Public Accounts Committee
Briefing: Mental Health Workforce (November 2026)

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Introduction
This evidence focuses on the implementation of the Mental Health Workforce Review Implementation and Delivery Framework, with particular emphasis on the workforce pressures arising from increasing levels of mental health need. It examines challenges within psychiatry and psychology, including workforce vacancies and their implications for service capacity and patient care. The evidence also considers the economic and societal benefits of investing in early intervention and prevention, which have an important role in reducing the burden of poor mental health and preventing avoidable harm.

Mental Health Workforce Review Implementation and Delivery Framework
The Mental Health Workforce Review Implementation and Delivery Framework Report refers to the statutory sector delivery of interventions and treatments. Importantly, it does not set out the workforce needs of the Community and Voluntary Sector services for people with poor mental health, or social care for people with a mental illness. Additionally, the review did not take account of service needs outside of mental health (e.g. physical health, care experienced Children, Older Adults/Dementia etc). Vacancies here continue to grow, pulling a limited workforce away from mental health services.

The 2022 Mental Health Workforce Review identified a shortfall of approximately 2,267 whole time equivalent posts and around 730 funded vacancies, representing a vacancy rate of 15.6%. Addressing these deficits is estimated to require approximately £150 million of investment over ten years through phased workforce expansion and service reform. The Framework identifies workforce pressures across psychiatry, psychology, nursing, pharmacy, social work, allied health professions and peer support services, and sets out measures to strengthen training capacity, workforce planning, staffing standards, recruitment and retention. Progress has been made in establishing the foundations for implementation. The Department of Health has completed a workforce rebasing exercise across all Health and Social Care Trusts, quantified workforce requirements, identified priority professional groups and services, and developed an Implementation and Delivery Framework to guide future workforce investment. This has provided the first region wide assessment of workforce need and established a framework linking mental health workforce planning to wider transformation programmes, including the Neighbourhood Model of Health and Wellbeing.

Recommendations 1 and 2 of the Workforce Review have largely been delivered through completion of the workforce gap analysis, prioritisation exercise and implementation framework. Governance arrangements and strategic priorities are now in place; however, workforce growth will not occur in the absence of investment. Significant challenges remain in reducing vacancies, expanding training capacity, developing multidisciplinary workforce standards, improving workforce intelligence and strengthening long term recruitment and retention. Northern Ireland's current approach to mental health workforce planning focuses on increasing overall workforce capacity, improving retention, expanding multidisciplinary roles, and introducing regional workforce planning to reduce competition between Trusts for scarce staff. The Workforce Review and implementation framework recognise regional inequalities and recruitment challenges,

including those experienced in rural areas, but largely seek to address these through system wide workforce growth and service redesign, rather than targeted geographic interventions.

In contrast, many comparable jurisdictions have adopted explicit rural recruitment and retention strategies. Scotland has invested in rural training pathways and "grow your own" workforce models, while Wales has used recruitment incentives, relocation support and targeted schemes for “hard to fill” posts. England has employed recruitment and retention incentives, and targeted funding for underserved areas, while countries Australia and Canada have combined financial incentives, bonded scholarships, housing support and enhanced career development opportunities to attract and retain staff in remote locations. The common theme internationally is that rural workforce shortages are treated as a place-based challenge requiring tailored solutions, whereas the Northern Ireland approach is principally a whole system workforce strategy. As a result, while the NI model may improve overall workforce supply, it offers fewer direct mechanisms to overcome the specific recruitment disadvantages faced by areas such as the Western Health and Social Care Trust. In summary, we have identified the workforce needs but we do not have the funding and workforce supply to meet the needs identified. In addition, the planning and workforce reviews that have been completed will invariably become outdated over the next few years and will need to be repeated after several years to inform commissioning of training places.

The Workforce Review is being implemented alongside the Neighbourhood Model of Health and Wellbeing, which intends to shift services from hospital settings into community and neighbourhood-based care. To support this transition, Health and Social Care Trusts will transfer approximately 2% of hospital expenditure into neighbourhood services annually over a three-year period from 2026/27 (around £50 million each year). This shift is expected to drive significant changes in commissioning arrangements, with a growing emphasis on prevention, early intervention, population health outcomes and integrated neighbourhood delivery models. The Framework also envisages an expanded role for the community and voluntary sector, with C&V organisations embedded within Integrated Neighbourhood Teams and recognised as key delivery partners in the design and provision of local services. Successful implementation will depend upon community capacity, sustained investment and the capacity of community providers to participate meaningfully in commissioning and service delivery. This presents a particular challenge for mental health services, where community mental health teams, psychology services, social work services, crisis teams and liaison services are already experiencing significant workforce pressures, alongside wider health system workforce pressures. Against the backdrop of a workforce deficit of more than 2,200 posts, concerns have been raised about the ability of services to absorb additional responsibilities while continuing to meet existing demand. Uncertainty also remains regarding the interaction between neighbourhood reform and wider budget pressures. While the Department has stated that the 2% transfer to neighbourhood services is not a savings requirement, it remains unclear whether this would operate alongside future departmental savings measures. I am concerned that mental health services could be required both to support neighbourhood reform and absorb wider financial reductions.

The implementation of Right Care Right Person (RCRP), particularly changes in how “Concern for Safety” calls are dealt with, may also exacerbate workforce pressures. The policy seeks to ensure that individuals with health and social care needs receive support from the most appropriate service rather than defaulting to a police response where no policing requirement exists. PSNI receives approximately 1,600 calls each month with a mental health component. Between April 2023 and April 2024, PSNI received 41,724 Concern for Safety calls, of which only 1,772 involved

a crime. These figures illustrate the extent of police involvement in incidents that may be more appropriately addressed through health and social care services. The successful implementation of RCRP is closely linked to the delivery of the Regional Mental Health Crisis service and Workforce Review and neither have progressed beyond the planning stages due to funding shortfalls. Without sufficient workforce growth across psychiatry, nursing, psychology, social work and community mental health services, there is a risk that health services may struggle to absorb activity that would previously have received a police response.

Evidence suggests that Statutory services are already under significant strain. The Royal College of Psychiatrists report that all five Health and Social Care Trusts were operating mental health bed occupancy rates above 100% during March 2025, substantially exceeding the recommended maximum level of 85% (with the Western Trust reaching 123%). Capacity pressures are also affecting patient care, with 42% of psychiatrists reporting daily delays in admission or access to inpatient treatment, 32% reporting weekly delays, and 89% reporting experiences of moral injury associated with difficult admission and discharge decisions. More than 10,000 people are waiting beyond target times for mental health services and the number awaiting a first appointment has increased by approximately 30% since 2019.

Psychiatry and Psychology

Evidence from the Royal College of Psychiatrists highlights substantial concerns regarding workforce sustainability. Of 237 established consultant psychiatrist posts, only 168 are substantively filled, while 34 are occupied by locums and 35 remain vacant. Similar challenges exist within the Specialty and Associate Specialist workforce, where approximately one third of posts are vacant or not substantively filled. The scale of these difficulties has intensified over time. Almost 29% of consultant psychiatrist posts were not substantively filled in 2025, compared with 25% in 2023 and 16.1% in 2017. Similarly, 34.2% of Specialty and Associate Specialist psychiatry posts were vacant or filled on a non-substantive basis, indicating a continuing deterioration in workforce stability.

The shortages are not driven by a lack of interest in psychiatry. At 73 applicants per place in 2024, applications far exceed the training places available. This suggests that workforce growth is significantly constrained by the low number of training places and lack of investment in training specifically. Retention remains a significant concern, the recent survey of NI psychiatrists highlighted high levels of stress and burnout with 72% of psychiatrists considering employment outside their current Trust, and almost one quarter indicating they may leave within the next year. Sadly only 7% believe that government policy sufficiently supports their work. The increasing reliance on locum staffing represents extremely poor value for money. Annual expenditure on psychiatry locums is estimated at approximately £11.2 million to £11.5 million, including around £8.6 million on consultant psychiatrist locums. This is estimated to be equivalent to the cost of 56 substantive posts.

Similarly, the Chief Psychological Professions Officer (CPPO) reports a clinical psychology vacancy rate of over 30% and 49.27% for the wider psychological professions. Again, insufficient training capacity perpetuated by years of under-commissioning is a key concern, with NI having only 1.09 training places per 100,000 of population compared to 1.89 in England. Again, there is an unquestionable demand for places with 368 applications for 21 places on the QUB Clinical Doctorate this year. These are all psychology graduates who have gained extra experience and /or postgraduate degrees, in order to apply. They represent a loss to the workforce as they take up training places elsewhere in UK or Ireland. Overall, NI produces hundreds of psychology

graduates annually and many want to work in mental health. Unlike England, Scotland and Wales, NI has not commissioned a lower grade of psychology training (Clinical Associate Psychologists/ Psychological Wellbeing Practitioners), which would increase workforce capability and capacity to deliver lower-level psychological interventions under supervision.

The CPPO's recommendations (Appendix 1) advocate a strategic, region-wide approach to strengthening the psychological professions workforce and improving access to timely, effective care. Priorities include expanding training places and commissions, ringfencing specialist training funding, and ensuring sustainable investment in substantive posts, recruitment, retention, career progression, supervision and staff wellbeing. Workforce capacity should be strengthened at all levels, with senior and consultant psychologists providing clinical leadership and supervision, supported by appropriately supervised trainees and support roles. Psychological expertise should be embedded in multidisciplinary service design, with provision planned around need and regional variation addressed. Individual, group, blended and digital interventions should be considered where appropriate. The Psychological Professions Framework and Forum can support collaboration, shared learning and coordinated planning. Progress should be monitored through agreed regional measures covering workforce capacity, waiting times, supervision, intervention availability, service-user experience and outcomes. The CPPO role provides an opportunity to coordinate workforce planning and service development, building a sustainable workforce that delivers safe, equitable, evidence-based psychological care across Northern Ireland.

Impact on delivery of mental health services

The scale of need is reflected in Child and Adolescent Mental Health Services (CAMHS). Recent statistics showed that 1,731 children and young people were waiting to begin treatment, with 37.6% waiting longer than the nine-week target for assessment. Whilst the Mental Health Strategy committed to increasing CAMHS investment to at least 10% of the mental health programme of care (PoC) spend. The 2025/26 Mental Health PoC was £469,761,000. 2025/26 CAMHS expenditure, including funds allocated to Beechcroft is £43,037,000 representing 9.2% of the total Mental Health allocation. The funding gap to reach 10% was therefore £3.94m.

Users and stakeholders continue to report difficulties in access to psychological therapies such as Dialectical Behaviour Therapy, and trauma focussed therapies. The Framework identifies psychology and psychological therapies as areas requiring significant expansion in both CAMHS and adult mental health services. These professions account for a relatively small proportion of the mental health workforce and funding, despite their necessary contribution to assessment, formulation, evidence-based intervention, multidisciplinary decision-making and recovery. It also identifies a widening psychology-specific workforce gap between the 2022 and 2025 reviews. Clinical psychology is identified as an urgent priority across adult mental health teams, including acute inpatient settings, addictions services, Personality Disorder services, community mental health teams, women's health, etc. Clinical psychology and psychotherapy are also priorities in CAMHS, with child and adolescent psychotherapy particularly underrepresented. The Review also highlights the importance of arts therapies and calls for the expansion of art, drama and music therapy.

The workforce difficulties is one reason for our high rates of anti-depressant prescribing (one in five adults have an antidepressant prescription and this rises to one in four women and 40% of women aged 40-65 years). It has also resulted in long waiting times for psychological therapies with some Trust waiting lists reported as extending beyond three years. Provision also varies

between Trusts and service areas, gaps in psychology provision in some specialist settings and recruitment difficulties associated with banding. The Review findings describe posts supported through fragmented funding across services, which can limit flexibility and encourage narrow, ring-fenced ways of working. Psychology workforce planning is not consistently integrated with service design and multidisciplinary team planning. Posts are generally cobbled together from small amounts of funding and/or temporary charitable funds. High workloads, pressure and vacancies create risks to staff wellbeing, burnout and retention. Reliance on locum and agency staff can provide temporary cover but is not a sustainable response to longstanding gaps and may increase expenditure. The workforce review highlights ongoing challenges in recruitment, retention and vacancy levels across psychological professions, reinforcing the need for long-term workforce planning and investment.

The Review also identifies limitations in standardised role definitions and regional workforce data. This makes it difficult to describe the full psychological professions workforce consistently, benchmark provision between services, or plan training and recruitment against need. Departmental mental health workforce figures do not represent every psychological professional working across health and other relevant sectors.

Early intervention and prevention

Latest data indicate that one in five people in Northern Ireland have a probable mental health problem. Poor mental health is associated with higher levels of disability and economic inactivity in Northern Ireland than in other regions. Mental health accounts for the largest proportion of Northern Ireland's 26% economic inactivity rate among people aged 16–64, while the estimated annual cost of poor mental health to our economy is £3.4 billion. These costs are not inevitable. Much can be done to reduce them by addressing the social determinants of mental ill health, including childhood adversity, poverty, housing and the barriers faced by disabled people, alongside effective prevention and early intervention. However, our current policy approach risks missing important opportunities to tackle these underlying causes. I have raised concerns that the proposed anti-poverty strategy will not adequately address the drivers of poverty or include sufficient measures to lift people out of poverty. Similarly, I have highlighted shortcomings in the disability strategy which mean that it is unlikely to lead to meaningful improvements to the lives of many disabled people. These are missed opportunities to reduce the inequalities that contribute to poor mental health. We need to ensure that investment in mental health services and workforce reform is accompanied by a stronger commitment to prevention, early intervention and action on the wider determinants of mental health.

Housing

Suitable housing, combined with tailored support is a cost-effective way to reduce the need for more costly mental health services. Evidence from service users at Inspire illustrates how supported housing provides stability, continuity and connection. Suitable accommodation, trusted support and community relationships can prevent crises, reduce hospital admissions and support recovery. Provision must reflect individual needs and aspirations while protecting dignity, privacy, autonomy and choice. Operationally, unsuitable or unavailable accommodation can delay hospital discharge for people with complex mental health needs. Increasing complexity places additional pressure on inpatient services, while outdated housing stock can restrict independence and progression. Housing, care, support and workforce requirements must therefore be planned and funded together. This is important because both the Mental Health Strategy and neighbourhood model commit to community-based care, recovery-focused services and appropriate provision for people with severe and enduring mental ill health.

Supported housing is essential infrastructure for delivering these ambitions, not a separate service.

Northern Ireland lacks a sufficiently integrated mechanism to translate supported-housing, health and social-care needs into planned, funded provision. A shared assessment is needed to bring together housing demand, support intensity, property suitability, workforce requirements and people's preferences, translating these into funded plans with clear responsibilities and measurable targets. Between 2021/22 and 2025/26, of 8,446 new social-housing starts, eight were identified as mental-health supported housing and 19 as supported housing for people with learning disabilities. Although these figures do not quantify unmet need, they highlight the importance of assessing whether supply meets current and future demand.

There is also a value-for-money imperative, psychiatric intensive care costs £9,000–£13,000 per person weekly, with acute wards costing up to £5,000. Delayed discharge caused by unsuitable accommodation can prolong reliance on expensive inpatient care and impede recovery. Inspire's recommendations include the joint assessment of need and planning and a cross-departmental housing, health, and social care five-year delivery plan. They advocate for a Northern Ireland supported housing policy with the Departments for Communities and Health jointly leading an approach aligning investment and planning, protecting individual rights and establishing clear goals and accountability. This should specify what provision is needed and align housing supply with capital, support and workforce funding.

The Department of Justice also has an important role in addressing the relationship between housing instability, offending, and rehabilitation. More than 60% of the prison population is currently held on remand rather than serving a sentence, with a lack of appropriate housing and accommodation options being a contributing factor to the high remand population. There is also a significant proportion of the prison population with existing and enduring mental health needs. On 01 October 2026, 51% of prisoners had a history of self-harm or attempted suicide on committal, 42% had an addiction and 55% had a mental health issue. Psychological conditions (11%), ADHD (13%), Dyslexia (9%), Autism (4%), Intellectual/Learning Disability (3%) and communication difficulties (3%) were also prevalent among men, women, and young men in prison. These figures highlight the high level of vulnerability within the prison population and the need for coordinated, cross-government interventions. Providing targeted housing support on release not only addresses penal population challenges but also provides the physical safety needed which promotes recovery and rehabilitation.

Childhood

If we are to reduce costs and boost the economy a focus on childhood is essential. Childhood is a critical period of brain development. Early relationships, the first three years, and experiences in educational settings all play an important role in shaping mental health, emotional development and young people's capacity to manage their wellbeing. The well-evidenced deterioration in the mental health of children and young people has informed the development of the Department of Education's *Children and Young People's Emotional Health and Wellbeing in Education* *Framework* and, more recently, the *Children and Young People's Emotional Health and Wellbeing* *Framework* developed by Health and Social Care. Together, these Frameworks represent an important policy shift towards prevention, early intervention and integrated support across education, health and community settings. Both frameworks recognise that emotional health and wellbeing is everyone's responsibility. They emphasise the importance of providing support according to assessed need, rather than requiring a formal diagnosis before intervention

can be accessed. This is consistent with the recommendations of the recent UK review of overdiagnosis of mental illness, autism and ADHD, which highlighted the need to address the pressures experienced by children, young people and their families, provide early support and ensure timely access to treatment. The Frameworks promote needs-led, strengths-based and trauma-informed approaches, supported by integrated pathways, earlier access to support and improved collaboration between statutory and community services.

However, policy commitments must be matched by investment and effective implementation. This must also span multiple departments to adequately address the social and health inequities that are key factors in peoples overall mental health. We can see some evidence of that collaboration already, but this progress needs to be protected. Urgent investment is required to ensure that the Education Framework reaches all schools and pupils. 49% of all schools (nursery, primary, post-primary, special schools and ETOAS) engaged with at least one programme offered under the EHWB Framework with a total joint investment from DoH and DE of £4.988million in the 2025/26 financial year. The HSC framework should align with the school's framework and provide a more robust system of support for young people across sectors. Given that the Health and Social Care Framework has only recently been published, it is vital that the Public Accounts Committee scrutinise the investment allocated to its delivery and monitor implementation to ensure that children and young people receive the support they need in a timely manner.

Investment in early intervention and prevention in Education is a priority. Social and emotional learning (SEL) should be central to prevention in schools, equipping children with skills to manage emotions, build relationships and navigate challenges. A meta-analysis of 213 programmes involving 270,034 pupils found improvements in wellbeing-related skills, behaviour and academic performance, equivalent to an 11-percentile-point academic gain. Public Health England analysis estimated societal returns of £5.08 per £1 invested in SEL and £1.58 per £1 invested in whole-school anti-bullying programmes. I have some specific concerns about scope, scale and timeframe of the reform process currently being managed under Transform Ed. These concerns highlight the need to ensure that curriculum reform and behaviour policy is informed by evidence about children's development, emotional wellbeing and the conditions in which children learn most effectively. Reform is welcome, but we must ensure that it is child centred, we must get it right because it is their futures we are impacting, scrutiny is essential.

Conclusion

In summary, the Mental Health Workforce Review Implementation and Delivery Framework provides a clear assessment of workforce needs and a roadmap for addressing longstanding workforce shortages. Significant progress has been made in understanding workforce requirements and establishing delivery structures. However, the resources required to deliver the proposed workforce have yet to be secured. Unless investment, training capacity and recruitment accelerate significantly, there remains a substantial risk that the ambitions of the Workforce Review and the Neighbourhood Model will exceed the capacity of the existing mental health workforce. To reduce the long-term burden of mental illness, we must prioritise prevention, early intervention and action on poverty, inequality and the wider social determinants of mental health. Supported housing is part of the infrastructure required to deliver the Mental Health Strategy and the neighbourhood model. A secure, suitable home combined with tailored support can promote recovery, support timely discharge, help prevent crisis and enable people to live as independently as possible within their communities. The Mental Health Strategy's ambitions for recovery-focused, person-centred and community-based care

therefore depend not only on health services, but on coordinated planning and investment across housing, health and social care. Investing in childhood is also essential to improving mental health, educational outcomes and long-term economic wellbeing. Promoting inclusion and wellbeing in schools, alongside social and emotional learning, is a cost-effective way to reduce the burden of mental illness. An independent assessment of TransformED's potential mental health impacts and greater accountability for early intervention are also needed. Both the Children and Young People's Emotional Health and Wellbeing in Education Framework and the Children and Young People's Emotional Health and Wellbeing Framework must be implemented across the region to ensure timely access to early intervention and support, helping to reduce the need for specialist mental health and other support services.

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Appendix

Chief Psychological Officer's Recommendations

- **Increasing training places is an imperative** and my recommendation is to aim to double clinical psychology places over the next 5 years, increasing at 4 places per year. This has a positive effect on waiting lists, and supervision of other professions, as clinical doctorate trainees carry a caseload during training.
- **Funding to provide training to the existing workforce should be ringfenced.** This includes psychotherapy, (e.g., Child and Adolescent Psychotherapy, Family and Systemic Psychotherapy, CBT, counselling etc)
- **Training expansion must be accompanied by sustainable investment in posts**, effective recruitment and retention, appropriate career progression, supervision capacity, supportive working conditions and workforce planning connected to service design.
- **Strengthen the workforce at different levels.** Consider how senior and consultant psychological capacity can provide clinical leadership, complex assessment and formulation, supervision and support for multidisciplinary teams, alongside appropriately supervised trainee and junior roles. Explore suitable development routes for psychology graduates and psychological support roles, with clear role definitions, governance and supervision.
- **Make psychological professions integral to service design.** The Department should work with Trusts, training bodies and service leaders to plan psychological input as a core component of multidisciplinary services, rather than an optional or separately funded addition.
- **Address variation in access and recruitment barriers**, and consider flexible evidence-based models of delivery, including individual, group, blended and digital approaches, where clinically appropriate.
- **Improve retention and staff wellbeing.** Support action on manageable workloads, access to supervision, career development and substantive recruitment. These measures are necessary both to retain experienced staff and to ensure that the workforce has capacity to deliver safe, effective and evidence-based care.
- **Build a reliable regional workforce picture.** Work with the Department, Trusts, EPIC and relevant partners to improve recording of psychological professionals across statutory services and other relevant settings. Workforce information should reflect current job roles and functions, not solely a person's original professional background, and should use agreed definitions to support consistent planning and benchmarking.
- **Strengthen regional collaboration and governance.** The Psychological Professions Framework and Psychological Professions Forum provide a foundation for professionals to connect across disciplines and organisations, share learning and support more consistent, safe and high-quality care. This work should contribute to shared priorities, clearer pathways and more coordinated workforce planning.
- **Accountability and measuring progress** Progress should be monitored through a regional set of measures, developed with the Department, Trusts and relevant partners. These should include workforce establishment and in-post whole-time equivalents, vacancies and vacancy rates using consistent definitions, training commissions and completion, recruitment and retention, access to supervision, waiting times, availability of psychological interventions and variation in provision across services. Service-user experience and outcomes should also be included, so that workforce changes are assessed not only by staffing numbers but by whether people receive timely, coordinated and effective psychological support.