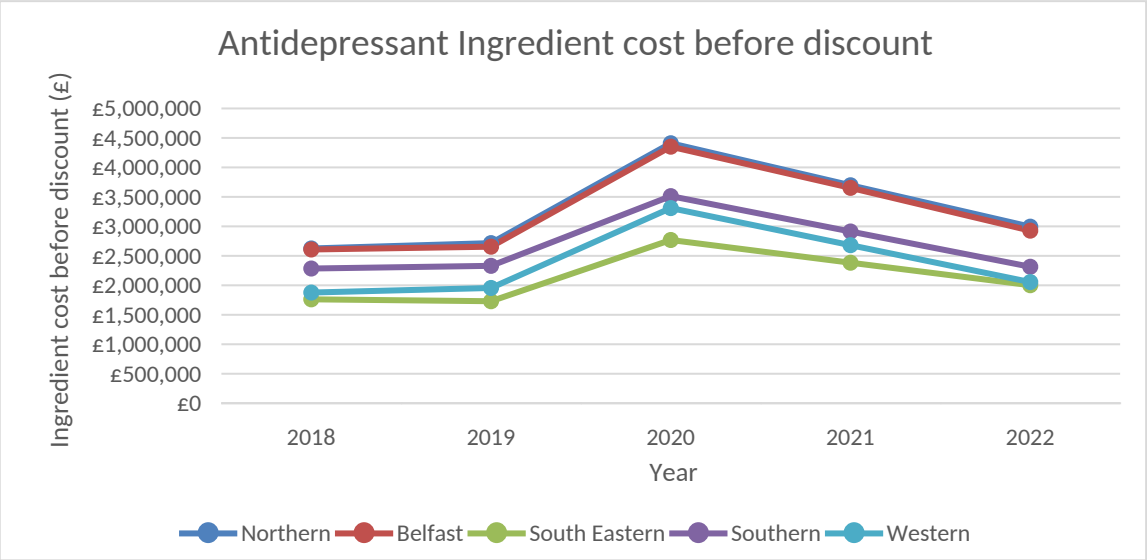


Figure 7: Ingredient cost (before discount) for antidepressants from 2018-2022

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

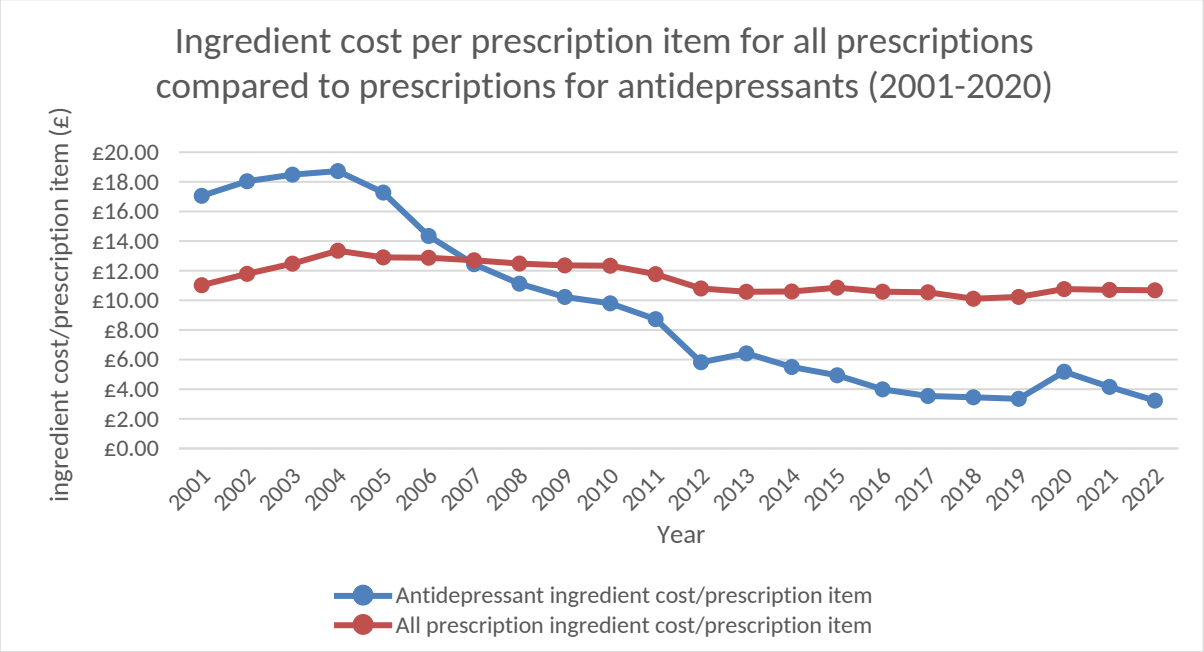


Figure 8: Ingredient cost per prescription item for all prescriptions compared to antidepressant prescriptions over time (2001-2022).

Source: Antidepressants BNF chapter 4 Section 3: https://hscbusiness.hscni.net/services/3177.htm

3.3 Funding antidepressant prescribing in Northern Ireland

Expenditure on GP prescribed products in Northern Ireland is in the region of £444m annually, relating to nearly 43m prescription items.[45] GPs are funded for prescribing medicines to their patients based on weighted patient populations.

GPs are encouraged to prescribe medicines by their generic name. This is because generic medicines are usually as effective as the branded versions, but can cost up to 80 per cent less, which frees up health service resources to pay for other treatments.

GPs choose from a preferred list of medicines (a formulary) which has been chosen on the basis of available evidence for their effectiveness and their safety. GP practices do not have a specific budget allocated for prescribing. Instead, practices are notified of an indicative prescribing budget to help them monitor how much they are prescribing. The method used for apportionment is a weighted capitation formula.[46]

Using this formula, primary care resources are allocated to Local Commissioning Groups (LPGs) and GP practices. The formula is not concerned with the absolute level of prescribing resources for Northern Ireland, but rather with ensuring equitable sharing of an already determined pot of resources across LCGs and GP practices.

The formula takes into account the relative size of the population being served, adjusted for an area or GP practice's share, based on relative need due to the age/gender structure and needs arising from deprivation, morbidity, number of care home residents and other sociodemographic factors.

These adjustments reflect the evidence-base on prescribing costs, for example, that care home residents have higher prescribing costs than other older adults. A review of this formula is currently included in the work plan for the Department of Health Information and Analysis Directorate (IAD).

4 Talking therapies

Psychological therapies have been demonstrated to be equally as effective as anti-depressant medication and are recommended by NICE for the treatment of depression.[47] Talking therapies can be used to treat a wide range of mental health conditions, including depression, anxiety, eating disorders, phobias, and addiction, and are often used in conjunction with medication for more serious conditions like schizophrenia and bipolar disorder.[48]

A range of different types of talking therapies exist, such as cognitive-behavioural therapy (CBT), counselling, psychodynamic therapy, humanistic therapy and mindfulness. They aim to improve mental and emotional wellbeing by helping people cope with their problems, understand their feelings and thoughts; increase self-esteem, confidence and resilience; reduce stress and achieve goals; build communication skills, express emotions and resolve conflict.[49]

There are however limitations, as there can be waiting lists or other barriers to access and availability; this approach does not suit everyone; and it requires commitment and responsibility on behalf of the patient. A detailed overview of the provision of talking therapies in Northern Ireland, the rest of the UK and the Republic of Ireland is contained in a recent research paper by RaISe (NIAR 44-2022).[50]

4.1 Effectiveness and cost-effectiveness of talking therapies

Psychological therapies such as Cognitive Behavioural Therapy (CBT) have been shown to be clinically and cost-effective and have demonstrated effectiveness in treating, maintaining progress, and preventing relapse in both depression and anxiety disorders.[51]

Research studies suggest that talking therapies can lead to cost savings by reducing the need for more expensive treatments, such as medication and hospitalisations. They can also improve work productivity and reduce healthcare utilisation.

4.2 Introduction of talking therapies in the UK

Access to talking therapies was introduced in England in 2008 via the "Improving Access to Psychological Therapies" (IAPT) programme (now renamed as "NHS talking therapies for anxiety and depression"). It was aimed at improving the provision of psychological therapies in line with clinical guidance from the National Institute for Health and Care Excellence (NICE) for the treatment of depression and anxiety disorders[52] (outlined previously in Figures 1-3).

As mentioned earlier, the programme involves a five-step approach to psychological care for people with depression and anxiety using stepped care models which match treatment intensity to client needs.[53]

An economic argument was central to the establishment of IAPT based on a cost–benefit analysis that outlined the benefits of increased employment, in terms of the increased revenue gained from people returning to work.

Evaluation of clinical and employment outcomes were central to the programme, and have shown some positive results. Evaluation of the NHS Talking Therapies suggests a significant positive impact on patients' mental health.[54] Through this programme, over 1 million people are seen each year, with 550,000 having a course

of therapy. Approximately 7 of every 10 people (67%) who had a course of treatment (two or more sessions) showed a reliable and substantial reduction in their anxiety/depression, and around 5 in every 10 (51%) improved so much they are classified as recovered.[55]

It is interesting to note however, the introduction of IAPT has not curbed the long-term increase in antidepressant prescribing rates in England.[56] However, this finding is based on data from over a decade ago, and no new evidence on this topic appears to be published.

4.3 Availability and access to talking therapies in Northern Ireland

Talking Therapy/Emotional Wellbeing Hubs were initially piloted within Belfast HSCT in 2015, but since have been rolled out across other Trusts within Northern Ireland.[57] People seeking support for mild to moderate mental health problems in Northern Ireland can access talking therapies: through GP counselling services; multidisciplinary teams (MDTs); and mental health hubs. Additional support is also provided by a range of voluntary and community groups.

GPs can pay into Local Enhanced Services (LES) to enable GP practices to treat patients with mild to moderate mental health conditions using counselling services. Recently, the Participation and the Practice of Rights (PPR) group and the #123GP campaign published a map of GPs offering in-house counselling services.[57]

Sixty-eight percent of GP surgeries in Northern Ireland offered a counselling service in 2020/2021. However, provision depends on where you live and varied from 52% in the Southern Trust to 83% in the Northern Trust. Such disparities suggest a ‘postcode lottery’ (where access to services is dependent on where you live). There is also evidence that the number of GP practices in Belfast offering counselling has declined since 2018, however, so too have the number of GP practices.

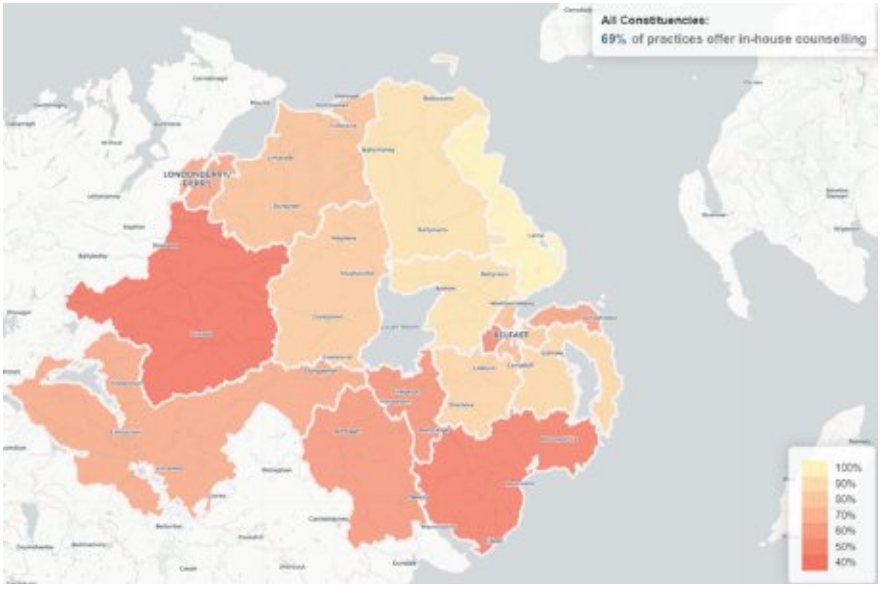


Figure 9: Percentage of GP in-house counselling per constituency area

Source: https://www.belfastlive.co.uk/news/health/northern-ireland-areas-least-access-19844754

Services can also be accessed through the multidisciplinary teams (MDTs) project, where mental health practitioners work alongside the GP practice teams. This model is currently available or in development in 5 of the 17 GP federation areas, with latest data indicating that 56.9 whole time equivalent (WTE) mental health practitioners and 5 mental health managers are employed.[58]

Talking therapy/emotional wellbeing hubs are available in all 5 HSCTs across Northern Ireland, however the geographic spread of these services varies across Trusts.[59] A stated objective in the new Mental Health Strategy 2021-31 is to expand the hubs to ensure coverage across all of Northern Ireland.

4.4 Expenditure on talking therapies in Northern Ireland

Allocation of funding for talking therapies is based on established commissioning processes which take account of need, strategic direction, value for money and ability to deliver the service.[60]

Due to the complicated nature of delivery and recording systems in health, overall expenditure on talking therapies is difficult to identify. Mental health care can be provided across a range of activities and services therefore costs cannot be easily disaggregated. For instance, costs associated with health promotion and children's services aimed at promoting mental health and wellbeing.

Over £7 million was invested between 2019-2022 across all five Trusts to enable GP practices to provide psychological therapies to treat mild to moderate depression (Table 2; Figure 10). Expenditure on talking therapies ranged from £493,992 in the Western HSCT to £4,078,128 in the Belfast HSCT. The mode of delivery differed across Trusts, with some Trusts allocating funding directly to specialist teams, whereas commissioned services from voluntary and community groups.[61]

Table 2: Expenditure on Talking Therapies in Northern Ireland by Health and Social Care Trust (2019-2022)

HSCT	Financial Year 1 April-31 March*				Additional Information
	2019/ 2020	2020/ 2021	2021/ 2022	2019-2022	
Western HSCT	£117,779	£190,355	£185,858	£493,992	This is the expenditure that is charged directly to the cost centres for Talking Therapies. Expenditure includes month 13 year end accruals
Southern HSCT	£206,888	£187,163	£116,129	£510,180	There is a reduction in spend from 2020 for Talking Therapies due to the development of the 'Steps to Wellness' programme. This is aligned to Improving Access to Psychological Therapies (IAPT) in the SHSCT
South Eastern HSCT	£234,903	£144,072	£332,229	£711,204	Spend in 2021/22 increased due to the availability of funding in the context of the Covid 19 pandemic.
Northern HSCT	£635,323	£308,860	£302,000	£1,246,183	The NHSCT does not have a talking therapies services, instead talking therapies are delivered by multiple teams across the Trust and it is not possible therefore to isolate and extract these costs. The Trust does have a contract with a Community & Voluntary provider to deliver emotional wellbeing services, these are a wider service than just talking therapies - however talking therapies does make up a significant part of the contract. The Trust has used this contract as a basis for the information provided.
Belfast HSCT	£1,426,651	£1,286,640	£1,364,837	£4,078,128	The 2019/20 figure includes non-recurrent spend linked to additional non-recurrent funding from HSCB
Total spend on Talking Therapies	£2,621,544	£2,117,090	£2,301,053	£7,039,687	

*This information has been provided by each of the Health and Social Care Trusts

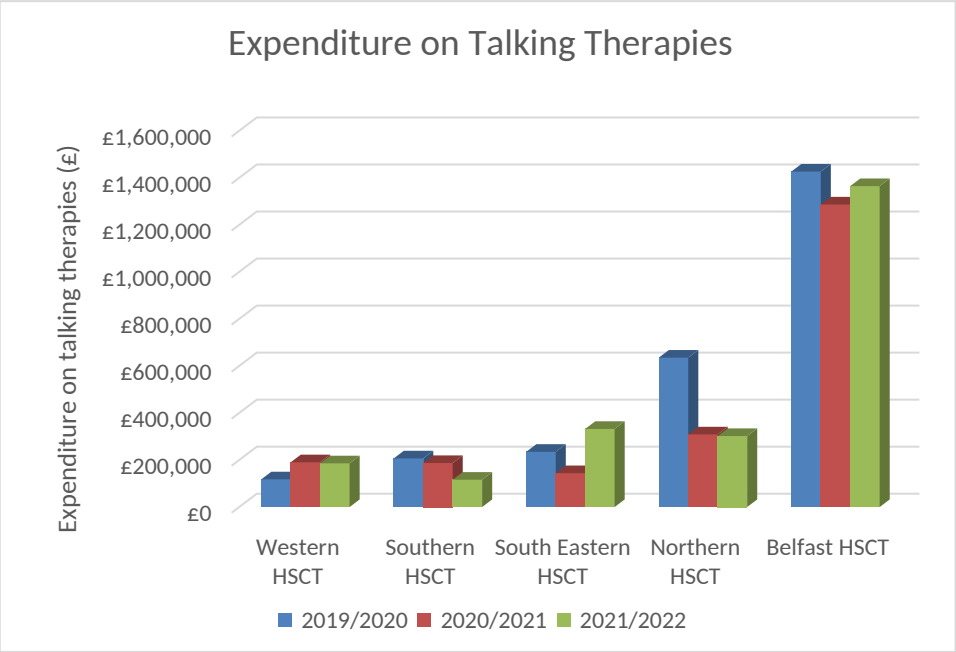


Figure 10: Expenditure on talking therapies 2019/20, 2020/21 and 2021/2022 by HSCT Trust

4.5 Assessing effectiveness of talking therapies in Northern Ireland

Data on referrals, number of sessions attended, number of missed appointments and outcome of the service are not routinely collected. Data on referrals and number of sessions are reported on GP Clinical Systems and collated monthly at a Federation level via Strategic Planning and Performance Group (SPPG) GPIP systems, and missed appointments may be held locally within GP practices. Waiting times are not captured as MDTs do not carry caseloads.[62]

Table 3: Patients waiting to access psychological therapies in Northern Ireland

	2018	2019	2020	2021	2022
Total number waiting	4,485	5,186	5,515	6,599	6,754
<13 weeks	2,562	2,302	1,779	1,882	1,814
>13 weeks	1,923	2,884	3,736	4,717	4,940

Source: Department of Health

The effectiveness and cost-effectiveness of psychological therapy provision in Northern Ireland is difficult to assess. Currently there are 6,754 patients on waiting lists, with 4,940 patients waiting more than 13 weeks; some of whom have been waiting significantly longer.

In a statement, the Department said its target from April 2022 was that no patient should wait longer than 9 weeks to access CAMHS, adult mental health services or dementia services, and 13 weeks to access psychological therapies.

4.6 Mental health statistics to support funding decisions

A longstanding criticism of health and social care is that people with mental health problems often fail to receive the same access to services or quality of care as people with other forms of illness. Given the transformation agenda, a review of mental health statistics was recently undertaken by the Office for Statistics Regulation (2021).[63]

They reported that a scarcity of robust mental health data in Northern Ireland has hindered the production of official statistics resulting in significant and fundamental data gaps. Currently, there is no regional picture of mental health, as data are collected in silos in each of the five Health and Social Care Trusts (HSCTs) making it impossible to determine how many people were accessing mental health services in Northern Ireland and whether their needs were being met.

Inconsistent data definitions and a fragmented IT infrastructure has led to poor data comparability with no single point of access to official statistics on mental health, making compilation of statistics to support policy decisions and service delivery difficult.

The NI Audit Office (2023) reported that there was a clear need to improve data around mental health services and to develop a clear outcomes measurement

framework to enable monitoring of services. They recommended that the Department should produce a data strategy in line with the recommendations contained within the Office for Statistical Regulations (OSR's) report. They said, to do this will involve substantial change and require investment in data systems.[64]

4.7 Cost implications for current and future care

Improving mental health is a key priority for the Northern Ireland Executive. This has been recognised in the 2016-2021 draft Programme for Government and the new Mental Health Strategy 2021-31. Nevertheless, mental health problems are rising in Northern Ireland, with almost 189,000 adults diagnosed with depression (as of March 2022) representing a 43% increase from March 2016. In addition, the full impact of COVID-19 and cost of living crisis has not yet been felt.[65]

Reports suggesting a sharp rise in the cost of antidepressant prescribing in Northern Ireland in 2020 were correct, albeit the rise was temporary and related to specific market conditions which have now been resolved. Generally, cost containment strategies have resulted in a downward trend in expenditure on antidepressants. However, the rate at which antidepressant prescribing is rising in Northern Ireland does create cause for concern. This trend is not however particular to Northern Ireland.

A separate report by the NI Audit Office[66] almost a decade ago on primary care prescribing reported that additional cost savings could be possible if cost containment policies were applied equally across all Trusts or GP Federation areas. Examples of inappropriate prescribing of antidepressants still pervades which waste resources that could be better used elsewhere. However, to achieve these additional efficiencies is not a costless exercise.

Some contend that antidepressant prescribing continues to rise because talking therapies have not been sufficiently resourced, or that access in socially deprived areas is worse than in more affluent areas. Evidence would suggest that both these conclusions are valid, however other factors are at play.

The infrastructural needs of talking therapies are more complex than prescribing of antidepressants – requiring a trained and skilled workforce. This is particularly important when addressing psychological trauma. Deploying staff to provide talking therapies can create gaps elsewhere in the health service. In the interim, a range of other interventions have been shown to be both effective and cost-effective (such as singing, arts and creativity interventions and dance) in improving health and mental wellbeing at relatively low cost.[67] in addition, such interventions have been shown to be generalisable, scalable and acceptable to those suffering from depression.

As outlined earlier in this report, talking therapies are not a substitute for antidepressants - in many cases they are used together. This means that as provision of talking therapies increase in Northern Ireland, it is unlikely that, in the absence of other measures, antidepressant costs will fall. In England, where talking therapies have been available since 2008, antidepressant costs continue to rise, and economic gains from decreased absenteeism has not been observed.

There are emotional costs and benefits to addressing deep rooted psychological problems rather than masking symptoms with medication, hence, talking therapies will not work for everyone. Determining what works, for whom, in what context is crucial if public monies are to be used to their best effect. As outlined by the Office for Statistics Regulation,[68] this requires high quality mental health data.

As stressed in a recent Northern Ireland Audit Office Report[69] tackling the weaknesses in mental health data will involve substantial change and require significant investment. Consequently, they recommended that the Department of

Health produce a data strategy, and develop an appropriate outcomes measurement framework. Both these actions in tandem, should support better decision making and allow better monitoring of the effectiveness of services to improve people's mental health.

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