

## **Equality Commission response to the proposed Delivery Plans for Programme for Government Indicators 6<sup>1</sup> and 9<sup>2</sup> (Mental health; personal care)**

In January 2016, the Commission set out a number of priorities<sup>3</sup> for delivery via the work of government over the 2016-21 mandate to address the health inequalities experienced by different equality groups. In our July 2016 response to the Programme for Government Framework consultation, the Commission recommended the inclusion of an indicator on improving support for adults with care needs, and supported the inclusion of indicators on improving mental health and reducing health inequalities.

We noted our support for the inclusion of proposed Outcome 4: We enjoy long, healthy, active lives; and the proposed inclusion of the following health indicators - on improving mental health; increasing healthy life expectancy and on reducing health inequalities; and improving the quality of the healthcare experience.

The Commission also highlighted the need to ensure improvement to the health outcomes across the Section 75 grounds and recommended that the Executive identify and remove barriers to health and social care and well-being, experienced by particular Section 75 equality groups. We also recommended investment in health care to address the specific needs of equality groups, including the health care needs of people with disabilities, and young people's mental health needs.

We noted that equality data in relation to the proposed lead measure on the *improving mental health* indicator is not collected across a number of Section 75 grounds; including disability, sexual orientation and race. Aligned to our overarching key PfG recommendation in respect of equality data, we recommended that this indicator is tracked not only in aggregate but also for each Section 75 ground.

The following considers the delivery plans (versions downloaded on 28 November 2016 and 5 December 2016) against the key inequalities and policy priorities highlighted by the Commission in January 2016.

We hope that this information, in tandem with our response to the consultation on the draft PfG, will be of assistance in the further development of the delivery plan.

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<sup>1</sup> % population with GHQ12 scores ≥4 (signifying possible mental health problem);

<sup>2</sup> Number of adults receiving personal care at home or self-directed support for personal care as a % of the total number of adults needing care

<sup>3</sup> ECNI (2016), Equality Priorities: [Programme for Government and Budget Recommendations](#)

**1. We recommend further commitments to the identification and removal of access barriers for older people; LGB people; transgender people; Irish Travellers and other minority ethnic people; and persons with learning disabilities.**

- a. We welcome that Outcome 4 'We enjoy long, healthy, active lives', contains an acknowledgement of 'the need to tackle systemic and/or attitudinal barriers to access that may lead to disadvantage and subsequent health inequalities within some communities'.
- b. We note the inclusion of '*health inequalities*' as a strategic aim of the *Healthier Lives* programme and the commitment to collaborate with the Department of Education on a potential research proposal, to learn from what is currently working to reduce health and educational inequalities in school. We acknowledge the commitment to develop better information and analysis on inequalities for HSC staff and organisations to inform priority setting and approaches.
- c. There is however no indication if the term '*inequality*', as set out in the Delivery Plan, is being used with reference to Section 75 categories or with a different focus - for example, with regards to deprivation, as is the case elsewhere in Outcome 4 and in the draft PfG.
- d. We welcome that women and those with a disability will benefit from specific commitments – for example a data development Agenda (designed in collaboration with the central regional disability forum).
- e. Whilst we acknowledge that the plans are high level and 'specific needs, experiences and priorities for individual policies, projects or service developments will be 'dealt with, as appropriate, at the individual policy, project or service development level', we are however concerned there is no explicit reference in the delivery plans to targeting inequalities experienced by lesbian, gay, bisexual people; trans people; Irish Travellers and other minority ethnic communities (including asylum seekers and refugees); and people with learning disabilities. We recommend that this is addressed in a revised delivery plan.
- f. Further, while we welcome the proposal to officially recognise parity of esteem for mental health, we note that there appear to be a number of potential gaps, or areas where commitments / actions could be developed and/or made clearer: For example:
  - a clear timeline, resources or follow-up plan to implement Bamford;
  - actions around building children and young people's resilience in schools;
  - commitments in relation to mental health service for those in higher education or services;
  - commitments in relation to those with severe mental illness;

- commitments in relation to address stigma and discrimination<sup>4</sup> including through new age discrimination legislation;
- g. In addition, while there are strong links between issues such as mental health, homelessness and unemployment<sup>5</sup>, these linkages have yet to be identified as part of the delivery plan for indicator 6. The Commission notes that there is a range of potential opportunities to address stigma and discrimination, including through the awareness raising initiatives being taken forward as part of the delivery plan for Indicator 42: Average Life Satisfaction score of people with disabilities.
- h. We recommend that the Department includes a clearer commitment in the PfG (and associated delivery plans) to engage with, and ensure delivery of, international obligations – particularly the UNCRPD. Using human rights standards to shape the plan also makes sense from a pragmatic perspective, as it will assist Government in future reporting to the UNCRPD Committee and in providing evidence to the Committee, during the upcoming examination of the UK State Party in 2017.

**2. Ensure investment in health care to address the specific needs of equality groups, including the health care needs of people with disabilities; and young people's mental health needs. We recommend a clearer, stronger commitment in the Delivery Plans to identify and address the inequalities experienced by Section 75 Groups.**

- a. We welcome a commitment to significant investment in primary care (including increasing the first year intake of GPs). We further welcome the acknowledgement of the right to independent living and the right to self-determination. We strongly support the need for the development of advocacy services and the concept of 'self-directed support' and we welcome action to address barriers and to increase take up of self-directed support and direct payments.
- b. We note the identification of 'emerging' priorities for action on mental health and the identification of 'emerging' agreement on need for more funding in mental health and the wider programme of action including publication of the refreshed suicide prevention strategy.
- c. We also welcome the 'emerging' focus on young people and mental health; and those with disabilities.

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<sup>4</sup> People with mental health problems experience particular inequities in their physical health status and in access to public services including health services (partly due to stigma or discrimination). Source: Harper, C., McClenahan, S., Byrne, B. and Russell, H. (2012): *Disability programmes and policies: How does Northern Ireland measure up? Monitoring implementation (public policy and programmes) of the United Nations Convention on the Rights of Persons with Disabilities in Northern Ireland*, pages

<sup>5</sup> Wilson, G. et al (2015): [Regress, React, Resolve - an evaluation of mental health service provision in Northern Ireland](#), Queens University Belfast for Action Mental Health, pages 82 & 92.

- d. With regards to addressing our specific recommendation regarding young people's mental health needs, we note an '*emerging*' acknowledgement of the need to improve CAMHS provision. We have previously recommended that the Department of Health ensure that provisions for Child and Adolescent Mental Health Services (CAMHS) are adequate. We welcome recognition of the need for focus on early intervention, including with Looked after Children (LAC).
- e. The Commission welcomes the acknowledgement of the right to independent living and the right to self-determination outlined in the delivery plan for indicator 5. We strongly support the concept of self-directed support, as having the potential to contribute to the realisation of Article 19, Independent Living, of the UN Convention on the Rights of Persons with Disabilities.
- f. We note the reference in delivery plan 5 to the 'muted' market response to the development of self-directed support (SDS) and the need to consider measures to stimulate the market. We welcome the inclusion of an option for individuals who do not wish to take an active role in directing or managing their support package for HSC Trusts to continue to arrange support services and options for service users to choose to adopt different levels of control for the different elements of their support package. However, the Commission is aware of that the Independent Living Fund (ILF) has been closed to new applicants since 2015. Whilst the roll out of SDS as proposed, under indicator 5 will likely have a beneficial impact on promoting independent living, it is not clear how the health, care and social needs of those who would hitherto been eligible for support from the ILF will be met.
- g. We continue to welcome the inclusion of an Indicator on improving support for adults with care needs. We note that indicator 5 seeks to capture the percentage of people who are satisfied with health and social care. However, it is not clear whether this will capture the extent to which the standard of care meets the needs of care recipients and promotes independent living, where this is the individual's wish.
- h. We therefore propose that the questions asked as part of the patient experience survey include questions, for those in receipt of domiciliary care, (i) as to whether the standard of care meets the needs of care recipients and additionally (ii) promotes independent living, where this is the individual's wish. Data collected with respect to these issues will enable more accurate reporting with respect to Article 19 of the UNCRPD.

**3. We continue to recommend that indicators are tracked not only in aggregate but also for each Section 75 group.**

- a. While we acknowledge the social gradient in health, tackling the socio-economic drivers of health inequalities alone is not enough. We recommend the Executive ensure investment in health care to address the specific needs across all section 75 categories.
- b. We welcome a commitment to develop better information and analysis on inequalities for HSC staff and organisations, to inform priority setting and approaches.
- c. We however note that equality data in relation to the proposed lead measure on *improving mental health* indicator is not collected across a number of Section 75 categories; including disability, sexual orientation and race.
- d. We further note the concerns raised by Action Mental Health and Royal College of Psychiatrists (RC PSYCH) in relation to the use of the measure *percentage of the population with GHQ12 scores greater than or equal to 4* (signifying a possible mental health problem), including its unsuitability in relation to measuring children's mental health<sup>6</sup>. In its response to the PfG framework, the RC PSYCH also noted that a self-reporting questionnaire measure might not capture morbidity effectively in particular groups, such as those with mental disorder, learning disability and cognitive impairment<sup>7</sup>. We note that the Department intend to continue to discuss and consider potential alternatives to this measure.
- e. Given the concerns noted by key stakeholders, we recommend that Department assure itself that the final indicator adopted is appropriate for its intended purpose, and is capable of not only measuring trends in aggregate, but also for each specific Section 75 category.
- f. We also note that there are gaps in the collection and/or use of information. For example, while the Department has taken the welcome step of introducing ethnic monitoring, the information collected does not appear to have been used in the delivery plan or screening documentation. We continue to recommend that the Department take steps to address such gaps.
- g. We also recommend that consideration is given to developing indicators, or a composite index, of the extent to which international obligations, including the UNCRPD, are being provided for relevant equality groups

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<sup>6</sup> A concern raised by Action on Mental Health (AMH).

<sup>7</sup> Royal College of Psychiatrists (2016): [PfG response](#)

**4. We recommend that a costed plan should be developed with funding linked to outcomes and timelines for the completion of goals.**

- a. The Commission recognises that the delivery plan appears to be at a very early stage in its development and notes the progress made by the Department in identifying a range of ‘emerging’ priorities through its engagement with key stakeholders.
- b. However, we are disappointed to note that, while there appears to be ‘emerging areas of consensus’ and a range of ‘proposed service developments under detailed consideration’, the only timetabled action is to set a clear policy and strategic context for the Plan by March 2017. We consider that a revised delivery plan should, for all planned actions, include a clear planned delivery date.
- c. While the Commission welcomes the inclusion of a proposed action to fully implement the mental capacity legislation and take forward a ‘post Bamford forward action plan’, we are concerned that actions appear not to have been costed and that implementation would appear to be dependent on the resource available. Furthermore, as the evaluation of the Bamford Report has not yet been published, it is not yet fully clear which aspects of the Bamford recommendations have not been realised. The Commission recommends that the evaluation is published as soon as possible with a view to informing the development of a post Bamford action plan.
- d. As set out in the Christie Commission report on the future delivery of public services in Scotland, if we are to have effective and sustainable public services capable of meeting the challenges ahead, we must prioritise expenditure on public services which prevent negative outcomes from arising. In addition, failure to cost implementation strategies has been identified as a major barrier to success in a number of jurisdictions<sup>8</sup>. Best practice dictates that Government should develop a funding programme to accompany any implementation plans, with funding linked to outcomes and timelines for completion of goals<sup>9</sup>.
- e. The Commission has previously highlighted the high rate of mental illness in Northern Ireland compared with other jurisdictions<sup>10</sup> and the impact of the conflict on the prevalence of mental health problems<sup>11</sup>.

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<sup>8</sup> For example, in the 2008 implementation review of New Zealand’s Disability Strategy, the lack of a national implementation plan and linked funding was identified as a serious barrier in making the strategy effective in the lives of people with disabilities. See Litmus, *New Zealand Disability Strategy Implementation Review 2001-2007* (Wellington: Commissioned by the Office for Disability Issues, 2008), p. 4.

<sup>9</sup> Flynn, E. (2014): [Summary of critical success factors in implementing national disability strategies](#)

<sup>10</sup> ECNI (2014): [Jurisdictional ‘Parallel’ Report on Implementation in Northern Ireland](#), page 24.

<sup>11</sup> ECNI (2014): [Jurisdictional ‘Parallel’ Report on Implementation in Northern Ireland](#), page 18.

- f. We note that the Royal College of Psychiatrists have highlighted that although the level of mental illness is 20-25% higher in Northern Ireland than England or Scotland and the suicide rate in the general population is currently the highest in the United Kingdom, per capita expenditure on mental health here has lagged behind that elsewhere in the UK<sup>12</sup>. A 2010 McKinsey report suggested that, once allowance was made for the higher levels of need, Northern Ireland spends less than half of England's per capita spend on supporting people with mental health problems and Learning Disability<sup>13</sup>. Research conducted in 2011 found that actual spending per capita on mental health services in Northern Ireland is 10-30% lower than in England, despite requiring nearly 44% higher per capita funding.<sup>14</sup>
- g. We have also identified a range of inequalities in health for particular Section 75 groups including:
- men's lower life expectancy, higher suicide rates and health risks in relation to alcohol, drug and substance abuse<sup>15</sup>;
  - the high percentage of gay men who have considered suicide<sup>16</sup>;
  - reports of significant problems with respect to how the prison service supports prisoners with mental health problems<sup>17</sup>;
  - mental ill-health among younger people and the limited availability of inpatient CAMHS treatment for young people<sup>18</sup>;
  - higher levels of poor physical health among people with mental health problems, especially those with severe and enduring mental illness<sup>19</sup>;
  - high levels of prejudicial attitudes towards people with mental ill-health<sup>20</sup>;
  - particular inequalities and barriers to accessing services for subgroups such as Travellers<sup>21</sup>, asylum seekers and refugees<sup>22</sup> and prisoners<sup>23</sup>.

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<sup>12</sup> The Commission to review the provision of acute in-patient psychiatric care for adults (2016): *Building on progress: achieving parity for mental health in Northern Ireland*, page 64 (Royal College of Psychiatrists).

<sup>13</sup> McKinsey (2010): *Reshaping the system: implications for Northern Ireland's health and social care services of the 2010 spending review*. Belfast: DHSSPSNI, cited in Royal College of Psychiatrists (2016), page 64.

<sup>14</sup> Appleby, J. (2011): *Rapid review of Northern Ireland health and social care funding needs and the productivity challenge: 2011/12-2014/15*. Belfast: DHSSPSNI, , cited in Royal College of Psychiatrists (2016), page 64.

<sup>15</sup> ECNI (2015): [Gender Policy Position – Priorities and Recommendations](#), para. 11.3, page 35.

<sup>16</sup> ECNI (2015): [Gender Policy Position – Priorities and Recommendations](#), para. 11.8, page 36.

<sup>17</sup> ECNI (2014): [Jurisdictional 'Parallel' Report on Implementation in Northern Ireland](#), page 24.

<sup>18</sup> ECNI (2015): [Age Policy Position – Priorities and Recommendations](#), para. 6.4, page 8.

<sup>19</sup> ECNI (2014): [Jurisdictional 'Parallel' Report on Implementation in Northern Ireland](#), page 42.

<sup>20</sup> 26% saying they would mind (a little or a lot) having a person with mental ill-health as a work colleague, while 24% and 37% respectively would mind having this person as a neighbour or as an in law

<sup>21</sup> Suicide rates are almost seven times higher for Traveller men than in the general population. For further information see <sup>21</sup> ECNI (2014): [Racial Equality Policy Position – Priorities and Recommendations](#)

<sup>22</sup> ECNI (2014): [Racial Equality Policy Position – Priorities and Recommendations](#), para. 7.13, page 32.

<sup>23</sup> ECNI (2014): [Jurisdictional 'Parallel' Report on Implementation in Northern Ireland](#), page 24.

- h. In addition to the range of multiple identity issues, we note that research by Action Mental Health (AMH) has also highlighted that people living in large rural catchment areas having significantly less access to mental health services than people living in urban areas<sup>24</sup>.
- i. We are aware that the Northern Ireland Executive has not yet ensured that sufficient funding is made available for mental health in Northern Ireland to achieve the service improvements envisaged by the Bamford Review. We note that stakeholders have recommended that mental health should be ring-fenced from any budget cuts as a key means of delivering on the goals of the Review in the current financial climate<sup>25</sup>.
- j. We consider that a revised delivery plan should, for all planned actions, include a clear planned delivery date and associated budget.

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<sup>24</sup> Wilson, G. et al (2015): [\*Regress, React, Resolve - an evaluation of mental health service provision in Northern Ireland\*](#), Queens University Belfast for Action Mental Health

<sup>25</sup> Wilson, G. et al (2015): [\*Regress, React, Resolve - an evaluation of mental health service provision in Northern Ireland\*](#), Queens University Belfast for Action Mental Health, page 2.