

CHAPTER 2

THE PRESENT STATE OF MENTAL HEALTH NEEDS AND PROVISION OF SERVICES

INTRODUCTION

2.1 Consistent informal advice and information from service users, carers and service providers emphasise the existence of significant gaps and deficiencies in service provision for people with mental health needs. Strategic planning, to be effective however, must be grounded on detailed population based information on mental health needs. This should include knowledge of:

- the prevalence of people with mental illness;
- the nature and prevalence of problems experienced by those suffering from mental illness; and
- the extent to which current services meet the needs of these people.

Each of these issues is considered in the following sections for mental health problems in general. The prevalence of those disorders for which regional provision are proposed are described along with specific service requirement (Chapter 6).

THE PREVALENCE OF MENTAL ILL-HEALTH

2.2 From a global perspective, the scale of the challenge posed by mental illness has become increasingly clear in recent years. One in ten adults worldwide are affected by mental health problems at any one time, accounting for over 12% of the global burden of disease.¹ Mental health problems account for over 30% of all years lived with disability, and in the developed world account for over 40% of the total burden of disability.

2.3 Within the United Kingdom (UK) there are significant variations in the level of mental health morbidity. Socio-economic deprivation has a significant impact on prevalence, reflected in, for example, the level of unemployment and the quality of

the social environment. The social deprivation experienced by the Northern Ireland community is among the worst in Western Europe.² In the period 1997 – 2002, average gross weekly household income in Northern Ireland was only 78% of the UK average. Northern Ireland's unemployment rate has been consistently higher than that of Great Britain, and in 2001 was 6.2%, almost 30% higher than the UK average. In addition, the community has experienced 30 years of civil conflict.

- 2.4 While social and economic factors contribute significantly to mental well-being the opposite is also true. Around half of the disabled population in the UK are economically inactive compared with only 15% of the non-disabled population. Moreover, people with mental health difficulties have the lowest employment rate of all disabled people (18% compared to 48%).³ In Northern Ireland more than a third of Incapacity Benefit claimants have a mental or behavioural disorder.⁴ In 2002, over 37,000 people were on Incapacity Benefit as a result of mental and behavioural disorders, and just under one in five people receiving Disability Living Allowance (DLA) gave mental health reasons as the main disabling condition.
- 2.5 Using the General Health Questionnaire, the Northern Ireland Health and Social Well Being Survey (2001) found a prevalence of mental health problems of 24% among women and 17% among men. Such rates are over 20% higher than the rates in England or Scotland.⁵
- 2.6 While at the present time we do not have an in-depth profile for Northern Ireland as a whole, a detailed prevalence study has been completed for the District of Derry⁶ The 1-year prevalence of psychiatric disorder was over 12%, consisting mostly of depressive and anxiety disorders. The overall prevalence was again greater than the UK average and similar to a deprived inner city area of London.⁷ The prevalence of psychotic illness was 0.46%, similar to findings from UK national surveys.
- 2.7 While this study does not allow one to generalise to the rest of Northern Ireland, it provides important pointers to the expected general prevalence of disorder elsewhere. In particular, it confirmed clear and strong associations between the level of psychiatric morbidity and poverty.⁸

- 2.8 Within Northern Ireland there is a significant variation in the level of social deprivation.⁹ Among the most deprived are homeless people. A recent study of homelessness in Belfast found that 37% had mental health problems, rising to 41% among single homelessness residents, half of whom had moderate or severe levels of mental health impairment, as well as high levels of unmet need for most services.¹⁰
- 2.9 The impact of 30 years of civil conflict on community mental health has been assessed in several community based studies. In a random sample of 1000 adults, Cairns and Mallett¹¹ found 16% to be “direct” victims and 30% “indirect” victims of civil conflict. Perception of being a victim was consistently associated with poorer psychological well-being.
- 2.10 Again O’Reilly and Stevenson¹² in a separate household survey found a positive association between the extent to which people and areas were affected by the conflict and significant mental health problems. A variety of evidence, including the findings of these prevalence studies,^{8, 11, 12} is revealing that the ceasefires have not been associated with any improvement in mental well-being. The civil conflict has, therefore, cast a long shadow on the mental health of the community in N. Ireland.
- 2.11 Suicidal behaviour is one of the major health challenges in Ireland, north and south: a challenge for mental health policy, services and the wider community. Suicide has increased substantially over the last 20 years, particularly among younger people. It is now the number one cause of death among 18-24 year olds in Ireland.
- 2.12 While suicide is a major health challenge, it is the tip of the iceberg. Recent research in Ireland and the UK have found rates among those who would consider committing suicide to be around 20% among young people, with 7% carrying out acts of deliberate self-harm. While the challenge is particularly in the area of primary prevention, the service needs of young people in psychological crises needs to be considered particularly at community and primary care levels.

NEEDS FOR CARE

- 2.13 Needs can be considered as problems which may benefit from care or treatment. Prevalence of mental ill-health is only an approximate guide to needs, as these are not just determined by symptoms, but from associated features such as impaired social functioning. Many aspects of a person's life may be disrupted as a consequence of a mental disorder. This may include suffering caused by symptoms, loss of independence, lower quality of life and difficulties with social interaction.
- 2.14 Assessment of population needs is an essential step in the planning of services. A systematic and comprehensive evaluation of mental health needs for care and treatment has not been carried out for Northern Ireland as a whole. However, in the District of Derry study, needs for care were found to be met in less than 30% of care episodes. In a large proportion, needs were not met because people had either not presented or not continued with treatment. This reluctance to engage with services, which has been confirmed in national studies,¹³ highlights a need for better public education and information and for services that are more accessible and user-friendly.
- 2.15 The generally agreed priorities for mental health services highlight the needs of the severely mentally ill. The District of Derry study included recording the number of people with psychotic disorder known to primary, secondary and non-statutory services. This gave a prevalence of 0.46%, consistent with the most recent UK prevalence estimates.¹⁴ Schizophrenia was the most single common diagnosis, present in over half.
- 2.16 The Medical Research Council Needs Assessment Interview was used to assess psychological and social need. While the most frequent problem areas related directly to illness, (eg psychotic symptoms, the effects of medication), neurotic symptoms (eg anxiety, depression) were also relatively common. The presence of such co-morbidity needs to be borne in mind in service provision. In addition, a wide range of problems were found in social functioning.
- 2.18 The wide profile of problems affecting this group of people highlights the need for a holistic approach to service development and delivery. Of equal importance for

service planning is the extent to which current services are meeting the needs of this group. While in the above study the most common problem area, psychotic symptoms, was for the most part being dealt with satisfactorily, medication side-effects were being addressed in just over half.

- 2.19 A substantial amount of unmet need was also identified in the areas of psychological and social functioning, including neurotic symptoms, under-activity, coping with household chores and shopping, where between one third and one quarter of all needs were unmet. The issue of unmet need in relation to neurotic symptoms may be important, not only for quality of life, but also in relation to the well-recognised high suicide risk among this group of people. Unmet need was greatest among males and people with longer duration of illness.
- 2.20 A new Northern Ireland Strategy for mental health must include better information on mental health and better information on service needs.

SERVICE PROVISION

- 2.21 A third element in the information requirements concerns services, both current and planned, and a matching of these to local population needs. As part of this Review, baseline information is currently being obtained on existing services provided by each Trust throughout the Board areas.
- 2.22 Mental Health inpatient provision in Northern Ireland, as in the rest of Ireland, is and has been significantly greater than in England. Historically this may have reflected greater commitment from local administration in providing for the most vulnerable in our society. However, the present relatively high level of provision reflects a lack of alternative provision, the result of deficiencies in the current and previous strategies, lack of investment and resources. Baseline information recently obtained from service providers for the Review indicates current acute inpatient provision for adults under 65 years to be approximately 50/100,000 adult (<65) population and continuing care inpatient provision for all adults to be 28/100,000 adult population. There is significant variability across Northern Ireland.

2.23 Local evidence points to high levels of need among people with the most severe forms of mental disorder and to significant service gaps, particularly in relation to co-morbid emotional needs and social provision. Services for the severely mentally ill in particular require better community provision and better resourcing of day care and community based interventions, including adequate numbers of appropriately trained staff.

THE ECONOMIC AND SOCIAL COSTS OF MENTAL ILL HEALTH

2.24 The Health and Personal Social Services expenditure on Adult Mental Health in the year 2002/03 was £110 million, 6.1% of the total expenditure on health and social care. Over half (57%) of the mental health expenditure was on hospital services.

2.25 However the total economic costs of mental illness is much greater than the direct health services costs. For example, the estimated economic effect of depression on employment, and hence on national productivity in cost terms is over twenty times greater than the costs falling to the health services¹⁵. In a recent study the Northern Ireland Association for Mental Health, in collaboration with the Sainsbury Centre for Mental Health, London, has estimated that the total financial cost arising from mental illness in Northern Ireland to be £2,852,000,000¹⁶. This includes the cost of care, loss of output and the human cost. It has been estimated that overall about 70% of the costs of mental illness is borne by the individuals who experience it and their families¹⁷.

2.26 Currently the Northern Ireland expenditure on mental illness services is less than the comparator expenditure in England. From the Needs and Effectiveness Evaluation Report the per capita expenditure for 1999/2000 in Northern Ireland was at a similar level to that in England. This, however, takes no account of the characteristics of the populations of the different countries with different levels of need.

2.27 Two significant indicators used in resource allocation formulae are dependence on income support and standardised mortality ratios. Research evidence shows a strong correlation between deprivation and need for adult mental health and social care services. In Northern Ireland the proportion of 16-64 year olds dependent on income

support is 60% higher than in England. The standardised mortality ratio, a measure of early death and a proxy for morbidity, for 65-74 year olds is 6% higher than in England. The Needs and Effectiveness Report estimated that Northern Ireland's need for mental health services was around 25% higher than in England.

- 2.28 Since 1999 and with implementation of the National Service Framework for Adult Mental Health there has been a significant investment in mental health services. Expenditure on mental health in 2002/03 accounted for 11.8% of public spending on health and social services compared with 8.4% in Northern Ireland for the same period, a difference of 30%¹⁷.

CONCLUSIONS

- 2.29 Present information on mental ill-health needs for treatment, care and service provision, together with economic evaluation, point to the requirement for greater investment in mental health services throughout Northern Ireland.
- 2.30 A new Northern Ireland Strategy for mental health must include better information on mental illness and better information on service needs. The evidence base for local practice must be underpinned by greater investment in epidemiological and mental health services research.
- 2.31 A holistic and comprehensive approach to service provision and mental health practice is necessary to address the high prevalence and the wide spectrum of health, psychological and social needs of people with mental health problems throughout our community.

