MENTAL HEALTH CHAMPION

The Economic Case for a Mental Health Regional Crisis Intervention Service in Northern Ireland

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Executive Summary

The economic case for reforming mental health crisis services in Northern Ireland is both compelling and urgent. This report highlights that mental health crises are currently costing **more than £45 million annually** across the health system, emergency services, the justice system, and wider society. This figure reflects only the immediate costs of responding to crisis episodes and does not account for longer-term impacts, repeat presentations, or wider economic consequences, meaning the true cost is likely to be significantly higher.

At the heart of the issue is a systemic mismatch between need and response. Many individuals who experience a mental health crisis do not require specialist mental health intervention, nor should they need to spend prolonged periods waiting in emergency departments. Yet, in the absence of consistent, accessible alternatives, hospital-based care has become the default response. This approach is not only costly but can intensify distress, particularly for individuals presenting with suicidal ideation or acute emotional crises.

The report demonstrates that a shift toward **community and voluntary (C&V) sector–led crisis interventions**, delivered as part of a regional mental health crisis service, offers a more effective and economically efficient alternative. A key model examined is Scotland's **Distress Brief Intervention (DBI)**, which provides a structured response combining immediate compassionate support with **14 days of follow-up community-based care**. Evidence from Scotland shows that **more than two-thirds of people presenting in crisis were successfully supported by community organisations**, reducing the need for ongoing engagement with statutory services.

The economic implications of this model are significant. The report estimates that if similar C&V sector interventions were implemented in Northern Ireland and succeeded in reducing inappropriate emergency department use, **savings of over £9 million per year could be achieved** from immediate costs alone. These savings are conservative, reflecting only short-term impacts. Further modelling suggests that if the mental health benefits of such interventions persist for even one additional month, the economic returns would increase substantially.

More broadly, the analysis shows that DBI is a cost-effective intervention under a wide range of assumptions. The estimated return on investment (ROI) is **£1.08 for every £1 invested from a public sector perspective**, rising to **£1.58 under different scenarios of uptake and sustained engagement**, and increasing further when the value of improved wellbeing and reduced burden on families is included. These findings indicate that community-based crisis support is not only affordable but can generate net savings across the system.

Importantly, cost-effectiveness in this context is not limited to direct financial savings. Interventions are considered cost-effective where they deliver measurable improvements in health and wellbeing for a reasonable level of investment. In the case of DBI, the cost per Disability Adjusted Life Year (DALY) averted falls well within accepted UK thresholds, confirming that the model represents good value for money even under conservative assumptions.

Beyond DBI, the report highlights additional interventions that can contribute to a more efficient and responsive system. **Improved triage models**, including multi-agency approaches, can ensure that individuals in crisis are directed to the most appropriate service at the earliest point of contact, reducing unnecessary use of emergency departments and police resources. Similarly, **targeted support for frequent callers** to emergency services has been shown to reduce demand significantly and generate cost savings. The report also identifies strong evidence for the cost-effectiveness of **brief psychological interventions delivered by non-specialists**, as well as emerging evidence supporting alternatives to emergency departments, such as **crisis cafés and outpatient or decision units** staffed by mental health professionals.

A critical insight from the report is that the benefits of crisis service reform extend well beyond the health system. Significant savings accrue to the **justice system, particularly through reduced demand on the Police Service of Northern Ireland**, as well as to ambulance services and social care. This underscores the importance of **cross-departmental collaboration**, particularly between health and justice, to ensure that individuals receive a compassionate and appropriate response from the right service. In the case of young people, effective crisis intervention also requires coordination with the **education sector**, as demonstrated by the DBI pilot in Scotland for individuals aged 13–18, which works in partnership with schools to identify and support vulnerable young people.

The urgency of reform is reinforced by rising levels of need. Recent data indicate substantial increases in emergency department presentations for suicidal ideation, alongside rising suicide rates in Northern Ireland. These trends place additional pressure on already stretched services and highlight the limitations of the current model. Without reform, costs will continue to rise while outcomes remain uneven.

The report also situates these findings within the broader policy context. **The Regional Mental Health Crisis Service**, first outlined in 2021, has yet to receive the level of funding required for full implementation. At the same time, the forthcoming introduction of the **Right Care Right Person** approach will change how police respond to mental health-related incidents, increasing the urgency of ensuring that appropriate health and community-based services are in place to meet need.

Taken together, the evidence presents a clear and consistent message. Investing in **C&V sector-led crisis interventions**, alongside improved triage and integrated pathways, can deliver substantial economic and social benefits. By focusing on individuals experiencing distress who do not require specialist care, the system can provide more appropriate, compassionate support and reduce unnecessary demand for high-cost services. In turn it can free up resources for those with acute clinical need.

In conclusion, the current system is both costly and inefficient. Viable, evidence-based alternatives exist that if combined create a regionally consistent crisis intervention service built around community-based delivery, cross-sector collaboration, and early intervention. Its creation offers a pathway to improved outcomes and better value for public investment. The findings support an urgent call for implementation, recognising that these services are not only clinically appropriate but represent a critical component of suicide prevention and system sustainability in Northern Ireland.

Introduction

Mental health crises have substantial immediate costs to health services in Northern Ireland. These costs are more than £45 million per annum to the health care system, including the Northern Ireland Ambulance Service, as well as the PSNI, Approved Social Worker Service and families. Some of these costs are due to very long wait times and delays in accessing services, including in hospital emergency departments. However, this is a very conservative and partial estimate as it does not include many of the costs for people in crisis who do not attend emergency departments, as well as the subsequent costs of mental health care and other service support beyond the immediate crisis. It also does not include knock-on effects on services due to constraints on resources that could otherwise be used to support people with other needs.

Some of these costs can be avoided through reforms to establish a Regional Mental Health Crisis Service. Diverting people appropriately away from specialist care where a crisis that can be addressed by non-specialist staff including those in community organisations also means that resources are then 'freed up' in specialist mental health crisis services to be used to support people with more severe mental health needs. Distress Brief Intervention (DBI)[1] is one type of community crisis intervention model that is promising. DBI is a non-clinical approach made up of two connected stages. At Level 1, trained front-line professionals, such as staff from health services, police, ambulance, and primary care support the individual by helping to reduce distress, offering a compassionate response, and, where suitable, providing a clear and confident referral to a DBI Level 2 service.

Level 2 is delivered by trained third-sector providers who contact the individual within 24 hours of referral. They offer community-based support focused on problem-solving, managing distress and wellbeing, developing practical plans, and helping individuals connect with relevant services and resources. This has been piloted, evaluated and subsequently rolled out across all of Scotland. We estimate that even under very conservative assumptions, the introduction of this model is likely to be cost effective and potentially help reduce costs not only to the health system but to other sectors, including the PSNI.

Whilst DBI is managed by a central team, it is delivered across level 1 and 2 by statutory and third sector partners to remain adaptive and responsive to the needs of the individual. There is a range of evidence on the effectiveness and cost effectiveness of other interventions; these include actions to support frequent callers to emergency services, multi-agency triage teams, the use of brief psychological supports, support to navigate health and other services, and increased access to multi-disciplinary teams. These interventions are part of the DBI Scotland approach, but examples of this practice already exist across pilot projects in Northern Ireland. The investment value comes from embedding that good practice across the region, strengthening the relationship between sectors and supporting all delivery partners on equal footing to ensure a wrap-around service that can meet the needs of the population. Collaboration needs to be intentional, with oversight and evaluation as demonstrated in the DBI Scotland model, and consistent with the vision for a regional mental health crisis service.

Northern Ireland Context

Mental health continues to be a critical public health priority in Northern Ireland. The divisions rooted in the 30-year conflict known as, the Troubles continue to cause trauma and contribute to ongoing political instability. Knowledge and awareness of mental health and wellbeing have increased, and people are recognising the impact of trauma and adversity. Demand for support is rising, particularly among children and young people, with more people experiencing distress, situational crises, self-harm and suicidal ideation. The NI self-harm registry 23/24 report[2] highlights a 74% increase in patients presenting to hospital emergency departments (ED) with suicide ideation since 2013. Of these, 7% leave before being seen by a clinician, and a further 8% leave before a decision is made on their onward care. The number of people who die by suicide has also increased, with the 3-year rolling average figure rising from 204 in 2017 to 238 in 2024 [3].

The Northern Ireland Mental Health Strategy launched in 2021 is designed as a 10-year plan (2021–2031) to transform mental health services[4]. The core aims are to improve mental health outcomes by reforming mental health services, including the creation of better crisis services, with workforce development, early intervention, and the integration of the community and voluntary sector organisations to a regional mental health service. It emphasises preventing "avoidable deaths" and providing "regionally consistent" services. However, since its launch, investment has fallen far short of the costings outlined in the funding plan. Meaningful change depends on sustained funding, political stability, better data, and the widespread adoption of trauma-informed practice. These conditions are essential to reduce rates of mental ill-health and to ensure timely access to services for those who need them.

The Mental Health Champion has been highlighting concerns about this lack of funding for the Strategy over the past five years[5]. In the first 5 years of the Strategy only 16% of the necessary funding has been provided, equating to only 1% of the overall budget needed for the 10 years of the Strategy. The very serious funding deficit precludes the ambition that transformation in mental health services could be delivered by 2031, without a very radical and significant increase in investment. This comes on the back of years of underfunding of mental health services generally. At £212 person Northern Ireland is the only UK nation spending less than £220 per person on mental health annually[6]. In England, for example, the spending is £264 per person.

A review of the deliverability of the Mental Health Strategy 'The Deliverability Review,'[7] also leaves no room for misunderstanding. It makes clear that the Strategy is not fully funded, and any funding that does become available should be directed towards the actions viewed as having the most impact. Two actions have been identified as short-term priorities: crisis services and in the mental health workforce. Both are necessary to stabilise the system and are foundations of transformation.

In this report we will concentrate on reforms to crisis services. The improvement of crisis services is a commitment of the Department of Health and features in the suicide prevention strategy, **Protect Life 2,**[8] as well as the **Mental Health Strategy (2021-2031)** and the **Substance Use Strategy (2021-31)**[9]. Reforms are also urgent given the introduction of Right Care Right Person[10], an approach designed to ensure that people, who have health or social care needs, receive a response from the right person, with skills, training, and experience to best meet their

needs. Its implementation in Northern Ireland brings into focus the distinct, but vital, roles of PSNI, emergency and health services and the importance of suicide prevention and crisis interventions on the ground. The Mental Health Champion highlighted the potential for this policy to lead to gaps in response capacity that need to be addressed as this change is implemented.

Transformation requires investment but the alternative, standing still, also carries significant costs, which this report explores. Increased and sustained pressure impact on service deliverability and morale and retention of the workforce, while delays and capacity demand impacts permeate across all sectors, including the community and voluntary sector. Delays in receiving treatment, and barriers to appropriate support will have a detrimental impact on the mental (and physical) health and wellbeing of individuals. This carries additional long-term costs not only to health but also to the economy in terms of productivity losses. There are various examples of good practice in the region, however inconsistency in the approaches to crisis responses on the ground creates disparities, and inequity, thereby further amplifying the impact of health inequalities across the region.

Understanding the economic cost of the current model of provision, as well as the costs and benefits of reforms, would inform the discussions about how the limited health budget should be utilised. To that end, the Mental Health Champion commissioned Associate Professor David McDaid and Assistant Professor A-La Park at the London School of Economics and Political Science to consider the economic costs of current provision. The model includes costs associated with the existing provision of services for people experiencing a mental health crisis and what some of the economic costs and benefits would be of investing in effective measures to support a regional crisis intervention service.

Before examining the economic case for action this report outlines the current treatment pathways for crisis intervention that operate in Northern Ireland, alongside the operational barriers that can impede access. These barriers are evidenced where possible by official statistics and supported by the accounts of professionals who support people in crisis, gathered during engagement sessions with the MHC team. A list of the professional groups who contributed to this work is included in Appendix A.

We would like to add a particular note of thanks to the Strategic Planning and Performance Group (SPPG) team whose mapping exercise completed for the regional crisis intervention service strategic group shaped our understanding of the ambition for what the regional crisis intervention service could encompass. It is our intent, that this report be considered alongside that mapping to inform and progress crisis services in NI.

Northern Ireland Crisis Intervention Pathways

The NI **Regional You in Mind Mental Health Care Pathway (2014)** stipulated that where a person is experiencing a mental health crisis which risks their personal safety, services will provide an emergency response within **two hours**, accessed under the emergency response pathway shown in Figure 1 below [11]. In some cases, a person's GP will be the initial point of contact, but many different frontline services may need to support a person to obtain an appropriate emergency response when experiencing distress. The pathway also committed to a recovery-based approach which involves the family in supporting a person's recovery. It also promoted suicide prevention through the delivery of safety planning interventions.

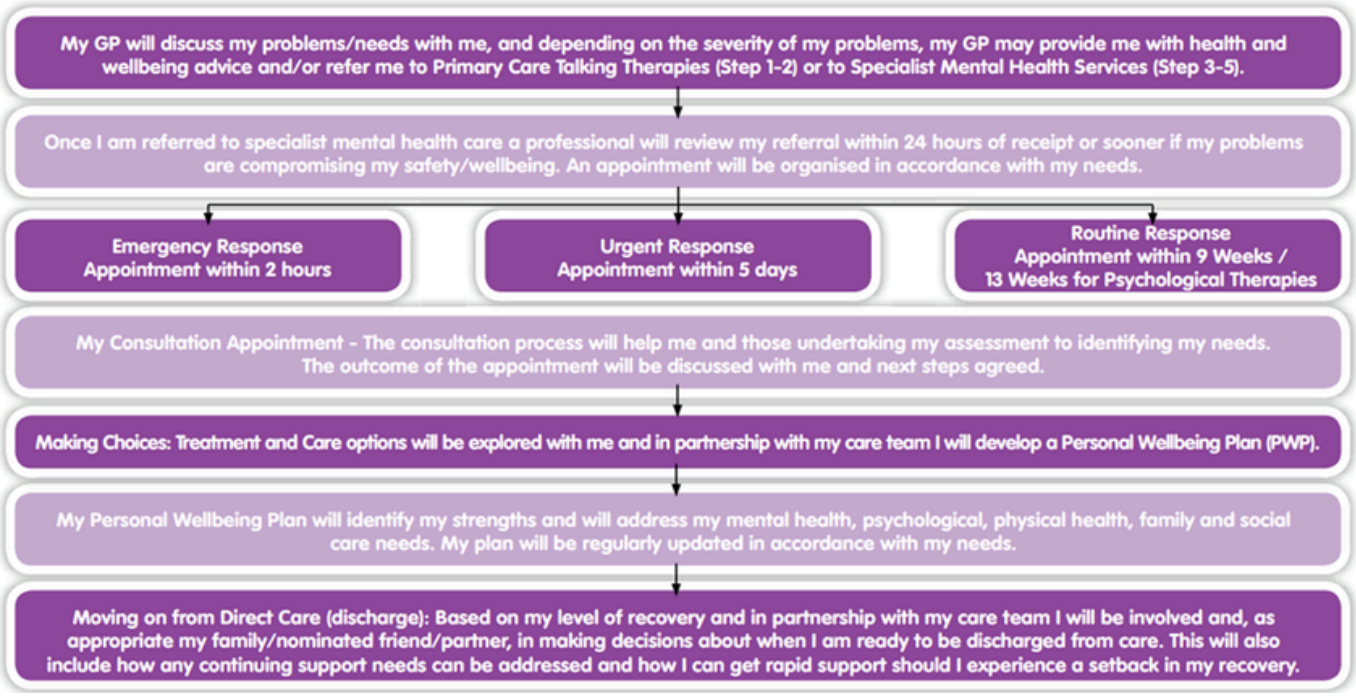

Figure 1: Care pathway at a glance: steps 1-5 mental health care

More recently the Mental Health Strategy 2021-2031[4] included two actions to establish a Regional Mental Health Crisis Service (RMHCS) (Box 1).

Action 12:
Create clear and regionally consistent urgent, emergency and crisis services for children and young people that work together with crisis services for adult mental health.

Action 27:
Create a Regional Mental Health Crisis Service that is fully integrated in mental health services, and which will provide help and support for persons in mental health or suicidal crisis.

Box 1: Actions to establish a Regional Mental Health Crisis Service

The development and objectives of the proposed model are outlined in **A Regional Mental Health Crisis Service For NI Policy Paper for Implementation**[12]. The proposed model would facilitate the integration of professionals trained in de-escalation within existing pathway access points including out of hours, primary care, emergency departments, Lifeline, 999/101 call lines, PSNI, NI Ambulance Service and Regional Emergency Social Work Services. In addition to access to the crisis services the regional model emphasises working together across 4 key components, shown in Figure 2[12]:

- Primary care and inter-agency partnership.
- Community crisis service.
- Mental health liaison services
- Crisis resolution home treatment services

Figure 2: Key Components of the Regional Crisis Intervention Service.

The Strategic Planning and Performance Group (SPPG) have recently completed a mapping exercise as part of the Regional Crisis Intervention Service strategic group which outlines the good practice that already operates across NI under each of these 4 components[13]. For example, the Crisis Assessment and Intervention team (CAIT) developed by the Belfast Trust provides rapid assessment for children and young people, Multi-Agency Triage Teams (MATT) divert clients from hospital emergency departments (EDs) toward community and home based teams when appropriate, Multi-Disciplinary Teams in primary care (MDT) embed mental health practitioners and social workers into primary care, and community navigators work within EDs. Each is an example of responsive, timely and patient centred care. The SPPG also detailed the implementation plan for this work[14]. Scaling these areas of good practice to regional coverage takes investment which the SPPG have considered in their mapping exercise. Those costings and implementation plans are critical to fully understanding the scope, ambition and promise of what can be achieved with a regional crisis intervention service.

A Need to Strengthen Community Crisis Services

In the absence of a regionally consistent crisis intervention service, access to support varies, while pressures on other parts of the health and emergency response systems create further delays. One area that is specifically under resourced or mapped is in relation to the community crisis services. As they sit outside of statutory services, there is large variation in the remits of community and voluntary (C&V) sector organisations delivering these services and their geographical coverage. The importance of delivery of services by the C&V sector is recognised in the Strategy [4], and scaling this component in a sustainable model needs bespoke consideration of funding and commission streams[15]. Challenges that have been highlighted for the C&V sector include low salary levels, difficulties in filling posts and a reliance on precarious short-term funding [15,16]. The recent C&V sector workforce review outlines the current barriers in incorporating the C&V sector into the wider mental health service landscape, and the gap in scope, yet also provides a recommended implementation plan to bridge these gaps[15]. It should be considered in the development of a regional crisis intervention service for NI. These challenges were also identified by the SPPG in their mapping report and it is expected that a regionally consistent community crisis intervention service would include immediate and follow up care at locality level as shown in Figure 3 [12].

There is the opportunity to learn from experience in Scotland, where the scalability of a community crisis intervention has been addressed within a wider regional crisis intervention service through the development of the Distress Brief Intervention (DBI) Framework [1]. This framework is consistent with the objectives for community crisis intervention in NI. The economic case for investing in DBI is discussed in more detail later in the report, making use of learning from the DBI Scotland evaluation process[17].

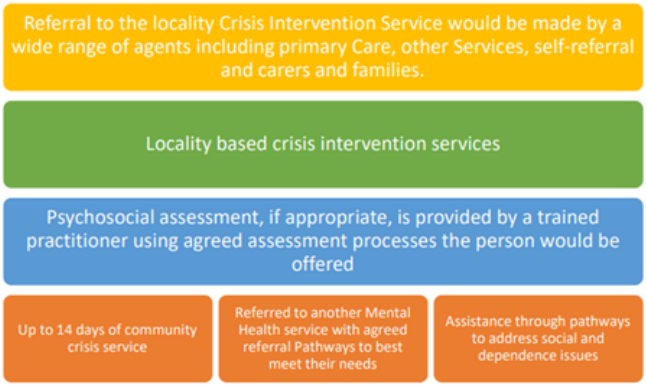

Figure 3: Community Crisis Service Component. Source: Department of Health, 2021.[12]

Current pathways of care

Not everyone seeking support from crisis intervention services requires ongoing treatment for a mental illness. Indeed, many mental health crises stem from factors such as financial stress, relationship breakdown, lack of social support or physical health concerns which can cumulate into an episode of crisis and acute distress wherein a person feels unable to cope. However when someone is experiencing crisis, and is potentially a danger to themselves or others it is essential that they are assessed by appropriately trained mental health professionals, who can determine if a mental health intervention is required, or if alternative supports that address the situational factors contributing to the crisis, for instance debt management and/or financial advice, would be more effective in supporting them.

Ideally, when a person is in crisis, they can be directed through multiple referral pathways to the appropriate crisis intervention team for assessment. These pathways should extend beyond the health sector, including primary care, and also encompass social services, youth services, the community and voluntary (C&V)

sector, education settings, and emergency services (PSNI/NIAS), as well as self-referral by the individual in crisis or concerned members of the public.

The appropriate pathway is dependent on the age of the individual or if they have a pre-existing diagnosis of mental illness:

- Older Adults: telephone conversation with Primary Care Liaison Service (PCLS) to determine optimal referral route if presenting within co-morbid conditions and referral to older adults' team if appropriate
- Adults: referred to PCLS and then when appropriate to crisis intervention service (seen within 2 hours)
- Adults with existing severe mental illness (SMI): direct referral to the Recovery Team
- Children and Young People (CYP): referral to Child and Adolescent Mental Health Service (CAMHS)

Currently crisis intervention pathways operate inconsistently across the region, potentially creating disparities in access. Difficulties in accessing crisis services and care pathways are exacerbated by system-level inconsistency and competing financial pressures within the Health Sector. As evidenced in the SPPG mapping report, multiple pilot and Trust based initiatives address barriers to access [13]. However, these have not been scaled regionally, exposing gaps in provision across the region.

The family, friends and professionals supporting someone experiencing crisis often report needing to wait with them for long periods of time to ensure their safety, until the appropriate assessment and suicide prevention intervention (such as a safety planning intervention) can take place. People experiencing a crisis also report increased difficulties in accessing services in cases where they have complex, co-occurring mental illness and substance disorders, as well as in cases where their difficulties do not easily align with a care pathway.

In the next section we look at some of the reasons for delays in access to services, making use of available data, paired with information obtained during direct engagement with the professionals who regularly find themselves in the position of supporting people in crisis. This is then used to help understand the scale of the economic cost.

Key Considerations for Delays in Access/Protracted Wait Times: An Overview of the Engagement Sessions and Relevant Data

Being under the influence of alcohol or drugs

An initial mental health assessment cannot be completed while a person is under the influence of drugs or alcohol as those substances influence behaviours. When a person is experiencing crisis in these circumstances the primary focus is on ensuring their physical safety until blood analysis confirms they are no-longer under the influence. This wait often occurs in hospital emergency departments, where individuals are usually supported by friends/ family members or other professionals in the statutory or C&V sectors, but not specialist mental health services.

Child and Adolescent Mental Health Service (CAMHS) operating hours and response times

CAMHS operates from 9-5pm Monday to Friday. Although a 24/7 service is available through the acute CAMHS managed care network, this is not regionally available. When a young person presents in crisis out of hours, including over the weekend, the regional out of hours social work team are contacted. Common reasons for these crises include self-poisoning and self-harm, as well as emotional problems. A young person in crisis is a safeguarding concern, and social services are contacted routinely in these instances. Safety plans are established to bridge the time gap until the young person can receive a mental health assessment with CAMHS. Emergency responses from CAMHS occur within 24 hours of referral, this differs from the 2-hour response target placed on PCLS.

Difficulty accessing CAMHS at the point of crisis was highlighted by GPs, Youth Workers, Multidisciplinary teams (MDTs) teams and a group of C&V sector organisations supporting children and young people known as the Re-imagine Collective. MDTs stated that CAMHS triage cases could be based on referral information rather than on seeing the patient. Crisis referrals should be seen on the same day, but this may happen on the next day due to capacity issues, and referrals can also be downgraded to urgent or routine, delaying response time. All the professionals spoken to voiced that they hold extra risk in supporting young people during this wait period. The level of monitoring and check-in required often goes beyond their remit and contracted working hours of staff. MDTs also highlighted that friends and family are routinely used in safety planning during wait periods to monitor people at risk of suicide. This raises questions on whether that practice is ethical given NICE guidance states that friends and family only be involved in this way if the patient has consented and been made aware of the limits to confidentiality their inclusion creates[18]. DoH have created SHARE guidance which advises on how to engage with patients when discussing issues of confidentiality and consent to share information.

CAMHS service leads reported that while most crisis referrals are seen within target timeframes and supported through the Acute Managed Care Network, several persistent system-wide challenges are undermining overall effectiveness. They feel there is broad confusion among professionals and families about the

distinction between universal CAMHS supports and the specialist clinical service, leading to frustration when referrals that do not meet the clinical threshold are labelled inappropriate despite clear Level 1 or Level 2 needs.

Rising numbers of neurodivergent young people, particularly those with ASD and ADHD, are placing further pressure on services that lack the tailored therapies, training, and capacity to meet their needs, compounded by increasing requests from schools for diagnostic assessment. In-patient provision has also diminished, resulting in overcrowded wards where young people are exposed to the distress and behaviours of others, including the impact of restraint. Although CAMHS remains more regionally consistent than adult mental health services, transition remains difficult, with many young people losing access to supports they previously relied on. Across all Trusts, workforce shortages, continue to limit capacity and the sustainability of multidisciplinary teams.

Hospital Emergency Departments as designated places of safety

Most often people in crisis are directed to hospital emergency departments which are deemed as places of safety. In the Mental Health (Northern Ireland) Order (MHO) 1986 [25] *"place of safety" means any hospital, of which the managing HSC trust is willing temporarily to receive persons who may be taken there under this Order, any police station, or any other suitable place the occupier of which is willing temporarily to receive such persons.* While attending EDs is crucial when a person experiencing crisis has a physical injury, it is also known that alternative entry points would be beneficial for those with no physical injury. Health professionals within EDs do not typically have training in mental health or crisis de-escalation. This increases the likelihood that a person in crisis may be discharged by health professionals without a referral to crisis intervention services or appropriate mental health assessment services, or indeed the likelihood that the person leaves without assessment due to the excessive wait period. These scenarios occur even when a physical injury is present or likely, for example in cases of self-harm and suicide ideation presentations for which NI keeps a registry.

Data for 2023/24 show 13,575 presentations to EDs for self-harm or suicide ideation,1.9% of all attendances to Type 1[1] and Type 2[2] EDs that year[2]. Of those presentations, 9% were under 18s, 88% were 18-64yr olds, and 3% were aged 65+. 6% overall were experiencing homelessness. In 5% of these presentations, patients left ED without being treated, the majority of whom (96%) left after seeing the triage nurse. 38% of the people who presented at EDs had consumed alcohol or drugs at the time of presentation, which delays their mental health assessment and impacts their subsequent care.

Average wait times in Emergency Departments can be substantial. Wait times varies greatly across the region, but information is available via a real-time interactive dashboard[3]. Presentations are triaged via the Manchester Treatment Scale which prioritises physical injury by acuity and the median wait time in ED varies greatly depending on triage level. In the most recent data for March 2026 only 31% of all patients at Type 1 EDs were discharged within 4 hours while 17% waited over 12 hours. The Information Analysis Directorate report on wait times in the 2025/26 year detail this variation, with summary facts in Figure 4[19]. It notes two median waiting times, approximately 4 hours for

[1] Major, 24-hour consultant-led units providing full resuscitation facilities for serious and life-threatening conditions.
[2] Consultant-led, single-specialty services focused on specific conditions rather than general, 24-hour resuscitation.
[3] https://datavis.nisra.gov.uk/health/ni-emergency-care-waiting-times-data-jan-mar-26.html

patients discharged home from ED, and 14 hours for those admitted to hospital. A breakdown by hospital is shown in Figure 5.

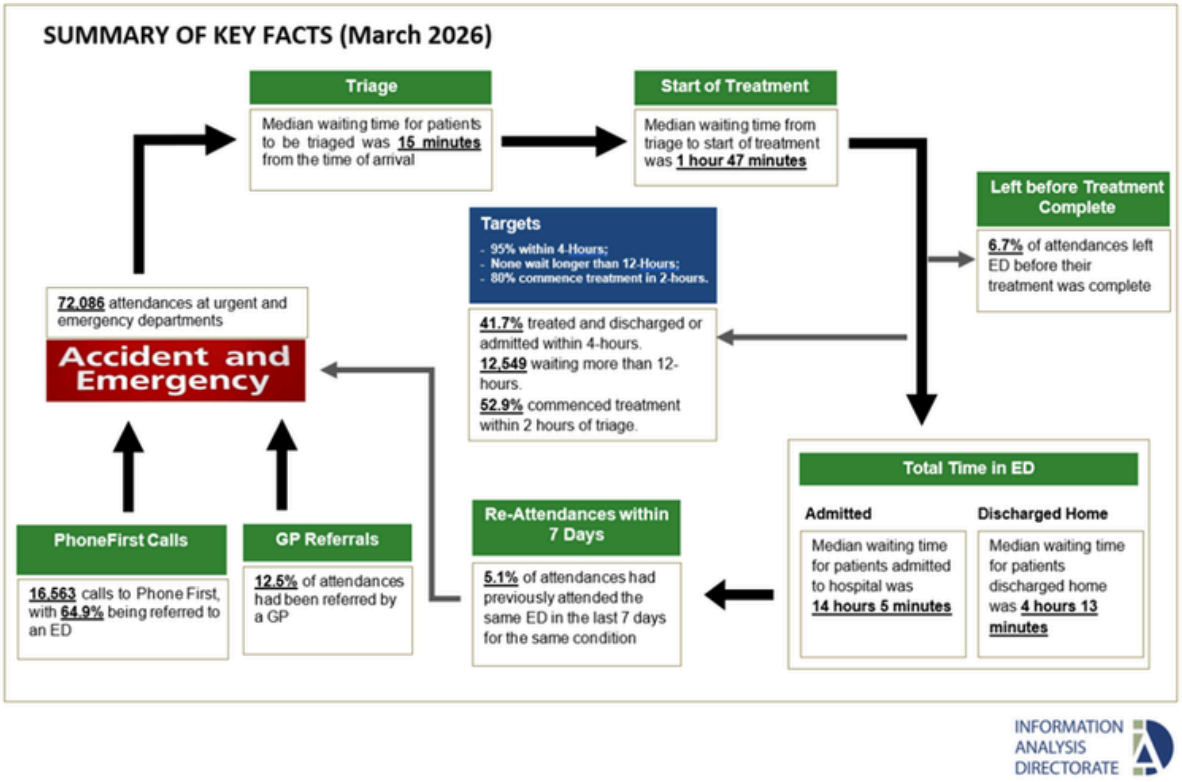

Figure 4: Median waiting times in Emergency Departments March 2026[19]

Department	Admitted				Discharged			
	Median (HH:MM)		95th Percentile (HH:MM)		Median (HH:MM)		95th Percentile (HH:MM)	
	Mar 2025	Mar 2026	Mar 2025	Mar 2026	Mar 2025	Mar 2026	Mar 2025	Mar 2026
Mater	12:32	10:33	43:22	29:00	4:36	5:24	16:12	15:47
Royal Victoria	11:53	12:55	31:52	30:16	6:42	7:29	19:05	21:00
RBHSC	6:04	6:16	11:13	11:25	3:05	3:21	7:51	8:01
Antrim Area	13:45	16:41	60:12	77:20	5:18	5:28	20:06	21:36
Causeway	21:31	20:42	92:33	75:02	3:48	3:56	13:36	17:35
Ulster	14:48	15:56	42:10	49:39	6:15	6:59	18:49	20:55
Craigavon Area	19:39	17:53	71:58	67:26	4:19	5:50	15:08	23:24
Daisy Hill	12:03	13:15	46:48	40:08	3:43	4:27	10:05	16:24
Altnagelvin Area	15:41	21:28	91:47	75:33	5:41	5:53	22:55	24:21
South West Acute	11:06	19:02	54:41	71:40	3:52	4:41	17:35	20:01
Type 1	**13:28**	**14:22**	**57:52**	**57:10**	**4:48**	**5:20**	**16:45**	**20:09**
Type 3	**8:28**	**6:50**	**29:29**	**26:26**	**1:26**	**1:34**	**6:30**	**6:32**
Northern Ireland	**13:12**	**14:05**	**57:16**	**56:30**	**3:51**	**4:13**	**14:47**	**17:45**

Source: Encompass / Regional Data Warehouse

Figure 5: Time spent in ED for those admitted to hospital/discharged home[19]

Northern Ireland Ambulance Service (NIAS) handover

The self-harm registry shows that 33% of persons presenting with self-harm or suicide ideation were taken to hospital via ambulance. While this is not a complete representation of all crisis presentations, it demonstrates that the NIAS is integral to the crisis intervention pathway.

Ambulances are staffed by at least two paramedics who stay with a patient until they can be handed over to health care staff through emergency department ambulatory care. The Northern Ireland Audit Office (NIAO) have reported that handover times have increased significantly since 2019, although the number of calls has remained consistent[20]. There are multiple reasons for this, but primarily handovers are dependent on the Manchester Treatment Scale. They therefore prioritise physical injury, and by default lengthen the handover time for people experiencing crisis with no or less urgent physical injury.

Only 7% of ambulance handovers happened within the 15-minute target during the 2023/24 reporting year, 34% took at least one hour and up to three hours, while 9% took more than 3 hours. The NIAO report makes clear that the situation has significantly worsened from 2019 and highlighted that further deterioration was noted outside of the review period. They noted that *"while our review has focused on the period from 2019-20 to 2023-24, the more recent months prior to publication of this report have seen some exceptionally poor performance. NIAS records multiple handovers of longer than 10 hours daily. In December 24, one ambulance handover at the Ulster Hospital took over 23 hours"* [20] The NIAO reports states handover delays have cost NIAS £50 million over the five year period, and that these costs will have grown in the subsequent years not included within the report.

It is also worth highlighting that the waiting times recorded in EDs do not include the handover times from the ambulance to ambulatory care. So, if a person is waiting on average 3 hours in an ambulance, they may wait a further 3 hours in the ED (after triage) to be seen, and only then will the handover process will have been completed allowing the paramedics to return to service. However, if they are accompanied by any other professionals or family members, they will be waiting at least until initial assessment/ treatment.

When speaking with the NIAS Complex case team who respond to frequent callers (those who've contacted 999 five or more times a month), for 80% of those who present with mental health issues, the handover delay is on the higher end of the scale for those in crisis with no or less urgent physical injury. **They report an average approximate wait time of between 4-6 hours, but it is common that wait times can exceed 12 hours, which is the length of a full shift.** They highlight that while waits are longer for less urgent cases, waits are increasing across the board and for those patients with acute physical need, such as those experiencing stroke or cardiac arrest, waits bring higher risk of permanent injury or death. Increased handover wait time also delay paramedics from being able to respond to other calls, reducing emergency response coverage across the region.

There are multiple reasons for the increased waits discussed in NIAO report, but the work of the complex case team highlights the importance and potential impact of having alternative handover sites either within hospitals or other appropriate health care settings[21]. The NIAO report makes clear that while limited investment of £1.3 million was allocated in 2021/22 to create those additional handover sites, improvements have not been sustained or made regionally consistent (Figure 6).

Hospital and Trust	Funding allocated in 2021-22	Funding allocated in 2022-23
Antrim Area Hospital (Northern Trust)	£0.63 million allocated which led to the creation of a five-bed ambulance handover area which became operational in June 2021.	£0.26 million allocated to continue operation of this facility. At April 2022, the Northern Trust planned to develop an additional waiting area for `fit to sit' ambulance patients by June 2022.
Craigavon Area Hospital (Southern Trust)	Almost £0.07 million funding allocated to support the creation of a six-bay arrival bay for ambulances, and a patient handover point plus additional staff to function in this area.	No funding allocated for ambulance handover zones and the handover area did not become operational.
Altnagelvin (Western Trust)	Almost £0.22 million allocated to facilitate the creation of a six-bed ambulance handover area and associated staff to operate it.	Almost £0.16 million allocated to this facility. However, the service was stood up and down depending on whether staffing levels were adequate and it was also used for overspill for mental health patients.

Source: NIAO using DoH information

Source: NI Audit Office Report - Ambulance Handovers in NI

Figure 6: Use of additional funding for ambulance handover zones

Police Service Northern Ireland (PSNI)

There is ongoing discussion regarding the appropriateness of the PSNI responding to people experiencing mental health crisis, and the PSNI will be implementing the **Right Care Right Person** (RCRP) policy[10]. This approach is a policing and mental health initiative being introduced in Northern Ireland to ensure that individuals experiencing crisis situations are supported by the most appropriate professionals, rather than relying on police as the default response. The model, which has already been rolled out in parts of England, aims to reduce unnecessary police involvement in mental health and welfare incidents. Instead, cases are directed to health or social care services unless there is an immediate threat to life, a risk of serious harm, or a criminal element.

In Northern Ireland, the PSNI's planned introduction of RCRP has sparked widespread discussion across the sector, including concerns about whether health services, inclusive of emergency response services and local C&V sector services, are sufficiently prepared to support the transition. Overall, the approach seeks to improve outcomes for vulnerable individuals while enabling police resources to focus more effectively on core public safety duties.

Key parts of that discussion focus on the amount of time PSNI officers spend in EDs with patients experiencing crisis [22-24]. Like the NIAS, PSNI officers cannot leave a patient until handover to the appropriate health professional. As discussed above, ED wait times can be lengthy and this wait is extended further when a patient is under the influence of alcohol or drugs. This means that at least two officers must remain with someone in crisis until handover is complete.

Regional Approved Social Work Service (ASWS)

A proportion of people presenting in crisis require treatment in a psychiatric hospital. When that treatment is refused, but still deemed necessary for the safety of the patient or others, they will be detained under the Mental Health (Northern Ireland) Order (MHO) 1986 [25]. The Mental Capacity Act 2016 replaces the MHO, but it still has not fully commenced [26], so both pieces of legislation operate in dual capacity and all matters of Deprivation of Liberty fall under the MHO. Detainment under the MHO is the most restrictive option and only employed as a last resort. It is rightly surrounded by legal requirements and safeguards and an essential part of the crisis intervention service for the most vulnerable of patients.

Where initial assessments within EDs, PCLS or by emergency services such as NIAS indicate that detention under the order is required the ASWS will be contacted. Approved Social Workers (ASWs) can ascertain if involuntary admission to an in-patient facility is required and have the power to convey the person to that facility. Although the patient has entered the crisis intervention pathway at this stage, there are a number of barriers to treatment which have economic costs. It is important to note that until a person is taken to the inpatient facility, they are held within the ED as it is deemed a place of safety. ASWs may then have to wait for a substantial number of hours with the person until they have been conveyed to hospital. During 2023/24 there were 998 compulsory admissions to all Hospitals under the Mental Health speciality, and 9 under the Learning Disability speciality.[27]

The ASWS operates at Trust level but there is regional consistency because their work relates to the MHO which is a legal requirement. ASWs advocate that EDs are not the best place to hold these patients as they have limited access to MH support via the PCLS, will be acutely distressed and potentially experiencing psychosis. ASWs express the view that patients they support feel they endure judgment from patients and staff who do not think they should be there.

The delays in access and conveyance have economic costs but also legal ramifications as they can lead to breaches in the timeframes for admission under the MHO. There can be lengthy delays in alerting the ASW that a patient in ED may require involuntary care. In some cases, this can be up to two days. The longest wait times are for in-patient beds, once on-site the ASW remains with the patient until they have been admitted. For patients requiring involuntary care, ASWs report that less than 13% of cases involve a PSNI response. Most patients arrive at ED via NIAS, other professionals or member of public known to the patient.

Although ASWs have the power to take patients to the in-patient facility involuntarily, they can delegate this power to PSNI, NIAS or a secure taxi service if the patient is unwilling to come with them and forcing the issue presents an increased risk of danger to themselves or others. The secure taxi service is very costly and only used when PSNI and NIAS are unavailable.

Waits for PSNI attendance regularly exceed the length of an ASW shift. As the ASW has to remain with the patient it reduces capacity within the wider service. There are also overtime costs incurred when outside of working hours or requiring handovers to regional out of hours social work services. The PSNI may request a warrant before attending which places additionally wait times on the process. NIAS stay in continued contact when their conveyance is requested, but there can be lengthy waits for this service as well.

Data from the ASW Minimum Data Set indicate that there were 376 protracted waits related to delayed admission to hospital beds, 117 delays related to the NIAS, 92 related to GP referrals and 57 related to the PSNI (who may have to convey a person to a place of safety) in the first 9 months of 2024. We do not have a precise breakdown on average wait times, but these protracted delays are at a minimum 3 hours and often much longer.

Multi-disciplinary teams (MDTs)

Primary care MDTs manage significant levels of mental health–related risk, frequently supporting multiple crisis presentations each day. They typically deal with 10 crisis presentations across Northern Ireland daily. While skilled in crisis assessment, the teams refer individuals to secondary care when risks exceed their remit, including cases involving imminent harm to self or others, severe mental illness, or the need for inpatient assessment. Clear pathways exist for adults, older adults, people with existing SMI, and children and young people, with referrals routed to PCLS, crisis intervention services, Recovery Teams, or CAMHS as appropriate.

However, substantial barriers undermine continuity and timeliness of care, increasing costs. Crisis intervention services often reassess and downgrade referrals from primary care. This can increase costs if it leads to individuals being sent home despite ongoing risk and placing considerable pressure on families to maintain safety. There are also additional costs for GPs if these people then end up re-presenting at the GP surgery in need of further assistance.

Delays within EDs exacerbated by staffing gaps, long waits, and environments unsuitable for highly distressed individuals, further reduce attendance and follow-through. These challenges are particularly acute for children and young people, who face high crisis thresholds, delayed assessments, and increased reliance on family-led safety planning.

Workforce constraints also significantly limit MDT capacity and coverage. Only a portion of GP federations currently have MDT provision and planned regional expansion risks deepening vacancies. Recruitment is hindered by restrictive banding structures, and the loss of experienced staff has reduced local knowledge within crisis pathways. Collectively, these system pressures contribute to inconsistent crisis responses and increased risk at the point of presentation.

Youth Work Services, voluntary and statutory

Youth Workers shared that in their experience young people in crisis are often not seen quickly enough by statutory services, leaving the youth sector to absorb significant additional risk and workload, despite not being commissioned to offer mental health crisis response. Youth workers engage daily with highly vulnerable young people, many of whom experience severe mental health difficulties, self-harm, substance misuse, and a lack of stable family support, often within families where mental health needs have gone untreated for generations. Accessing crisis services can be unpredictable, with assessments frequently undertaken by locum staff and long waiting times, often over six hours, during which youth workers remain with the young person. Young people who have used substances face further delays, as assessment cannot proceed until blood results are clear, and it is increasingly difficult to keep them in the emergency department environment.

Professionals highlighted that safety plans often fail to reflect the realities of young people's lives, overlooking risks linked to housing insecurity, family breakdown, paramilitary involvement, criminal coercion and exploitation. Many young people living in temporary accommodation or hostels, or those frequently absconding, remain at heightened risk, particularly when peers and family members have died from addiction or suicide. Early discharge from CAMHS, or

decisions that a young person is “not in crisis” further contribute to young people falling through gaps. As a result, youth organisations have expanded their roles to meet need, undertaking additional training, hiring therapists, as well as liaising with social services, GPs, mental health practitioners and housing teams, despite none of this being covered by core funding. This diverts resources from their primary work, but they continue to provide this support given that these young people are not receiving the support elsewhere.

Significant systemic gaps persist, particularly for young people ageing out of CAMHS with no ongoing support, those becoming involved with youth justice due to unmet behavioural or mental-health needs, those with limited contact with education, as well as deteriorating health. While youth organisations value the work of healthcare providers, they remain deeply concerned that thresholds for access are too high, and that young people at risk are being left without help. As a result, the C&V sector is increasingly forced to create ad hoc supports to fill widening gaps in the system.

Additional Barriers to Accessing Crisis Support

Through engagement with professional groups who support people experiencing crisis we are aware of system level and group specific factors which can impact on access to crisis support. Although there are no figures or data to indicate the scale of these barriers in NI, they are worth noting as they should be considered in the design of any regionally consistent crisis intervention service. Indeed, when discussing these barriers, professionals highlight how they can create a cycle of crisis, wherein the underlying concerns are never addressed appropriately, continually leading to escalation and eventually crisis scenarios.

Staff turnover and recruitment

Multi-disciplinary teams (MDTs) broaden the experience and support available at the first point of contact within the healthcare system, but their impact is limited by inconsistent availability, with only seven GP federation areas covered and some of these operating with partial staffing. While plans are in place to scale MDTs regionally this year, there is uncertainty about how the additional vacancies created will be filled, highlighting the need to review current banding structures and recruitment criteria, which currently prevent experienced staff, such as long-serving Band 5 nurses, from applying for Band 6 roles. Expanding entry routes through on-the-job training would help strengthen workforce supply[27]. Loss of experienced staff has already affected service quality, with newer recruits, including some recently qualified, taking on senior positions; although clinically capable, their limited local knowledge is affecting the depth and accuracy of triage assessments.

Youth Workers and C&V sectors represented in the Re-imagine Children's Collective, a group of ten leading regional charities in Northern Ireland united in a shared mission to transform children's social care, highlighted that the increased use of locums in assessment centres can create a "lottery" of who will interact with the young person, as not all will have any knowledge of the local area or contributing factors which may be driving the current crisis presentation.

Differing professional opinions of crisis thresholds

Earlier we noted that MDTs also highlight the crisis intervention service conducts its own triage assessment and frequently re-categorises referrals from crisis, which should be seen within four hours, to urgent, with a ten-day response time, or routine, which can take up to nine weeks. Initial assessments completed in primary care, often by experienced Band 7 clinicians, are not accepted, and patients are reassessed by Band 6 staff.

When referrals are downgraded, individuals in crisis are typically sent home, often returning to primary care while families are left to manage safety without adequate support. This approach relieves pressure on secondary care capacity but leaves vulnerable people without timely help at a point of significant risk. Within CAMHS, triage is based on referral information, and although crisis referrals should be seen the same day, capacity limitations mean this is sometimes delayed to the following day, with referrals also subject to downgrading to urgent or routine categories.

At a wider GP level, a GP's decision to refer someone to the crisis service depends not only on their clinical assessment but also on their own capacity, level of mental health training and familiarity with the patient. Because GPs vary greatly in their experience and confidence in managing mental health presentations,

thresholds for referral can differ significantly. When the crisis intervention team does not accept a referral, responsibility for managing the person's safety and ongoing risk is placed back on the GP, who may not always have the time, resources or specialist skills needed to do so safely. GPs do need more training in this area, but consideration should be given to how responsibility and risk can be shared so that all health professionals feel comfortable and competent in supporting a person in crisis.

Focus on physical presentation treatment before psychological intervention

During a meeting with the Royal College of Paediatricians and Child Health, practitioners highlighted a growing concern about the limited engagement of psychiatry and psychology services when young people present to EDs or are admitted to paediatric wards, where physical health remains the primary focus despite increasing mental-health-related presentations. Psychiatric assessments often take place only after discharge, leaving paediatric staff, who lack appropriate training, responsible for managing distress, risk and safety in environments not designed for mental health crises.

Emergency wards have no anti-ligature spaces, creating significant risk, and EDs are frequently used to hold young people when no alternative placement is available, despite being unsuitable and unsafe, particularly for children. The recent increase in ward age limits from 14 to 16 has contributed to a rise in mental health presentations and greater demand for staff trained in safe restraint. Admissions have grown by 24%, linked to difficulties accessing primary care.

Eating disorder assessment criteria are rigid, and Avoidant/Restrictive Food Intake Disorder (ARFID) is not recognised, leading to physical health deterioration and, at times, the use of forced feeding without CAMHS support, compounded by ongoing issues such as school avoidance and family breakdown. With no appropriate services for ongoing support, physical and psychological needs escalate. While increased CAMHS funding is welcome, it does not extend to the wider health services that must respond to children and young people experiencing mental health crises.

Scope and remit of C&V sector organisations supporting young people and their families

The C&V sector organisations within the Re-imagine Children's Collective are not designed or commissioned as crisis or mental health services, yet they are increasingly stepping into crisis roles because young people face significant barriers to accessing statutory support across multiple systems. Long waiting lists, often around six months, to access early-intervention and prevention services mean many young people escalate into crisis before receiving help. For those under 18, the referral pathway typically involves social work, GP assessment and referral to CAMHS, but therapeutic interventions are limited, appointments are restricted to office hours and fixed locations, and non-attendance often leads to discharge and a return to the C&V sector, creating a recurring cycle of challenges. CAMHS' medicalised approach often fails to address the complex social and environmental issues underlying crisis and in securing appropriate support for 16–18-year-olds. For young people over 18, crisis referrals usually occur via GP assessment or attendance at ED, but assessment delays, limited informal support networks and the need for staff to remain with individuals, often untrained for crisis care, place additional pressure on services.

Across both pathways, young people are frequently discharged without follow-up support and redirected to the C&V sector. Where safety

planning is required, plans are sometimes written without consulting the C&V organisations expected to provide monitoring, welfare checks or 24-hour wraparound support. These demands often exceed the organisations' remit, training and capacity, yet they undertake the work because no other service is available. As risks increase across all sectors, C&V organisations are managing levels of complexity they are neither resourced nor trained for. They have expressed concern that statutory services do not fully understand their roles or limitations, but they also show willingness to expand crisis-related work if supported through appropriate training, recognition, coordinated planning and secure funding. This requires changes to commissioning, dedicated coordination of the diverse C&V landscape and wider reform of children's and young people's services as recommended in key reviews, most recently the Independent Review of Children's Social Care Services in Northern Ireland led by Professor Ray Jones in 2023 [28].

Multiple systemic pressures are driving crisis presentations, including domestic abuse, parental mental ill-health, poverty, financial stress, housing insecurity, and substance misuse, with newer unclassified substances contributing to unpredictable and high-risk behaviours. Certain groups are particularly vulnerable: neurodivergent young people and those with learning disabilities face reduced access to specialist services, prolonged social work vacancies and inconsistent support. Schools increasingly struggle to manage complex needs, often relying on reduced timetables. Social care pressures mean many children lack a key worker, and the support offered often reflects team capacity, rather than assessed need.

Young people in care frequently experience disrupted relationships with services, limited placement options, reduced access to secure care and significant anxiety about transition to adulthood, where support systems change dramatically. C&V organisations often step in to teach life skills and help young people navigate housing and financial insecurity, despite this being beyond their formal remit. Other high-risk groups include young people at risk of sexual or criminal exploitation, many of whom have little family support, live in unstable or unsafe environments and experience repeated crises without interventions that address underlying vulnerabilities. Unaccompanied minors seeking international protection also face significant challenges due to trauma, limited access to psychological therapies, cultural barriers and heightened fears about immigration policy; despite rising crisis calls among this group, avenues for support remain minimal.

Taken together, these pressures have intensified over the past decade. Needs are becoming more complex while access to statutory support is narrowing, leaving all sectors managing increasingly high-risk situations. Although the C&V sector is skilled in prevention and early intervention, it is being forced to redirect focus towards responding to crises, many of which were preventable with earlier support. These organisations have already suffered the bereavement of losing young people they supported and are actively contributing to system-change discussions. However, they stress that young people are being harmed and lives are at risk now, reforms cannot be left to unfold over many years. Despite the aspiration of a "no wrong door" approach, young people increasingly experience the opposite: encountering barriers, delays and closed pathways at every point of contact.

Group Specific Considerations

People experiencing homelessness

The Simon Community's 2023 report highlights the deep interconnection between homelessness and mental health, noting that people experiencing homelessness often have complex needs shaped by trauma, substance use, and long-standing distrust of health services due to previous negative experiences[29]. While hostels offer a sense of safety, homelessness services are only funded to provide housing support and are not resourced to manage acute mental health crises, despite frequently being relied upon to do so. When individuals in crisis seek help, the primary pathway is attendance at EDs for assessment by the crisis intervention team, yet they regularly face barriers including stigma from both staff and other patients, long waits, lack of dual-diagnosis progress, and instances of being discharged without assessment. Waiting times of 10–12 hours are common for homeless people, often requiring police officers to remain with the individual for the full duration, while assessments are delayed further when detoxification or stabilisation is required. During these periods, hostel staff, who are neither trained nor equipped for such situations, are left managing acute risk.

For many people experiencing homelessness, crisis is not a short episode but a chronic state in which opportunities for timely intervention are repeatedly missed. This results in a cycle of crisis, help-seeking, discharge without support, and escalating behaviour that leads to critical incidents requiring emergency response services. These incidents carry significant personal and organisational costs, from physical danger and property damage to emotional tolls on staff and residents, increased supervision demands, and financial pressures on services that are not funded for such intensive support. Additional concerns exist for people banned from hostels and placed in B&B accommodation with minimal support, rough sleepers who often present to ED following suicide attempts, and those within the prison population, where mental health needs and experiences of homelessness are highly prevalent.

Some targeted support exists through the Complex Lives Model and Health Inclusion Teams in Belfast, jointly delivered by homelessness organisations, Belfast Health and Social Care Trust and the Public Health Agency, with a focus on physical health and the ability to make mental health referrals. However, these supports are limited geographically and cannot meet wider demand. To better understand need and risks, it is critical to obtain data on major adverse incidents, reviewing self-harm registry data, especially for homeless populations, and examine age-specific patterns. Overall, the system leaves people experiencing homelessness navigating prolonged crisis without appropriate, timely intervention, placing unsustainable pressure on both statutory and community services.

Young people with increased vulnerabilities

Young people with care experience often face significant challenges because they lack consistent family support and frequently feel unheard after years of being moved through multiple services and placements. Many live in a near-constant state of crisis, repeatedly cycling through support systems after discharge, with PSNI involvement common when they go missing. Although they remain connected to social work teams, increasing staff pressures mean that many do not have an allocated keyworker. Staff turnover can mean important context gets overlooked during crises presentations or places the burden of providing that context through retelling onto the person experiencing the crisis. This burden of retelling, can itself be re-traumatising. Placement

availability is also limited, with growing concern about the lack of suitable options for younger children and restricted capacity in secure care. As these young people approach adulthood, there is significant concern about how they will access support once they turn 18, leading C&V organisations to step in to teach budgeting, independent living skills and to help them navigate hostels, food banks and other services such as employment, training and welfare support that lie far outside traditional care pathways. Administrative Data Research UK (ADR) found that young adults with care experience are at a higher risk of self-harm and death by suicide. Just under two fifths (39.7%) of people who die by suicide in NI were known to social services in childhood[30].

Children at risk of child sexual exploitation often come from highly vulnerable situations, with many having care experience and living in unstable accommodation such as hostels or sofa-surfing arrangements. They typically have little or no family support and seek connection from individuals who exploit that need, placing them in dangerous situations. While these young people often present in crisis, crisis responses alone do not address the underlying instability of their environments or help them recognise the risks surrounding them, leaving them exposed to continued harm.

Similarly, children at risk of criminal coercion are drawn into witnessing or participating in criminal activity, including paramilitary-linked behaviours in some areas. These experiences can damage their mental health, bring them into contact with the justice system, and lead to threats against their lives. The constant exposure to danger fuels ongoing periods of crisis, yet available supports often focus on immediate risk rather than the structural and social factors driving the coercion.

Young people seeking international protection face an additional set of profound vulnerabilities. Unaccompanied minors have no/limited family network, and progress in expanding access to psychological therapies for this group has been limited. Many services lack cultural competence and an awareness of the complex trauma these young people have experienced, with little recognition that each transition between services can itself be traumatic. Rising fear linked to immigration policy changes, has further eroded their sense of safety. As a result, crisis presentations among this population are increasing, yet their pathways to support remain extremely constrained.

Autistic and Neurodivergent people

Neurodivergence is a natural variation in how people think, process information, and interact with the world, and does not inherently cause mental distress. It includes conditions such as autism, ADHD, dyslexia, and dyspraxia, which are lifelong differences in brain functioning. Awareness has increased due to better diagnostics, social awareness, and reduced gender bias, with growing recognition that girls and women often present differently than boys.

Difficulties typically arise when neurodivergent individuals face environments designed for neurotypical people, leading to stress, sensory overload, and increased risk of burnout. Many, especially women, have historically gone undiagnosed, often receiving treatment for issues like anxiety or depression instead of their underlying neurodivergence. Greater awareness, early identification, and strong support services for both children and adults are essential to improving outcomes and quality of life. Navigating a neurotypical world can place significant strain on the mental health of neurodivergent individuals. A Northern Ireland study found that neurodivergent young people reported markedly higher levels of anxiety and more frequent suicidal thoughts than their neurotypical peers [31]. They were also more likely to experience cyberbullying, highlighting an increased vulnerability to online harm.

Autism NI operates a weekday helpline staffed by a small team, and although it is not designed as a crisis response service, it is frequently contacted by people experiencing crisis because they have been unable to access support elsewhere. Their insight illustrates how crisis presentation can look different for Autistic and neurodiverse people, and is consistent with reports from health professionals in recent research[32,33]. Autistic people are significantly over-represented in mental illness and suicide statistics and experience markedly lower life expectancy, yet their crises often go unrecognised due to widespread misunderstanding about how autistic distress presents. Many autistic individuals mask their symptoms, dissociate in overstimulating environments, or speak in a monotone or calm manner even while in severe crisis. As a result, their mental health concerns are often incorrectly attributed to autism itself, leading to exclusion from appropriate treatment. Families can also struggle to recognise autistic traits in themselves or their children, further delaying help-seeking and support.

Emergency departments remain overwhelmingly unsuitable for autistic people: they are bright, noisy and chaotic, exacerbating sensory overload at a time when individuals already feel dysregulated. There is a strong need for sensory-appropriate, low-stimulus spaces for anyone presenting in crisis without an urgent physical health issue, alongside broader environmental adjustments that would benefit neurodivergent and neurotypical patients alike. The service landscape also requires on-site mental health professionals who are trained in autism, able to distinguish between autistic traits and mental health symptoms, and able to communicate using clear, direct, notes-supported approaches. Misdiagnosis, including bipolar disorder or schizophrenia, remains a concern when behaviours driven by sensory overload are misinterpreted. Therapies such as cognitive behavioural therapy (CBT) often rely on metaphor or visualisation techniques that can heighten anxiety for autistic people, underscoring the need for adapted, neuro-affirmative therapeutic approaches. Additionally, alexithymia means some autistic individuals struggle to express emotions outwardly, making it easy for clinicians to underestimate their level of crisis or risk.

Parents and carers consistently highlight the strain placed on families due to unsupported need, including high levels of stress, social isolation, relationship breakdown and increased risk of children entering care. School anxiety and non-attendance are common, often preventing parents from working and creating financial hardship. Despite these challenges, a broader understanding of population-level need is hampered by gaps in data: autism diagnoses are not recorded consistently in healthcare records, where they are frequently subsumed under general disability categories. Better regional data collection, aligned with approaches used elsewhere in the UK, would enable more accurate assessment of demand and more effective service planning. Research evidence, including economic literature reviews and multiple studies shared by Autism NI, reinforces the urgency of addressing these gaps to ensure autistic people can access timely, appropriate support.

An Overview of the Economic Costs of Poor Mental Health in Northern Ireland

The full economic costs of poor mental health in Northern Ireland have been estimated to be at least £3.4 billion per annum [34]. In addition, we have previously estimated that the lifetime costs to the economy for all ED attendances for self-harm, as well as completed suicides in Northern Ireland are between £300 and £400 million, per annum [35] .

At a population level these costs are so significant because mental health conditions are among the most common reasons for poor health. One source of information on the impacts of poor mental health, relative to other conditions, is the international Global Burden of Disease Study (GBD) for 2023[36,37]. This dataset includes estimates of the prevalence of mental health conditions, as well as their impact as measured by the number of Disability Adjusted Life Years (DALYs) associated with each condition. DALYs combine time lost due to premature death and time spent living with disability. A DALY value of 1 represents a year of healthy life lost. DALY values of 0 represent time spent in perfect health. It also provides data on Years Lived with Disability (YLD) due to a condition, for example depression or bipolar. We focus on YLDs here, as the DALY metric only includes estimates of premature death for suicide and self-harm, as well as for eating disorders. Data are broken down by age group and gender across the entire lifespan.

The GBD dataset has the advantage of being periodically updated and subject to peer review [37] and is increasingly utilised in mental health research internationally. Epidemiological data used in the GBD model for Northern Ireland draw on data from comparable high-income countries, which are then applied to Northern Ireland[4].

Figure 7 shows that Anxiety Disorders and Depressive Disorders are the third and fourth most leading causes respectively for YLD for the population of all ages in Northern Ireland. They are also the leading causes of YLD in people aged 15-49. This is similar to the situation in Scotland and Wales. In England anxiety and depression are the second and third most contributors to all age YLD. Anxiety and depression are the third and fifth most leading causes of all age YLDs in the Republic of Ireland.

The importance of support for people experiencing a mental health crisis

Some of these impacts of poor mental health can be averted or mitigated through early and appropriate support for people; this includes support for people experiencing a mental health crisis. Better support implies appropriate pathways of care and support when people experience mental-health related distress. As we have noted many people during a crisis will seek help from their statutory health services, including local hospital ED services. While support through these services and admission to hospital is a vital element of any mental health system, for example following self-harm or because they are experiencing psychotic symptoms, many people potentially would benefit more from alternative forms of support provided outside of hospital settings. As noted earlier in this report, actions are needed to prevent/mitigate some of the underlying diverse

[4] This is also the case for all jurisdictions in the UK and for the Republic of Ireland

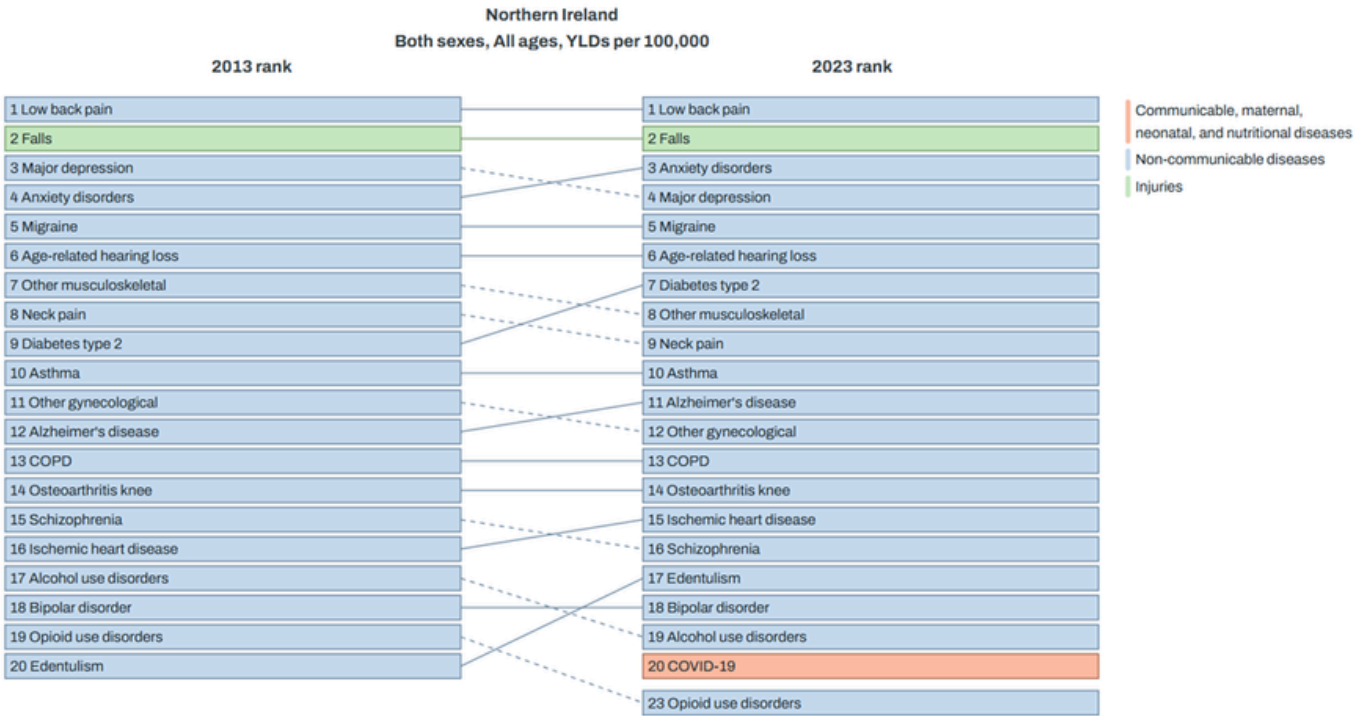

Figure 7: Leading contributors to total years lived with disability in Northern Ireland 2013 and 2023[36]

personal and socio-economic determinants of poor mental health. These include issues around poverty, insecure housing, discrimination, poor family relationships and social isolation.

In many cases people of all ages experiencing mental health distress can be supported outside of hospital emergency services; in fact, spending time in hospital may be very unsuitable for many people. A well designed and implemented regional mental health crisis service model could provide better co-ordination and linkages between the many different non-hospital centric services that can help people during a crisis, including primary care out-of-hours, mental health liaison, the NIAS, PSNI, and C&V sector services. This, in turn, can reduce pressures on hospital based mental health services, providing them with more time to provide help and support to people in crisis experiencing the very highest level of distress, as well as intentional self-harm.

This section in the report looks at the potential economic case for investing in different types of crisis intervention services. The costs of not taking action are considered. Evidence on the case for investment in interventions is then explored and the return on investment from a non-statutory service intervention known as the Distress Brief Intervention (DBI) modelled. We have chosen DBI for modelling as this is an intervention recently piloted and scaled up across Scotland. Different scenarios are presented, varying some of the parameters and assumptions in the modelling analysis, e.g. around the uptake, costs and effectiveness of the service.

Not Taking Action to Reform the Approach to Mental Health Crises in Northern Ireland is Costly

Continuing with the status quo and not taking action comes with substantial costs. We have estimated that very conservatively, just looking at the immediate costs of dealing with some aspects of mental health crises in Northern Ireland, that each year these have costs of at least **£46 million**. (Table 1). These estimates are very partial, given data limitations. They do not look at many of the costs for people in crisis who do not attend emergency departments, as well as the subsequent costs of mental health care and other service support beyond the immediate crisis. They also do not include many costs that fall on GPs and other primary care services, as well as knock-on effects on social workers, and community and voluntary sector workers due to the constraints on remaining resources that are used to support people with other (non-mental health related) needs. There will also be additional impacts on the Fire and Rescue Service that are not included. For young people there will be additional impacts in the education sector, for teachers, other school staff and fellow students, as well as additional costs related to safeguarding for youth workers and others, who for example, as we have discussed earlier may have to be present at the ED for long periods of time.

Table 1: Estimate of the some of the annual immediate care and support costs for people experiencing mental health distress in Northern Ireland

Sector/Service	**Cost (£ millions)**
Specialist Mental Crisis Care Services	24.1
Attendance at Hospital Emergency Departments	6.7
PSNI support for people in crisis	4
Northern Ireland Ambulance Service	7.2
Families / Friends	3.67
Approved Social Worker Service	0.15
Total	**45.82**

Despite these limitations the costs shown in Table 1 fall on many different sectors including hospital trusts, primary care and specialist mental health teams, the PSNI, NIAS, ASWS, Youth Workers, C&V sectors and families. The SPPG point to 90,000 - 100,000 contacts with specialist mental crisis care services every year[13]. This equates very conservatively to costs of between **£24.1 million to £26.8 million per annum**.

Many people seek help from their local hospital accident and emergency services for mental health and emotional distress. In 2023 around 25 people per day presented to the Mater and Royal Victoria hospitals EDs for mental health and emotional distress[38]. Applied to all of NI this would mean that

hospitals EDs for mental health and emotional distress[38]. Applied to all of NI this would mean that between 6% and 7% of all ED attendances in Northern Ireland are for new and existing mental health crises [38,39]. This is about 40,000 attendances at Hospital EDs at a conservative direct cost (using the NHS England tariff (VB09Z) for a Category 1 ED investigation and Category 1-2 treatment) to the trusts of **£6.7 million**.

Each year the PSNI have to deal with around 40,000 non-crime related incidents, a large number of which are mental health related [40]. They have also estimated that more than 100,000 hours of PSNI time is taken up dealing with mental health related matters at a cost of **£4 million per year** [41].

A recent 4 week survey found that police can wait on average for 14 hours in ED with someone they have responded to with a mental health crisis [40] (in part because of duty of care obligations). The PSNI have also confirmed to us that at least two officers are required to wait with the person requiring assessment. Between 1 January 2023 to 14 April 2023 alone, the PSNI spent approximately 4,550 hours in hospitals with people in mental health crisis, which would imply more than 13,000 hours in hospital every year [23].

In 2024/2025 the NIAS received 232,147 calls. If similar patterns to those seen in Scotland were seen [42] we could expect almost 23,000 ambulance conveyances to various settings, including 51% to hospital emergency departments at a conservative cost of **£6.2 million** (assuming mean costs of £272 per conveyance)[43]. As discussed earlier in this report, ambulance paramedics may wait for a substantial amount of time at the ED awaiting formal handover of the person in crisis to the ED. If on average this waiting time is 5 hours, this would add a **further £1.0 million to these costs**.

Family members may also have to accompany relatives, especially young people, if they go to a hospital emergency department during a crisis. If we conservatively assume that one family member or friend attends 3 in 4 of all crises, for an average of 6 hours per visit, this would conservatively mean lost earnings of **£3.67 million per annum** (valuing this time using the NI median hourly wage rate).

As we noted earlier, approved social workers also can have a role in assessing the needs of some people in distress. These ASWs can also have protracted waits of many hours with the person in crisis until they receive appropriate follow up care, which can include compulsory hospital admissions. Even if just 2% of people in the ED require this support, and these waits last for an average of 3 hours, then there is still **an additional cost of £0.15 million per annum**. This is likely to be a significant underestimate of costs.

Overview on the Economic Case for Investment in Different Services within the Regional Mental Health Crisis Service

Crisis services provide help and support to some of the most vulnerable people in society, at some of the most difficult points in their lives. This includes times of mental distress and suicidal crises. At such times people need access to immediate rapid help, as well as ongoing support to aid recovery. Previous reviews have highlighted gaps in the current service model, highlighting the importance of safe, accessible alternatives to ED care and more support for alternative services provided by the community and voluntary sector[44]. Some alternatives already exist in parts of Northern Ireland, and have been highlighted earlier in this report and in work by the Mental Health Champion[6]. They include multi-agency triage teams, community navigators in ED departments to link people with help, community crisis services, crisis cafes, and the suicide prevention helpline 'Lifeline'. However there are gaps, and these include the lack of short-term co-ordinated support for people in distress, provided by non-statutory (community and voluntary) sector providers for people who do not need to be supported by specialist mental health services [45].

We have analysed the potential return on investment from different elements that can be included in the Regional Mental Health Crisis Service. It is important to state that interventions must be effective in order to have a positive return on investment, thus the economic case does depend on the strength of the evidence on alternative approaches to crisis care. Here we provide a brief overview of the case for some potential interventions.

It is also important to stress that for interventions to be considered cost effective they **do not need to save money, but rather that any additional costs incurred are considered value for money give the level of additional benefits achieved**, for example reduced levels of distress, better mental health and better quality of life are considered. In some cases, however, interventions can lead to both better outcomes and lower costs.

There is some international evidence on the economic case for different interventions/elements of a services that may be implemented/scaled up in the regional mental health crisis service. However, the evidence is nuanced, and the context in which services are implemented, as well as the availability of wider supports may have an impact on how well interventions can work.

Some of this evidence is about supporting people with severe mental health conditions and needs to be delivered by specialist mental health services, for example crisis resolution and home treatment teams. However, the majority of people experiencing mental distress do not need this level of specialist support, nor are they best supported by spending long periods of time in hospital ED departments. They may need a range of supports that can be provided in the community, by non-clinical staff. In some case the reasons for distress will also be linked to living circumstances, for example the cost of living and debt problems. We focus here on approaches to particularly address this group of people, who make up the majority of people who experience a crisis.

Distress Brief Intervention

One potential intervention, developed in Scotland, that is targeted specifically at distress is called the Distress Brief Intervention. It has the potential to make a difference to people's lives and avoid some costs to 'blue light' emergency services and the health and social care system.

In 2016, the Scottish Government launched the Distress Brief Intervention programme, to test out a new approach to provide connected, compassionate support to people presenting in distress but who do not require further emergency service involvement [1]. This was the first programme of its type in the world. After initial referral by front-line workers such as the police, ambulance services, social services and primary care (Level 1 support), ongoing support (Level 2 support) is offered to those who require it for up to 14 days by trained non-clinical staff who are based in local community organisations. Individuals can then be signposted on to non-statutory or statutory organisations if this is considered appropriate.

After successful piloting it is being rolled out to support people in distress aged 16 and over across all of Scotland's Health and Social Care Partnerships. Pathways from Police Scotland and the Scottish Ambulance Service to DBI are also being developed. A pilot evaluation included some evidence on pathways of care following contact with DBI and also reported on the cost of implementation and successful engagement with people in distress [17].

This evaluation found that two-thirds of individuals who were referred to Level 2 DBI services made use of the support from the community sector workers, helping to reduce unnecessary use of health care services. After the end of the DBI intervention (maximum 14 days support) only 28% of these individuals were signposted to statutory services, as the DBI intervention allowed for more individual tailored assessment of ongoing needs through non-statutory services.

Costs per successful contact (2024 prices) are £392 (which includes the full 14 days of support). This is considerably less than the costs to all sectors and families for an individual who would present to an ED which we estimate conservatively to be £544 just for the initial service contacts (with no costs of follow up services, including use of specialist mental health care services included). This suggests that it is a cost-effective intervention if implemented in Northern Ireland.

We look in more detail at the case for DBI in section 10 of this document under a range of different assumptions. In the base-case scenario DBI potentially would be considered cost effective in Northern Ireland from a health and social care system perspective with a cost per disability adjusted life year averted of £17,155; it would be cost saving when taking into account a reduction in costs to the PSNI through successful contact with DBI. The analysis is conservative as it does not take into account any longer-term benefits that might arise from successful intervention, including a reduction in further use of specialist mental health services and further contacts with the health care system related to intentional self-harm. Nor does it take into account the benefits of freeing up resources from other services to be used for to meet other needs.

A version of DBI for young people aged 13-28 has also been piloted and an evaluation very recently published. This has involved the use of DBI pathways within schools, where young people can be referred to DBI community supports. This pilot evaluation found that young people's distress levels decreased, although many young people would have preferred a longer period of DBI support than the standard 14 days that were offered. 80% of young people

who were referred to Level 2 took up the offer of support.

This recent report however states that "This evaluation did not explore the cost effectiveness of the under 18s elements of DBI. There is some indication that access to DBI reduces workload for school staff and may reduce inappropriate referrals to CAMHS. Clarity regarding the intended impact of DBI on service use and whether the service aims to generate any cost efficiencies in terms of reducing demand on other services such as CAMHS is required before cost effectiveness of the programme can be fully assessed" [46].

There are other limitations in what we know about the impact of DBI. The only evaluations to date are those commissioned by the Scottish government and this means there is a lack of evidence on the long-term impacts of DBI, as well as its impact on risk of suicide and self-harm, although that is currently being evaluated in Scotland. We also know in the Scottish evaluation 47% of those who used DBI did have another contact with front-line services because of distress in the subsequent three months, but no comparison was made on re-presentation rates for people who received usual care.

Multi-Agency Triage teams

Multi-agency triage teams (MATTS) are another potentially important element of a crisis service. As previously noted, the PSNI in particular have highlighted the pressures of having to deal with a very large number of mental health related incidents. MATTS involve mental health practitioners and paramedics working alongside police officers; they assess calls and then attend events which they believe to be mental health related. They have been successfully used in Northern Ireland, with only 96 of 439 (22%) of people supported by MATT over an 18 month period between 2018 and 2020 needing to go to an ED [44].

Elsewhere, a rapid synthesis of evidence on police-related triage interventions [47] indicated that some of these may help reduce risk of hospitalisation, including potentially diverting people away from police detention under the Mental Health Act 1983 (Section 136). There is, however, still very limited assessment of cost-effectiveness and the review called for this to be built into future evaluation. However, an earlier modelling study making use of data from Sussex police did find that health and criminal justice costs were lower using a street triage model, where community police work with mental health professionals compared to usual practice; however, longer term impacts on mental health outcomes were not measured [48].

Supporting frequent callers to emergency services

In Northern Ireland, a pilot evaluation looked at a new approach to address frequent callers to the ambulance service [49]. The NIAS identified frequent callers (defined as 5 calls in one month or 12 calls in 3 consecutive months) and worked with Red Cross key workers who knew the local community and support options. Their role involved working intensively with frequent callers, often face to face for long periods of time to bring them to appointments or ensure that they were on the right programme, in effect making sure any care plans were implemented.

In this uncontrolled pilot study involving 48 frequent callers, call patterns and ambulance service trips were compared in the 3 months pre-intervention and 3-months post the involvement of the key workers. More than half of all calls were primarily due to mental health problems and a further 17% were for addiction. There were 55% fewer 999 calls; 66% fewer ambulance responses and 61% fewer ambulance conveyances to hospital, with **estimated net annual costs averted of £1.94 million**.

More generally however, there appears to be very little research on the level of

mental health in frequent callers and about the effectiveness and cost effectiveness of approaches to reduce hospital visits. Data in England indicate 0.67% of the population are frequent callers, accounting for 16% of ED attendance, 29% of all ambulance journeys and 26% of all hospital admissions at a total cost of £2.5 billion per annum[50]. Mental health is one of the principal reasons for these call outs, suggesting that better support for frequent callers may help relieve some pressure on the emergency services. [50,51]

Increased access to multi-disciplinary teams in primary care that include mental health specialists

The cost effectiveness of community mental health teams is well established, however the evidence base on mental health specialists in primary care teams remains rather limited. A 2020 review found that while there were some positive benefits, the evidence base was too limited to make any conclusions on effectiveness and cost effectiveness [52]. Some more recent work in an observational study in England where mental health nurses were embedded in primary care does suggest that mental health outcomes were improved as a result of this programme[53]. However, the evidence base remains too limited to draw strong conclusions about the cost effectiveness of these teams.

Increased use of peer-support worker delivered psychological support

People with lived experience of poor mental health can become peer-support workers trained in the delivery of one-to-one peer support to people already known to mental health services. Recent evaluation in England indicates that peer support worker delivered intervention for people already in hospital, and continued after hospital discharge, is associated with a reduction in future the use of hospital psychiatric inpatient services, without having any detrimental impact on mental health outcomes [54].

There is also new (currently under review) evidence from a trial on the cost effectiveness of a brief peer support worker delivered community-based support programme focused on recovery and empowerment for people living with mental health conditions in multiple countries including Germany. This study, led by one of our report authors, A-La Park, indicates that in Germany these peer-delivered interventions may be associated with up to a 30% reduction in use of hospital inpatient services over the following year. This programme also appeared to help mental health recovery. The context in Germany is quite different though, as there is no long history of mobile community mental health services.

Increased use of brief psychological support that can be delivered by a wide range of actors, including community and voluntary services, after training

There is good evidence on the effectiveness and cost effectiveness of a range of brief psychological supports, particularly for depression, anxiety, and trauma that can be delivered by many different people without clinical expertise, after a few days of training. For example, we have assessed the cost effectiveness of Problem Management Plus (a freely available resource developed by the WHO) and found it to be cost effective in Spain for frontline health workers and Italy for refugees and migrants [55,56]. This shift away delivery of psychological supports by specialists substantially reduces the costs of service delivery.

Alternative settings to EDs for crises

For individuals who need a greater degree of immediate support, there are potential alternatives to ED and conventional mental health services. They include crisis cafes and what are known as 'psychiatric decision units' in England.

Crises Cafes

Some crisis cafes are in place in Northern Ireland, funded in various ways, including through the National Lottery. In England the NHS Long Term Plan on mental health highlights crisis cafes as offering an alternative approach in relation to supporting a self-defined mental health crisis that is not necessarily clinically assessed or defined. Cafes emphasise person-centred approach and holistic models of care that address not just the immediate mental health crisis, but also other factors that may be contributing to the individual's distress, such as housing instability, financial stress, or relationship issues. There remains no robust independent evaluation of the effectiveness or economic case for crisis cafes[57]. Recent qualitative research is however very positive [58] and some preliminary evidence suggests that crisis cafes may be associated with an 8% lower hospital admission rate[59]. There may also be additional benefits due to reduced ED, police and ambulance contacts.

Psychiatric decision units

'Psychiatric decision units' (PDUs) have been recently evaluated as an alternative to hospital emergency departments for people experiencing a mental health crisis in England. They vary in configuration but are, in general, hospital-based, with a high staff-to-client ratio (mainly mental health nurses), 24 hour /7 day a week services that do not have beds but can provide care and support to an individual for up to 72 hours. Meta-analysis of a small number of international studies indicated that these types of units can reduce length of stay and hospital admissions [60].

A recent study in England found some reductions in psychiatric admissions, emergency department visits and wait times following opening of psychiatric decision units. It also found some reductions in the length of stay when admitted to hospital [61]. There were some short-term cost savings to the NHS, although these did not outweigh the costs of running psychiatric decision units. However, the units were seen as preferable to hospital EDs by people experiencing mental health crises

Crisis Resolution and Home Treatment Teams

While many people presenting to services can be best supported by non-medical community-based services and/or primary care, some people will need much more intensive support for a more severe mental health crisis. Inpatient mental health care is expensive; and there are alternative approaches that can be considered. These can include use of specialist Crisis Resolution and Home Treatment Teams (CRTs). They assess people being considered for acute hospital admission and potentially provide intensive home treatment as an alternative from of care. People typically may be referred to CRTs from ED departments or by their GPs.

The evidence that these teams can reduce the likelihood of future hospitalisation, especially in a UK context, is mixed [62-64]. However, many of these studies are quite dated. Recent evidence from other countries is very positive. For example, in the Netherlands a trial reported a 36% reduction in average number of days in hospital (42 versus 67) for people in a crisis (one third with diagnosis of psychosis, and 40% with depressive disorders) who were referred to intensive home treatment compared to hospital-based care [65]. The CRT had a 75% chance of being cost-effective from a health system perspective, with a mean saving per quality adjusted life year (QALY) gained of €22,759 [66]. There are also positive findings from a trial in Germany [67] and quasi-experimental study in Switzerland [68].

Modelling the Economic Case for Investment in Distress Brief Intervention

In the previous section, we highlighted a range of interventions that can help people in a crisis. Here we look in more depth at the potential initial benefits of investment in one specific intervention, DBI. This may help divert people in distress away from pathways that are not appropriate to their needs, with a particular focus on reducing the number of people who inappropriately spend time in hospital EDs or in contact with specialist mental health crisis services within the health care system. The service may help in providing access to immediate co-ordinated community delivered non-statutory support that has been highlighted as a gap in the existing provision of services.

Approach to modelling

To do this we have drawn on the results of the DBI pilot evaluation in Scotland. While there are limitations in this approach because of the study design (which did not have a comparator group) in both empirical evidence on levels of effects and also on costs from this evaluation, but we have adopted a conservative approach in our analysis in terms of the potential benefits and assumptions on cost savings from DBI. Our modelling is even more conservative because we make no assumptions about the longer-term impacts on different care pathways. We focus only on the immediate impacts of providing alternative forms of support for people who would otherwise present at hospital ED. We vary our assumptions on short-term impacts, for instance on how changes in the level of effectiveness of alternatives pathways of support might impact on the potential economic return on investment, as well as considering whether any additional costs relative to improvements in quality of life would be considered cost effective.

Our modelled scenarios consider the potential for DBI to reduce the number of people in distress presenting to specialist mental health crisis services, as well to acute hospital accident and emergency departments. We also look at the potential impacts on PSNI and ASWS resources in managing crises in the community and accompanying some people to EDs, and also on the need for family/friends to support a person who has gone to the ED as a result of experiencing distress.

We have also considered immediate and short-term potential impacts on quality of life. We assume that negative impacts on quality of life (as measured through avoidance of time spent living with disability) are alleviated when DBI is successful, but only assume that these benefits last for one month, we make no assumptions about longer term impacts, although we double these quality of life benefits to two months in scenario analysis. We have used the disability weight used in the Global Burden of Disease 2023 study for moderate levels of anxiety to approximate the impact of distress on quality of life in our base case scenario, but have varied this weighting to more severe conditions, including moderate depression and severe anxiety. Individuals may present with other conditions, most of which have higher disability weights.

We also assume that individuals who do genuinely need to be seen by specialist mental health services after participation in DBI, will still ultimately be seen by these services; thus, we do not take into account any possible reduction in longer term use of specialist mental health services. There may even be a risk that some people are inappropriately diverted away from

specialist services, however there is insufficient information to look at this in the model.

Our modelling analysis does include the costs of training and initial set-up for DBI. Data for Scotland are available on some of the costs of training, e.g. to train GPs, PSNI, ambulance and other emergency service workers on the initial steps related to DBI as training for individuals to know when to refer some individuals on to continuing support through DBI for a period of 14 days and/or knowing when to refer on to specialist mental health services. These costs may be different in a Northern Ireland context. Some of these costs would also be borne by multiple sectors, e.g. time would need to be found for frontline line professionals supporting people in a crisis to be trained.

We have included costs for the establishment of a central co-ordinating function for the service, based on the cost per person supported after the service was put in place in Scotland. This is however a very crude mechanism for estimating costs; there may potentially be economies of scale which reduce the overall cost of co-ordination when delivered at a national level rather than for four pilot study areas.

All of that said, we have assumed that the cost of providing DBI is equivalent to the cost per person referred to Level 2 support in Scotland. We have assumed that the initial contacts (where Level 1 support would be given) would take place anyway when an individual has a crisis. We have then looked at the potential economic benefits that would be gained by through different levels of illustrative investment in DBI. We have varied some of our modelling assumptions to establish how these then impact on the overall case for investment.

All costs are reported in 2024 £s, as well as using data from the DBI evaluation, most of our assumptions around the costs of health services are taken from unit cost data from England. The costs of PSNI support uses Northern Ireland specific local information on police salaries and current levels of support for people experiencing a mental health crisis. We have not discounted costs or benefits given the short time horizon covered in the analysis. We also make no assumptions about repeat crises and therefore potentially repeat contacts with DBI services.

Results of modelling analysis

Table 2 provides information on the potential return on investment, which compares the cost of intervention with the costs that can be averted, as well as the cost per disability adjusted life year averted. We do this under our base case scenario (with and without initial development costs) and under several alternative scenarios.

In our base case scenario, we go with the experience in Scotland where 65% of all referrals were contacted within 24 hours and overall, 56% of all those offered Level 2 support subsequently made a successful planned exit from this support. We have assumed that the distress that they are experiencing has a detrimental impact on quality of the life that is equivalent to that for someone experiencing moderate anxiety and assume that the benefits of DBI in terms of diversion away from ED and statutory specialist mental health crisis services last for only 1 month.

As Table 2 shows the estimated return on investment, i.e. the potential economic costs averted compared to the cost of investment is £0.64 for every £1 invested when a health system only perspective is adopted, and development costs are included. This rises to a return of £1.08 for every £1 invested when reductions in PSNI time needed to support people in crisis are considered, and to £1.31 when a reduction in the time needed for family members to support someone in ED is also considered. If a monetary value of £20,000 per DALY averted is attached to DALY benefits, then the return in investment would rise to £1.74.

The cost per disability adjusted life year (DALY) averted from a health system perspective alone would be £17,155. Typically, a cost per DALY averted of £30,000 or less would be considered cost effective in the UK; so, this figure is within this threshold. When costs to the PSNI are included then the intervention becomes cost saving, with better outcomes and lower costs compared to no intervention. It should be stressed that we are limited by the short time duration used in our analysis of just one month. If benefits on quality of life, as measured by DALYs averted in this model, were to persist for a further month then the cost per DALY gained falls to £8,577.

These figures are positive, but our base case scenario is deliberately conservative, so the benefits may be underestimated. Once the DBI system is set up the initial costs associated with development costs are no longer needed, so the intervention costs fall (although there will need to be some ongoing training), and then the economic case becomes even stronger. In this case the cost per DALY averted from a health and social care system perspective is £12,490 with a return on investment of £0.71 for every £1 invested, rising to £1.20 for every £1 invested when impacts on the PSNI are considered.

We also vary the costs of DBI by 20%, including development costs. Even if DBI costs were 20% higher the intervention would still likely be considered cost effective from a health and social care system perspective alone at £26,720 per DALY gained (assuming a cost-effectiveness threshold of £30,000 per DALY averted is used). If the costs of intervention were to fall by 20% then the cost per DALY gained falls to £7,590. What this indicates is that relatively small changes to the cost of the intervention can have a substantial impact on the economic case for investment. If DBI were to be implemented and scaled up, then potentially costs might be reduced through economies of scale.

We also varied assumptions on the level of successful engagement at DBI Level 2. If this was reduced by 20% to a 45% successful engagement rate then the ROI from the health and social care, as well as public purse perspective, including impacts on the PSNI would be £0.51 and 0.87 per £1 invested respectively. It would more than break even (ROI £1.05) if impacts on families were considered. The cost per DALY averted from the health and social care system alone perspective would be £29,111 and £8,045 from a health and social care and public purse perspectives. If engagement rates and successful completion of DBI Level 2 support could be increased by 20% to 67%, then the case for investment increases, with ROIs of £0.77, £1.30 and £1.57 from the health care, public purse and broader perspective including family impacts. The cost per DALY averted from the health and social care perspective would be £9,154 and cost saving from broader perspectives. Furthermore, increasing the duration of quality-of-life benefits by one month and also assuming that distress has a greater adverse impact on quality of life, similar to that for moderate depression or severe anxiety, rather than mild depression, would also mean the intervention would be even more cost effective.

In Table 2 we also combine the most unfavourable and favourable assumptions into pessimistic and optimistic scenarios respectively. In the pessimistic scenario the intervention would not be considered cost effective, with a cost per DALY averted from a health and social care perspective of £41,068. The cost per DALY averted would however fall to an acceptable £20,002 if the reduced demands on the PSNI were included, In the most optimistic scenario, which assumes beneficial impacts on mental health persist for 2 months, the model has ROIs ranging from £0.94 per £1 invested from a health system perspective to £11.09 from a societal perspective (including the monetary

value of disability adjusted life years averted). The cost per DALY gained would be just £506.

In summary from our scenario analysis, the case for DBI appear promising, but there are many uncertainties and careful piloting and collation of data on longer term impacts would be helpful to help reduce some of the uncertainties.

In Table 3 we look at the potential benefits if the aim is to reach different percentages of the at-risk population; we assume this is the estimated 39,990 contacts with EDs due to mental health distress across Northern Ireland each year that we have used in our model. For example, if the aim is to provide support for 50% of the target population, i.e. 19,995 potential crises events, then in the base case scenario this would require an investment of £5.94 million per annum, it would lead to the successful engagement with DBI Level 2 of 8,734 individuals in crisis, averting ED attendance. Immediate costs averted to the health system would be £3.86 million, with £2.61 million averted to the PSNI (i.e. freeing up PSNI time) and family time costs valued at £1.37 million also avoided. This would still mean there would be net costs to the health system of £2.07 million, but it would lead to more than 124 DALYs being averted, equivalent to a notional extra 124 people living a full year of life without any negative impact on their quality of life. The cost per DALY averted would be a favourable 17,155.

It is important to note that in the base case scenario there will always be net costs to the health system, although there is a positive return on investment if impacts on the PSNI are also considered. Net health system costs are substantially greater under the pessimistic scenario due to the lower number of people helped and an unfavourable cost per DALY from the health and social care perspective of £41,068. The optimistic scenario, with a cost per DALY averted from a health and social care perspective of just £506 highlights how small changes in assumptions can make a large difference to interpretation of results.

Overall interpretation of DBI scenarios

Overall, our analysis indicates that there is an economic case for investing in DBI. This case can be made even when using conservative assumptions on costs, effects and the short-term duration of impacts. Our model is focused on adults rather than young people; initial evaluation in Scotland suggests DBI can work for young people below 18 but no evident on cost effectiveness was collected. It may be the case that the economic case is stronger because of the extra supported needed for people below 18, but this needs to be examined in future.

There are many uncertainties on what we know. It will be important to learn more from the Scottish experience, including from frontline professionals that have been involved in the DBI pilot and subsequent rollout. For example, learning more about the experiences, both positive and negative of the ambulance and police services in Scotland. For example, how well were they able to train individuals in DBI Level 1, and how often has training had to be refreshed. How were the time costs of training people in DBI Level 1 accounted for? Perhaps fundamentally, we need to know more about what can be learnt from the way in which the proponents of DBI engaged with the frontline emergency services to make DBI happen. Furthermore, what role was played by different government departments (other than health) in this process in Scotland?

It would also be important to get a good overview from Scotland of the resources required for development and co-ordination activities at a national level rather than just for four pilot areas. Are there economies of scale that reduce marginal costs as the activity is scaled up? Are there particular challenges for the model in rural

areas? Critically it would be good to know more about the longer-term trajectories of care and support for people who receive DBI support. Does DBI Level 2 lead to a longer-term reduction in episodes of crisis and need for support? If it does it would strengthen the case further for DBI. Other questions include what more can be learnt about the experience of people who declined the offer of DBI Level 2 support?

There are also budgetary implications to consider. As we have highlighted the economic evidence on multiple crisis interventions is far from clear, but there is a case for a number of different interventions and there will be a need to balance any investment in DBI with other potential activities. We note for example the potential complementary role that could be played by support interventions focus on providing support to very frequent callers to the emergency services, with some analysis in Northern Ireland reporting that this also has positive economic as well as health benefits.

Table 2: Short-term return on investment and cost per DALY averted from DBI under different scenarios

	DBI cost	Successful engagement rate	DALY weight used	Duration of quality-of-life benefits	Return on Investment				Cost per DALY averted		
					Health	Plus PSNI	Plus, Families	Societal	Health	Plus PSNI	Plus, Families
Baseline Scenario (including initial development costs)	296.84	56%	0.133	1 month	0.64	1.08	1.31	1.74	17,155	Cost Saving	Cost Saving
Baseline Scenario (excluding development costs)	267.89	56%	0.133	1 month	0.71	1.2	1.45	1.93	12,490	Cost Saving	Cost Saving
Costs increased 20%	356.21	56%	0.133	1 month	0.53	0.9	1.09	1.45	26,720	5,654	Cost Saving
Cost decreased 20%	237.47	56%	0.133	1 month	0.8	1.35	1.64	2.17	7,590	Cost Saving	Cost Saving
Engagement decreased 20%	267.89	45%	0.133	1 month	0.51	0.87	1.05	1.39	29,111	8,045	Cost Saving
Engagement increased 20%	267.89	67%	0.133	1 month	0.77	1.3	1.57	2.09	9,184	Cost Saving	Cost Saving
Duration of impact increased by 1 month	296.84	56%	0.133	2 months	0.64	1.08	1.31	3.9	8,577	Cost Saving	Cost Saving
Use DALY weights for moderate depression	296.84	56%	0.396	1 month	0.64	1.08	1.31	2.57	5,762	Cost Saving	Cost Saving
Use DALY weights for severe anxiety	296.84	56%	0.523	1 month	0.64	1.08	1.31	2.97	4,362	Cost Saving	Cost Saving
Pessimistic Scenario	356.21	45%	0.133	1 month	0.43	0.72	0.87	1.16	41,068	20,002	8,974
Optimistic Scenario*	214.31	67%	0.523	2 months	0.94	1.58	1.92	11.09	506	Cost Saving	Cost Saving

*Assumes no development costs

Table 3: Implementation costs to cover population at risk of contact with mental health crisis services

Population targeted; implementation cost; population successfully reached; initial costs averted health system, PSNI, families, ROI

% Target Population covered	DBI Implementation Cost (£s m)	Target Population	Target Population reached who would otherwise attend ED	Costs Averted (£s m)			Net Health System Costs (£s m) (Savings if Negative Value)	DALYs averted	Cost per DALY averted (£s) health and social care system only
				Health	PSNI	Families			
Baseline Scenario									
10%	1.19	3,999	1,747	0.77	0.52	0.27	0.41	24.82	17,155
25%	2.97	9,997	4,367	1.93	1.31	0.68	1.04	62.05	17,155
50%	5.94	19,995	8,734	3.86	2.61	1.37	2.07	124.1	17,155
75%	8.9	29,992	13,101	5.79	3.92	2.05	3.11	186.15	17,155
100%	11.87	39,990	17,467	7.72	5.22	2.74	4.15	248.2	17,155
Pessimistic Scenario									
10%	1.42	3,999	1,297	0.62	0.42	0.22	0.81	19.86	41,068
25%	3.56	9,997	3,243	1.55	1.05	0.58	2.02	49.64	41,068
50%	7.12	19,995	6,485	3.09	2.09	1.09	4.02	99.28	41,068
75%	10.68	29,992	9,728	4.63	3.14	1.64	6.05	148.92	41,068
100%	14.24	39,990	12,971	6.18	4.18	2.19	8.06	198.56	41,068
Optimistic Scenario									
10%	0.97	3,999	2,247	0.93	0.63	0.33	0.05	117.12	506
25%	2.43	9,997	5,616	2.32	1.57	0.82	0.11	292.8	506
50%	4.86	19,995	11,234	4.63	3.14	1.64	0.23	585.61	506
75%	7.3	29,992	16,849	6.95	4.71	2.46	0.34	878.41	506
100%	9.73	39,990	22,466	9.27	6.27	3.28	0.46	1,171.22	506

Summary Implications

- Mental health crises have substantial immediate costs in Northern Ireland. We estimate these very conservatively to be more than £45 million per annum in costs to the health care system, including the NIAS, as well as the PSNI, ASWS and families.

- Many people who experience a crisis **do not need to be supported by specialist mental health service or need to spend hours waiting in ED**.

- There **will be additional substantial costs associated with ongoing support for people in crises**, particularly when the initial response is not appropriate and people are then more likely to have further crises events.

- **Diverting people appropriately away from specialist care** where a crisis that can be address by non-specialist staff including those in community organisations also means that resources are then 'freed up' in specialist mental health crisis services to be used to support people with more severe mental health needs.

- There is some **evidence on the effectiveness and cost effectiveness of interventions that can change pathways of care for people in distress or with mild to moderate mental health problems.**

- **Distress Brief Intervention being rolled out across Scotland appears promising**. DBI for people aged over 18 has led to more than two-thirds of people coming into contact with the service being subsequently supported by community groups, and 56% successfully completing the Level 2 intervention. The costs of DBI provision are lower than the costs for someone who ends up in hospital ED. DBI also provides 14 days of ongoing support. There is also some newly published evidence on DBI for young people aged 13-18.

- DBI has a potential conservative return of investment of £1.08 for every £1 invested from a public purse perspective. This is likely to be very conservative. **Our ROI ranges from £0.90 to £1.58 under different scenarios**. If two-thirds of contacts with ED services could be avoided through the use of DBI then this potentially could avert costs of over £9 million per annum.

- Limitations of the case for DBI include a lack of long-term evidence on impact, as well as lack of information on impacts on self-harm and suicide, although the latter are now being evaluated in Scotland. **If benefits persist, even by just one month, then the economic case is substantially greater**.

- **Various forms of triage that help ensure that people experiencing a mental health related crisis receive timely support from mental health staff can also reduce costs for both 'blue light' and health services.** However, while costs are lower it is important to strengthen what we know about the longer term impacts on people who receive this service in the UK. (There has been a recent call for evidence on this from the UK National Institute for Health Research)

- There is some **promising but very limited evidence also on support for frequent callers of emergency services**. Many of whom have mental health issues. This includes some work in Northern Ireland suggesting that this has a positive economic return on investment.

- The economic evidence base **needs to be strengthened on multi-disciplinary mental health specialists embedded in primary care**.

- There are multiple studies showing that **various forms of brief psychological therapy can be delivered by non-specialists, including peer workers and members of community organisations**. Many studies point to their cost effectiveness in addressing conditions including depression, anxiety and trauma. They will have lower delivery costs.

- There is **some evidence on the economic benefits of alternatives to hospitals care for people experiencing a crisis**, including crisis cafes and different types of units that do have mental health staff but no beds and provide a safe space for someone experiencing a crisis. The evidence is though limited and is mixed. It needs to be strengthened.

- In the same way there is **mixed evidence on the cost effectiveness of crisis resolution and home treatment teams** for people with severe mental health conditions who experience a crisis.

- Investment in **combinations of these and similar interventions within regional mental health crisis service** is likely to be cost effective and importantly improve outcomes for people.

- **Quantifying the magnitude of overall benefit is challenging, as this requires good information on the nature and severity of mental health issues when people experience distress**. We have been modelling scenarios on this assuming different levels of need.

- We can be confident that **focusing much more on people in distress who do not need specialist mental health support is likely to have a positive return on investment, actually saving resources** through providing more tailored and appropriate non-clinical support to help people through a crisis.

- **This will also free up resources within the health sector and 'blue light' services.** DBI as implemented in Scotland is one possibility, but there would also be benefits from training people within community organisations to deliver brief psychological support, alongside better forms of triage when people contact the emergency services. Frequent callers to emergency services are another group that could benefit from support from community organisations.

- From a policy perspective **not all of the benefits from these crisis interventions fall on the health system**, for example there are potential benefits to the justice system. This implies **good co-ordination and collaboration is needed between health and justice**. In the case of young people there will also be a need for the **education sector and health to collaborate well**. For example, the DBI pilot in Scotland for young people aged 13 -18 relies on partnerships with schools to identify young people who would benefit from DBI support.

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Appendix A: Acknowledgements

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