Accessing Mental Health Treatment & Support in NI

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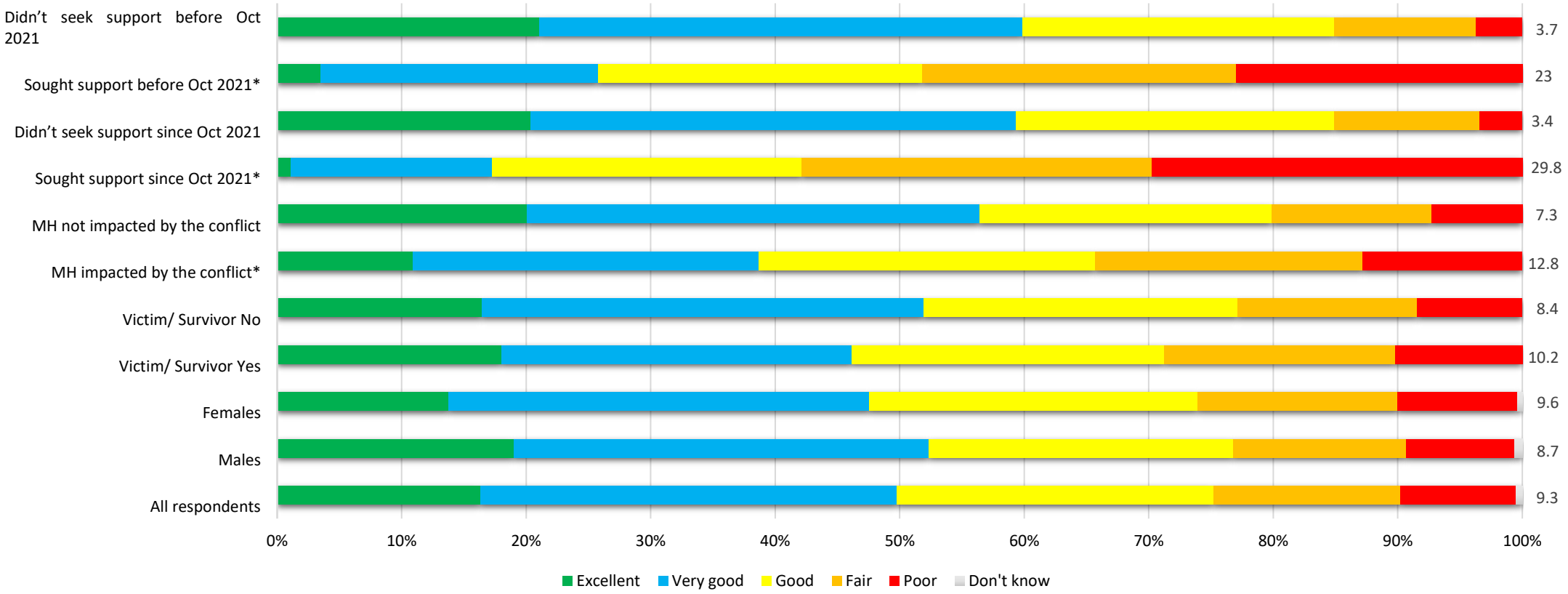
MENTAL HEALTH CHAMPION

What we asked

- General Mental Health (self-report)
- General Wellbeing over past two weeks (WHO-5 index)
- Meeting the legal definition of Victim or Survivor of the NI Conflict (CVS 2021 study)
- Mental Health impact of the conflict regardless of meeting legal definition (CVS 2021 study)
- Sought support at any time since October 2021
  - What support was offered
  - Who provided it
  - How long it took to access effective treatment
- Sought support at any time before October 2021
  - What support was offered
  - How long it took to access effective treatment

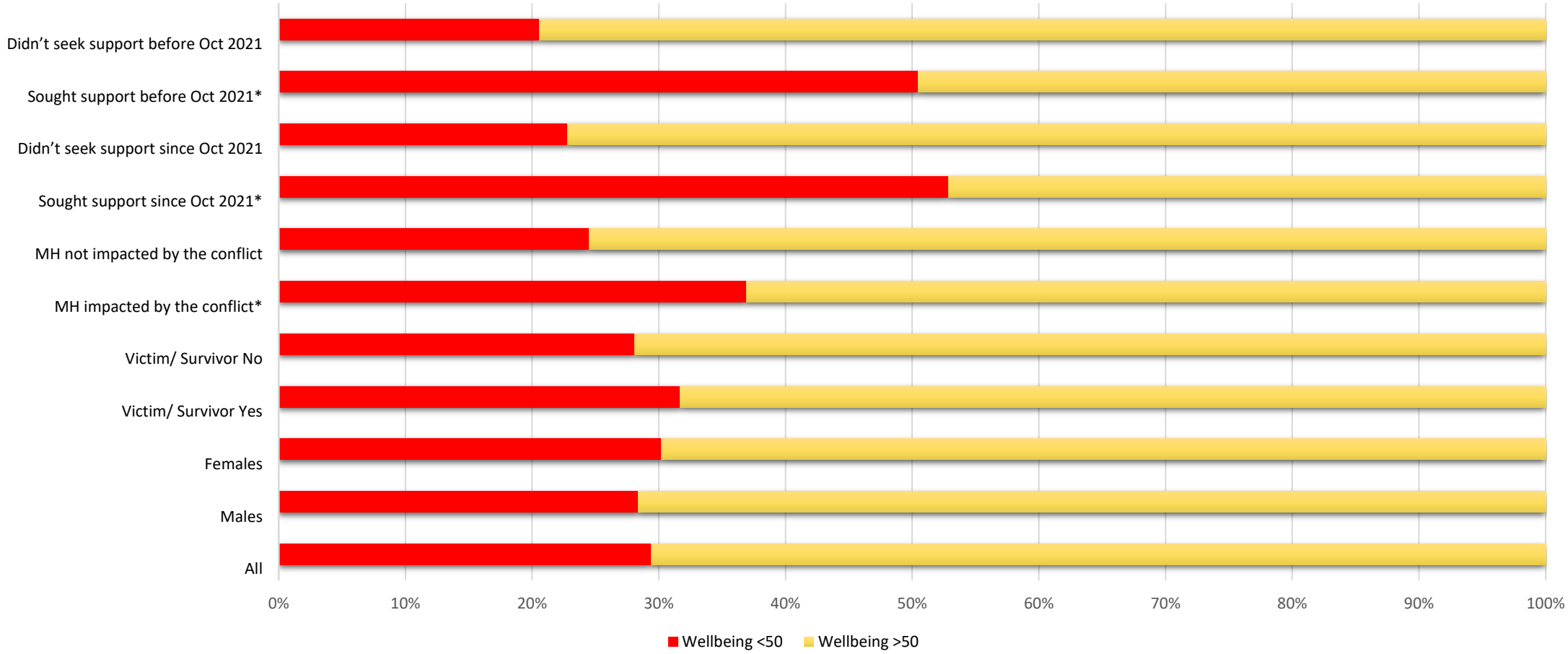
General Mental Health

excellent 16.3%; very good 33.5%; good 25.4%; fair 15%, poor 9.3%



General Wellbeing

70.6% had good wellbeing (>50 WHO-5)



Impact of the Conflict

29.9% - conflict had an impact on their mental health (vs 21% in CVS survey).

Significantly higher % of males (35.9% vs 22.5% of females).

17.8% met the legal definition of Victim/ Survivor (vs 29.2% in CVS survey).

64.5% of those who met the definition of Victim/ Survivor, also stated their mental health was negatively impacted by the conflict.

Those who reported that their mental health was impacted by the conflict had significantly poorer wellbeing.

Services Offered (since 2021, n=227)

GP OR PRIMARY CARE 79.7%

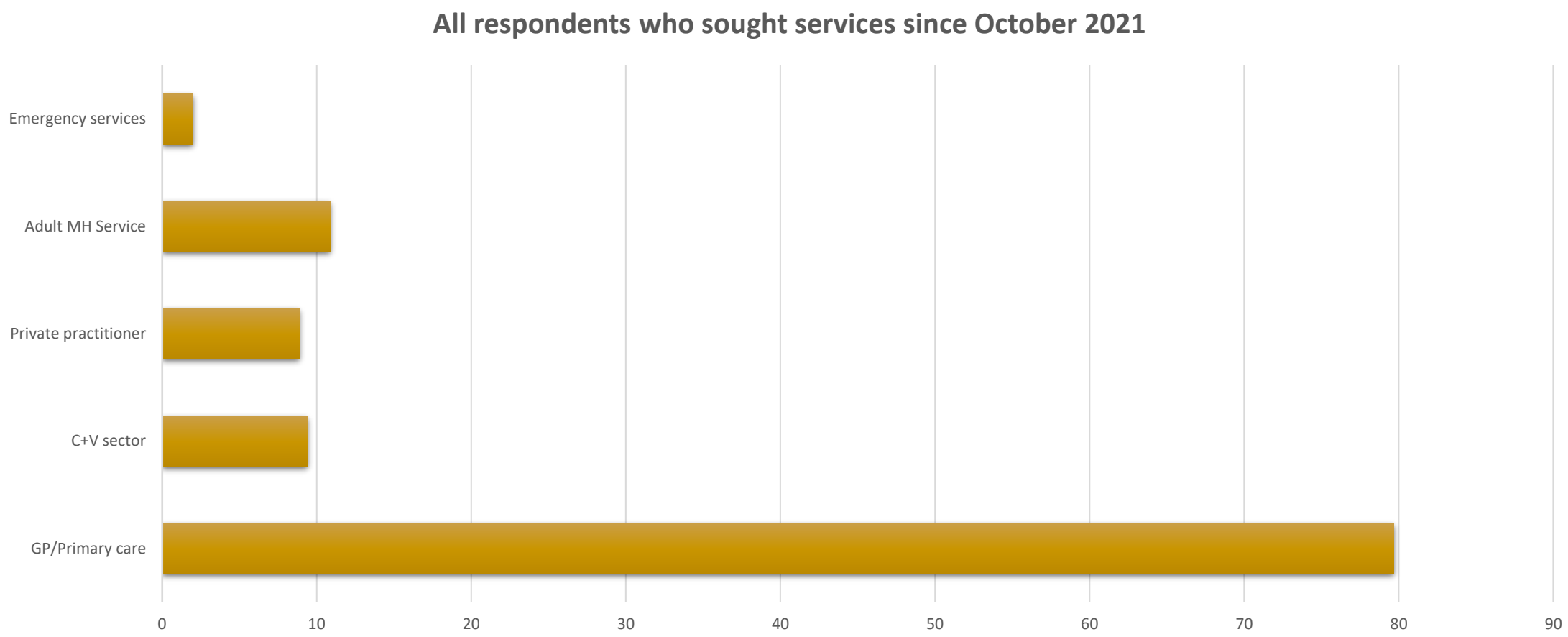
C&V SECTOR 9.4%

PRIVATE PRACTITIONER 8.9%

ADULT MENTAL HEALTH 10.9%

EMERGENCY SERVICES 2.1%

Services offered



Mental Health Services

Primary care is the main service → Prioritise MDTs

Growing private sector

Community and Voluntary Sector

Statutory services (AMHS)

Emergency services → Crisis Intervention Service

Mental Health Strategy →

Integration to Single Regional Mental Health Service

What interventions were offered?

Both medication & NPIs were offered to 32.3% since Oct 21 (37.6% prior to 21).

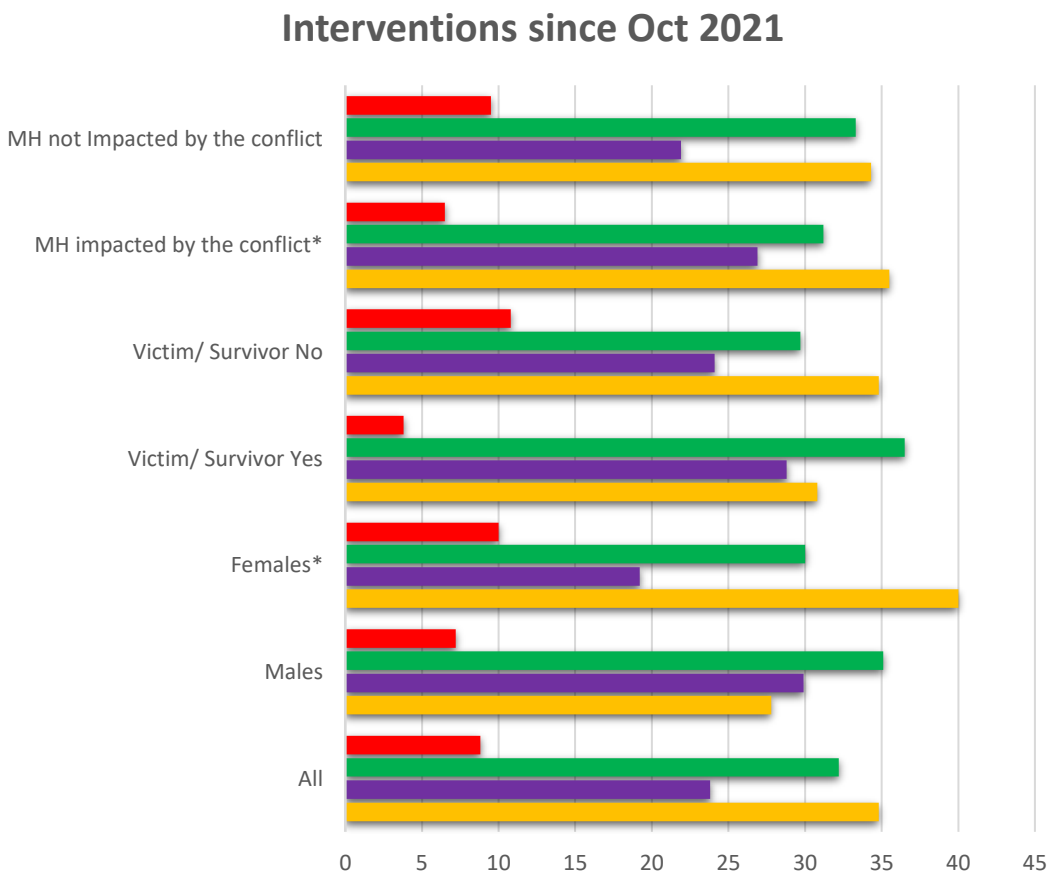
Medication offered to 66.8% since Oct 21 (70.4% prior to Oct 21).

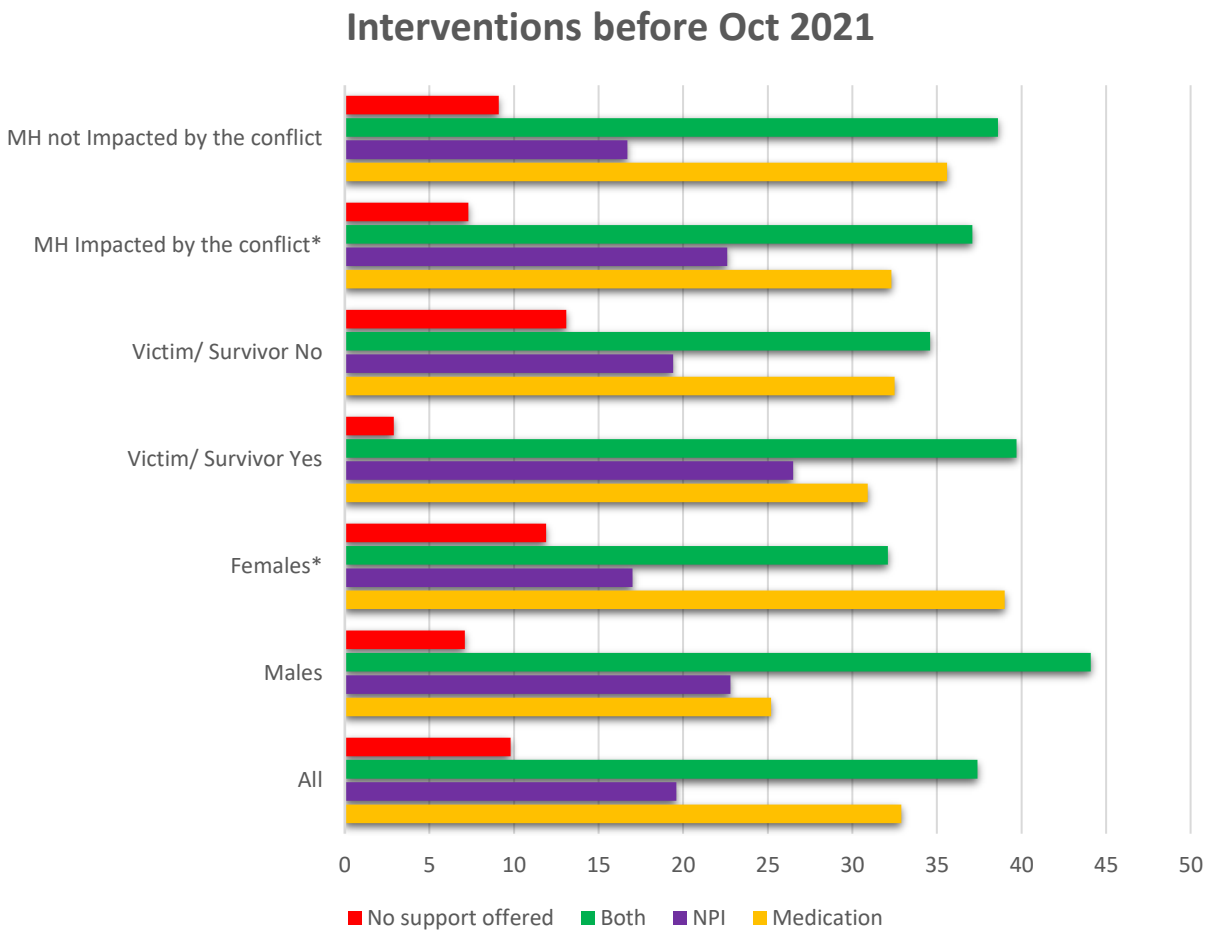
Medication was the **only** intervention offered to 34.8% since 21 (32.9% prior to 21).

Non-Pharmaceutical Interventions offered to 56% since 2021 (57% prior to 21).

NPIs were the **only** intervention offered to 23.8% since 21 (19.6% prior to 21).

Medication & NPIs





Soc Psychiatry Psychiatr Epidemiol (2013) 48:81–93
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ORIGINAL PAPER

Prevalence and treatment of 12-month DSM-IV disorders in the Northern Ireland study of health and stress

Brendan Bunting · Samuel Murphy · Siobhan O'Neill · Finola Ferry

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Major Depressive Disorder 7.9%
Any mood disorder 9.6%

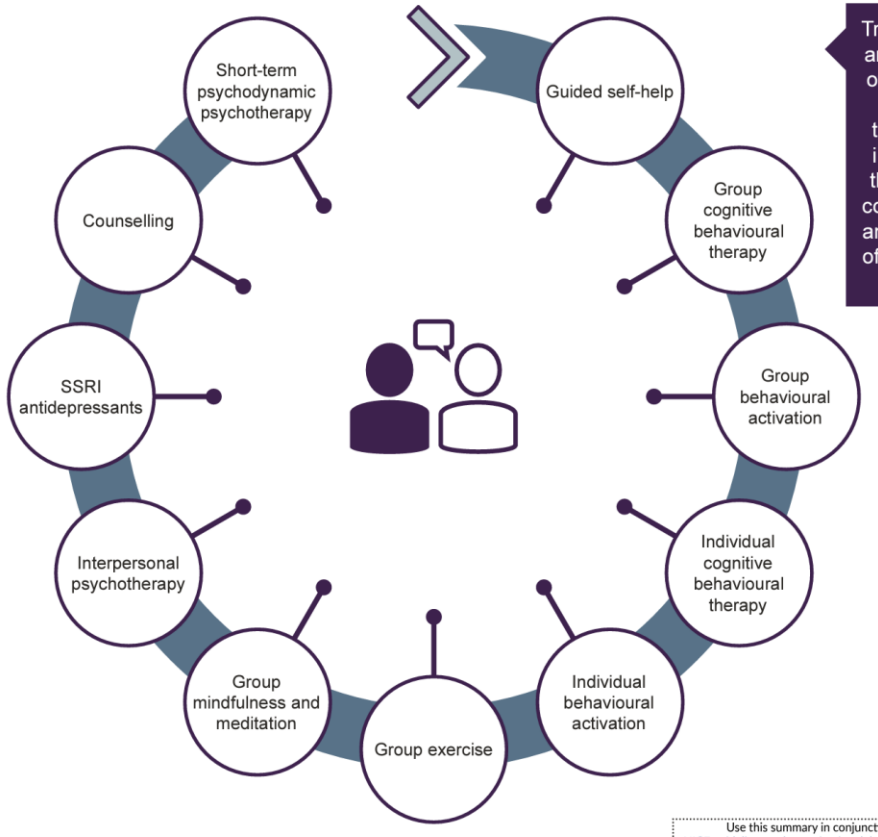
19.6% mild
37.3% moderate
43.1% severe

Depression in adults: discussing first-line treatments for less severe depression

Discuss treatment options and match the choice of treatment to clinical needs and preferences, taking into account that any option can be used as first line, but consider the least intrusive and least resource intensive treatment first (guided self-help).

If the person has a clear preference, or experience from previous treatment to use as a guide: support the person's choice, unless there are concerns about suitability for this episode of depression.

Do not routinely offer antidepressants as a first-line treatment, unless that is the person's preference.



Treatment options are listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors.

NICE National Institute for Health and Care Excellence

Use this summary in conjunction with table 1 in the NICE guideline on depression in adults: treatment and management.

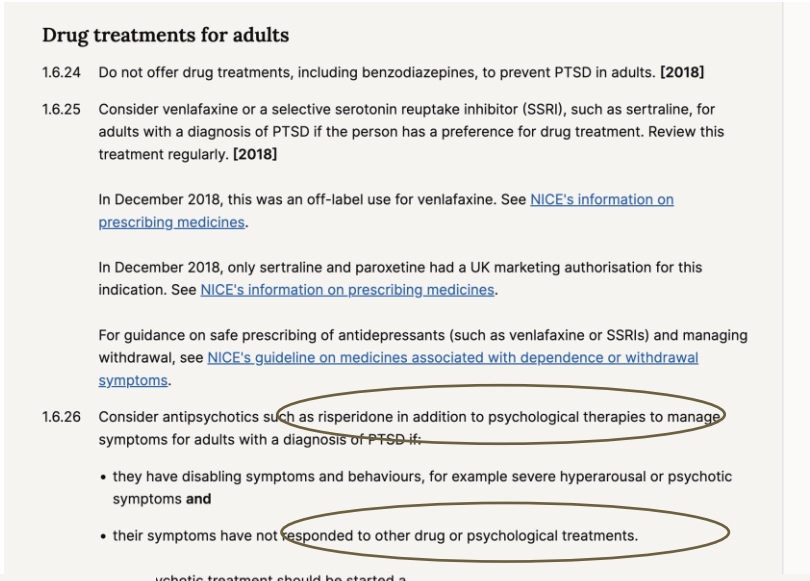
Anxiety disorders

Any anxiety disorder 14.6%

34.7% mild
33.1% moderate
32.2% severe

Specific phobia 7.2%
41.8% mild
32.2% moderate
25.9% severe

PTSD 5.1%
27.8% mild
31.1% moderate
41.1% severe



Drug treatments for adults

1.6.24 Do not offer drug treatments, including benzodiazepines, to prevent PTSD in adults. **[2018]**

1.6.25 Consider venlafaxine or a selective serotonin reuptake inhibitor (SSRI), such as sertraline, for adults with a diagnosis of PTSD if the person has a preference for drug treatment. Review this treatment regularly. **[2018]**

In December 2018, this was an off-label use for venlafaxine. See NICE's information on prescribing medicines.

In December 2018, only sertraline and paroxetine had a UK marketing authorisation for this indication. See NICE's information on prescribing medicines.

For guidance on safe prescribing of antidepressants (such as venlafaxine or SSRIs) and managing withdrawal, see NICE's guideline on medicines associated with dependence or withdrawal symptoms.

1.6.26 Consider antipsychotics such as risperidone in addition to psychological therapies to manage symptoms for adults with a diagnosis of PTSD if:

- they have disabling symptoms and behaviours, for example severe hyperarousal or psychotic symptoms **and**
- their symptoms have not responded to other drug or psychological treatments.

Treatment for adults

1.6.16 Offer an individual trauma-focused CBT intervention to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. These interventions include:

- cognitive processing therapy
- cognitive therapy for PTSD
- narrative exposure therapy
- prolonged exposure therapy. **[2018]**

1.6.17 Trauma-focused CBT interventions for adults should:

- be based on a validated manual
- typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve processing trauma-related emotions, including shame, guilt, loss and anger
- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance
- have a focus on re-establishing adaptive functioning, for example work and social relationships
- prepare them for the end of treatment
- include planning booster sessions if needed, particularly in relation to significant dates (for

ychotic treatment should be started a mendations on how to use antipsycho phrenia in adults). **[2018]**

ember 2018, this was an off-label use ibing medicines.

1.6.18 Consider EMDR for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a non-combat-related trauma if the person has a preference for EMDR. **[2018]**

1.6.19 Offer EMDR to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a non-combat-related trauma. **[2018]**

1.6.20 EMDR for adults should:

- be based on a validated manual
- typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- be delivered in a phased manner and include psychoeducation about reactions to trauma; managing distressing memories and situations; identifying and treating target memories (often visual images); and promoting alternative positive beliefs about the self
- use repeated in-session bilateral stimulation (normally with eye movements but use other methods, including taps and tones, if preferred or more appropriate, such as for people who are visually impaired) for specific target memories until the memories are no longer distressing
- include the teaching of self-calming techniques and techniques for managing flashbacks, for use within and between sessions. **[2018]**

1.6.21 Consider supported trauma-focused computerised CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event if they prefer it to face-to-face trauma-focused CBT or EMDR as long as:

- they do not have severe PTSD symptoms, in particular dissociative symptoms **and**
- they are not at risk of harm to themselves or others. **[2018]**

1.6.22 Supported trauma-focused computerised CBT interventions for adults should:

- be based on a validated programme

Time taken to access effective interventions

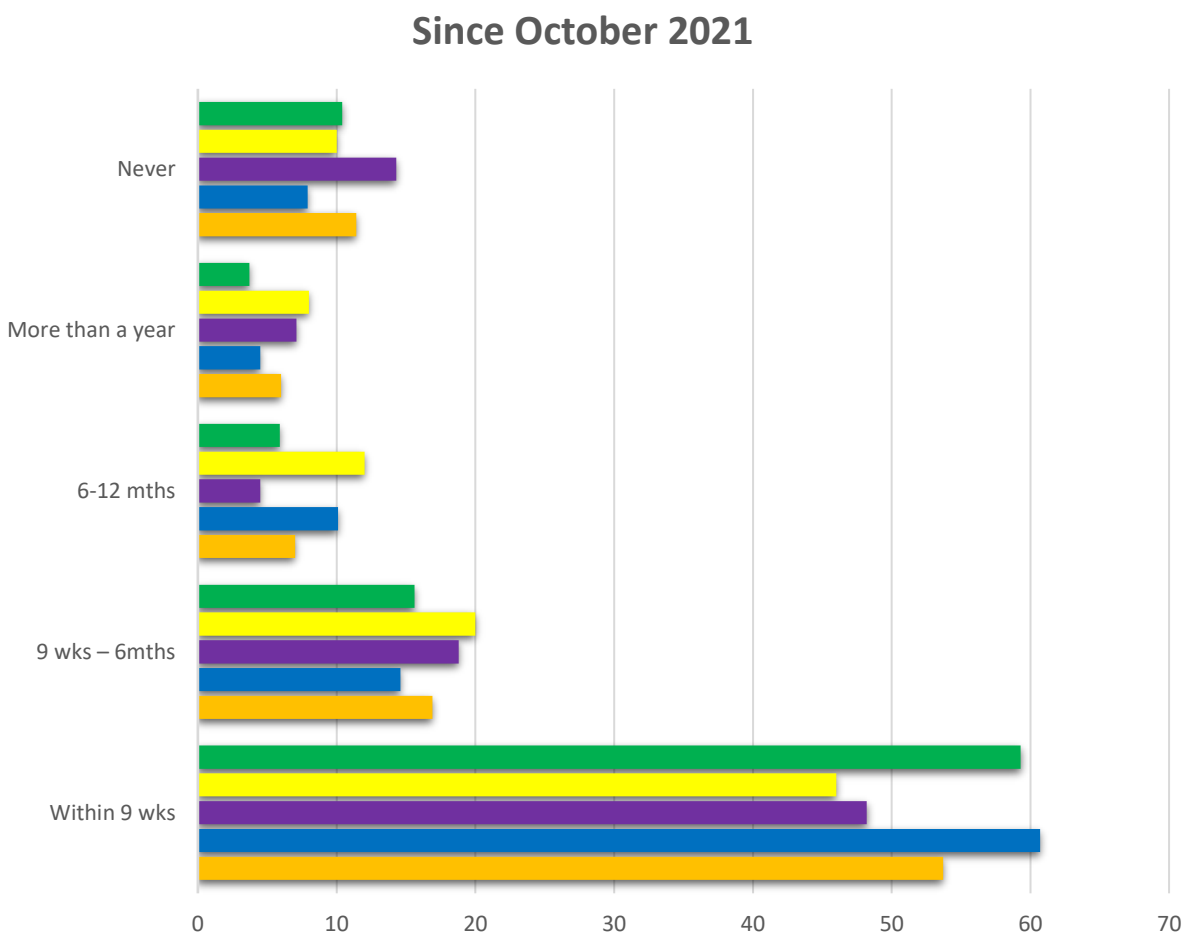
54.6% received an intervention “which led to an improvement” in their mental health within 9 wks (after Oct 21).

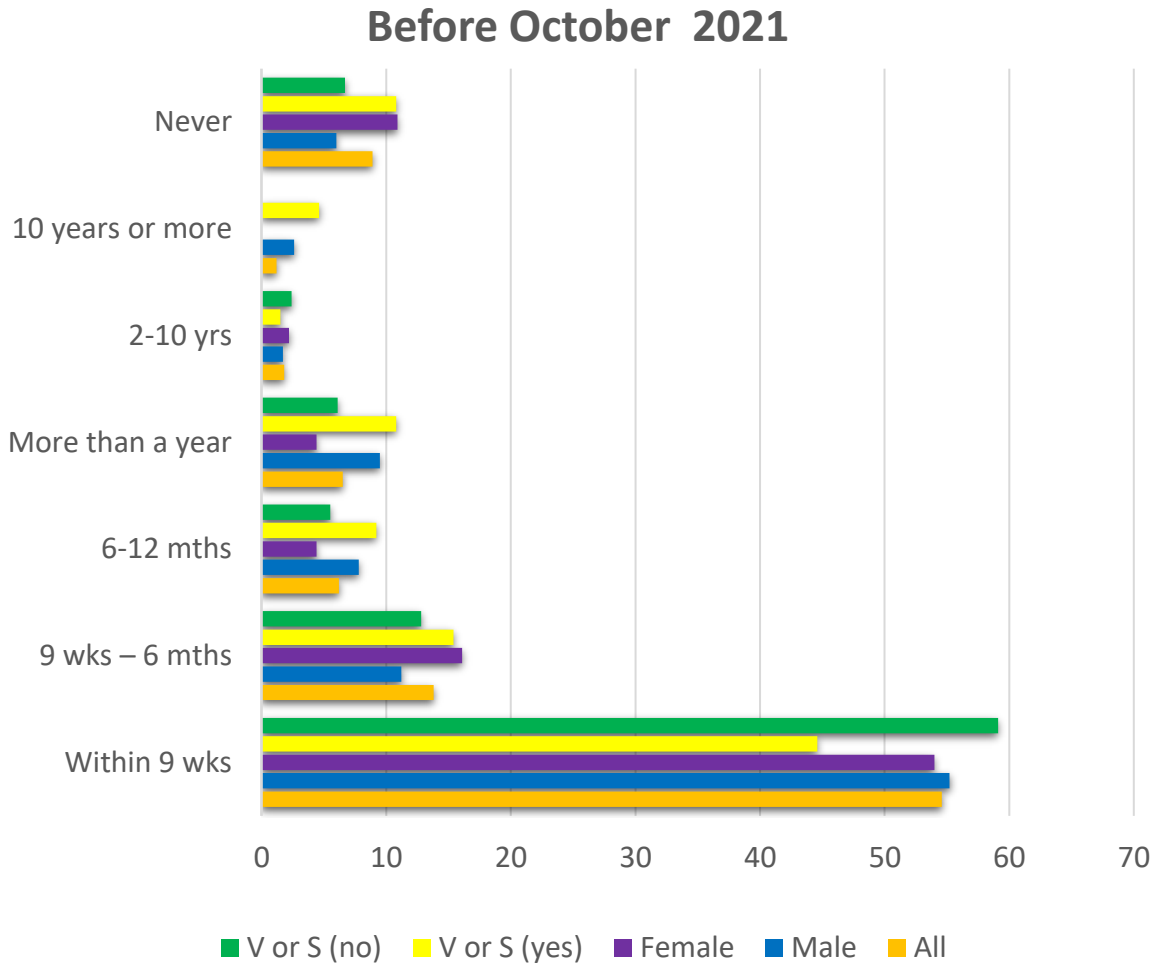
53.4% before Oct 21.

69.9% received effective support or treatment within 6 months (16.5% 9wks–6mths; 13.8% before 21).

11.5% never (since 21) (8.9% before 21).

Time taken to access effective support





Waiting Times

9 wk target not met 46.6% since Oct 21, 45.4% before 21.

More than one in ten since Oct 21 have never received an effective intervention. (8.9% before 21).

Lower %s of V&S received interventions in 9 wks (more complex needs?).

Higher %s of males received effective interventions in 9 wks (since Oct 21).

Discussion

Relatively small sample

Lack of info on severity, diagnosis etc.

Missing info on type of NPI vs diagnosis

Need to improve MH Services so all get recommended interventions in 9 weeks.

Implement Mental Health Strategy.


Questions?