Mental Health Workforce Review
Implementation and Delivery Framework

From Recommendations to Enabling Outcomes Focused Action
for People, Populations, and Professions

Creating the System Conditions | Enabling Action | Delivering Impact

Final Report – June 2026

Please note figures in this report are rounded to the nearest.

1. Executive Summary

This Executive Summary presents an overview of key findings, challenges, and priorities for action, reflecting recommendations one and two from the Mental Health Workforce Review 2022. Recommendation One required the development of a costed gap analysis to inform financial planning, whilst Recommendation Two called for the prioritisation of services and the identification of key appointments necessary to deliver safe and effective services. For context, the Northern Ireland Mental Health Service Workforce Review 2022–2032 provided the first comprehensive assessment of staffing needs across child, adolescent, and adult mental health services, and was designed to complement the service development ambitions outlined in the Mental Health Strategy 2021–2031.

Key Findings

This report identifies:

- A significant workforce gap of approximately *2,267 posts, requiring an estimated investment of £150,604 million over the next decade to deliver the staffing requirements identified. In practice, this would mean circa *£15 million more each year to the mental health workforce baseline, so that the additional investment builds up to £150.6 million over ten years. This would also necessitate recruiting approximately *227 additional staff annually throughout this period. Such a reality poses considerable challenges, both in terms of the fiscal position and the capacity to recruit this number of staff year on year. The absence of a long-term investment and workforce plan has resulted in short-term, single-year approaches to both workforce planning and service development. Inevitably, this has impacted mental health services' ability to forward plan and to ensure sufficient staff to meet demand.

- Persistent staff shortages across a range of clinical roles remain a significant concern, impacting service stability, the ability to meet demand, and professional capacity to comply with regulatory requirements. Currently, it is estimated that more than 730 posts within mental health services are substantively vacant representing approximately 15.6% or ratio of 1 in every 6 posts vacant (equating to approximately £46M). This shortage directly and adversely affects service capacity, delivery, quality, safety, and the accessibility of care. To maintain stable services, prioritising and urgently filling these vacancies is essential. However, there is currently no coherent regional plan in place to address this recurring issue.

- Structural disconnects between mental health service design and workforce planning. This has resulted in a misalignment between services development and workforce planning. Workforce planning tends along unidisciplinary lines and there is currently no formal mechanism in place to enable multidisciplinary workforce design in mental health. This inevitably has led to a mismatch between the ambitions for service delivery and the availability/capacity of the workforce to achieve these ambitions. It has also contributed to workforce displacement when a specific service development attracts staff from other areas of the mental health delivery system, often compounded by the lack of a backfilling strategy. This inevitably undermines the stability of core services.

- The Department of Health's Reset agenda provides a strategic opportunity to accelerate mental health reform through the better integration of workforce and service planning. This includes supporting neighbourhood-based models of care, prevention and early intervention, and making fuller use of community and voluntary sector capacity to improve outcomes and system sustainability.

- Whilst there is a strong commitment to multidisciplinary working, there are currently no whole system workforce standards or specifications to govern or guide the composition of mental health teams or service design. The absence of robust integrated, multidisciplinary planning mechanisms has inevitably led to significant inconsistencies in team composition, roles, and functions. These inconsistencies contribute to variations in both the accessibility and capacity of mental health services within service areas and across the region.

- Maintaining a balance between service specialisation and the stability of core services presents significant challenges. Whenever new specialist services are developed or expanded, staff frequently transition from core service roles into these specialist positions. Over time, this movement has undermined the capacity and stability of core services.

  To address this, it is essential to focus on upskilling and reskilling the core mental health workforce. This includes broadening the range of psychological therapies available and expanding the scope of practice, enabling core services to respond to a wider spectrum of needs. This approach is also closely linked to the adoption of a population-based model, which will require a comprehensive, whole-system strategy for mental health workforce

planning, one that considers the staffing requirements across primary, community, secondary, and specialist mental health care settings. Moving forward, this also needs to include the development and optimisation of the community and voluntary sectors as key delivery partners.

- The prevailing service delivery models tend to adopt a transactional approach to demand management through the application of various thresholds/criteria. This segmentation often leads to fragmented care pathways and creates bottlenecks, particularly at key transition points between primary and secondary mental health services, child and adolescent and adult services, as well as between core and specialist services. Such an approach to managing demand results in unmanaged shifting of service pressures from one area to another, frequently contributing to the growth of waiting lists—for example, in accessing psychological therapies or specialist expertise.

  This pattern underscores the urgent need for new models that provide earlier access to a range of community-based biopsychosocial supports, promote social prescribing, lifestyle coaching and enable greater integration and shared care across service boundaries. Developing a population health-focused, neighbourhood and partnership-based approach, including active collaboration with the community and voluntary sector, will be essential to respond more effectively to demand and optimise resources throughout the mental health system.

- The absence of a systematic decision-making framework for prioritising services and workforce development makes it difficult to determine which service areas and roles should be addressed first, beyond those traditionally regarded as core or mandated by statutory requirements. This absence has led to the insufficient inclusion of other essential professional roles—such as Allied Health Professions, Peer Support Workers, Pharmacy, and Psychological Therapists etc.—that are equally critical for delivering a genuinely recovery-oriented model of mental health care. Additionally, specialist areas of practice frequently rely on a limited number of specialists, which directly affects the capacity and resilience of these services. Uncertainty in resource planning also means that training programmes are often ad hoc and not viable due to insufficient participant numbers, undermining the sustainability and effectiveness of workforce development.

- The quality and accuracy and reliability of data regarding mental health workforce remains a recurrent challenge. The option of a unified workforce registry aids effective workforce planning and monitoring and may also impact the optimisation of staff. It is within this context that there is an urgent and pressing need for the standardisation of workforce definitions and the development of a robust data system to support effective workforce planning both now and into the future.

- Persistent challenges in capturing precise and accurate workforce information. The absence of reliable workforce data and an effective system for tracking the workforce undoubtedly impact mental health services planning ability and to anticipate workforce needs and respond proactively to existing and new emerging demand. It is also clear that inconsistencies in definition and role descriptors have resulted in both service and role variation across the region. Inevitably, establishing a unified, centralised workforce registry will be a critical step forward. Facilitating the development of a real-time system with agreed workforce definitions will enable meaningful benchmarking both within and across service areas and the optimisation of staff in responding to both current and future service demands. In this context, investing in data infrastructure is not simply an administrative exercise—it is a strategic imperative for building a resilient, adaptable, and effective mental health service for the years ahead.

Summary of Workforce and Service Priorities

- There is a clear and pressing need for a coherent strategic framework to inform service design and workforce prioritisation. Trusts and Chief Professional Officers have identified a limited number of professional roles as immediate short-term priorities. These include consultant psychiatry, psychology, pharmacy, nursing, approved social work, and peer support.

  Although some of these roles have understandably been prioritised in response to acute workforce pressures, this focus risks narrowing the strategic lens if considered in isolation of other professional groups—most notably allied health professionals (AHPs) and community and voluntary sectors whose expertise is fundamental to the modernisation, integration, and transformation of mental health service delivery. Therefore, should additional investment become available, these initial priorities, whilst indicative, may not exclusively determine how new resource will be deployed. This will require a collective system-wide approach which

ensures those workforces which can have the greatest impact in meeting current and emerging demand are prioritised.

- From a strategic perspective, the workforce challenges facing mental health services represent a critical opportunity to strengthen system resilience through more deliberate alignment between service priorities and forward workforce planning. In response to sustained growth in demand, Trusts and Chief Professional Officers, supported by their teams, have identified a set of service priorities aimed at stabilising delivery and focusing workforce development.

  These include strengthening the role and function of community mental health teams; enhancing crisis resolution and home treatment services; reducing waiting times for psychological therapies; prioritising child and adolescent mental health services; addressing substance misuse; and expanding therapeutic provision within and across acute mental health care settings. While these priorities are necessary and appropriate in the current context, they also reflect a predominantly reactive response to prevailing patterns of demand. The Reset Agenda therefore provides a strategic opportunity to move towards a more systematic and integrated approach to service and workforce prioritisation—one that goes beyond short-term demand management to support the development of innovative models of care.

  Such models would rebalance how demand is addressed, strengthen prevention and early intervention, make fuller and more strategic use of expertise within the community and voluntary sectors, and support the development of neighbourhood-based approaches to mental health service design. Collectively, this approach has the potential not only to improve outcomes and access, but also to optimise the system's capacity to absorb pressure, respond more flexibly to changing need, and improve performance over time.

- The persistent mismatch between workforce planning and service priorities highlights both a structural gap in the guidance governing multidisciplinary team configuration and the need for stronger integration between professional and service planning leadership in the determination of priorities. While workforce standards exist in a limited number of areas, such as CAMHS, these remain largely specialty-specific and do not support a whole-system approach.

Developing a coherent, regionally agreed framework that integrates clinical, professional, and service planning into a single authoritative reference would strengthen consistency, reduce unwarranted variation, and support the more strategic deployment of skills. Crucially, establishing a single, authoritative regional multidisciplinary workforce framework would underpin more resilient mental health services by enabling clearer prioritisation and more integrated planning across regional, place-based, and neighbourhood levels.

Summary Of Enabling Priorities for Action

1. ***Stabilise Services and the Mental Health Workforce Development***

Develop a system-wide, multi-year mental health workforce plan that addresses immediate vacancies while building long-term capacity. This includes expanding undergraduate and postgraduate training over the next three years across nursing, medicine, social work, psychology, pharmacy, and allied health professions, supported by dedicated funding.

Introduce mutual aid and cross-boundary arrangements to ensure clinical cover in high-risk areas and to better share specialist expertise through longer-term regional agreements.

Strategically redeploy regional underspends to relieve immediate workforce pressures, focusing on roles that can be mobilised quickly while protecting essential professional posts. This should include accelerated training in evidence-based psychological therapies, development of advanced clinical roles, better use of underrepresented therapeutic professions, and adoption of evidence-based digital and technology-enabled solutions.

Develop Whole-System Approach to Managing Workforce Movements: This action advocates for the development of a coordinated, system-level strategy to oversee workforce movements between primary care core and specialist mental health services. Rather than relying on isolated, service-specific planning this approached reinforces the need for the development integrated planning mechanism and oversight to ensure that staff are deployed effectively, with the right expertise in the right places.

2. Expand Optimise and Standardise

Maximise opportunities for **workforce growth and skills development** by utilising existing knowledge and skills and/or accelerate the upskilling/reskilling across all disciplines. Commission a **three-year mental health development programme** to increase access to evidence-based therapies and strengthen recruitment into therapy-focused roles.

Accelerate **service model standardisation** across core and specialist services by developing and implementing a comprehensive **multidisciplinary clinical (case) management framework**, aligned with the Mental Health Outcomes Framework.

Prioritise the expansion and integration of **value-adding clinical roles**, including advanced practice models, to increase capacity and resilience.

Subject to funding, and ahead of formulation of Mental Health Disciplinary Team Composition Standards, develop the business case for a £**50m workforce development fund with a view to recruit over the next three years** at least one-third of the 2022 workforce recommendations.

3. Strengthen Workforce Intelligence Through Data

Reform workforce intelligence by establishing **standardised workforce definitions** and a **centralised workforce registry and dashboard**. This will enable real-time monitoring, better forecasting, and more informed strategic decision-making.

4. Integrate Service and Workforce Planning

Move to a **phased, multi-year workforce planning model** that includes primary care and community and voluntary sectors. Adopt a **multi-criteria decision-making analysis (MCDMA)** approach to align workforce priorities with service development.

Develop clear **multidisciplinary team (MDT) composition standards**, strengthen integration between workforce planning and service design, and establish **MDT shared decision-making mechanisms** (e.g. Mental Health MDT Councils) to support system-wide consistency and accountability.

5. Standardise, Integrate, Develop, Adopt Innovative Models of Care Delivery

As part of wider mental health reform, **rethink how demand is met** by redefining the role of community mental health teams and shifting towards **neighbourhood-based models of care**. Strengthen integration between community services, primary care, and the voluntary and community sector.

Create a **population-based mental health model of practice** aligned with neighbourhood health and wellbeing frameworks. Systematically evaluate and scale effective innovations, including digital, virtual, and technology-enabled therapies, through a structured scoping review of emerging best practice.

Update and extend the **"Working Together, Learning Together" framework** to cover all aspects of mental health services and support the development of **neighbourhood mental health teams**, improving coordination, access, and continuity of care.

Towards an Integrated, Sustainable Mental Health System: Strategic Framework for Service and Workforce Transformation

This report sets out a clear direction for strengthening the coherence, effectiveness, and sustainability of mental health services through the systematic integration of service and workforce planning. In an environment characterised by rising and increasingly complex population need, constrained public resources, and persistent workforce pressures, existing ad-hoc and short-term planning approaches have resulted in fragmented decision-making and inconsistent service configuration. Such approaches are no longer sufficient to secure high-quality, equitable, and sustainable mental health care.

The central policy proposition of this report is that **integrated, forward-looking decision-making must replace reactive, siloed planning**. To achieve this, the report establishes the adoption of a **co-designed Mental Health Multi-Criteria Decision-Making Analysis (MCDMA) framework** as the primary lever for system reform and the cornerstone of integrated service and workforce planning. The framework provides a structured, transparent, and evidence-based mechanism to guide prioritisation, investment, and service redesign across the mental health system.

The MCDMA framework is anchored in four explicit and balanced decision-making domains

- **Meeting Need** – doing the right things first - ensuring decisions are driven by population need in the most integrated inclusive way possible.
- **Making an Impact** – prioritising approaches that deliver the right evidence-based and experiential outcomes, at right time.
- **Ensuring Deliverability** – testing feasibility by aligning the right skills, roles, and capacity in the right place, supported by robust implementation planning; and
- **Delivering Value** – maximising value for people, communities, and the system through developing right models, pathways, processes and ensuring the most efficient outputs and cost

Together, these domains provide a coherent framework for aligning strategic intent with operational delivery and for directing limited resources towards interventions with the greatest potential to improve population mental health and system performance. Importantly, the framework is designed to operate across the full continuum of mental health provision — including primary care, core and specialist services, and services delivered in partnership with the community and voluntary sector — thereby enabling whole-system prioritisation rather than isolated, service-specific decision-making.

Central to the effectiveness of this approach will be the development of **mental health multidisciplinary team (MDT) composition standards**, which will govern the design of mental health teams, by defining the optimal combination of professional roles, skills, and competencies required to deliver agreed models of care safely, consistently, and effectively. By establishing clear parameters for team composition, the standards address unwarranted variation, strengthen consistency across regional and local systems, and reinforce the alignment between service models, workforce capability, and outcomes.

Collectively the Mental Health Multi-Criteria Decision-Making Analysis (MCDMA) framework and the development of multidisciplinary team (MDT) composition standards establish a coherent, system-level architecture for prioritising services and workforce investment in line with the Department of Health's Reset agenda. They provide a consistent, transparent and evidence-led basis for decision-making across regional, place based (Trusts) and neighbourhood levels, strengthening collective leadership, shared accountability and system coherence. Crucially, these frameworks enable a decisive shift away from reactive, annualised decision-making towards proactive, population-based planning focused on stabilisation, reform and sustainable delivery. Placed at the centre of mental health service and workforce planning, these mechanisms provide a robust platform for delivering high-quality, equitable care closer to home, enabling the right care to be delivered by the right workforce, in the right place and at the right time, while supporting improved outcomes, workforce resilience and a sustainable mental health system.

2. Report Introduction

This report sets out the analytical and strategic foundations for addressing Recommendations One and Two of the Mental Health Workforce Review. It brings together the evidence required to understand the scale and nature of current workforce challenge and establishes the case for a more coherent, system-wide approach to service and workforce decision-making. The focus is on creating a clear line of sight between population need, service priorities, workforce capacity, and investment decisions, while avoiding prescriptive assumptions about solutions. In doing so, it provides a structured frame within which subsequent sections can examine options, test feasibility, and support informed, transparent choices about the future mental health services and workforce planning model.

This work also supports delivery of the Department's Reset agenda. While the report focuses on workforce costs, priorities and implementation, its broader purpose is to support the development of sustainable, neighbourhood-based models of mental health care, with a stronger emphasis on prevention, early intervention, multidisciplinary working and integration with primary care, community and voluntary sector partners. The workforce and service planning framework set out in the report is intended to help ensure that future investment decisions support both service stabilisation and longer-term transformation.

Context and Rationale

The Northern Ireland Mental Health Service Workforce Review 2022–2032 marked a pivotal milestone in mental health service planning. For the first time, it established a comprehensive and authoritative baseline of the mental health workforce across Northern Ireland. Completed in 2022 and published in July 2023, the Review provides a robust assessment of current workforce capacity and future staffing requirements across child, adolescent, and adult mental health services. It quantifies the scale of workforce need and identifies the core professional roles required to address existing pressures and respond to emerging population demand over the next decade.

A core purpose of the Review was to support delivery of the Northern Ireland Mental Health Strategy 2021–2031. By translating strategic ambition into defined and costed workforce requirements, the Review provided a critical mechanism for aligning service transformation with workforce supply. It establishes the workforce foundations necessary to improve access to care, strengthen prevention and early intervention, support recovery-focused practice, and enable new and more effective

models of service delivery. Delivering these objectives was and still is contingent on the expansion, diversification, and sustained development of the mental health workforce.

By establishing a clear baseline position, the 2022 Workforce Review provided the essential platform for system-wide workforce planning. The 2022 baseline was therefore a crucial enabling towards stabilising service provision, strengthening workforce resilience, and enabling mental health teams to deliver safe, effective, and person-centred care at scale, both now and over the lifetime of the Strategy.

Scope and Limitations of the Review

This report reflects the scope and parameters of the Mental Health Workforce Review undertaken in 2022 and is therefore primarily focused on Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services, including specialist mental health provision. In setting this focus, the report recognises the importance of a whole-system approach to mental health workforce planning—one that acknowledges the full spectrum of mental health need across primary care, statutory services, and the community and voluntary sector.

While wider system dependencies and interfaces are acknowledged—including the contribution of primary care, education-based mental health provision, and mental health support embedded within physical health and wellbeing services—the report does not seek to comprehensively quantify workforce requirements within these areas. Although aspects of mental health provision for older people are referenced, the psychiatry of old age workforce required to meet the needs of people with neurodegenerative or cognitive-related conditions is not fully addressed. Similarly, while the growing prevalence of neurodevelopmental mental health needs is recognised, the workforce required to adequately support this population is not comprehensively modelled.

The report also acknowledges emerging demographic and epidemiological pressures, including the increasing mental health needs of people living with complex, long-term, and enduring physical health conditions. However, the workforce implications arising from these intersecting needs fall outside the current scope of analysis. Collectively, these limitations reinforce the need for further, more detailed system-wide workforce planning that extends beyond the parameters of this review and reflects the interconnected nature of mental health, physical health, and social care delivery across the life course.

Centrality of Workforce Development

The *Mental Health Strategy Deliverability Review 2026–2029* (October 2025) identifies the capacity, capability, and sustainability of the mental health workforce as one of the most critical determinants of the Strategy's overall deliverability. It highlights sustained under-investment in workforce development and training as a fundamental structural constraint that has limited progress to date. In response, the Review positions workforce development and reform as the principal enabling factor—and a central strategic lever—through which long-term mental health service transformation can be realised. It concludes that addressing this deficit requires a coordinated, whole-system response that brings together service prioritisation, multidisciplinary workforce planning, and regionally coherent models of care, underpinned by sustained investment and consistent system leadership.

The Review is explicit that addressing this deficit requires a coordinated, whole-system response. This includes integrated service prioritisation, multidisciplinary workforce planning, and regionally coherent models of care, all underpinned by sustained investment and consistent system leadership. Crucially, it recognises that an effective mental health workforce depends on a genuinely whole-system approach—one that balances workforce requirements across primary and secondary care, while also strengthening the capacity and role of the community and voluntary sector as a core delivery partner.

Aligned with this direction and closely linked to the HSC Reset ambition—particularly the shift towards neighbourhood-based models of health and social care—mental health workforce planning nationally and internationally is increasingly evolving towards a more integrated, population-based orientation. This approach seeks to address mental health and emotional wellbeing across the full continuum of need and across the life course. From this perspective, workforce development is most effective when it is shaped not only to respond to acute demand, but also to intentionally build resilience, capability, and therapeutic capacity upstream—closer to where people live and where communities play an active role in promoting mental health and recovery.

However, the report also makes clear that this reorientation must be pursued with intentionality, strategic balance, collective professional leadership, and system stewardship. In practical workforce

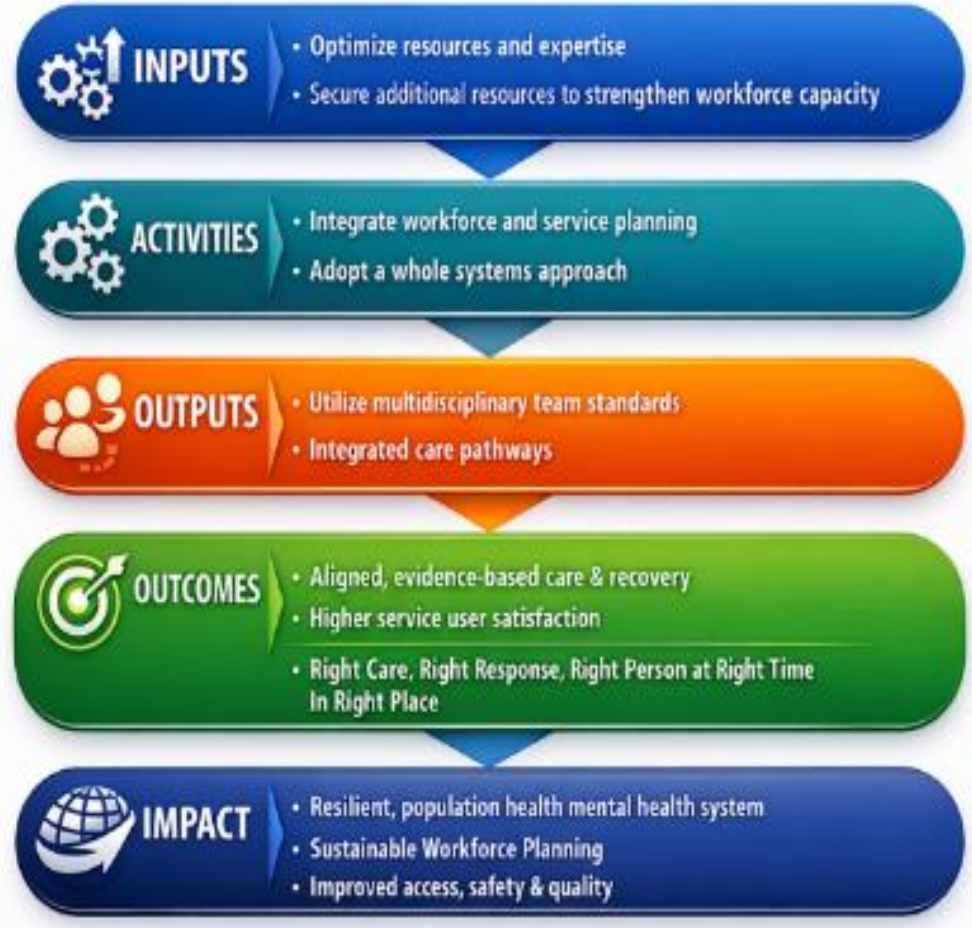
and service planning terms, this requires an explicit understanding of the interdependencies across the stepped-care model and wider inter-sectoral interfaces. Neighbourhood-based and early-intervention approaches are most effective when they strengthen overall system resilience and coherence, optimise scarce workforce resources, and avoid unintended demand shifts or workforce displacement. From this standpoint, protecting the integrity, sustainability, and specialist expertise of core and specialist mental health services is best understood not as a competing priority, but as a foundational enabler of reform.

Achieving the right balance across the continuum of need—between prevention and treatment, generalist and specialism, and neighbourhood delivery and regional expertise—therefore emerges as a central strategic leadership challenge in building a resilient, adaptive, and sustainable mental

health system. **This challenge provides the organising logic for the remainder of the report**, including the focus in subsequent sections on service and workforce prioritisation, integrated planning frameworks, and the development of multidisciplinary team composition standards to support delivery at regional, place-based, and neighbourhood level.

Workforce Development as the Foundation of Mental Health System Reform

This figure illustrates the programme-level theory of change underpinning this report. Addressing the workforce gap through a costed assessment of need (**Recommendation 1**) and aligning service and workforce priorities through integrated planning (**Recommendation 2**) provides the foundation for developing a balanced, multidisciplinary mental health workforce. When distributed effectively across the stepped-care continuum—encompassing neighbourhood-based, core, and specialist services—this enables greater system resilience, improved service coherence, and more sustainable use of resources.



Collectively, these aim to support the development of an adaptive mental health system capable of responding to population need across the life course, in line with the Mental Health Strategy and HSC Reset ambitions.

Challenges Facing Mental Health Services

Mental health services are confronted with a series of complex and interrelated challenges that

substantially affect their capacity to meet the rising needs and demands of the population. These difficulties have been exacerbated by a legacy of underfunding and the absence of effective long-term workforce planning, which has hindered the expansion of both core and specialist services. The breadth of unmet needs—including the urgent requirement for prevention and early intervention, as well as responding to emerging demographic changes—continues to place increasing pressure on the workforce.

Recruitment and retention issues, together with persistent staff vacancies, further intensify these workforce challenges. Such shortages not only undermine the operational capacity of mental health services, but also directly impact the safety of service users, the quality of care delivered, and the overall experience for individuals seeking support.

Strategic Purpose

Within the context outlined above, the Department of Health Mental Health Directorate has commissioned this work to address **Recommendations One and Two** of the Mental Health Workforce Review. Together, these recommendations are intended to establish a coherent and sustainable approach to mental health service and workforce planning.

Recommendation 1 – Determine the Workforce and Funding Gaps

Recommendation One necessitates the development of a **comprehensive, costed mental health workforce plan** that accurately quantifies the gap between the current workforce and the staffing levels required over the next decade. The primary purpose of this plan is to provide a robust foundation for financial planning and to support a phased approach to addressing identified workforce shortages.

The successful delivery of this phased approach is dependent on **proactive and forward-looking workforce planning**, particularly given the significant lead-in times required for professional education, training, and the recruitment of critical roles. Crucially, the effectiveness of a costed and phased workforce plan is contingent upon moving away from traditional, annualised undergraduate and postgraduate planning models and towards a **multi-year strategic planning approach**.

This shift will require the establishment of **dedicated recurrent funding** for education, training, and professional development, enabling the ongoing upskilling and development of the existing workforce. A robust multi-year workforce plan for mental health must also adopt an **integrated, multidisciplinary approach**, taking account of policy directives, population need, agreed service priorities, professional requirements, and the emergence of new models and ways of working.

Recommendation 2 –Prioritising Service and Workforce

Given the scale, complexity, and breadth of service and workforce developments required within mental health services—as set out in both the Mental Health Strategy and the Mental Health

Workforce Review—Recommendation Two explicitly recognises the **structural disconnect between service planning and workforce planning**.

This recommendation seeks to enable the **systematic prioritisation of service developments** to inform and align the recruitment and deployment of key professional roles. It strongly advocates for the establishment of a **robust and transparent framework** to support integrated service and workforce planning, ensuring that prioritisation decisions are evidence-based, coherent, and aligned with both service need and workforce deliverability.

The adoption of such a framework is essential to facilitating the effective prioritisation and recruitment of critical roles and to supporting the sustainable delivery of safe, high-quality mental health services.

Developing a Unified Model for Prioritisation

There is currently no unified model to enable the effective prioritisation of both services and workforce within mental health provision. The recent Mental Health Strategy Deliverability Review highlights the need to streamline mental health processes and approaches, reducing fragmentation and unnecessary variability both within and across services. Addressing this challenge requires the development of a comprehensive decision-making framework, designed to support robust planning and prioritisation—especially when managing competing demands in an environment with limited resources.

In advance of establishing a standardised approach for service and workforce prioritisation, as detailed in section two of this paper, a pragmatic interim method has been adopted. This approach draws on the expertise and practical insights of Trusts and Chief Professionals to profile near-term priorities over the next three years, and to prioritise the critical professional roles required to address immediate pressures. This will facilitate the progressive and systematic adoption of a new, integrated service and workforce planning and prioritisation model, designed to assist in the optimisation of existing resources and to support forward planning for workforce requirements aligned with population needs.

Report Structure and Section Summaries

Section 1: Mental Health Workforce Review – Gap Analysis :- Provides a comprehensive assessment of workforce shortfalls, vacancy pressures, and capacity constraints across mental health services. It quantifies the scale of the workforce deficit and outlines the associated financial implications, establishing a robust evidence base to inform future workforce planning and investment decisions.

Section 2: Workforce and Service Prioritisation:- Identifies the key workforce roles and service areas requiring focused investment and immediate action. It sets out priority areas to stabilise services, address critical staffing gaps, to enable resources to be directed to areas of greatest need and impact.

Section 3: Integrated Workforce and Service Planning Framework:- Introduces a structured framework that aligns service design with multidisciplinary workforce planning. It establishes an evidence-based decision-making approach to ensure workforce development is systematically linked to population need, service priorities, and sustainable models of care.

Section 4: Priorities for Action:- Translates the analysis and findings into a clear, deliverable, and action-oriented roadmap. It defines practical, system-wide priorities to stabilise services, optimise the workforce, and enable phased implementation of strategic objectives.

This report is structured to provide a clear, evidence-based progression from understanding the scale and nature of the mental health workforce challenge, through to the identification of priorities and the actions required to address them. Each section builds sequentially on the previous analysis, ensuring a coherent line of sight between workforce need, service priorities, decision-making frameworks, and implementation. The structure is designed to support transparent planning, informed prioritisation, and the translation of the Mental Health Workforce Review recommendations into practical, system-wide action.

- ***Section 1: Mental Health Workforce Review Gap Analysis*** – This section provides a comprehensive analysis of the gap between the current mental health workforce and projected future requirements as detailed in the Mental Health Workforce Review 2022. It includes an updated summary of current staffing levels for 2025, examines existing vacancies, highlights concurrent workforce challenges, and presents a financial analysis of the scale of investment and planning needed to achieve the workforce objectives outlined in the review.

- ***Section 2: Determining Mental Health Workforce and Service Priorities*** – The second section profiles the principal workforce and service priorities, drawing upon insights and recommendations from Trusts and Chief Professional Officers. This section identifies the most critical roles and service areas requiring immediate attention over the next three to four years, ensuring that existing and future resources are directed where they are needed most to support effective service delivery and workforce stability.

- ***Section 3: Standardising, Integrating Mental Health Services Planning, Decision-Making and Workforce Prioritisation*** – This section introduces a standardised model for mental health decision-making aimed at facilitating the integration of service delivery and multidisciplinary workforce planning. The model offers a structured framework to systematically prioritise resources, enabling system and clinical leaders to optimise multidisciplinary expertise and direct funding towards emerging needs and service priorities throughout the duration of the current mental health strategy. Implementing standardised processes for resource allocation and prioritisation, will enhance the efficacy of mental health service planning, whilst ensuring service-workforce design at regional, service delivery level (Trust areas) and Neighbourhood level is aligned with the ambitions detailed in the regional mental health service outcomes framework. This also includes integrating the vital role of the community and voluntary sectors.

- ***Section 4: Enabling Priorities for Action*** – This concluding section sets out the central priorities for action, drawing directly from the evidence and analysis presented in Sections One and Two, as well as from the collaborative discussions underpinning the development of the Mental Health Multi-Criteria Decision-Making Framework outlined in Section Three. Rather than presenting new recommendations, the priorities for action are designed as practical steps that translate the principal recommendations of the 2022 Mental Health Workforce Review into an actionable roadmap. This approach ensures that the identified actions respond to emerging issues and immediate needs, providing a clear and targeted pathway to address the critical challenges and priorities highlighted throughout the review.

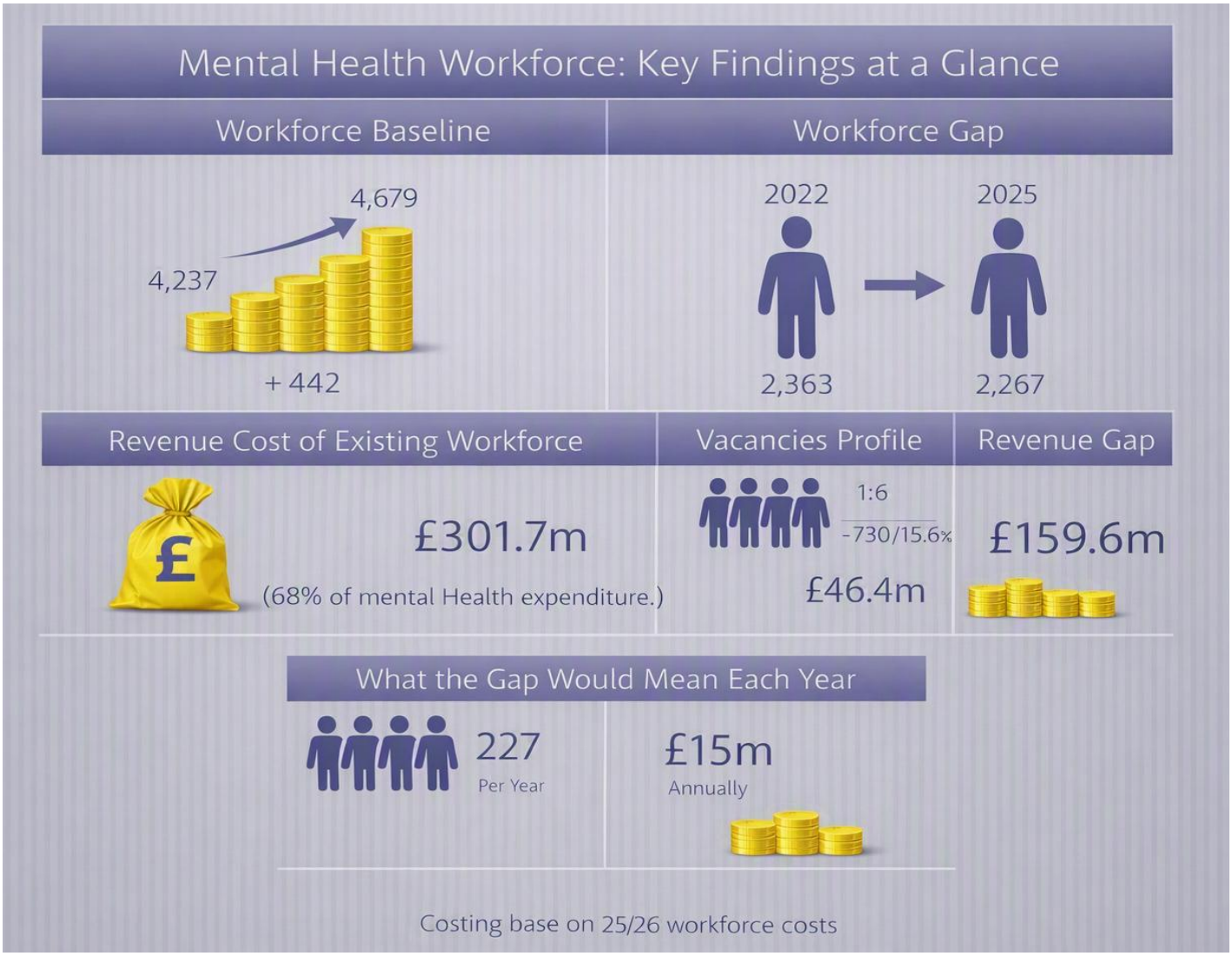
3. Section One Mental Health Workforce Overview and Funding Gap Analysis

Section 1: Mental Health Workforce Review – Gap Analysis :- Provides a comprehensive assessment of workforce shortfalls, vacancy pressures, and capacity constraints across mental health services. It quantifies the scale of the workforce deficit and outlines the associated financial implications, establishing a robust evidence base to inform future workforce planning and

3.1 Section 1: Mental Health Workforce Review Workforce Gap Analysis

This section examines the current baseline of the mental health workforce, providing a detailed analysis of staffing levels, vacancies, and funding requirements as of 2025. The purpose of this section is not to revisit or revise the review's original findings, but to provide an updated assessment of the current workforce profile. To achieve this, a thorough rebasing exercise was conducted in partnership with Health and Social Care Trusts, with the resulting data used to determine the level of funding required to address the workforce gaps identified in the 2022 review.

The section also explores the persistent gap between workforce capacity and service demand, building on data from the 2022 Mental Health Workforce Review. The analysis highlights the scale of investment needed to address ongoing shortfalls and discusses the implications for policy and future planning. By establishing a robust evidence base, this section sets the foundation for informed decision-making and targeted action throughout the rest of the report.



Please Note: -The Difference in 2022 data and 2025 is largely attributable to improve data collection and my not indicate a real terms increase in Staffing Complements. Vacancies maybe filled using short bank, agency or locums.

Mental Health Workforce Capacity, Gap Analysis and System Implications

The infographic above presents an integrated summary of the mental health workforce position, synthesising baseline staffing levels, the scale and persistence of the workforce gap, associated revenue implications, and projected recruitment requirements derived from the 2025 workforce rebasing exercise. In 2022, the Mental Health Workforce Review established a baseline of *4,237 whole-time equivalent staff. By 2025, the rebased workforce baseline increased to *4,679 posts, representing a net increase of *443 posts. However, this apparent growth is largely attributable to improvements in workforce data capture, classification, and profiling, rather than reflecting a substantive real-terms expansion in workforce capacity.

Critically, the rebasing exercise does not materially alter the underlying structural position. The workforce gap was estimated at approximately *2,363 posts in 2022. Re-modelling based on the 2025 rebased data indicates only a marginal reduction to around *2,267 posts—a decrease of just *96 posts over the period. While this represents a modest numerical change, it does not constitute a meaningful reduction in the scale of unmet need. The persistence of a gap of this magnitude continues to impose significant constraints on service capacity, operational resilience, and effective workforce planning. Current and forecast demand trends indicate that this shortfall remains a fundamental impediment to the delivery of safe, timely, and effective mental health services.

From a financial perspective, the total estimated revenue cost of the mental health workforce in 2025 is approximately *£301.6 million, accounting for around *68% of total mental health expenditure, estimated at *£400 million. Closing the workforce gap identified in the 2022 Mental Health Workforce Review would require an additional recurrent investment of approximately £150.6 million. This figure underscores both the scale of the workforce challenge and the necessity for sustained multi-year financial commitment to address it in a planned and deliverable manner.

Based on current projections, eliminating the workforce gap over the next decade would require the recruitment of approximately *227 additional staff per annum. To meet this target, the mental health workforce would need around £15 million in new funding every year for ten years. This isn’t a one-off £15 million increase—it means adding £15 million more each year on top of the previous year, building up to about £150 million in total. Even where funding is secured, sustaining recruitment at the required level would present a significant challenge under current arrangements, particularly given constraints within existing education and training commissioning models and wider workforce supply pipelines, alongside the absence of a fully integrated, system-wide approach to service design and workforce planning.

High vacancy levels further exacerbate these pressures. Current estimates indicate approximately 730 vacancies across mental health services, equating to 15.6% of funded posts—nearly one in every six roles remaining vacant or not substantively filled. The estimated revenue cost of these vacancies is approximately £46.4 million. While short-term reliance on bank, agency, and locum staffing mitigates immediate service risk, this approach is neither cost-effective nor sustainable as a long-term workforce stabilisation strategy.

Overall, the analysis confirms that, notwithstanding modest adjustments arising from the 2025 rebasing exercise, a persistent and material gap remains between current workforce supply and the capacity required to deliver the ambitions of the Mental Health Strategy. This directly reinforces **Recommendation 1** of the 2022 Mental Health Workforce Review, which called for a clear, costed assessment of workforce need alongside a sustained, multi-year investment strategy to address a structurally embedded workforce shortfall.

However, the evidence also demonstrates that workforce expansion alone will be insufficient to resolve the scale and persistence of the gap. Consistent with **Recommendation 2**, addressing the challenge requires a fundamental shift towards integrated service and workforce planning, supported by improved workforce intelligence and a robust prioritisation framework. Without such integration, incremental investment risks reinforcing existing service configurations rather than enabling the service transformation required to respond effectively to population need.

From a population-health perspective, the analysis further highlights the false economy associated with continued under-investment in prevention, early intervention, and community-based models of care. Insufficient upstream capacity increases reliance on higher-intensity services, amplifies workforce pressures, and perpetuates systemic demand–capacity imbalance. A population-health-led approach—focused on reducing the incidence, severity, and recurrence of mental illness—must therefore be treated as a core workforce sustainability strategy rather than a peripheral or adjunctive intervention.

These findings indicate that long-term system resilience will depend on the development of a robust, whole-system workforce strategy that simultaneously delivers **Recommendation 1** through phased, costed investment and **Recommendation 2** through integrated, needs-led prioritisation of services and roles. Such a strategy must be aligned with service redesign, education and training capacity, recruitment pipelines, and prevention-focused models of care. In the absence of investment and whole-system alignment, mental health services will remain constrained by reactive planning and escalating demand. Given the current system position, maintaining the status quo is

not a viable option. Accordingly, this paper is intended to support the development of an integrated, whole-systems approach to service and workforce planning—aimed at stabilising services, optimising existing resources, and leveraging new investment to meet both current and future population mental health needs.

Scope of the Analysis

It is important to clarify that this analysis focuses specifically on Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services. It does not currently address workforce requirements within older people's services or the community and voluntary sectors as these were outside the scope of the Mental Health Workforce Review. However, a separate review of the size, scale and capacity of the community and voluntary (C&V) sector has recently been completed, in response to Mental Health Strategy Action 17 which committed to fully integrating the C&V sector into mental health service delivery. The findings from that review, once implemented, will provide a more comprehensive picture of the overall workforce profile across statutory and non-statutory sectors.

Workforce Data Systems

During the rebasing process, it became evident that there is no single, unified overview capturing all aspects of the mental health workforce. This highlights the pressing need to develop a system capable of consolidating and standardising workforce data across all relevant sectors, thereby supporting more effective workforce planning and resource allocation.

The lack of a unified mental health workforce registers or dashboard creates significant difficulties in consistently monitoring and tracking workforce data. At present, mental health staffing information is predominantly managed at the level of individual Health and Social Care (HSC) Trusts, resulting in workforce intelligence being distributed across a range of programmes of care, such as primary care, children's services, adult services, older people's services, and third sector providers. Each of these operates under distinct service models and management structures, and they are not always coordinated within a unified mental health care system.

Workforce Definitions and Categorisation

While there is a degree of consistency in how workforce categories are classified, for example by medical, nursing or post grade, there remains significant variation in the naming conventions for

specific roles, the composition of multidisciplinary teams, and the processes for recording staff in post and vacancies, both within and across professional groups. To address this, Trusts were asked to align their mental health staffing profiles with the professional categories established in the Mental Health Workforce Review, in order to generate the most accurate projection of the workforce cost gap. Adopting this standardised approach has enabled meaningful comparison of data collected in 2022 and 2025. With further refinement, this categorisation method has the potential to support future workforce baselining, strategic planning, and targeted investment, thereby strengthening the overall effectiveness and sustainability of mental health workforce planning.

Recap of The Mental Health Workforce Review Recommendations 2022

Mental Health Workforce Professional Categories	CAMHS Mental Health Workforce Review Recommendations 2022 Table 31 Page 73			Adult Mental Health Workforce Review Recommendations 2022 Table 32 Page 75			Combined Mental Health Workforce Review Recommendations 2022 Table 30 Pages 71-72		
	Current	*Future*	*Gap*	*Current*	*Future*	*Gap*	*Current*	*Future*	*Mental Health Workforce Gap*
Medical	42	53	11	161	278	117	203.0	331.0	128.0
Nursing	119.5	212	92.5	1196.6	1630	433.4	1316.1	1842.0	525.9
Social work	134	140	6	448	525	77	582.0	665.0	83.0
Psychology	20	64	44	98	182	84	118.0	246.0	128.0
OT	9	35	26	150	272	122	159.0	307.0	148.0
Physiotherapist	0.0	23.0	23.00	7.00	56.00	49.00	7.0	79.0	72.0
SLT	0.0	33.0	33.00	28.00	63.00	35.00	28.0	96.0	68.0
Dietetics	1.0	33.0	32.0	6.0	44.0	38.0	7.0	77.0	70.0
CAMH/Adults Psychotherapy	2.0	19.6	17.6	0.0	0.0	0.0	2.0	19.6	17.6
Trainee Psychotherapy CAMHS	0.0	4.4	4.4	0.0	19.0	19.0	0.0	23.4	23.4
Psychotherapy CBT	0.0	0.0	0.0	16.0	73.0	57.0	16.0	73.0	57.0
Pharmacy	0.0	13.0	13.0	2.0	141.0	139.0	2.0	154.0	152.0
Art/music/drama	2.0	35.0	33.0	0.0	65.0	65.0	2.0	100.0	98.0
Mental Health Practitioners GP	3.0	0.0	0.0	49.0	202.0	153.0	52.0	202.0	150.0
Social care	17.0	0.0	0.0	182.0	224.0	42.0	199.0	224.0	25.0
Counsellors	3.0	0.0	0.0	48.0	52.0	4.0	51.0	52.0	1.0
Management and Admin	56.0	114.0	58.0	477.0	776.0	299.0	533.0	890.0	357.0
Nursing support	29.0	33.0	4.0	762.0	310.0	*0.0*	791.0	343.0	0.0
Psychology associate	3.0	19.0	16.0	10.0	73.0	63.0	13.0	92.0	79.0
OT. Support	1.0	1.0	0.0	20.0	9.0	*0.0*	21.0	10.0	0.0
Physio support	0.0	0.0	0.0	0.4	11.0	10.6	0.4	11.0	10.6
Assistant Pharmacy	0.0	0.0	0.0	0.0	7.8	7.8	0.0	7.8	7.8
Associate Physician	0.0	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0
SLT Support	0.0	0.0	0.0	0.0	5.0	5.0	0.0	5.0	5.0
Assistant practitioner	0.0	57.0	57.0	131.0	173.0	42.0	131.0	230.0	99.0
Peer support	0.0	0.0	0.0	0.0	53.0	53.0	0.0	53.0	53.0
Independent advocates	2.0	2.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0
Transition worker	0.0	5.0	5.0	0.0	0.0	0.0	0.0	5.0	5.0
Total (rounded to	444	896	476	3793	5245	1915	4237	6141	2363.3

Mental Health Workforce Recommendations 2022 – Gap Analysis

The Mental Health Workforce Review conducted in 2022 established a benchmark for the number of future whole time equivalent (WTE) staff working within mental health services, encompassing both Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services. In 2022, the number of staff working in mental health services was estimated to be 4,237 whole time equivalent staff. Of this total, CAMHS accounted for 10.5% (444 staff) while Adult Mental Health Services represented the remaining 89.5% of the workforce (3,793 staff).

Projected Workforce Requirements and Gap

In 2022, a comprehensive demand analysis was undertaken to forecast mental health staffing requirements for the following decade. The analysis determined that to deliver mental health services effectively and meet anticipated demand, the workforce would need to expand to approximately 6,141 staff members. Comparing this projection with the number of posts in 2022 revealed a significant shortfall, with an estimated gap of around 2,363 additional posts required over the ten-year period. Addressing this gap would necessitate new recurrent funding and the recruitment of at least 236 additional staff per year, on top of existing recruitment efforts, for the next ten years.

Breakdown by Service Area

Breaking this gap down further, the Review concluded that CAMHS would need to at least double its workforce, with an increase of at least 476 posts over 10 years. This is in part in recognition of the legacy of underinvestment in CAMHS. For Adult Mental Health Services, an expansion of approximately 1,461 posts would be necessary, equating to a growth of 45%. These findings underscore the substantial scale of workforce development required to ensure that mental health services are equipped to meet future needs effectively and sustainably.

Professional Groups Requiring Expansion

This first comprehensive baselining of mental health workforce requirements identified that, although all major professional groups require additionality, several key professions needed significant expansion. In both Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services, the greatest areas recommended for growth were Psychology, Psychological Therapies, Pharmacy services, and Allied health professions, particularly in the need for more practitioners in Art, Drama, and Music Therapies.

Considerations and Limitations

It is important to acknowledge, as highlighted in the 2022 Review, that this figure represents an estimate. Further substantial service development will be required to address unmet needs and comply with emerging legal or statutory requirements. As such, the actual demand for mental health staff is likely to exceed the projected 2,363 whole time equivalents. Additionally, these projections do not account for staffing requirements currently being assessed within the community and voluntary sector, or those arising in response to neurodegenerative and mental health needs associated with an ageing population.

Investment Strategy and Prioritisation

At this juncture, it should be emphasised that the Mental Health Workforce Review did not prescribe a formal hierarchy for the prioritisation of workforce roles. Instead, its recommendation centred on the creation of a phased, costed investment strategy designed to systematically address the documented workforce deficit in individual professional grouping and role. The workforce recommendations set out in the review were also not intended to represent an absolute or final position, but rather a foundation upon which future workforce and service developments could be built.

This is particularly relevant given that the review was conducted during the early stages of Strategy implementation, with an understanding that workforce requirements would evolve in response to changing models of care. It also acknowledged the competing reality between workforce demand, supply, and the challenges associated with retention and the need for core service stabilisation.

Whilst the review considered the key service development actions outlined in the Mental Health Strategy, it did not specifically align the recommended workforce complement with specific service developments, except perhaps in the case of primary care. This observation is not a criticism of the review; instead, it underscores the necessity for a systematic process that reconciles workforce needs with service development in a planned, logical, and sequential manner. Adopting such an approach would ensure that the investment plan supporting workforce development is also integrated with the financial plan for mental health service development and transformation.

Rebasing and Profiling of Mental Health Workforce Costs

To provide an up-to-date and accurate profile of the costs associated with the recommendations outlined in the Mental Health Workforce Review, it was both recommended and agreed that a comprehensive rebasing and profiling of the current staffing complement across mental health

services was essential. This process was guided by the key professional categorisations established in the Mental Health Workforce Review.

Undertaking this exercise revealed several challenges, primarily due to variations in data and differences in workforce categorisations across organisations. In response, and in close partnership with Health and Social Care (HSC) Trusts, the 2025 workforce rebasing initiative aimed to align the current mental health workforce with the professional categories defined in the Mental Health Workforce Review. This alignment was critical to enable meaningful comparative analysis and support future workforce planning.

As previously noted, there is currently no dedicated registry for the mental health workforce that would enable the systematic tracking and monitoring of workforce changes and developments. Nevertheless, the foundational work undertaken through the Mental Health Workforce Review has established a baseline that can be used to profile both the present and future workforce more effectively.

The table below presents the results of the 2025 mental health workforce rebasing exercise, undertaken to establish an updated and more accurate baseline of the current workforce position.

Regional Mental Health Workforce 2025 WTE -Rebasing Profile								
Mental Health Workforce Staff in Post				Mental Health Workforce Vacancies 2025			% Vacancies	Total of Staff In Post + Vacant Post 2025 Baseline
Professional Categories	CAMHS	Adult	Total	CAMHS	Adult	Total	%Vacancies within each Speciality	Total Staff In-Post + Vacancies
Medical	36.96	166.17	203.13	9.17	46.95	56.12	21.6%	259.25
Nursing & Midwifery	135.18	1,427.37	1,562.55	22.64	213.30	235.94	13.1%	1,798.49
Social Work	111.41	415.47	526.88	2.00	55.21	57.21	9.8%	584.09
Psychologist	18.13	95.94	114.07	8.43	25.27	33.70	22.8%	147.77
Psychotherapy	3.70	31.70	35.40	1.00	10.74	11.74	24.9%	47.14
Counsellor	3.00	20.86	23.86	1.00	2.83	3.83	13.8%	27.69
OT	9.47	131.48	140.95	3.30	38.15	41.45	22.7%	182.40
Physio	0.00	4.99	4.99	0.00	0.65	0.65	11.5%	5.64
S&L	1.50	0.60	2.10	0.00	0.00	0.00	0.0%	2.10
Dietitian	5.54	6.00	11.54	1.15	3.68	4.83	29.5%	16.37
Arts therapist	1.00	1.00	2.00	0.00	0.00	0.00	0.0%	2.00
Pharmacy	2.00	13.68	15.68	2.00	1.40	3.40	17.8%	19.08
MH Pract	21.98	27.36	49.34	8.54	4.50	13.04	20.9%	62.38
Support	32.66	621.29	653.95	0.00	173.02	173.02	20.9%	826.97
Admin & Mgt	55.69	476.60	532.29	5.73	89.39	95.12	15.2%	627.41
Other	15.00	55.57	70.57	0.00	0.00	0.00	0.0%	70.57
TOTAL (rounded to nearest)	453	3,496	3,949	65	665	730	15.6%	4,679

The rebasing aligns Trust-reported staffing data to the professional groupings and role definitions used in the 2022 Mental Health Workforce Review, enabling consistent comparison over time. This approach provides a refined assessment of staff in post, substantive vacancies, and funded

establishments, and forms the evidential basis for quantifying the current workforce gap and associated funding implications set out in this section.

Please note the background data underpinning the table above has been retained by the DOH Workforce Policy Team and includes a breakdown by Trusts. This comprehensive dataset presents clear opportunities for further analysis and review. By examining the detailed breakdowns across individual Trusts, it becomes possible to identify and address variations in the composition of mental health teams. Such analysis would support the identification of best practices, highlight areas where professions or roles are underrepresented, and enable targeted interventions to ensure more balanced and effective team structures. Adopting a systemic approach to service and workforce standardisation across Trusts could facilitate greater consistency in the delivery of mental health services and promote equitable access to specialist skills. This approach as discussed in section 3 of this paper will facilitate the development of clear benchmarks for team composition, informed by evidence and service needs.

To maintain the integrity and reliability of the rebasing process, each Trust was asked to update their 2022 workforce data and profile their staff in post and substantive vacancies according to the professional categorisations set out in the 2022 Mental Health Workforce Review. The following table summarises the findings of this rebasing exercise from all five Health and Social Care Trusts. This process has subsequently facilitated the calculation of the projected workforce funding shortfall.

The table above indicates that there are now *4,679 funded positions across both Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services. When compared to the 2022 baseline figure of *4,236, this represents an additional *443 posts. While this number of additional posts might initially appear to signal positive progress for mental health services, as noted this is likely this due to improved data collection methods. Many of these posts probably existed prior to 2022 but were not captured in the original baseline, meaning the apparent growth largely reflects a more accurate identification of existing roles rather than a substantial expansion of the workforce.

Overview of Additional Posts Identified but not Included to the 2022 Data

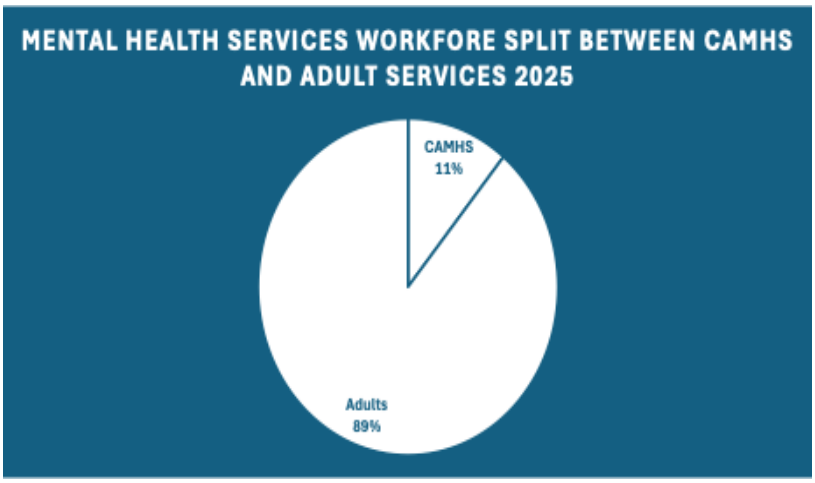
For ease of reference, the following table provides a breakdown of these roles. Further analysis of these bespoke and specialised roles would be warranted, particularly to better understand their contribution to the current workforce composition. As illustrated in the table above, several new role descriptors identified in 2025/26—totalling approximately 430 WTE—were captured. Of these,

around 359 WTE could reasonably be aligned with existing professional groupings, while the remaining 70.6 WTE, due to their more generic or ambiguous descriptors, were more difficult to assign confidently to a specific professional category.

Other Posts Not Included in the 2022 Review							
Band 8A Family Therapist	1.00	Assistant ECT Manager (band 6)	0.80	Registrar	0	Counsellor Band 8A	1
Band 4 Team Assistant	1.00	Band 6 Encompass Implementation Lead (Admin)	2.00	Band 7 CAMHS Lead Nurse	2.00	Band 8A Occupational Therapist	1
Band 5 Emotional Health and Wellbeing in Schools	5.00	Band 7 Deputy Service Improvement Manager (Admin)	1.00	Band 7 Physical Health Lead Nurses for CMHTs	1.00	Band 8B Occupational Therapist	1
Band 7 Emotional Health and Wellbeing Team Lead	1.00	Band 8A Condition Management Prog Team Lead	1.00	Practice Innovation Nurse (Band 7)	1.00	Band 8B Speech & Language Therapist	1
Band 7 Referral Co-ordinator	2.00	Band 8A Locality Manager	9.70	Band 8A Nurse Manager	3.00	Band 5 Dietitian	1
Band 7 Substance Misuse Worker	1.00	Band 8 A Service Manager	2.00	Band 8A Nurses - not specified	31.72	Creative Therapy Support Worker Band 5	1
Band 7 Eating Disorder Practitioner	2.00	Band 4 Peer Recovery Trainer	1.57	Band 8 A Snr Addictions Nurse	1.00	Band 6 Mental Health Practitioner	40
Band 7 ADHD Practitioner	1.00	Band 7 Desginated Adult Protection Officer	1.00	Band 8A Lead Nurs Co-ord	1.00	Band 2 Social Care Worker	1
Band 7 Business Support Manager (Admin)	1.00	Band 7 Housing Support Manager	1.00	Band 8C Lead Nurse	1.00	Band 3 Social Care Worker	128
B5 Business Support Manager	5.00	Band 6 Addictions Practitioner	5.90	Band 7 Health Visitor	0.80	Band 6 Social Care Worker	1
Dual Diagnosis co-ordinator (Band 7)	1.00	Band 7 Bereaved by Suicide Manager	1.00	Band 7 Midwife	2.40	Band 4 Assistant Psychologist (psychology)	11
Patient Flow Co-ordinator (Band 7)	1.00	Band 5 MH & Recovery Pract	0.80	Band 8A Social Worker	2.00	Band 5 Assistant Psychologist (psychology)	2
SI Lead Certified Instructor (Band 7)	1.00	Band 6 MH & Recovery Pract	2.00	Band 8C SW Lead	1.00	Band 3 Peers Support Worker	14
Clinical MAPA Instructor (Band 6)	2.00	Band 7 Deputy Service Manager	1.00	Band 6 Psychologists	1	Band 8B Head of Service	1
Assistant ECT Manager (band 6)	0.80	Band 7 Lead Practitioner	2.80	Band 7 Psychological Trauma Specialist	1	Band 8A AHP Lead	1
Band 6 Encompass Implementation Lead (Admin)	2.00	Band 7 Snr Addictions Practitioner	9.00	Band 8B Clinical Psychologists	11	Band 8A Administrative	1
Band 7 Deputy Service Improvement Manager (Admin)	1.00	Band 7 Recovery Facilitator	1.00	Band 8D Consultant Psychologist	3.75	Band 8A Service Improvement Manager	1
Band 8A Condition Management Prog Team Lead	1.00	Band 7 Think Family Practitioner	1.00	Band 9 Head of Psychology Services	2	Band 8A Towards Zero Suicide (TZS) Co-Ordinator	1
Band 8A Locality Manager	9.70	Band 7 Winter Pressure Co-ordinator	1.00	Counsellor Band 5	5	Admin Role Band 6,7,5,4,3	74
Total	39.50	Total	45.57	Total	72	Total	282

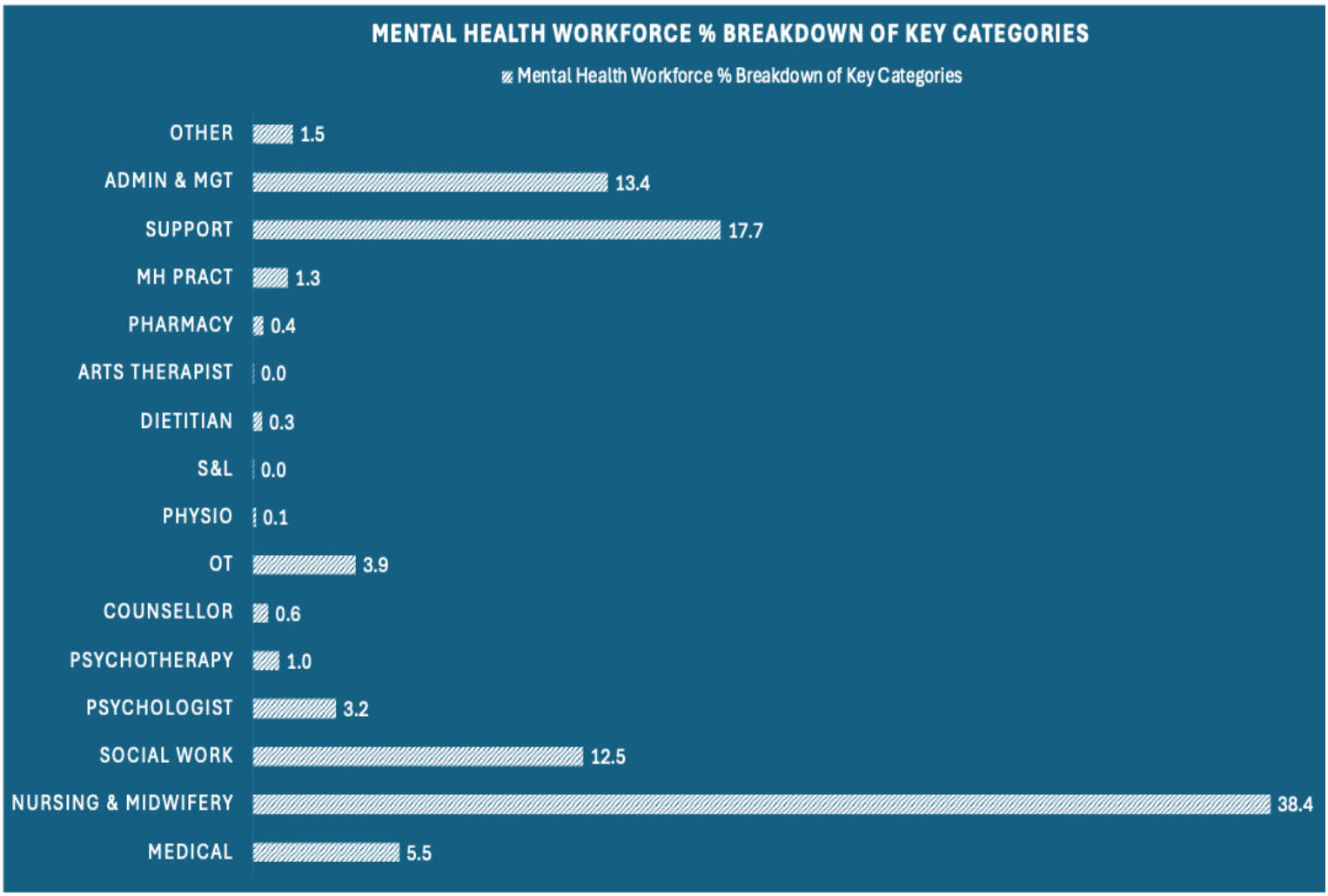
CAMHS and Adult Mental Health Workforce Ratio

This rebasing exercise demonstrates the CAMHS to Adult Mental Health workforce ratio remains largely unchanged from the 2022 baseline. The CAMHS workforce now comprises 518 whole time equivalent (WTE) positions, representing an increase of 74 posts compared to 2022. This means CAMHS now makes up approximately 11% of the overall mental health workforce. In contrast, Adult Mental Health Services now account for 4,161 posts (an increase of 368 posts from the 2022 baseline), representing the remaining 89% of the workforce.



Professional Composition of Mental Health Services

The data presented in the following graph provides a breakdown of the current workforce.



Mental health nursing forms the largest single professional group within mental health services, accounting for approximately *38% of the workforce. Support roles collectively make up 18% of the total, encompassing positions such as nursing assistants, social care support workers, associate clinical psychologists, allied health professional support roles, assistant practitioners, and peer support workers. Management and administrative roles—including positions such as Mental Health Directors, Assistant Directors, Clinical Leads, bed or team managers, and a broad range of administrative support staff—constitute approximately 13% of the workforce. It is important to recognise that these roles are integral to the operational structure of mental health care delivery. By contrast, the smallest proportion of the workforce is made up of pharmacy, psychology, psychotherapy, and a diverse array of allied health professional roles.

The Multidisciplinary Nature of Mental Health Services

This wide spectrum of roles illustrates the fundamentally multidisciplinary nature of mental health service provision. A diverse range of therapeutic and specialist roles—including care delivered by the community and voluntary sector—demonstrates the necessity for a tailored, multidisciplinary approach to workforce planning. Such an approach must ensure all professional groups required for accessible, timely, safe, and effective mental health care are considered.

Current Workforce Planning Mechanisms

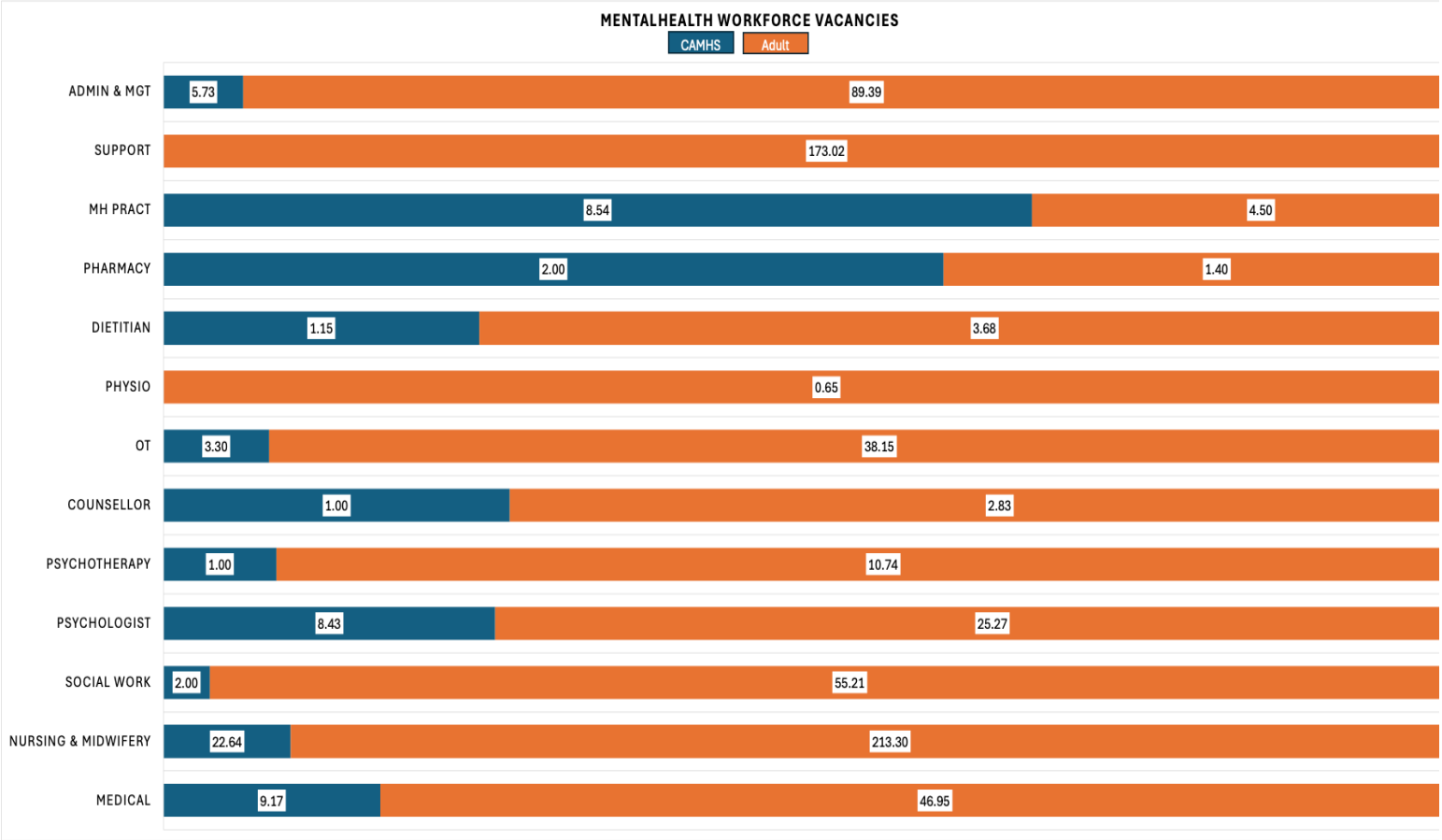
Upon reviewing current workforce data and planning mechanisms, it is evident that there is presently no integrated multidisciplinary planning model or workforce service model in place to identify the specific professional requirements for each mental health service. Section three of this paper will therefore propose a new integrated planning and prioritisation model, designed to support a population needs-based approach to workforce planning in mental health care.

Future Directions: Population-Based Workforce Planning

Looking ahead, the development of a population-based workforce planning model—one that leverages the unique blend of professional skills within mental health—will help ensure a comprehensive approach to addressing and resolving service and workforce gaps. By enabling effective planning for both undergraduate and postgraduate training, the model can offer a flexible ‘plug and play’ response to shifting service needs and demand. This adaptability is crucial, as it ensures that the workforce remains equipped to respond to the evolving requirements of service users, thereby supporting the overarching aims set out in the mental health strategy and the mental health outcomes framework.

Mental Health Workforce Vacancy Overview

The chart below provides a comprehensive overview of current vacancies across mental health care services, with a particular emphasis on gaps within key professional roles. It reveals notable



shortages not only in medical positions—where over a quarter of posts remain unfilled—but also in nursing, psychology, psychological therapies, and administrative roles. This visual summary highlights the persistent difficulties in recruiting and retaining skilled professionals across the multidisciplinary mental health workforce, reinforcing the urgent need for targeted workforce planning and investment to guarantee high-quality, accessible care.

Current Vacancy Statistics

At present, 730 positions remain unfilled, representing 15.6% of all funded posts. Within CAMHS, 66 positions (12.6% of the total) are vacant, this equates to approximately 5 vacancies for every 40 staff while Adult Mental Health Services account for 665 vacancies or 16%, this equates to a ratio of 1 vacancy for every 6.26 staff. Although some of these gaps are temporarily bridged by locum or agency staff, such a high level of vacancies continues to significantly affect the delivery, consistency and capacity of mental health services.

Impact on Service Delivery

This reality, as highlighted later, is further exacerbated by the 2022 workforce gap. Persistent shortages, particularly in specialist and clinical roles, not only place increased pressure on existing staff but also risk compromising service quality and accessibility for service users.

Recruitment and Retention Challenges

As set out in the Mental Health Workforce Review there is a need to address the persistent and long-term recruitment and retention challenges. Addressing both scale and distribution of these vacancies, along with the future workforce gaps, will require the development of a strategic approach which moves from an annualised workforce planning cycle to a multi-year workforce planning cycle, one that also aligns and prioritises key roles with service planning priorities.

3.2 Overview of Mental Health Workforce 2025 Re-basing Profile Costs

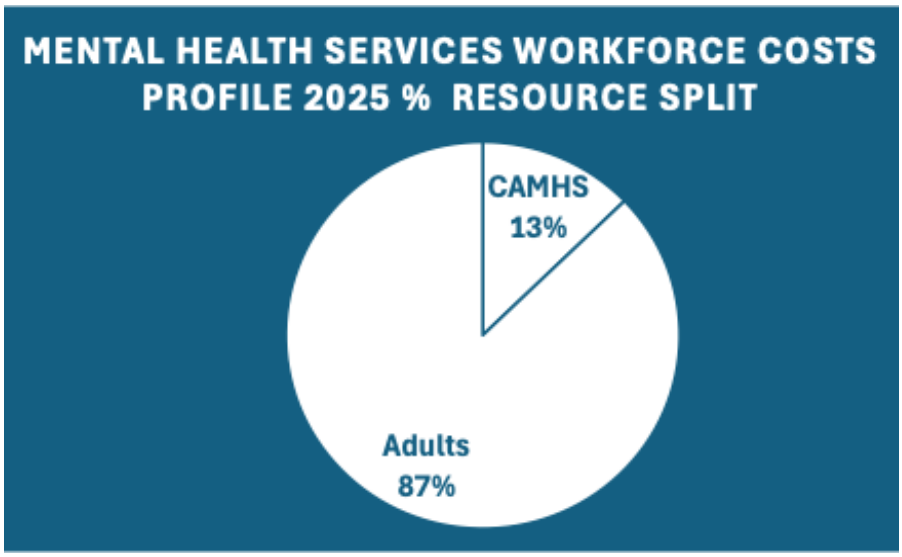
The following table sets out the key costs associated with the current workforce profile. Mental health nursing represents the largest area of investment within mental health services, which is commensurate with its position as the largest component of the workforce. In contrast, professions such as psychology, psychological therapies, and allied health professionals account for a

Staff Grouping	Child & Adolescent Mental Health Services Staff In - Post Cost Profile	Adult Mental Health Services Staff In-Post	Mental health Workforce Total Staff in Posts Costs	Child & Adolescent Mental Health Services Staff Vacancy Costs	Adult Mental Health Services Vacancy Cost	Total Mental Health Vacancy Costs	Total Staff in posts and Vacancy Costs
Medical	6,551,432.28	29,337,458.11	£35,888,890	£1,660,174	£8,578,501	£10,238,675	£46,127,566
Nursing & Midwifery	8,908,807.10	86,091,649.20	£95,000,456	£1,359,430	£11,968,128	£13,327,558	£108,328,014
Social Work	7,836,713.85	27,797,469.39	£35,634,183	£133,961	£3,609,877	£3,743,838	£39,378,021
Psychologist	1,716,101.76	9,450,971.38	£11,167,073	£733,871	£2,185,811	£2,919,682	£14,086,755
Psychotherapy	276,264.33	2,423,397.98	£2,699,662	£74,006	£794,823	£868,829	£3,568,491
Counsellor	234,230.91	1,418,716.97	£1,652,948	£74,006	£209,437	£283,442	£1,936,390
OT	655,624.95	8,484,163.68	£9,139,789	£219,260	£2,340,994	£2,560,254	£11,700,042
Physio	0.00	330,278.33	£330,278	£0	£38,971	£38,971	£369,248.9
S&L	111,008.78	51,731.52	£162,740	£0	£0	£0	£162,740
Dietitian	395,941.25	400,180.35	£796,122	£85,107	£270,871	£355,978	£1,152,100
Arts therapist	49,046.16	59,954.66	£109,001	£0	£0	£0	£109,001
Pharmacy	118,106.90	978,022.52	£1,096,129	£118,107	£100,476	£218,583	£1,314,713
MH Pract	1,317,803.50	1,885,131.36	£3,202,935	£551,356	£297,898	£849,255	£4,052,189
Support	1,350,458.83	25,199,485.46	£26,549,944	£0	£6,889,533	£6,889,533	£33,439,477
Admin & Mgt	2,839,960.38	24,111,148.57	£26,951,109	£241,877	£3,895,926	£4,137,804	£31,088,913
Other	967,597.87	3,897,447.85	£4,865,046	£0	£0	£0	£4,865,046
TOTAL	**33,329,098.87**	**221,917,207.32**	**£255,246,306**	**£5,251,154**	**£41,181,247**	**£46,432,401**	**£301,678,707**

comparatively smaller share of investment. While it is essential to optimise the contribution of the existing workforce across all disciplines, there is a clear need to develop multidisciplinary models which achieves a balance and strengthens underrepresented professional groups. Achieving this balance will support the development of a more integrated multidisciplinary workforce, enhancing collaboration across services and ultimately improving outcomes for individuals, families, and communities.

Funding Allocation Across Mental Health Services

The total funded workforce across mental health services (staff in-post plus vacancies) currently stands at just over £301,678,707 based on 2025/26 costs. This amounts to approximately 68% of existing mental health services funding. Of this, the CAMHS workforce (£38,580,252) accounts for nearly *13% of the overall workforce funding allocation, with Adult Mental Health Services (£263,098,454) representing the remaining *87%.



Vacancy Funding and Immediate Pressures

Notably, as highlighted above, workforce vacancies represent almost 16% of the total funding, equating to nearly *£46 million. CAMHS equates to *£5.3mand Adult equates to *£41m. This level of vacancy investment underscores the critical need for a strategic approach in optimising this funding to address some of the immediate workforce pressures.

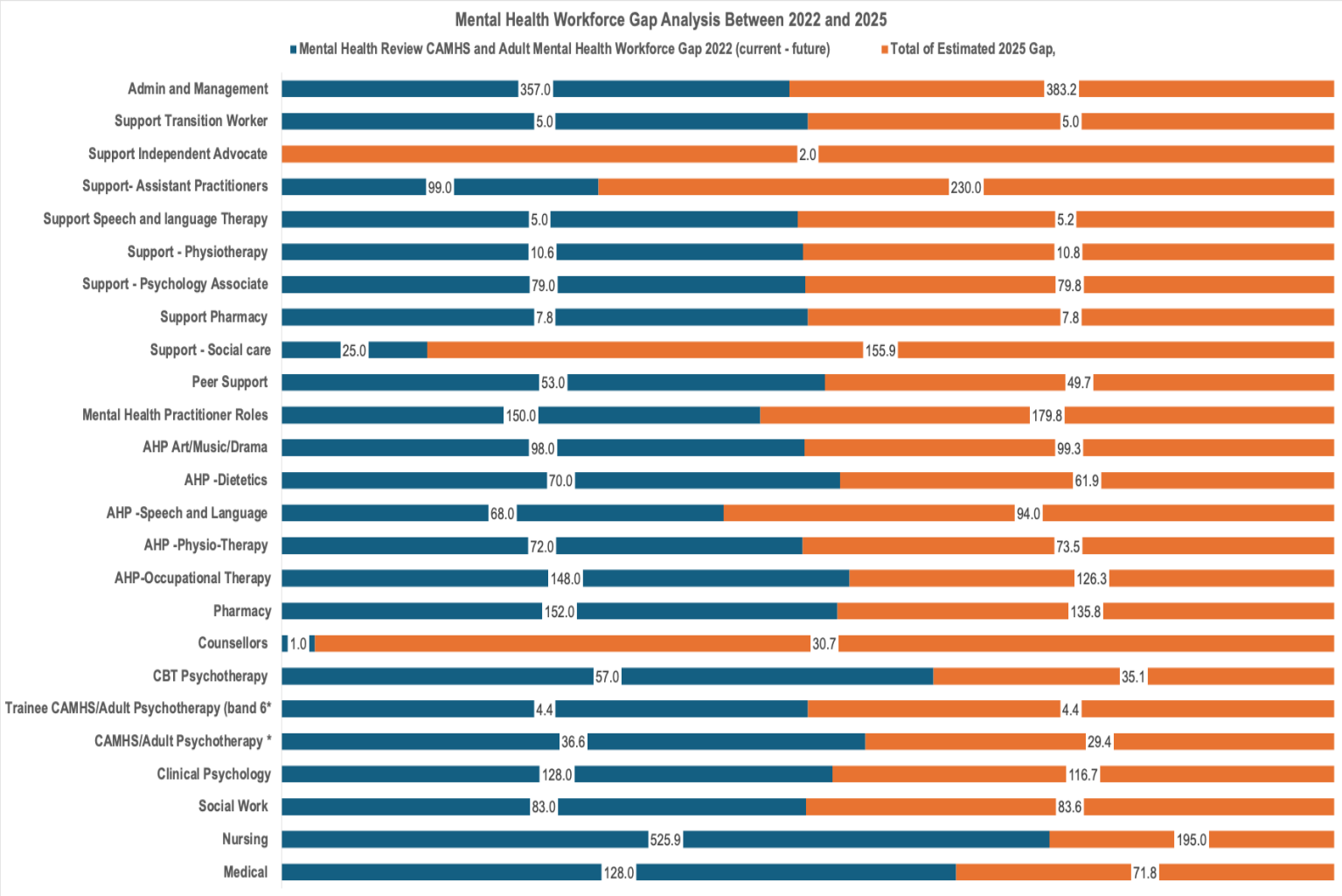
This includes identifying and leveraging opportunities to redirect underspends to support the reskilling and upskilling of current staff, as well as progressing new, innovative service delivery models and utilising evidence-based mental health and wellbeing enabling technologies to reframe and repurpose expert clinical resources.

There was some evidence that often unspent funding often contributes to breakeven and perhaps also to recurrent saving, whilst this is a feature of wider demand given the legacy of underfunding this can have a disproportionate impact on mental health service capacity. This serves to point out

the need to protect all mental health investment but to reconfigure its use in ways which optimises its value.

Mental Workforce Comparison Between 2022 and 2025

As noted above, there are some differences between the 2022 and 2025 baseline workforce data. However, this variation may be partly due to natural changes in the workforce and, importantly, improved data collection methods introduced during the 2025 rebasing exercise. In 2022, the estimated number of whole-time equivalent staff working in mental health was approximately *4,237, with a future workforce recommendation of 6,141 whole time equivalents resulting in an estimated shortfall of circa *2,363 posts. By contrast, the 2025 analysis identifies a workforce gap of circa *2,267 representing a small reduction of 96 posts compared to the 2022 figure. As previously discussed, this slight decrease is largely a result of enhanced data collection and more accurate reporting. The chart below summarises the differences in workforce gaps between 2022 and 2025, highlighting the main areas and professional categories where whole-time equivalent shortfalls persist. The workforce gap has increased in certain areas—such as associated psychology roles—



while it has decreased in others, notably in medical and nursing with modest fluctuations observed across additional roles.

The observed change in the nursing workforce profile is largely attributable to an increase in Band 5 posts. In contrast, the medical workforce analysis required a more detailed reassessment due to significant variation between the 2022 *Ernst & Young* Mental Health Workforce Review baseline and Trust-reported medical staffing positions in 2025. To address these discrepancies, a comprehensive validation exercise was undertaken to improve the accuracy and reliability of medical workforce data.

This validation process involved multiple engagements with Trusts, who were asked to resubmit updated data on filled and vacant medical posts within defined parameters. Trusts reported on consultant psychiatrists, specialty and associate specialist (SAS) doctors, and Trust-employed or locum doctors, while excluding NIMDTA resident doctor posts to ensure consistency. The scope was refined to include CAMHS, adult psychiatry, and psychiatry of older adults, with dementia psychiatry roles excluded. It was also agreed that approximately half of old-age psychiatrists would be counted within overall psychiatry numbers. These clarified parameters enabled a more robust and contemporary assessment of both workforce capacity and vacancy levels.

It is important to note that this approach does not directly replicate the 2022 methodology, which may have excluded Trust-employed doctors and a wider range of vacancies. Rather than retrospectively adjusting the 2022 estimates, this exercise provides an updated and more accurate picture of the current medical workforce position.

The differences between the 2022 and 2026 exercises reinforce the need to move towards clearly defined multidisciplinary workforce composition standards. Such standards would support more precise identification of required disciplines aligned to service demand, improve statutory compliance, enhance quality and safety, and better accommodate evolving models of care.

A detailed comparison of the October 2025 and April 2026 datasets identified a reduction in the reported medical workforce baseline from 321.9 WTE to 259.2 WTE. However, when 21.2 previously excluded posts are incorporated into the April data, the apparent psychiatry gap reduces from 93 WTE to 71.8 WTE. This recalibration, when assessed against the 2022 Ernst *& Young* recommended baseline of 203 WTE, the April 2026 position reflects a net increase in the count of funded medical post of 56.2 posts, adjusting the estimated medical gap from 128 WTE in 2022 to 72 WTE.

Overall, this exercise highlights the persistent and systemic challenges associated with medical workforce data capture. These challenges are multi-factorial: Trusts operate different directorate structures and service configurations; historic commissioning decisions and pilot initiatives have created uneven workforce profiles; and there is no single authoritative source of truth. These issues are further compounded by extensive reliance on temporary staffing models—such as trainees, clinical fellows, agency and Trust locums, and retire-and-return arrangements—which mask the fragility of the substantive workforce and undermine consistent core service delivery.

The current psychiatry vacancy rate of approximately 24%, combined with a limited supply of trained psychiatrists to fill funded posts, remains a critical risk. Importantly, funding for these posts already exists within HSC budgets. It would be misleading to interpret the revised figures as a reduction in ambition or commitment to medical workforce expansion; this is not the case.

Nevertheless, the 2025 prioritisation exercise ranked psychiatry as a high system priority, and expansion of the medical workforce therefore remains central to workforce planning. This validation exercise provides a clearer and more credible evidence base for decision-making.

Looking ahead, the Multi-Criteria Decision-Making Framework (MCDMF) and the development of Multidisciplinary team composition standards will be used to assess demand–capacity gaps within a wider system context, explicitly recognising the role of multidisciplinary supports. Pragmatically, regardless of precise baselines, a significant workforce gap remains, and it remains a key strategic ambition to reduce this gap as far as is realistically achievable.

Although time constraints prevented a more detailed breakdown of the factors driving these changes, the workforce data generated during 2025 will prove invaluable for regional mental health service planning leaders, professionals, and service delivery managers. This database will enable comprehensive analysis of role variations between Trusts, supporting a clearer understanding of how shifts in workforce gaps can inform service development priorities.

The establishment of this database will allow for a thorough analysis of role variations across different Trusts, providing clearer insight into how changes in workforce gaps can shape service development priorities. Furthermore, the 2025 dataset can provide a foundation for developing a minimum mental health workforce data set or dashboard. Such detailed analysis will help to pinpoint the specific factors driving workforce changes and ensure that workforce planning remains closely aligned with evolving service requirements. Leveraging workforce intelligence generated through the 2025 database will also assist in informing the development of multidisciplinary team

composition and the standardisation of teams. This is explored in greater detail in section 3 of this report.

Mental Health Workforce Cost Gap

Having identified the workforce gap for 2025, a baseline has been established to assess the fiscal implications of this shortfall. In costing the workforce, the Department of Health's 2025 workforce costs largely reflect the Agenda for Change pay scales, Medical Pay Scales, and Executive Pay Scales. Given that staff costs will inevitably fluctuate over the next ten years, it is crucial for financial gap analyses to be regularly updated to reflect changes in pay and pricing.

Exclusion of Additional and Oversubscribed Roles

In calculating the workforce gap and associated costs, approximately *430 additional posts not previously included in the 2022 baseline have been excluded in order to ensure comparative analysis. While these posts have been excluded to enable direct comparison with the 2022 baseline, these additional posts do not alter the overall recommendations detailed in 2022.

Crucially, many of these additional posts, are essential to the effective delivery of mental health services. Similarly, in nursing, the additional posts mainly involve bespoke positions, in physical health, health visiting, midwifery, substance misuse, specialist nurse leads, and nurse care coordinator roles. In social care, the added posts are predominantly senior professional leads and extra band 2 and 3 social care workers.

For mental health practitioners, the increase is mainly in band 6 practice roles. In management and administration, the additional posts chiefly comprise senior service manager roles, senior administrative staff, as well as medical and team secretaries. The 'other' category, comprising 71 posts, includes bespoke roles not previously classified, such as family therapy, substance misuse specialists, emotional health and wellbeing staff, patient flow and recovery facilitators, mental health locality managers, and various mental health training positions.

This 2025 rebasing exercise underscores the necessity for a centralised mental health workforce registry or dashboard, as well as the need to reach consensus on category definitions to ensure consistency of data collection across all service-providing organisations.

Ensuring Precise Comparison and Strategic Planning

To ensure the closest possible comparison with the professional role categories and cost assumptions established in the **2022 Mental Health Workforce Review**, the 2025 rebasing analysis

was modelled and aligned to the original role definitions and scope used in that review. This methodological approach was essential to enable analytical integrity of the workforce gap assessment.

During the 2025 rebasing exercise, improved workforce intelligence and more comprehensive Trust-level reporting identified **higher recorded counts in several roles**, particularly within **Band 5 nursing and in nursing support roles.** Consistent with the 2022 Review methodology, these increases are interpreted as a **data rebasing effect**—reflecting improved visibility and classification of posts—rather than evidence of surplus workforce capacity. In many cases, these roles existed in practice prior to 2022 but were either reported inconsistently or fell outside the defined scope of the original baseline.

For the purposes of calculating the workforce gap and associated costs, roles **that were not explicitly included within the 2022 Review's professional role baseline, or** where the 2025 rebased count exceeds the level assumed in the 2022 baseline—have been **neutral-weighted (set to zero) in the gap analysis**. This technical adjustment does not imply that these roles are unnecessary, excessive, or of lesser value. Rather, it is an intentional methodological control designed to:

- maintain **direct comparability** with the 2022 Review recommendations and projections.
- prevent **inflation or distortion of the aggregate workforce gap** that would arise from including roles not costed or modelled in the original review; and
- ensure that the resulting gap analysis continues to clearly surface **genuine deficits in clinical expertise, senior decision-making capacity, and advanced or specialist practice**, which remain structurally under-resourced across the system.

Including increased counts in roles that were not part of the 2022 baseline would risk obscuring critical shortages in priority professions. and could dilute the strategic signal required to guide future investment decisions. By holding these roles neutral within the gap calculation, the analysis preserves a clear line of sight between the **original workforce ambitions**, the **current rebased position**, and the **remaining unmet requirement**.

It is also important to emphasise that this neutral-weighting approach should not be interpreted as negating the importance of these roles. On the contrary, the increased visibility of these roles in the 2025 rebasing exercise instead creates opportunities for **workforce optimisation, skill-mix review, and service redesign**, which are more appropriately considered through integrated multidisciplinary workforce planning rather than through gap quantification.

Consistent with the 2022 Review's conclusions—and with the integrated planning framework set out in Section 3 of this report—any consideration of repurposing, upskilling, or redeploying these roles must be undertaken within a **system-wide multidisciplinary workforce planning framework**, informed by Chief Professional Officers and aligned to agreed service models and outcomes. This ensures that workforce decisions move beyond aggregate headcount comparisons towards **intentional, evidence-based deployment of skills**, supporting improved outcomes for people with mental health conditions and sustainable recovery across services.

Overview of the Estimated Workforce Gap and Indicative Funding Shortfall

Building on the data from the 2025 rebasing exercise, a comprehensive analysis was conducted to quantify both the current workforce gap and the corresponding financial shortfall required to address this gap. This process involved a detailed comparison across the professional categories outlined in the 2022 mental health workforce review and cross referencing these with the data generated from the 2025 re-basing data in order accurately estimate the funding gap and use this information to inform future funding bids for mental health services as required by recommendation two – to develop a costed plan to inform mental health services financial planning.

To ensure rigour and consistency, the workforce gap was systematically broken down by the same professional categories used in the 2022 review, enabling a clear and direct comparison of how the shortfall has evolved over time. The results are visually represented in the accompanying table, with the 'pink' column specifically highlighting the current core estimated gap in the workforce for each category.

This enabled the mapping of funding requirements across each professional category which provide a useful benchmark for the strategic planning and prioritisation of both resources and the workforce. This methodology ensures that future funding requests are grounded in robust data, thereby strengthening the case for investment and enabling the effective prioritisation of any new resources that may become available. In summary, the comparative analysis between 2022 and 2025 set out in the table below not only quantifies the evolving workforce gap but also clarifies the scale of investment required to address this gap and to respond to growing service demand.

2025 Estimated Workforce Gap and Associated Costs

Building on the data from the 2025 rebasing exercise, a comparative analysis was undertaken to quantify the current workforce shortfall and the associated financial pressures relative to the 2022 Mental Health Workforce Review baseline. By aligning the 2025 rebased workforce position with the

Workforce	Mental Health Review CAMHS and Adult Mental Health Workforce Gap 2022 (current - future)	Mental health Workforce 2025 Baseline Profile	Additional Posts Not Included in 2022 Baseline	2025 Workforce Position- (Excluding additional posts)	2022 Workforce Future Workforce Baseline Position	2025 Workforce Baseline Gap excluding addtional post	Change in Workforce Gap Between 2022-2025	Total of 2022-2025 Gap, where minuses within categories are zeroed	Funding Needed to Address Gap
Medical	128.0	259.2	0.0	259.2	331.0	71.8	56.2	71.8	£ 10,752,786.14
Nursing	525.9	1798.5	44.9	1753.6	1842.0	110.0	415.9	195.0	£ 14,386,546.00
Social Work	83.0	584.1	3.0	581.1	663.1	82.0	1.0	83.6	£ 5,051,495.16
Clinical Psychology	128.0	147.8	18.5	129.3	245.9	116.7	11.4	116.7	£ 9,657,283.61
CAMHS/Adult Psychotherapy *	36.6	9.5	0.0	9.5	38.9	29.4	7.2	29.4	£ 2,737,383.58
Trainee CAMHS/Adult Psychotherapy (band 6*	4.4	0.0	0.0	0.0	4.4	4.4	0.0	4.4	£ 263,800.52
CBT Psychotherapy	57.0	37.6	0.0	37.6	73.0	35.4	21.6	35.1	£ 2,594,645.31
Counsellors	1.0	27.7	6.0	21.7	52.4	30.7	-29.7	30.7	£ 2,272,966.52
Pharmacy	152.0	19.1	0.0	19.1	153.9	135.0	17.0	135.8	£ 9,902,669.04
AHP-Occupational Therapy	148.0	182.4	2.0	180.4	306.7	126.3	21.7	126.3	£ 8,751,895.39
AHP -Physio-Therapy	72.0	5.6	0.0	5.6	78.6	73.0	-1.0	73.5	£ 4,932,553.29
AHP -Speech and Language	68.0	3.1	0.0	3.1	96.1	93.0	-25.0	94.0	£ 6,257,176.19
AHP -Dietetics	70.0	16.4	0.8	15.6	77.5	61.9	8.1	61.9	£ 4,444,029.02
AHP Art/Music/Drama	98.0	2.0	1.0	1.0	100.0	99.0	-1.0	99.3	£ 7,272,301.77
Mental Health Practitioner Roles	150.0	62.4	40.2	22.2	202.0	180.0	-30.0	179.8	£ 13,304,772.76
Physician Associate	0.0	2.9	0.0	2.9	1.0	0.0	0.0	0.0	£ -
Peer Support	53.0	18.3	14.3	4.0	53.0	49.0	4.0	49.7	£ 2,437,593.97
Support - Nursing	0.0	516.8	0.0	516.8	343.0	0.0	0.0	0.0	£ -
Support - Social care	25.0	242.5	127.6	115.0	224.0	109.1	-84.1	155.9	£ 6,876,676.52
Support Pharmacy	7.8	0.0	0.0	0.0	7.8	7.8	0.0	7.8	£ 281,023.56
Support - Psychology Associate	79.0	25.3	13.0	12.3	92.0	79.7	-0.7	79.8	£ 3,911,921.43
Support - Occupation Therapy	0.0	20.8	1.8	19.0	10.0	0.0	0.0	0.0	£ -
Support - Physiotherapy	10.6	0.4	0.0	0.4	11.0	10.8	-0.2	10.8	£ 476,291.33
Support Speech and language Therapy	5.0	0.0	0.0	0.0	5.2	5.2	-0.2	5.2	£ 229,325.45
Support- Assistant Practitioners	99.0	0.0	0.0	0.0	230.0	230.0	-131.0	230.0	£ 9,877,739.74
Support Independent Advocate	0.0	0.0	0.0	0.0	2.0	2.0	-2.0	2.0	£ 148,011.71
Support Transition Worker	5.0	0.0	0.0	0.0	5.0	5.0	0.0	5.0	£ 370,029.28
Admin and Management	357.0	627.4	78.2	549.2	890.0	340.8	16.2	383.2	£ 23,413,062.54
Others Additional Posts not Included in 2022 baseline	0.0	70.6	70.6	0.0	0.0	0.0	0.0	0.0	£ -
Total	*2363.3*	*4680.34*	421.8	*4259*	*6140*	*2088*	275.5	2266.6	*£ 150,603,979.82*

original professional categories and recommended staffing levels set out in 2022, the table below provides an estimate of the remaining workforce gap and the recurrent investment required to address it. This comparative approach enables a clearer assessment of how far the system has progressed, where structural shortfalls persist, and the scale of the cost gap that must be considered in future workforce and financial planning.

It important to point out a correction to Speech and Language Therapy Workforce. The apparent reduction in the speech and language therapy workforce between 2022 and 2025 reflects a data reconciliation issue rather than an actual contraction in workforce capacity. The 2022 Workforce Review indicated 28 posts in post; however, validation undertaken as part of the 2025 rebasing exercise confirmed that there are only 3 substantive posts. This discrepancy is attributable to data calculation and categorisation errors in the 2022 baseline rather than a reduction in funded or delivered services. The rebased 2025 position means the gap is not, as previously reported, 68 but 94. This now provides a more accurate representation of the true workforce baseline for planning and comparative analysis purposes.

Following the exclusion of additional posts identified through the 2025 rebasing exercise to ensure consistency with the 2022 baseline, the projected mental health workforce shortfall in 2025 remains substantial, at approximately ***2,267 whole-time equivalent posts**. Based on current pay assumptions and the workforce projections set out in the Mental Health Workforce Review, this gap equates to an estimated **recurrent funding requirement of approximately *£150 million**. This headline figure illustrates the scale of additional investment required to align workforce capacity with current and anticipated service need.

However, it is important to recognise that this estimate is **conservative** and does not fully capture several material cost drivers that affect the operational sustainability of the workforce. In particular, the modelling does not account for the impact of workforce absence, including maternity leave, sickness absence, and other temporary reductions in capacity. Given the demographic profile of the workforce—predominantly female and relatively young—these factors have a demonstrable operational impact. In practice, mitigating this impact may require the application of an additional staffing “quotient”, for example through planned over-recruitment, to maintain safe and effective service delivery. Any such adjustment would increase the overall revenue requirement beyond the £150 million estimate.

In addition to revenue implications, workforce expansion of this scale carries **significant capital and infrastructure consequences** that are not reflected in the above costings. Additional staff will

require appropriate accommodation, clinical and non-clinical space, digital infrastructure, and supporting facilities. Existing estate pressures across mental health services mean that additional capital investment is likely to be necessary to enable workforce growth at scale.

There are, however, opportunities to **mitigate some infrastructure pressures through service and workforce redesign**. Alternative models of working—such as extended service hours (e.g. 8am–10pm provision, six-day working) and more flexible use of estate—could reduce peak-time space requirements while also improving service accessibility and choice. Such models may support wider system objectives, including enabling service users to maintain employment and social participation, which are themselves protective factors for mental health and wellbeing.

Taken together, these considerations highlight that while the £150 million estimate provides a necessary revenue baseline for financial planning, **it should not be interpreted as a comprehensive estimate of the full system cost** associated with addressing the workforce gap. A realistic investment strategy will need to take account of absence cover, infrastructure requirements, and the adoption of new models of working alongside straightforward growth in staff numbers.

Annual Investment and Recruitment Requirements

To bridge the gap between current and projected workforce requirements, as identified earlier report, would requires an **additional £15 million recurrent investment in year one, with a further £15 million added to the baseline in each subsequent year**, resulting in a cumulative investment of approximately **£150 million over ten years**. In terms of staffing, this equates to recruiting at least *227 additional posts each year. When combined with the current *730 vacancies, this equates to almost *300 posts needing recruitment annually for each year of the next decade.

Challenges with Current Workforce Planning Models

The scale of the gap cannot be effectively addressed using the existing workforce planning model or current commissioned undergraduate and postgraduate training places. Crucially, the disconnect between service planning and workforce planning complicates the prioritisation of key roles. Given the competing priorities across multiple mental health service areas, rising demand, and resource constraints, it will be increasingly challenging to focus investment without a strategic, integrated, multi-professional workforce planning model. Such a model would enable effective prioritisation of both existing and future investment. While there is broad consensus on the importance of multi-disciplinary workforce planning, there is a clear need to develop integrated mechanisms that bring

together service planning and delivery, workforce planning, and professional leadership across organisations.

3.3 Section 1: Priorities For Action

Action 1 – Develop a Strategic Plan to Address Vacancies and Optimise Funding

Develop a system-wide strategy to tackle the high level of vacancies, especially within specialist and clinical roles. This should involve making optimal use of existing funding, redirecting underspends to facilitate the upskilling of current staff, and introducing innovative service delivery models.

Action 2 – Transition to a Phased, Multi-Year Planning Model

Establish new mechanisms to move away from the traditional annual planning framework by adopting a phased, multi-year approach.

Action 3 – Integrate Service and Workforce Planning into a Unified Framework

Bridge the structural gap between service delivery and workforce planning by creating an integrated, multidisciplinary decision-making model. This unified framework will facilitate the prioritisation of essential roles and services, optimise resource allocation, and ensure workforce development is aligned with changing population needs and policy objectives.

Action 4 – Establish a Centralised Mental Health Workforce Register or Dashboard

Develop and implement systems capable of consolidating and standardising workforce data across all mental health sectors. A centralised register or dashboard will support enhanced monitoring, consistent data collection, and more effective workforce planning.

4. Section 2: Determining Mental Health Workforce and Service Priorities

Section 2: Workforce and Service Prioritisation: - Identifies the key workforce roles and service areas requiring focused investment and immediate action. It sets out priority areas to stabilise services, address critical staffing gaps, to enable resources to be directed to areas of greatest need and impact.

Section Two: - Determining Workforce and Services Priorities

Recommendation Two: Phased Prioritisation of Mental Health Services

Recommendation two of the Mental Health Workforce Review report highlights the necessity for a phased approach to prioritising services as part of implementing workforce requirements. This approach should include a structured plan for recruiting key roles and additional team members progressively over the next decade.

Current Challenges in Services and Workforce Prioritisation

Upon review and discussion of potential strategies for effective prioritisation, it became clear that mental health services currently lack an agreed set of prioritisation criteria and a unified mechanism to systematically integrate service planning with workforce planning. At present there is no standardised model for multidisciplinary team composition across the breadth of mental health services and their subspecialties, limiting the ability to identify and prioritise key roles effectively. This absence contributes to fragmented service development and inconsistency in clinical team configurations. In addition, the lack of integrated planning across the life course and between service boundaries further compounds these challenges, reinforcing variability and reducing overall system coherence.

Risks Associated with Uncoordinated Workforce Movements

It is important to emphasise that these observations are not intended as criticism. However, without a coordinated approach, there is a risk that workforce resources may shift from one service area to another in an unplanned manner, potentially undermining the stability and effective delivery of services. Although this is a complex issue, it is evident that the current level of vacancies is partly attributable to the movement of staff from one area of mental health practice to another. Such shifts are often driven by opportunities for career progression and may, in some cases, highlight unnecessary movements within the workforce that could have been avoided.

Balancing Specialisms and Core Service Capacity

This is a result of not developing or expanding both the capacity and capability of core mental health service provision.

Whilst there is good reason to develop bespoke specialities in response to unmet need, this can often be at the expense of core mental health service provision. This does not mean that developing specialisms is not important; however, what it does signify is the urgent need to increase the specialisms within core services and develop the capacity to respond to a greater range of need, enabled by having the right multidisciplinary mix within team structures. While the creation of bespoke specialties is a valid response to unmet needs, it frequently comes at the expense of weakening core mental health services. This is not to suggest that developing specialisms lacks value; rather, it highlights the urgent need to enhance specialisations within core services. By strengthening the multidisciplinary composition of teams, core services will be better equipped to address a broader spectrum of needs, ensuring a more responsive and effective mental health system.

Stakeholder Feedback and the Need for System-Wide Planning

Feedback from stakeholders underscored the need for a comprehensive, system-wide approach to workforce planning—one that bridges primary, community, and specialist mental health care. In light of these considerations, it was agreed that a robust, integrated mechanism for multidisciplinary service and workforce planning must be developed. Such a mechanism will enable effective prioritisation of services and ensure that workforce planning is closely aligned with service needs. This alignment is crucial to delivering the right services, in the right places, with the right people and skills, as envisioned in the mental health strategy.

Establishing a Regional Mental Health Service System

The establishment of a Regional Mental Health Service system and the formation of a Collaborative Board present a significant opportunity to accelerate the development and implementation of a systematic service and workforce planning model across all aspects of mental health provision. Section Three of this document will explore this model in greater detail.

Interim Approach: Immediate Priorities and Longer-Term Strategy

In the interim, before the full implementation of an integrated workforce and service planning framework, a phased approach has been adopted. This pragmatic strategy enabled the identification of immediate workforce priorities over the next one to three years, while simultaneously supporting the development and rollout of a comprehensive, system-wide framework to integrate mental health

services and workforce planning. The specifics of this forthcoming framework are discussed in Section Three of this document.

Trust-Led Identification of Workforce and Service Priorities

As part of this pragmatic approach, each Health and Social Care (HSC) Trust was asked to use its expertise and understanding of current pressures—along with consideration of the transformation required over the next one to three years—to identify its top five workforce priorities and top five service priorities.

It is important to note that while these identified priorities provide an initial focus and guiding direction, they are not intended to exclude the development of other critical workforce areas highlighted in the Mental Health Workforce Review. Nor do they diminish the need to create a comprehensive suite of modern mental health care services, particularly those targeting unmet needs.

Rather, this initial prioritisation serves as a stepping stone, helping to lay the groundwork for the development of transformative systems and processes. Ultimately, the goal, as detailed in the Mental Health Strategy and as reinforced by both the Mental Health Collaborative Board and Reset agenda, is to establish a modern, fit-for-purpose mental health care service with the appropriate structure and multidisciplinary team composition to deliver safe and effective care for the people of Northern Ireland.

Collective Analysis and Next Steps

The analysis presented below provides an overview of collective perspectives of the five HSC Trusts and each of the Chief Professional Officers within the Department of Health.

Overview of Mental Health Workforce Short-Term Priorities

To identify the professions and roles requiring the most urgent attention, each HSC Trust, along with the Chief Professional Officers, undertook a comprehensive review of the professional roles set out in Section 1 of this document. This review was twofold: firstly, it involved evaluating and ranking the recommended roles based on current service and workforce pressures; secondly, it considered which roles have the greatest potential to drive innovation and support the development of more effective models of care. By maintaining this dual focus—addressing immediate operational

challenges whilst also enabling the strategic evolution of service delivery—Trusts and Chief Professional Officers ensured that their prioritisation decisions were both responsive to present needs and aligned with future ambitions. This approach facilitates the immediate prioritisation of workforce needs, whilst also strengthening the multidisciplinary impact through forward-thinking planning.

Collaborative Prioritisation Process and Its Challenges

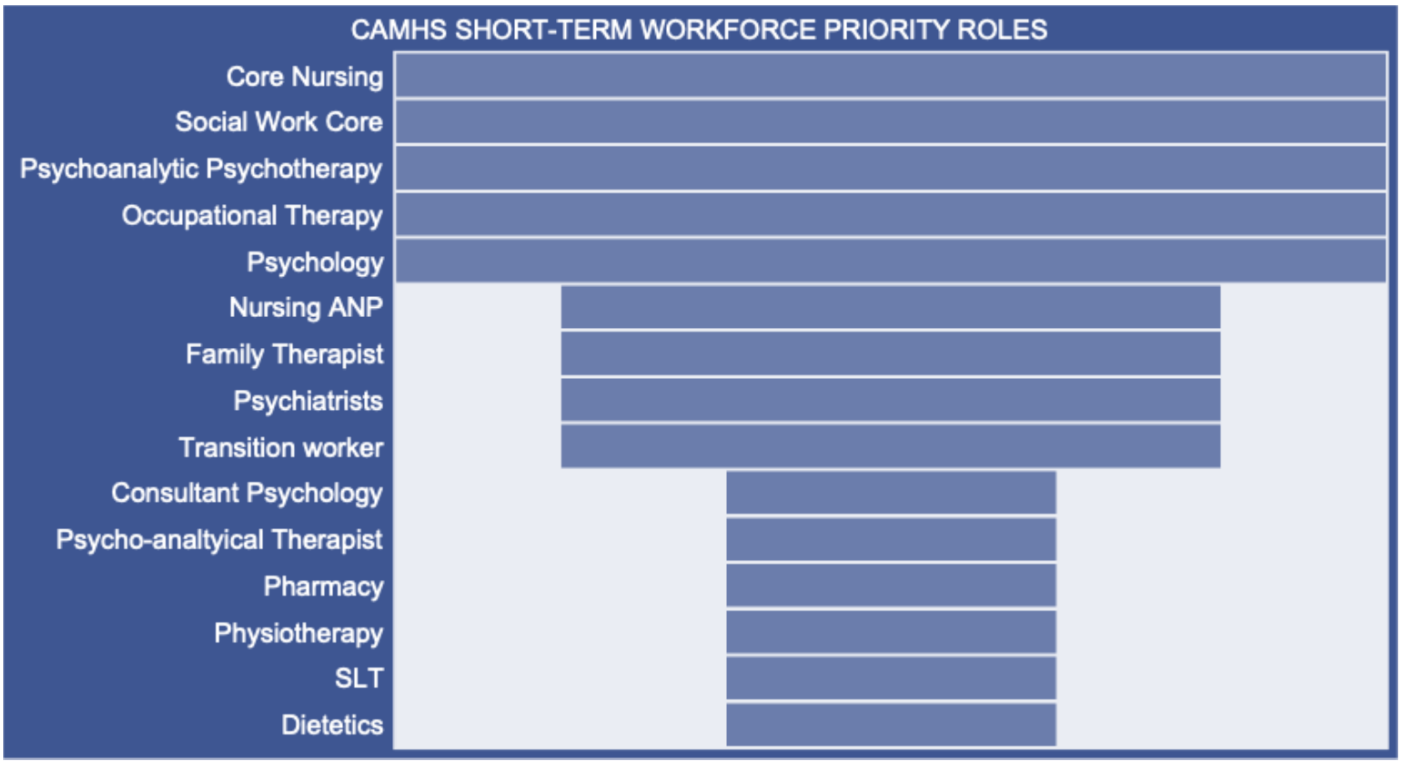
The summary below presents the key findings from this collaborative prioritisation exercise. The process was inherently complex, primarily due to the absence of a robust multidisciplinary team (MDT) workforce planning framework within mental health services. This lack of an established framework contributed to inconsistencies, including the underrepresentation of various professions in the co-design of mental health services. Additionally, the varied, and sometimes conflicting, needs of different professional groups across mental health services further complicated the prioritisation process.

Despite these challenges, the Trusts and Chief Professional Officers adopted a structured methodology that enabled them to identify and rank their top five workforce priority roles. This approach facilitated the pragmatic rankings of professional roles, culminating in the following funnel charts, which illustrate the professional roles most frequently prioritised across all five Trusts. These visual representations offer an accessible overview of the most commonly recurring workforce priorities, helping to inform future strategic decisions.

It is important to note there are prioritisation nuances between individual Trust rankings, largely reflecting differences in local workforce needs. However, the funnel charts establish a broad consensus regarding priority roles, subject to the availability of new funding or the repurposing of existing resources. This consensus provides a strong foundation for targeted workforce development, enabling mental health services to address pressing needs and support the delivery of high-quality, multidisciplinary care.

Overview of Health and Social Care Trusts Child and Adolescent Mental Health Workforce Priorities

Identified CAMHS Workforce Priorities



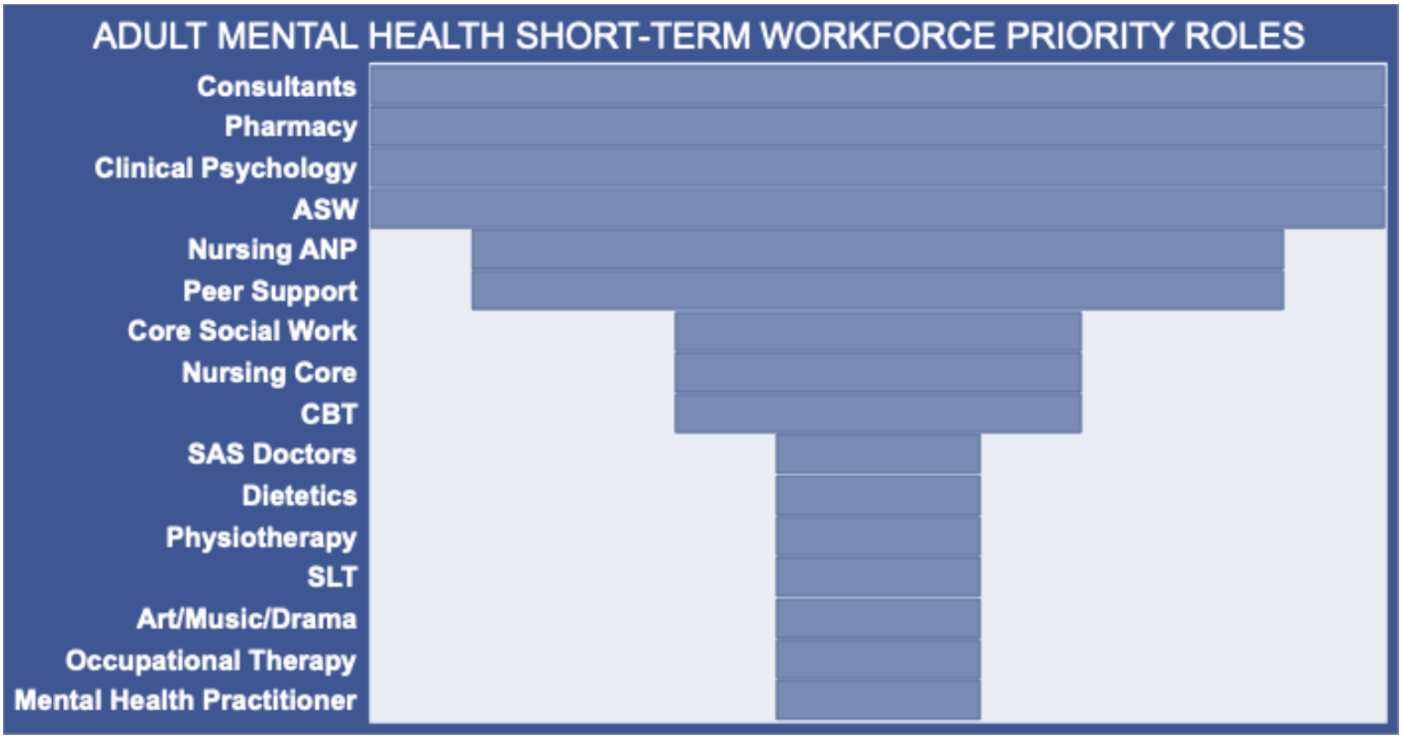
The funnel chart above illustrates the principal workforce priorities identified by Health and Social Care (HSC) Trusts in relation to Child and Adolescent Mental Health Services (CAMHS). Nursing, social work, psychotherapy, occupational therapy, and clinical psychology are consistently identified as the highest priorities. This collective emphasis reflects the urgent need to expand capacity within CAMHS, particularly to address growing demand, reduce waiting times, and respond to the significant underrepresentation of psychotherapy within the current workforce. In parallel, there is a clear requirement to strengthen the breadth and integration of multi-modal therapeutic interventions, with clinical psychology playing a central role in enhancing the range and effectiveness of care provided.

As second-level priorities, Trusts identified Advanced Nurse Practitioners and Consultant Psychiatrists, emphasising their importance in managing higher acuity cases and enhancing the provision of systemic family therapy. At the third tier, roles such as Consultant Clinical psychologists, Psychoanalytical Psychotherapist, Pharmacists, Speech and Language Therapists, and Dietitians were highlighted for their clinical expertise and contributions to comprehensive care.

The rationale for prioritising these professional roles in CAMHS is clear: delivering high-quality, holistic mental health care for children and adolescents requires a robust multidisciplinary team. Each role brings specialised expertise essential for assessment, intervention, and holistic care planning. By reinforcing these teams, services can more effectively reduce waiting lists, ensure timely access to care, and manage complex cases such as eating disorders, neurodevelopmental conditions, and improve transitions to adult services.

Sustained investment in training, supervision, and clear career pathways is crucial to building a resilient workforce, supporting staff retention, and maintaining service excellence. Ultimately, prioritising these roles addresses rising demand, improves outcomes for young people and families, and ensures service sustainability in alignment with best-practice guidelines.

4.1 Health and Social Care Trust Adult Mental Health Services Workforce Priorities



The funnel chart above highlights the principal workforce priorities identified by Health and Social Care (HSC) Trusts for adult mental health services.

Tier 1: Highest Priorities

Consultant Psychiatrists: The prioritisation of Consultant Psychiatrists is consistently identified as the foremost workforce need. This reflects persistent challenges in recruitment,

training, and retention, as well as the increasing responsibilities introduced by the Mental Capacity Act and the rising complexity and demand for mental health services. This necessitates the development of a strategic action (system-wide) to address vacancies in Consultant Psychiatrist posts, with a particular focus on Trusts experiencing the most significant shortages. Targeted recruitment in these areas is essential for levelling up services, reducing unwarranted variation, and promoting greater stability across the region. This approach supports the standardisation of multidisciplinary teams (MDTs) within all mental health services.

Pharmacy Services: Pharmacy was identified as a compelling priority due to its underrepresentation within mental health teams. Enhanced pharmacy input enables personalised pharmacological interventions and mitigates the risks associated with polypharmacy.

Research evidences the significant and multifaceted role pharmacy plays in mental health care. A systematic review by Finley et al. (2019) demonstrated that pharmacist-led medication reviews in psychiatric settings can reduce medication-related problems and improve therapeutic outcomes for patients with severe mental illness. The study highlighted pharmacists' contributions to optimising medication regimens, reducing adverse drug events, and supporting safer prescribing practices—particularly important in the context of complex polypharmacy often encountered in mental health populations. [Finley, P. R., Crismon, M. L., & Rush, A. J. (2019). Evaluating the impact of pharmacists in mental health: A systematic review. Psychiatric Services, 70(10), 902-909.]

Further evidence from the Royal Pharmaceutical Society (RPS) underscores the value of clinical pharmacists in multidisciplinary mental health teams. Their report "The Role of Pharmacy in Mental Health" (RPS, 2021) outlines how pharmacists improve medicines safety, provide expertise in psychotropic drug management, and deliver patient-centred care through medication counselling and adherence support. The RPS also notes that pharmacists are instrumental in addressing physical health comorbidities, which are prevalent in people living with mental illness. [Royal Pharmaceutical Society, 2021. The Role of Pharmacy in Mental Health.]

Additionally, a study by Bingham et al. (2022) found that integrating pharmacists into community mental health teams led to a reduction in prescribing errors and improved patient satisfaction, with pharmacists acting as accessible sources of medication advice and

facilitating communication between service users and prescribers. [Bingham, J., Mathers, N., & McGregor, F. (2022). Impact of pharmacist integration into community mental health teams. International Journal of Clinical Pharmacy, 44(1), 89-97.]

Collectively, these studies provide robust evidence that pharmacy services are critical to high-quality, safe, and holistic mental health care, supporting the rationale for their prioritisation within multidisciplinary teams. Therefore, investment in pharmacy expertise improves patient safety, optimises medication management, and alleviates pressure on psychiatrists and nursing staff.

Clinical Psychology: Regarded as an urgent priority across all mental health teams, including acute inpatient services. Expanding psychological leadership and access to evidence-based therapies ensures alignment with NICE guidance, reduces waiting lists, and supports measurable improvements in clinical outcomes.

There is robust evidence demonstrating that clinical psychology interventions improve outcomes in mental health care and contribute to safer, more sustainable recovery. Extensive systematic reviews found that the multi-modal approach by clinical psychologists is highly effective in reducing the severity of mental health symptoms, leading to better clinical outcomes and lower relapse rates. This aligns with NICE guidance, which recommends evidence-based psychological therapies as a first-line intervention for a range of mental health conditions.

Clinical psychologists also play a key role in multidisciplinary teams by providing leadership in assessment, formulation, and intervention planning, which enhances team decision-making and supports recovery-focused care. A study by Johnstone et al. (2015) highlighted that integrating clinical psychologists into acute inpatient settings led to more person-centred care, improved therapeutic environments, and better long-term recovery outcomes for service users, including reduced rates of readmission and improved quality of life.

Approved Social Workers (ASWs): ASWs were also identified as a fundamental workforce gap, given the requirements of the Mental Health Order, Adult Safeguarding, and Mental Capacity Act.

Tier 2: Secondary Priorities

Advanced Nurse Practitioners (ANPs): Advanced Nurse Practitioners (ANPs) are increasingly recognised as pivotal members of multidisciplinary mental health teams, both in inpatient and community settings. Their advanced clinical skills, including assessment, diagnosis, treatment planning, and non-medical prescribing, enable them to provide integrated care for service users with complex mental and physical health needs.

Research consistently demonstrates that ANPs improve access to timely care, reduce waiting times, and provide continuity for service users, particularly in augmenting the role of consultant psychiatrists. Their ability to independently manage caseloads and make autonomous clinical decisions improves the safety, efficiency, and flow of people through mental health care services. Studies have also shown that ANPs deliver care that is comparable to, and in some cases exceeds, that provided by other healthcare professionals in terms of patient satisfaction, safety, and clinical outcomes. ANPs are associated with improvements in symptom management, reduced hospital admissions, and enhanced support for recovery-oriented approaches in mental health.

A systematic review by Delaney and Robinson (2015) found that ANPs in mental health settings contributed to reductions in relapse rates and readmissions, as well as improved therapeutic relationships and patient engagement. The integration of ANPs aligns with wider workforce transformation initiatives in mental health, supporting more efficient use of specialist skills across teams. Evidence from service evaluations in the UK and Ireland suggests that ANPs enhance multidisciplinary team functioning, increase service capacity, and foster innovation through leadership and advanced practice roles.

In summary, the evidence base strongly supports the prioritisation of Advanced Nurse Practitioners within mental health services. Their advanced clinical skills, prescribing authority, and holistic approach make them essential for bridging workforce gaps, improving access, and delivering high-quality, person-centred care that meets the complex needs of service users.

Peer Support Workers: A growing body of research demonstrates that prioritising peer support roles in mental health services leads to improved outcomes and facilitates sustainable recovery for service users. Systematic reviews and meta-analyses consistently report that peer support interventions are associated with a range of positive impacts,

including increased hope, helping to normalise recovery and offering practical strategies for managing symptoms and setbacks, as well as reductions in hospital admissions and relapse rates. Repper and Carter (2011).

Their presence within multidisciplinary teams enables the development of recovery communities, which is essential in building resilient recovery-oriented communities/neighbourhoods. The National Institute for Health and Care Excellence (NICE) acknowledges the value of peer support in its guidelines, recommending that peer support be included as a component of comprehensive mental health care, particularly for individuals with severe and enduring mental health conditions. NICE highlights that peer support contributes to more person-centred care, helps individuals develop coping skills, and supports long-term recovery.

Tier 3: Key Priorities

Strengthening the roles of core nursing and social work is critical for enhancing the stability and effectiveness of mental health services. In particular, Band 6 and Band 7 posts in nursing and social work were highlighted as essential to this aim. Senior clinical decision-makers, such as specialist nurse practitioners and experienced social workers, bring significant benefits to mental health care. Their expertise supports improved clinical outcomes, reduces waiting lists, and increases overall service capacity. Furthermore, these senior roles are pivotal in effective risk management and effective case management.

Within this tier, there was a clear call to prioritise and increase the number of cognitive behavioural therapists. This is considered fundamental to effectively reducing psychological therapy waiting lists and ensuring timely access to care for those in need. Moreover, expanding the role of cognitive behavioural therapy (CBT) across various mental health services is not only essential for alleviating service bottlenecks but also for enhancing the overall quality and consistency of psychological interventions. By integrating CBT and other therapeutic modalities more broadly—beyond discreet psychological therapy settings—upskilling the existing workforce has the potential to address a wider spectrum of needs and deliver better outcomes.

Tier 4: Key Priorities

Allied Health Professional Roles in Mental Health

Occupational Therapy, Physiotherapy, Dietetics, and Speech and Language Therapy

The cluster of other roles identified includes Occupational Therapist, Physiotherapy, Art, Music and Drama, Speech and Language Therapy, and Mental Health practitioner roles in primary care. Among the top five priority roles, occupational therapy, dietetics, speech and language therapy, and physiotherapy stand out as key areas for development, particularly in relation to addressing service gaps and ensuring equitable access across all Trusts.

There is a clear need to strengthen the presence of occupational therapists—especially in teams and settings where their input is currently limited, such as in subspecialties like substance misuse, eating disorders, and Child and Adolescent Mental Health Services (CAMHS). By enhancing occupational therapy provision, services can significantly reduce waiting times for essential therapeutic interventions.

Furthermore, increased access to occupational therapy supports sustained recovery for service users by addressing both immediate and long-term rehabilitative needs. This targeted investment not only levels up service provision across the region but also ensures that specialist expertise is available to those who need it most, contributing to better outcomes and a more resilient mental health care system overall.

Creative Therapies: Art, Music, and Drama

There was also recognition of the importance of art, music, and drama therapy in mental health care. There is a clear and growing recognition of the need to advance the role of art, music, and drama therapies within mental health care. The integration of these creative therapeutic modalities warrants careful consideration and, indeed, prioritisation in any comprehensive review of psychological interventions. This is especially pertinent given the robust evidence supporting their effectiveness. Research consistently demonstrates that art, music, and drama therapies not only alleviate a wide range of mental health symptoms but also play a significant role in promoting sustainable recovery. These therapies offer alternative pathways for expression and processing of complex emotions, particularly for individuals who may not engage fully with traditional verbal therapies.

By harnessing creative expression, these interventions facilitate cognitive and emotional reprocessing, foster resilience, and contribute to improved overall well-being. Prioritising the

inclusion of art, music, and drama therapies as core components of psychological care will ensure that mental health services are both evidence-based and responsive to the diverse needs of service users, ultimately enhancing recovery outcomes and quality of life.

Mental Health Practitioner Role

Finally, within this cluster, there was clear recognition of the critical need to further develop the mental health practitioner role within primary care settings. Strengthening this role is essential for expanding access to early intervention and supporting the delivery of mental health care at the community/neighbourhood level. However, it is equally important to acknowledge that effective workforce planning must ensure robust integration between community and primary care services. Without a coordinated approach, there is a significant risk of fragmentation, duplication of effort, and instability in service provision. Therefore, the development of mental health practitioner roles in primary care should be strategically aligned with comprehensive workforce planning across both sectors. This integrated approach will maximise resource utilisation, enhance continuity of care, and ultimately improve outcomes for service users by ensuring that care is delivered seamlessly across the entire mental health system.

Conclusion: Strategic and Flexible Prioritisation

In summary, the prioritisation of these roles should not be viewed as rigid or exhaustive, but rather as a strategic response to the dual imperatives of stabilising existing services and driving meaningful transformation within the adult mental health system. These workforce priorities reflect a clear and urgent need to enhance safety, expand service capacity, and address the escalating complexity and demand faced by mental health services. Crucially, this approach recognises the necessity for robust professional support and the importance of managing workloads to ensure that neither the safety of service users nor the quality of care is compromised. By balancing immediate system pressures with longer-term service development, these priorities lay the groundwork for a resilient, responsive, and high-quality mental health workforce capable of meeting both current and future needs.

4.2 Chief Professional Officers Mental Health Identified Workforce Priorities

Background and Review Process

Chief Professional Officers (CPOs) from each discipline were tasked with reviewing the 2022 workforce recommendations for their respective professions. The primary aim was to identify key roles that should be prioritised for immediate progression—subject to the availability of additional funding and/or the optimal use of any underutilised resources.

Systemic and Integrated Approach

Importantly, there was a shared recognition of the necessity for a systemic and integrated approach to mental health service development and workforce planning. Any priorities identified were therefore considered within this wider strategic context.

Summary of Priorities

The tables below present a summary of each Chief Professional Officer's/Profession Leads perspective on their specific workforce priorities. These priorities were developed through multiple discussions and were shaped by various influencing factors, including professional requirements, immediate service needs, therapeutic gaps, and workforce shortages.

Chief Professional Officer – (Medical) Mental Health Indicative Workforce Priorities

Urgent Need to Address Consultant Psychiatrist Vacancies

The Senior Medical Officer (SMO) for Mental Health and Learning Disability underscored the urgent need to address consultant psychiatrist vacancies. The SMO emphasised that vacancies should be filled in a targeted manner to facilitate the 'levelling up' of those trusts with the greatest deficits. This approach will help stabilise services, reduce variation, and promote standardisation of multidisciplinary team working across all mental health services.

Fill Current 74 Consultant on a targeted basis to facilitate 'levelling up' of those Trusts with the greatest deficits.

Progress the Recruitment of 1/3 of Psychiatrist Posts. This includes expanding both core and higher training posts for resident doctors, with an appropriate spread of across mental health services and sub-specialism - 10-15 New Posts

Plan and recruit approximately one third of the total posts for Specialty, Associate Specialist, Doctors Equating 22 WTE.

Invest in Postgraduate clinical leadership training including providing backfill for clinical duties, to enable medical staff to meaningfully contribute to service design, service improvement and clinical governance.

Address and Improve Workforce Interfaces/Competing demands - Expansion of the psychiatry workforce needs to include those roles required to support other regional service developments including the next phase of MCA implementation, ADHD, dementia services, intellectual disability, neurology review, academia and the Judiciary

Expansion of Training Posts and Specialisms

Achieving this will require significant and sustained expansion of core and higher training posts for resident doctors, with an appropriate distribution of specialisms and endorsements to meet current needs—namely General Adult Psychiatry, Psychiatry of Old Age (functional aspects), CAMHS, Forensics, Addictions, Rehabilitation, and Psychotherapy. Prioritising consultant recruitment is essential for providing leadership in team development.

The Role of Consultants in Service Development

Additional consultants are a core requirement for each mental health team. Consultants are also fundamental to delivering training, supervision, and support for the development of the rest of the medical workforce and, potentially, the wider multidisciplinary team. Expansion of other grades and disciplines would not be feasible without first increasing consultant numbers. Investment in new MDT models of working will create cohesive teams, which will be crucial across hospital and community services to enable medical staff to work to their strengths. This will include senior pharmacy input and Advanced Nurse Practitioners. Overall, the SMO recommends planning for at least one third of the recommended consultant posts and Specialty/Specialist Doctor roles.

Training Expansion to Address Gaps

The primary priority is to expand postgraduate training to fill current gaps, with targeted recruitment to support trusts with the greatest deficits. This approach aims to stabilise services, reduce regional variation, and promote standardisation of multidisciplinary team working. A sustained increase in core and higher training posts—across specialities such as General Adult Psychiatry, Psychiatry of Old Age, CAMHS, Forensics, Addictions, Rehabilitation, and Psychotherapy is critical for the patient safety, and the stabilisation of the psychiatry and wider mental health workforce. Additionally enhanced exposure to mental health during undergraduate training will support recruitment into expanded resident doctor training schemes, without necessitating an overall increase in medical student numbers.

Wider Workforce Planning and Leadership Roles

Beyond direct service provision, the SMO highlighted the need to re-establish MH rehabilitation services, enabling people with complex, enduring mental health needs to access evidence-based interventions that reduce disability, morbidity and mortality. Workforce planning must also account for broader roles in clinical leadership, service development (e.g., neurology, learning disability, dementia strategies), implementation of legislation (such as the Mental Capacity Act), academia, and the judiciary. Funding responsibilities for these roles—particularly for training posts and for support of non-traditional pathways (Portfolio Pathways)—require clarification as part of medical workforce planning.

Chief Professional Officer –(Pharmacy) Mental Health Indicative Workforce Priorities

The Essential Role of Pharmacists in Mental Health Care

The Chief Pharmaceutical Officer and regional pharmacy leads underscored the vital contribution of pharmacists for ensuring safe, effective, and tailored medication management and medication optimisation in mental health care. Pharmacists are uniquely placed to address the risks of polypharmacy, oversee medicine surveillance and adherence, and promote non-medical prescribing within mental health services.

Findings from Recent Workforce Reviews

Pharmacists are currently under-represented in multidisciplinary mental health teams in Northern Ireland. Tackling this gap is a key priority and is consistent with the broader workforce development aims of the Chief Professional Officers and Trusts. The 2022 workforce review highlighted a low starting point for Mental Health Pharmacy Services, as pharmacy was only included as an appendix and not fully considered in the original workforce review. Moreover, the 2023/24 published funding plan (August 2023, Action 18) confirmed that funding has not yet been allocated for a 1.0 WTE Band 7 pharmacist per HSC Trust from the main Mental Health Workforce Review (MHWFR).

Stabilising and Expanding Pharmacy as a Core Discipline in Mental Health Services

Mental health pharmacy services across Health and Social Care (HSC) Trusts in Northern Ireland remain at an early stage of development, having evolved from a comparatively small baseline. Nevertheless, all Trusts have collectively contributed to a regionally agreed Mental Health Pharmacy Workforce Plan, developed as part of the addendum to the Mental Health Strategy Workforce Review and completed in 2021. This plan provides the strategic direction for the progressive development of mental health pharmacy practice and is scheduled for formal review to ensure continued alignment with system priorities and emerging service need.

Recognising both the scale of unmet clinical need and the continued underrepresentation of pharmacy within multidisciplinary mental health teams, HSC Trusts reached collective agreement in October 2025 on a prioritised set of mental health pharmacy posts for progression. This decision reflects a clear and pragmatic acknowledgement that the pharmacy workforce must be expanded in a deliberate, phased, and sustainable manner—both to enhance direct support for service users and to strengthen the effectiveness of the wider multidisciplinary team.

The development of the mental health pharmacy workforce is being advanced within the context of the wider regional pharmacy career and professional development framework, with Trusts working in partnership with the Northern Ireland Centre for Postgraduate and Learning Development (NICPLD) and the Royal Pharmaceutical Society (RPS). In particular, the RPS post-registration framework—spanning enhanced practice, advanced practice, and consultant pharmacist roles—provides a credible, structured pathway for pharmacists specialising in mental health. As additional posts are funded and embedded, this framework will support credentialing at appropriate levels, strengthening clinical leadership, medicines optimisation, and independent prescribing capability. This approach is fully aligned with Department of Health (NI) guidance on the development of Advanced Practice Pharmacists.

Trusts are also preparing to integrate new postgraduate training pathways, with newly qualified pharmacists entering the professional register in summer 2026 as independent prescribers. This represents a significant opportunity to establish prescribing competence early, prior to entry into specialist areas such as mental health, ensuring that future workforce supply is both clinically capable and service-ready.

Given the availability of established specialist postgraduate education in mental health pharmacy, actively leveraging and commissioning these programmes represents a pragmatic and proportionate

response to current and emerging workforce pressures. Strengthening and more effectively utilising pharmacy expertise alongside medical and nursing roles will enhance multidisciplinary capacity, improve medicines optimisation, and increase clinical resilience—without displacing the essential leadership responsibilities of psychiatry or mental health nursing.

In this context, the College of Mental Health Pharmacy (CMHP) provides nationally recognised specialist training routes, including the Psych 1 and Psych 2 programmes, alongside specialist technician training, all supported through bursary funding. In addition, postgraduate certificate and diploma programmes in psychiatric pharmacy, delivered through Aston University and accessible via NICPLD CPD funding streams, provide further depth of specialist capability. Taken together, these opportunities support Theme 2, Action 18 of the Mental Health Strategy and align directly with the implementation of the mental health pharmacy posts prioritised in October 2025. Collectively, these actions create visible and credible career pathways in mental health pharmacy, comparable to those available in other well-established multidisciplinary professions. This is critical not only for recruitment and retention, but for embedding pharmacy as a core, value-adding discipline within mental health teams—particularly in medicines optimisation, polypharmacy management, patient safety, and shared clinical decision-making.

The 2025 prioritisation represents a pragmatic first step in stabilising and expanding core mental health pharmacy services, with a clear intention to further develop the specialty in line with service need. This approach supports improved outcomes for patients and service users, while enhancing the effectiveness and safety of multidisciplinary mental health care.

Leadership and Workforce Development Priorities

Strong pharmacy leadership will be essential to shaping future workforce and service priorities. In this context, prioritising the establishment of a Band 8b Mental Health Pharmacy Lead in each Trust is a critical enabler. These roles will provide strategic clinical leadership, drive workforce development, and support the implementation of fast-track induction and development pathways that build specialist knowledge, advanced skills, and independent prescribing capability across the mental health pharmacy workforce.

Chief Professional Officer – (Psychological Services) Mental Health Indicative Workforce Priorities

Priority 1:-Stabilisation and Expansion off Psychology Workforce Across Acute, Secondary Care Acute and Specialist Services equate to 25 WTE Consultant/8C Clinical psychologists Posts 25 posts spread across all Trusts

Priority 2: -Addressing Psychological Therapies Waiting Lists and Psychological Therapy Demand This requires expanding 8A and increasing Band 7 Psychological Professions /Psychotherapists: 50 – 60 posts & Band 5/6 Psychological Profession: 40-60 posts - introduction of Clinical Associate psychologists (CAPs) in keeping with rest of UK.

Priority 3:- Workforce Development and Training Expansion. Increase workforce training capacity by adding at least 5 D ClinPsy training places annually for the next 3–5 years, Systematic introduction of the Clinical Associate Psychologist -20 WTE Band 5/6 per year) & Roll out the development of Psychological Wellbeing Practitioner roles -40 places per year)

Priority 4:-Increased funding should be prioritised for training in evidence-based psychological interventions, e.g. Masters in Cognitive Behaviour Psychotherapy, Master/Doctoral in Child and Adolescent Psychoanalytic Psychotherapy (Dpsych) and in Systemic Family therapies etc

Priority 5:- Modernising psychological therapy delivery models involves upskilling staff, providing clinical mentorship, and enhancing the integration of psychological therapies within multidisciplinary teams across various service settings.

The Role of the Chief Psychological Professions Officer

The Chief Psychological Professions Officer, a relatively new role, is central to overseeing the development and mainstreaming of psychological therapeutic models within mental health care. There is robust evidence for the impact of psychological interventions across a range of mental health conditions.

It is important to note that the term “psychological therapists” is intentionally used as an umbrella term to include all practitioners delivering a broad range of evidence-based psychological therapies. This encompasses, but is not limited to, Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), medical psychotherapy, Child and Adolescent Psychoanalytical Psychotherapy (C&APT), counselling and other specialised modalities. The purpose of adopting this inclusive terminology is to ensure that service planning, workforce expansion, and training initiatives address the full spectrum of psychological interventions needed across different service settings and populations. By recognising the diverse expertise within the psychological therapy workforce, services can better meet the complex and varied mental health needs of individuals, and support the delivery of high-quality, multi-modal care as outlined in the key priorities for workforce stabilisation and development of a multi-disciplinary approach.

Key Priorities: Stabilisation and Expansion of Services

The Chief Psychological Professions Officer highlights five key priorities with a particular focus on the stabilisation and expansion of secondary care acute and specialist services. The primary goal is to ensure these services are fully staffed to deliver high-quality, multi-modal interventions for complex cases. Achieving this objective requires significant investment in senior psychology roles.

Addressing Variability and Gaps Across Trusts

It is important to acknowledge that there is significant variability across Trusts regarding psychology posts within specialist crisis, personality disorder, eating disorder, substance misuse, gender services, and acute inpatient services. Notably, gaps in service provision have been identified in PICU wards and for older adults. For instance, some Trusts lack psychology provision in specialist acute services altogether, while others have a limited number of posts that have proved difficult to fill, largely due to issues with banding. Addressing these challenges necessitates investment in highly specialised skills, as outlined in the table above, and the development of psychological infrastructure as a core discipline within every mental health team.

Development of Consultant and Practitioner Posts

The development of Consultant Band 8C Clinical/Practitioner Psychology posts will not only increase the teams' required ability to work with high-complexity presentations, integrating multiple evidence-based therapies, but will also enhance current service capacity through specialist knowledge in advanced psychological assessment and case formulation; psychological measurement and evaluation skills; supervision, leadership, and consultation; and research and service development. Recruiting at this level will also enhance capacity via trainee and junior psychology practitioner posts.

Tackling Waiting Times and Modernising Service Delivery

The reality is that waiting times for psychological therapies continue to lengthen, with individuals now waiting well beyond the recommended guidelines. Tackling these waiting lists is essential and should be a core priority in the expansion and diversification of psychological therapist roles. To address these challenges, new service delivery models are required, such as blended stepped-care

pathways that incorporate face-to-face, group, and digital options—thereby increasing both capacity and flexibility. The Reset neighbourhood model also presents opportunities to develop innovative service sites and approaches. Additionally, there is an untapped workforce of approximately 400 psychology graduates who could be upskilled to support psychological assessments, triage, and early interventions.

Investing in Workforce Development and Training

Given the robust evidence base supporting psychological therapies, there are considerable opportunities to expand service capacity and improve patient outcomes by investing in workforce development and broadening training pathways. This includes the adoption of modernised models for delivering psychological therapies—such as digital, blended, and group formats. This will require strategic investment in training and development, protected time for learning, and the development of new models of practice.

Recognising the realities and interdependencies, effective forward-thinking workforce and service planning is essential. However, for clinical psychology and other fragile psychotherapy disciplines, achieving an appropriate balance of capacity across service areas and functions remains a significant challenge. The small pool of qualified clinical psychologists and the limited number of training commissions create persistent difficulties, especially when demand for expertise spans the entire system.

When funding is secured for only a handful of clinical psychology sessions, recruitment often relies on piecing together posts across multiple services. This approach is unsustainable and is unworkable. As illustrative example of the challenges arising from piecemeal funding can be seen in the recent efforts to introduce standardised models across all psychology posts. In practice, it has become evident that the recommended number of psychologists—such as those required in specialist areas like diabetes—cannot be feasibly recruited within current constraints. This situation underscores the importance of having a comprehensive overview across services and calls for a pragmatic approach from service managers and Heads of Psychological Services. Ultimately, this brings to the fore the necessity for proactive and sophisticated workforce planning to secure a sustainable supply of clinical psychology expertise, fully recognising the wide-ranging demand present throughout the system.

Chief Professional Officer –(Nursing) Mental Health Workforce Indicative Priorities

Strategic focus for mental health nursing (professional priorities)

In response to the Mental Health Strategy ambitions and the system pressures set out in this report, the Chief Nursing Officer, working with regional nursing leadership, has identified a set of professional priorities for the future direction of mental health nursing. These priorities are anchored in a population-health approach and reflect the requirement for workforce planning to be informed by population-level intelligence, so that mental health nurses have the skills, competencies, and clinical expertise to deliver safe, effective, and equitable care across primary care, community, acute, and specialist settings

Within this context there was a professional emphasis is the reorientation of mental health care towards **prevention and early intervention** across all levels of delivery. From a nursing leadership perspective, this included strengthening public-health-informed practice that addresses mental ill health alongside the significant social and physical health inequalities experienced by people living with mental health conditions. This approach also supports the strategic direction of HSC Reset by enabling care that is closer to home, better integrated across pathways, and more responsive to need through neighbourhood and community-based delivery models

From a strategic nursing standpoint, positioning population-health at the core mental health service planning was viewed as prerequisite in responding to current and future demand. This as a priority needs to be capable of responding to both demographic trends and presenting complexity. Whilst acknowledging the older people mental health largely sit outside the scope of the mental health workforce review, it was nevertheless recommended that future mental health workforce and service planning models must be agile in responding to the evolving needs of an ageing population while also strengthening upstream provision for children, young people, and families including maternal mental health provision. This was identified as an upstream priority area both in term of promoting early intervention, but also in reducing the risk of long-term mental health need across the life course.

In the above context there was clear professional consensus that future mental health services cannot rely on cyclical, reactive responses to demand. Instead, nursing models needed to prioritise preventative, personalised person-centred approaches, which were both adaptable and capable of working across neighbourhood, community, and specialist settings. Inevitably this requires a mental health nursing workforce equipped with strong population-health capability; advanced assessment, therapeutic and clinical leadership skill in shaping, designing and delivering responsive, equitable, and sustainable mental health system at both individual, community and population levels

Strengthening the Nursing Workforce

Set within this strategic context, senior nursing leadership fully acknowledges the scale of the workforce gap identified in this report and recognises workforce sustainability as a critical system risk requiring decisive action. Building and maintaining a resilient talent pipeline is therefore positioned as a core professional priority. This included expanding undergraduate and postgraduate training capacity, strengthened the quality/scope of clinical placement, and the development of robust attractive career pathways across all levels of practice—particularly specialist, advanced, and consultant nursing roles. Importantly, nursing leadership emphasises that workforce planning must explicitly account for the long lead in times required to train and develop practitioners, ensuring that decisions taken now secure medium- and long-term service resilience rather than short term mitigation.

From an operational perspective, there is also a strategic and professional need to deepen workforce intelligence to support more accurate planning, to enable the optimisation of nursing resource as well as identify areas for targeted investment. Inevitably this includes more granular

analysis of vacancy patterns, sickness absence, retention and turnover, age profile, and reliance on bank and agency staffing. These indicators provide essential context for defining workforce gaps, directing investment to the most impactful areas, and maximising the contribution of the existing workforce across services and settings.

Recognising the continued financial constraints described in the report, nursing leaders advise that workforce and service planning should be accompanied by a structured appraisal of current models of care, including active exploration of innovative and evidence-informed approaches that are fit for purpose and adaptable to changing demand. Where underspends exist, the professional case may need to be framed around strategic reprofiling of these resources into key professional priority areas that deliver the greatest population-health impact, while maintaining sufficient flexibility across Trusts and service settings to respond to local context within an agreed regional framework.

Finally, there was also a recognition that workforce planning was much broader than staffing numbers alone. This included given consideration to systematic measurement of quality, safety, clinical outcomes, and service-user experience. Integrating safety, effectiveness, and outcomes intelligence into workforce/service planning was considered essential to ensuring that emerging risks and unwarranted variation are identified early and addressed proactively.

Nursing Key Professional Development Priorities

The following priorities have been identified in the context of the Chief Nursing Officer having commissioned a comprehensive review of mental health nursing which is expected to report later this year. This review will play a fundamental role in shaping both future models of practice and the key workforce nursing priorities. More broadly the development of the mental health workshop will also be shaped by leveraging the NIPEC ***Career and Development Model for Nursing and Midwifery*** (published December 2025) to guide professional development. This model outlines levels of practice with the required knowledge, skills, and experience, integrating career pathways and a learning and development framework to support ongoing progression.

Immediate Priorities: Stabilising the Workforce and Expanding Training

In determining priorities, it was recognised that an immediate priority must be the stabilisation of the mental health nursing workforce and the urgent expansion of undergraduate mental health nursing places. This expansion was viewed as essential for addressing both existing vacancies and enabling ongoing professional role development by ensuring an effective pipeline of registered nurses. This

inevitably need to be underpinned by recruitment strategic which promotes careers in mental health nursing as rewarding and attractive and as consequence ensure commissioned place are filled.

Promoting Advanced Nurse Practitioners (ANPs)

Given the pressure on the mental health workforce and the value-adding roles of Advanced Nurse Practitioners (ANPs), these advanced roles were deemed a priority, particularly in supporting consultant psychiatrists and strengthening senior clinical decision-making.

Expanding Specialist Nursing Roles

Considering the mounting pressures on acute mental health crisis services, community mental health, substance misuse, and eating disorder services, there is a need to further grow Band 6 and 7 nurse specialist roles. Over the next three to five years, the mental health nursing workforce must adapt to meet these evolving challenges.

Broadening Core Practice and Enhancing Education

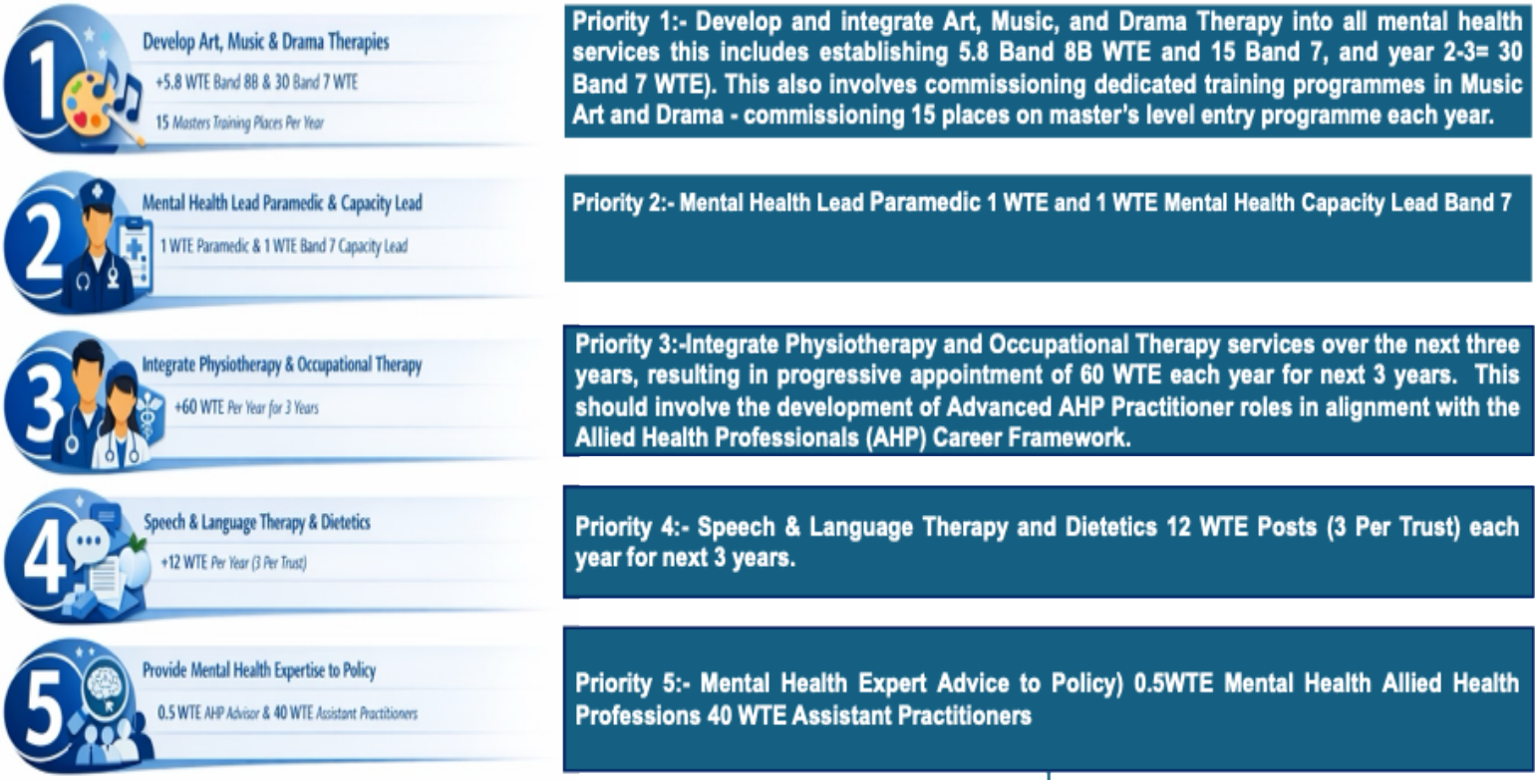
This includes broadening the scope of core mental health nursing practice, thereby increasing capacity within the Adult Mental Health (AMH) system to respond to present and future demand. It also involves enhancing undergraduate education by embedding evidence-based psychological practices, investing in non-medical prescribers and Consultant Nurses, and upskilling and reskilling the existing workforce to ensure alignment with best practice.

Career Progression and Retention

Finally, supporting career progression and retention remains a central priority, which could also include investing in a mental health Accelerated Year in Nursing Practice (AYINP) that could potentially address the current shortfall in mental health nursing.

Chief Professional Officer (Allied Health Professions) Mental Health Workforce Indicative Priorities

The Chief Allied Health Professional Officer, in collaboration with Trust leads, has identified several roles that require further development and integration within mental health services. There is



increasing recognition of the therapeutic benefits that art, music, and drama therapists offer in supporting psychological wellbeing and helping individuals process and reframe their experiences. However, these therapists remain significantly underrepresented within the mental health workforce, despite their crucial role in enabling creative psychological recovery.

Rationale for Allied Health Profession Priorities

The rationale underpinning these Allied Health Profession (AHP) priorities is to address persistent service gaps and improve equitable access to AHP services across Trusts and regions, thereby enhancing outcomes for people with mental health needs.

Strategic Positioning of Allied Health Professions within Mental Health Workforce Priorities

Within the context of the Chief Professional Officer's engagement with professional leads, several core workforce priorities were identified. During these discussions, explicit concern was raised regarding the current profile and positioning of Allied Health Professions (AHPs) within established

workforce priorities. There was recognition that existing approaches risk inadvertently reinforcing traditional workforce models, rather than fully leveraging the breadth, capability, and established contribution of AHPs to deliver innovative, evidence-based, and person-centred models of mental health care.

The *Ernst & Young Mental Health Workforce Review (2022)* clearly positioned Allied Health Professionals as a **key workforce** in the development, stabilisation, and reform of mental health services. The review highlighted that AHPs are central to delivering therapeutic, recovery-oriented, and preventative approaches, and to driving the adoption of innovative workforce models capable of responding to current and future mental health demand. In this context, AHPs play a critical role across the whole system, including early intervention, community mental health teams, crisis response, hospital avoidance, trauma-informed practice, and rehabilitation.

Importantly, the review also highlighted significant waiting lists for allied health professional interventions, underscoring the need to explicitly acknowledge these pressures within workforce prioritisation processes. Doing so is essential to ensure that people with mental health needs can access timely and appropriate AHP interventions as part of an integrated, multidisciplinary response, rather than allowing unmet allied health to need to become a hidden driver of escalation and service pressure elsewhere in the system.

The *Ernst & Young* review further emphasised the need for innovation in workforce design to meet rising and increasingly complex mental health needs. It was within this context that the **Chief AHP Officer and AHP Professional Leads** strongly advocated for the explicit inclusion of AHPs within the system's top workforce priorities. At a system level, this represents a clear opportunity to strengthen alignment with existing workforce review recommendations by ensuring that AHPs are recognised as a **core professional grouping** within workforce prioritisation and decision-making frameworks.

There was also recognition that current approaches to prioritisation and decision-making would benefit from re-appraisal to better support shared professional leadership and collective decision-making across disciplines. This is critical to addressing any residual misperceptions regarding the positioning of the AHP workforce as core discipline in responding to both current service pressures and future demand. This is particularly important given the well-established contribution of AHPs to prevention, recovery-focused practice, and the reduction of pressure on acute and secondary care services.

A key theme emerging from this report is the need to strengthen a collective approach to decision-making in relation to both service and workforce prioritisation. Currently, many decisions continue to follow traditional, profession-specific lines, which can influence how resources are subsequently allocated. As outlined in the next section, the development of multidisciplinary team structures will enable the meaningful inclusion of Allied Health Professional (AHP) leads alongside other professional workforce leaders. These standards once developed will help to ensure funding and prioritisation decisions are informed by the full breadth of professional expertise across the system.

Expanding and Modernising Models of Allied Health Practice

In parallel, there is a strong evidence-based case for introducing and expanding areas of allied health practice with a demonstrated impact within mental health services, including **art, music, and drama therapies**. These disciplines offer significant therapeutic value across both Child and Adolescent Mental Health Services (CAMHS) and adult services, particularly in the context of sustained psychological therapy waiting lists.

The art therapies workforce is well positioned to support the therapeutic transformation of mental health services, alleviate workforce pressures, and contribute to reducing waiting lists by engaging individuals who may not benefit from, or are unable to access, traditional talking therapies. More consistent integration of music, art, and drama therapies within multidisciplinary teams can broaden scope of practice, enhance early-intervention capacity, and strengthen crisis response and rehabilitation pathways. There are also clear opportunities to partner with the Voluntary, Community and Social Enterprise (VCSE) sector, whose capacity and expertise can help address both immediate and longer-term workforce challenges.

AHPs also represent a **critical and expanding component of a modern mental health workforce**, including the crucial contribution of **physiotherapy** as a value-adding therapeutic intervention that strengthens care at the interface between mental and physical health. This role is particularly significant given the high prevalence of physical health comorbidity and deconditioning associated with severe and enduring mental illness, the impact of psychotropic medication, trauma, and prolonged inactivity during episodes of mental ill health. Integrating physiotherapy more systematically within mental health services supports functional recovery, physical resilience, and improved long-term outcomes.

Equally, **Speech and Language Therapy (SLT)** and **Dietetics** have substantial therapeutic value in mental health contexts and are critical to improving outcomes in key populations. Strengthening SLT and dietetic capacity is particularly relevant where communication needs, eating and nutritional difficulties, neurodevelopmental complexity, and physical health risks intersect. In these pathways, timely intervention is central to supporting engagement, personal expression, recovery, and preventing deterioration and escalation for vulnerable people across the life course.

In addition, **paramedicine** represents a growing workforce opportunity within mental health services—particularly in enabling integrated crisis and community responses and strengthening *Right Care, Right Person* approaches. This includes strengthening clinical leadership through the evolving **Mental Health Lead Paramedic** function, creating further opportunities to enhance triage, clinical decision-making, and interface design across urgent care, community services, and crisis pathways.

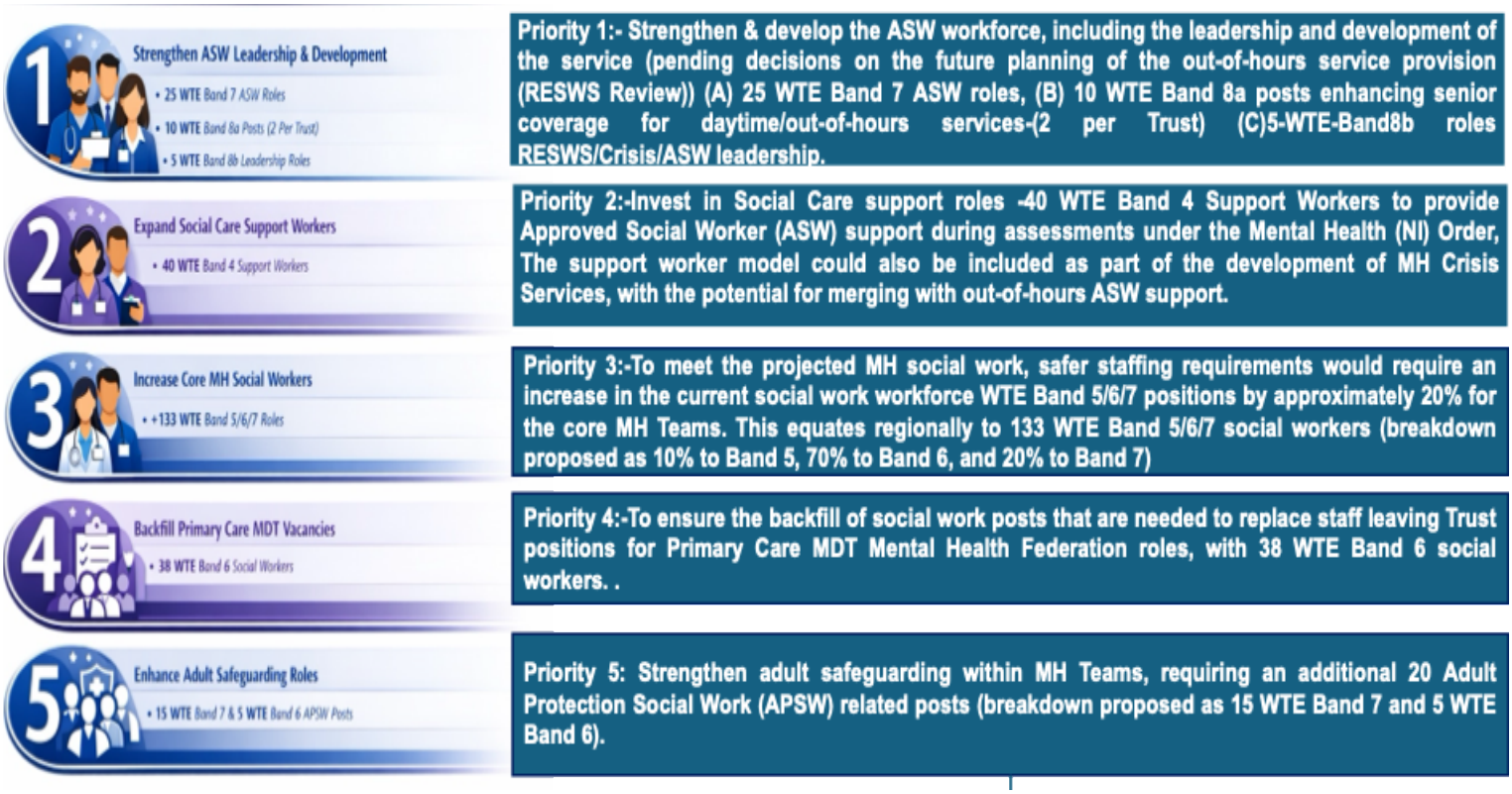
Advanced and Specialist AHP Roles: Workforce Sustainability and System Resilience

There is a clear and increasing opportunity to grow **advanced and specialist AHP roles**, supporting more resilient services while improving recruitment, retention, and workforce sustainability. The development of advanced and specialist AHP roles—aligned with the **AHP Career Framework**—offers a major opportunity to strengthen clinical leadership and address critical workforce challenges by augmenting senior clinical decision-making capacity across mental health services.

While stabilising existing services remains an immediate priority, this should be viewed as a **catalyst for modernisation and service improvement**, rather than a constraint on innovation. In this context, any repurposing of vacancy funding or allocation of new investment must retain sufficient flexibility to support transformation. Restricting funding solely to narrow delivery priorities risks limiting innovation and may further exacerbate the AHP workforce gap already identified within the mental health workforce review.

A more balanced and strategically aligned approach—grounded in collective leadership, shared professional decision-making, and explicit recognition of AHPs as a core discipline—will therefore be essential to delivering sustainable, inclusive, and future-focused multidisciplinary mental health services.

Chief Professional Officer – (Social Work) Mental Health Workforce Indicative Priorities



Role of Social Workers in Mental Health Services.

The Chief Social Work Officer underscored the indispensable contribution that social workers make through their commitment to improve social well-being. The ability of social workers to recognise the quality of people's relationships, their sense of choice and control in decisions affecting them and their lives and in providing support and an empathetic understanding of individuals and their families, as part of a wider system. In addition, social workers undertake a leading role as part of the statutory and legislative functions in the mental health sector, which sees the introduction of new adult protection legislation and the roll out of Primary Care Multi-disciplinary Teams and MH practitioners in GP Federations. Social workers constantly strive to improve the lives of others by helping and advocating for people while continuing to encourage empowerment and self-determination through a strengths-based approach.

Importance of Safer Staffing for Social Work in MH Services

Their work is multifaceted, encompassing assessment of needs, review and care planning, hospital discharge planning, crisis intervention and support, safeguarding, case management, ongoing commissioning of care and care coordination. A core role for social work is also around promoting social justice by recognising and tackling social inequalities, upholding human rights which can be impacted when people are affected by mental health difficulties. This can be particularly meaningful

to people requiring treatment, which may include periods in hospital. Safer staffing and ensuring the caseload capacity and numbers of social workers in the community teams is central to improving the lives of others and for ensuring everyone is receiving the best care in a timely way.

As social work is a relationship-based profession and training includes advanced relationship skills, their role supports connection, listening and learning what's important, doing so with empathy and working together with people through a person-centred and co-produced approach. Through their systemic approach, social workers address not only the needs and well-being of individuals, but they also recognise each person as part of a family with social, economic and environmental factors that influence their lives, which can be highly complex when working with individuals and families impacted by mental health. Social workers are also particularly skilled in relation to social determinants of mental ill health, social antecedents to episodes of mental ill-health and social solutions. This awareness supports social workers to work from an early intervention and preventative approach.

Social workers are trained and develop their understanding of oppression and strive to promote anti-oppressive practice, recognising that oppression and discrimination can occur at the personal, cultural and structural level and bring challenge to their own and others practice. Therefore, the social work role, values, professional expertise and understanding is especially relevant to supporting and engaging people with mental health difficulties and ensuring their rights and well-being are recognised and upheld, in what is often a medically focussed system.

Meeting Statutory Responsibilities and Legal Frameworks

A core aspect of social work responsibility lies in fulfilling statutory duties under the Mental Health (NI) Order and Mental Capacity Act and to act as Approved Social Workers. These legal frameworks require social workers to undertake assessments, make complex decisions regarding capacity and risk, and uphold the rights of those experiencing mental ill health. The ASW workforce and services have been impacted by other system pressures, such as the limited acute bed supply and prolonged waits. The ASW workforce is seen as a key priority to develop both through increasing social workers trained as ASWs and the roles supporting and leading the services. The review of out of hours services will lead to an agreed regional direction and there have remained gaps in support and delays in delivery. There is a requirement to support ASWs during the assessment, prolonged waits and conveyancing through improving on the ground support, through support workers and access to senior staff in and out of hours which will be critical for the future development of the service.

Introduction of Adult Protection Legislation

In addition to their statutory functions, social workers are at the forefront of adult safeguarding, intervening to protect those at risk from harm and promoting their wellbeing through preventative and responsive measures and respect for the individual's choices and preferred outcomes. The introduction of the Adult Protection Bill is a significant change as it introduces new duties and responsibilities which require a trained and experienced workforce. Developing this workforce leads to the critical need to backfill the vacancies, which are often left in core MH Teams as staff progress onto the specialist roles.

Implementing the Right Care Right Person (RCRP) Framework

Furthermore, social workers have a key role in supporting the evolving Right Care Right Person (RCRP) approach, which aims to ensure that individuals in mental health crisis receive the most appropriate and timely support on multiagency models. By integrating statutory obligations with therapeutic practice, social workers are one of the key professions who can bridge the gap between legal requirements and the delivery of safe and effective care in this context. However, it is important to point out that Right Care Right Person has implications for the whole system and will also place demand on other key professions and these also need to be factored into overall workforce configurations.

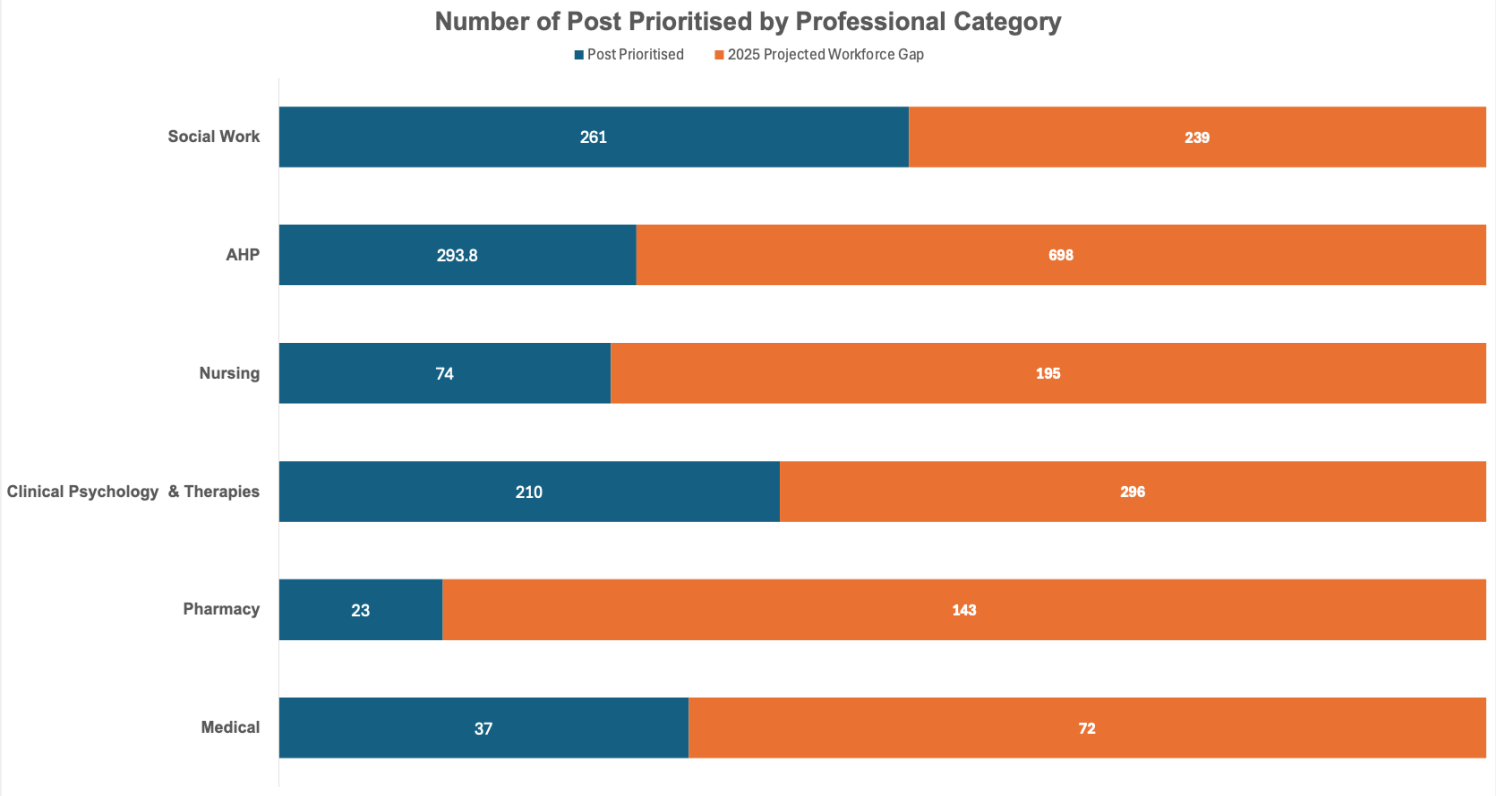
Centrality within Multidisciplinary Teams

This alignment of responsibilities is closely mirrored in the priorities set by HSC Trusts, highlighting the centrality of social work within multidisciplinary teams dedicated to delivering high-quality, holistic mental health services. The collaborative efforts of social workers—alongside other health and social care professionals—are fundamental to meeting the complex and evolving needs of service users, ultimately contributing to improved outcomes across mental health care provision.

Summative Conclusion Comparison with the 2022 Mental Health Review

When considering the collective recommendations put forward by the Chief Professional Officers and other professional leaders, the graph below illustrates the number of posts prioritised by professional category in comparison to the recommendation made in the 2022 Mental Health Review. Notably, the number of social work positions prioritised is now greater than the number

originally recommended in the 2022 review. This variance is not inconsistent with previous recommendations, as the 2022 review acknowledged that its initial estimate for social work posts was provisional and would be further refined following the completion of the ongoing social care review at that time.



Addressing Workforce Imbalances

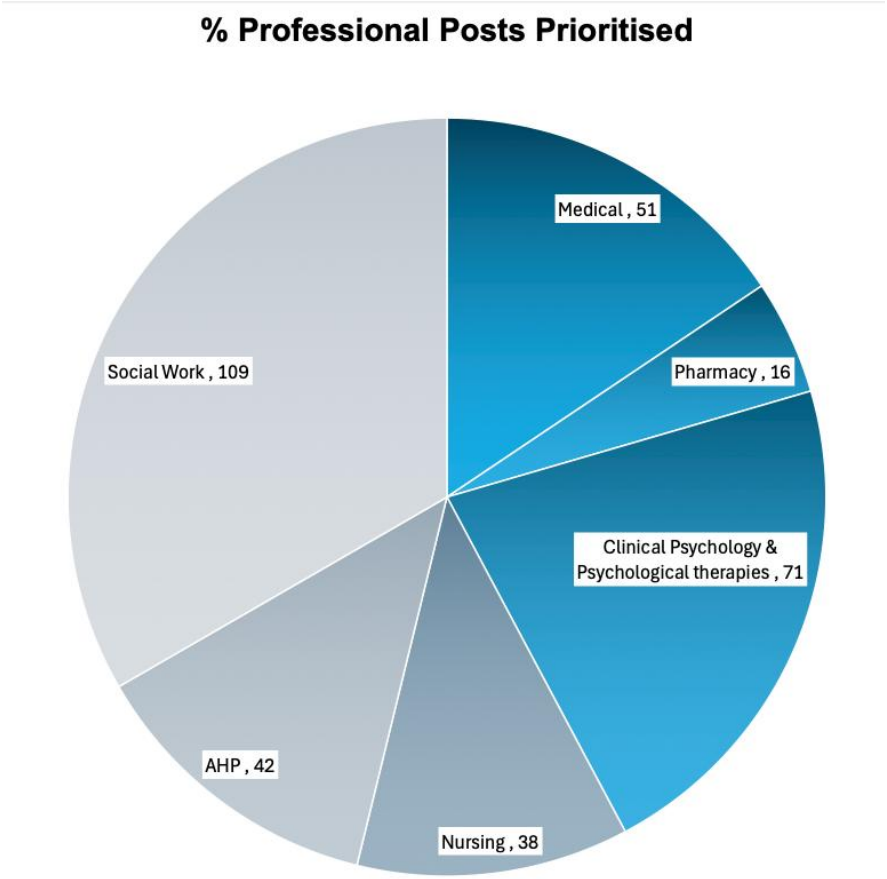
Given the range of Allied Health professions, and the historically significant underrepresentation within mental health teams, the graph demonstrates that a larger proportion of posts have been prioritised to address existing gaps and ensure a more balanced, multidisciplinary workforce. Similarly, the uneven distribution of psychology and psychological therapy roles across services has been recognised, necessitating substantial prioritisation of these roles to meet current service demands.

It is also important to highlight that, although the prioritisation of new medical posts appears proportionally smaller, this must be understood in the context of ongoing medical vacancies. One of the most urgent priorities for consultant psychiatrists is to fill the current 74 medical vacancies. Similarly, stabilising nursing services requires focused efforts to address the 236 existing nursing vacancies. Tackling these gaps is essential for both immediate workforce stabilisation and the long-term sustainability of these core professional roles. Whilst a pragmatic approach has been adopted

by Pharmacy there is also a need to further explore, how the role of pharmacy could be further enhanced and embedded within core and specialist mental health multidisciplinary workforce configuration given its low base.

Proportion of Prioritised Posts

Overall, as illustrated in the chart below, nearly 40% of all posts recommended in the 2022 review have now been prioritised for development. This substantial proportion reflects both the shifting demands within mental health services and a clear recognition of critical workforce areas in need of targeted investment. Importantly, the prioritisation of certain professional roles reflects a range of historical workforce imbalances, and the need to create equitable service provision across the full spectrum of mental health care. It also underscores the necessity to develop and reach consensus on the optimal multidisciplinary composition of mental health teams, ensuring that future service models are resilient, balanced, and responsive to the evolving needs of the population.



Workforce Dynamics and Decision-Making Frameworks

The prioritisation approach also reflects a nuanced understanding of workforce dynamics and the complexities of service delivery, especially in the way professional and service priorities are identified and agreed upon. While there is clear consensus on the importance of professionally balanced teams, the process for designing these teams requires a comprehensive, overarching decision-making framework—one that is objective, data-driven, and focused on achieving measurable outcomes. Equally important will be testing deliverability to ensure that the numbers prioritised should funding be available can be delivered within a reasonable time frame.

Challenges in Prioritisation

As discussed earlier, the absence of an integrated framework that aligns service priorities with workforce needs continues to present significant challenges when it comes to prioritising one professional group over another. Each profession brings essential, unique contributions to mental health services, and all have valid, critical priorities that warrant careful consideration. Further refinement of the priorities outlined above will be necessary to ensure the most effective allocation of resources.

Guiding Service and Workforce Planning Priorities

In practical terms, the preceding analysis and subsequent discussions offer a strong indication of the actions that should be taken in both service and workforce planning over the next one to three years. The priorities identified will play a key role in guiding future service redesign and informing the direction of any new investment. However, they should be regarded as indicative rather than definitive. Their application must be supported by a balanced, system-wide decision-making approach that considers the needs and contribution of all professional groupings. This is essential to ensure that investment and development do not inadvertently reinforce existing workforce imbalances, particularly for underrepresented professions, but instead support a more equitable and multidisciplinary distribution of capacity across the system.

Pragmatic Workforce Estimates

Pending the development of a robust multi-criteria decision-making framework for mental health and the establishment of clear standards for multidisciplinary team composition, it is both pragmatic and reasonable to estimate that prioritising approximately one third of the recommended posts will serve several key purposes. Firstly, this approach would represent tangible progress towards implementing the recommendations of the 2022 review. Secondly, it will help stabilise existing services, addressing the most immediate workforce pressures and creates the necessary foundation for introducing innovative ways of working and supporting the transformation and modernisation of mental health services. Ultimately, this approach supports the stabilisation and modernisation of mental health services, paving the way for reforms that are responsive to both immediate and long-term population needs.

Strengthening the Workforce Pipeline

A central theme highlighted by the CPOs was the critical importance of strengthening the workforce pipeline at both undergraduate and postgraduate levels. Expanding the supply of trained professionals was viewed as fundamental to addressing current and future vacancies across mental health services. This also included improving the flow of qualified staff ensuring that there is adequate capacity not only to fill new and existing posts but also to backfill positions vacated by those staff progressing into senior or advanced practice roles.

Chief Professional Officers' workforce priorities were broadly aligned around the following key objectives:

- Stabilising the mental health workforce—ensuring sufficient staffing to meet current and future demands.
- Transforming mental health services through the reset agenda—focusing on innovative service redesign and improvement.
- Building a resilient, skilled, and responsive workforce—developing staff capable of addressing both immediate service pressures and the long-term needs of the population.
- Developing a multidisciplinary approach—prioritising the effective integration of professional expertise, collaborative working, and the cultivation of a population health perspective.
- Safer staffing

Alignment of Trust and Professional Priorities

A clear consensus has emerged between Trust priorities and those of Chief Professional Officers regarding the critical workforce roles recommended for prioritisation over the next one to three years. Estimates derived from Trust recommendations and professional officer input suggest that, at present, approximately one third of the staffing levels recommended in the 2022 review may provide a pragmatic basis for workforce planning. However, a significant barrier remains—the persistent underfunding of mental health services in Northern Ireland—which complicates efforts to expand and optimise the workforce. Equally pressing is the need to make better use of existing resources. Exploring new models of working within mental health could facilitate more effective demand management. There is robust evidence supporting the role of prevention and early intervention in reducing mental health risks but achieving this requires a fundamental shift towards a public health approach.

The Neighbourhood Model: A Promising Path Forward

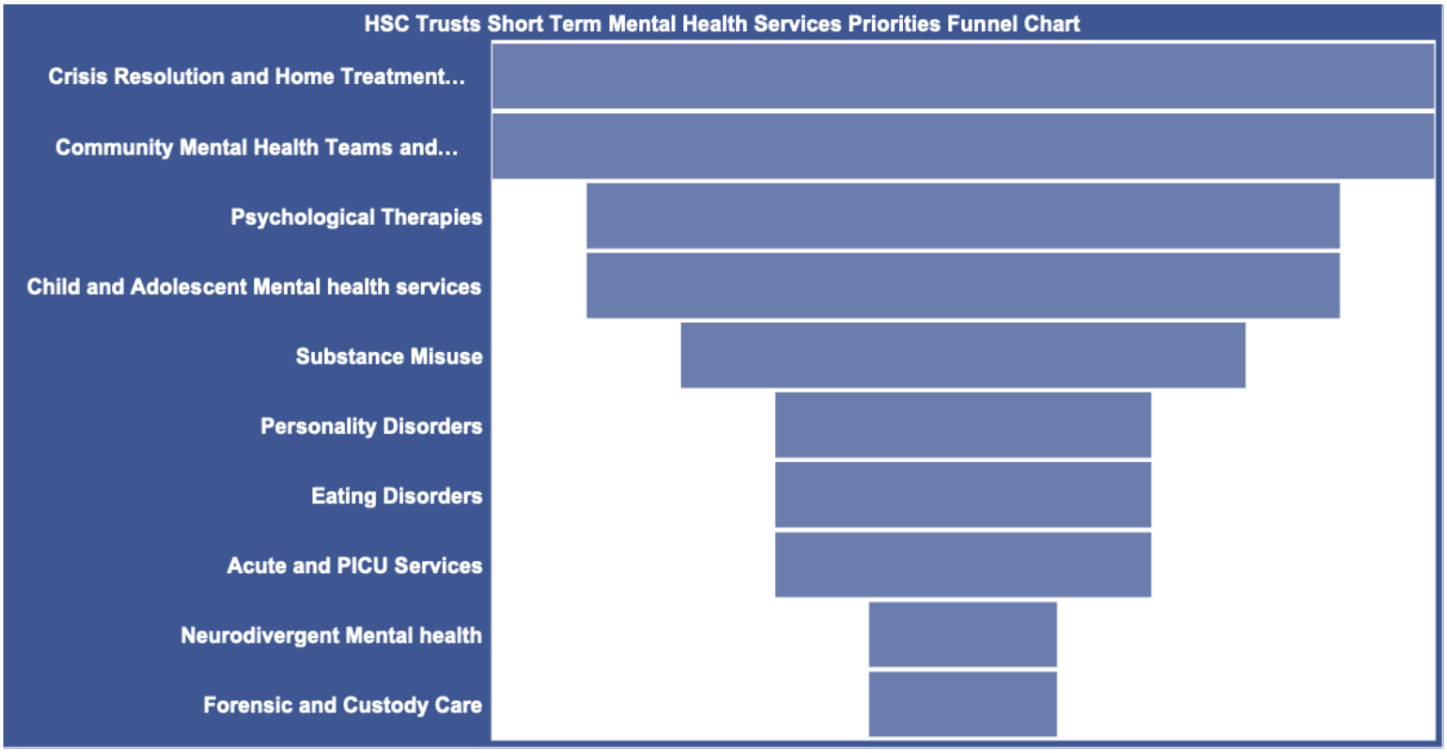
One promising avenue for transformation is the adoption of the neighbourhood model. This approach has the potential to enable the required shift towards public mental health, fostering local ownership, shared decision-making, and the harnessing of community assets to meet local population needs.

Despite longstanding recognition of the importance of a public mental health approach, its delivery remains a formidable challenge due to the systemic complexities inherent in mental health services unable to shift left due to the sheer level of demand services are grappling with.

The current service model, predominantly structured around outpatient paradigms, needs reform and redesign. A neighbourhood, primary care, and community mental health care approach has the potential to enable the emergence of innovative approaches which optimise mental health workforce expertise in different and more imaginative ways.

The creation of an integrated primary care, neighbourhood, and community mental healthcare model will not only maximise the therapeutic expertise of mental health professionals but also strengthen collaboration with local community, voluntary sector organisations, and other partners.

4.3 Overview of HSC Trust Mental Health Services Development (Short-Term) Priorities



Priority 1: Community Mental Health Teams

All five Trusts consistently ranked the development and investment in community mental health teams among their top priorities. This consensus reflects widespread recognition of these teams as the backbone of mental health care, essential for providing timely assessment, intervention, and ongoing support within individuals' local communities. However, increased specialisation and diversification in recent years have diluted their core function and effectiveness.

Revitalising community mental health services is critical. By supporting individuals in their neighbourhoods, these teams can facilitate recovery and stability in familiar environments. Integrating physical healthcare for those with severe mental illness further ensures a holistic approach. Investment in care teams—including care management and supported living—is necessary to address rising demand and enhance service effectiveness.

Current departmental initiatives aim to reform and standardise service provision across all trusts, broadening clinical specialities to improve both capacity and capability. Achieving an appropriate balance between community mental health teams and specialist services is fundamental, as is the creation of models that encourage cross-team and cross-specialty collaboration. Addressing the interface between primary and community care is particularly urgent, since siloed service development has historically hindered a population-based approach.

To overcome these challenges, a more integrated model is required—one that adopts a neighbourhood perspective, encourages knowledge and skill sharing, and embeds both outreach and in-reach clinical care. Diversifying the workforce and emphasising evidence-based psychological and therapeutic interventions are imperative. The development of a population health management framework will help ensure that individuals receive appropriate care at the right time and for the necessary duration. Frameworks such as the Choice Partnership Framework and the Working Together, Learning Together Psychological Therapeutic Framework are recommended to maximise team effectiveness.

Priority 1: - Crisis Resolution and Home Treatment

Trusts also identified crisis resolution and home treatment (CRHT) as a key priority. These teams play a central role in prevention, early intervention, de-escalation, and acute support for individuals and families, thereby avoiding unnecessary hospital admissions. Robust crisis response models, integrated with community, voluntary, and multidisciplinary primary care teams, reduce pressure on inpatient resources. Expanding the multidisciplinary skill set—incorporating psychology, non-medical prescribing, and allied health professionals—is essential for strengthening these services.

Priority 2: Child and Adolescent Mental Health Services (CAMHS)

Investment in CAMHS is the second key priority, with a particular focus on prevention and early intervention. Most mental health issues emerge before age 25, and early support can significantly improve long-term outcomes. Research indicates that about 75% of mental health disorders begin before age 24, underscoring the need for early identification and intervention to reduce severity and persistence. Early intervention leads to better educational, social, and health outcomes, as well as reduced long-term societal and economic costs.

Expanding CAMHS capacity and capability—especially through a wider range of multidisciplinary roles in psychotherapy, psychology, allied health professions, psychiatry, nursing, and social work—is crucial. Improving transitions between child/adolescent and adult mental health services is emphasised, including the development of young adult mental health responses to bridge care gaps. Enhanced primary care involvement and family-centred therapeutic approaches are vital for preventing escalation and addressing neurodiverse mental health needs. This requires new skills, an expanded multidisciplinary care model, and closer collaboration with developmental services

such as autism and ADHD care. Overcoming organisational barriers to integrated, person- and family-centred care is also essential.

Priority 2: Psychological Therapies

Addressing long waiting lists for psychological therapies remains a pressing concern, they are often a proxy-indicator of unmet/unaddressed population needs. Timely, evidence-based psychological interventions, play a fundamental role in improving outcomes for both common and complex mental health conditions. Research (NICE Guidelines CG123, 2011; Cuijpers et al., 2016) demonstrates that early intervention reduces symptom severity and improves long-term recovery.

Psychological therapeutics are foundational to safe, effective, and integrated mental health care and need to be strengthened as a core function across all levels of the stepped-care model. Improving access to psychological therapies, including within inpatient, specialist, need specific and crisis services, remains essential to preventing escalation, reducing acuity, and supporting recovery. Evidence shows that integrating clinical psychologists into multidisciplinary teams improves clinical outcomes, reduces readmission rates, and enhances overall experience of metal health care (Shafran et al., 2021; James et al., 2019). In addition, evidence shows that early access to trauma-informed, and psychologically informed interventions is also associated with faster recovery and a reduced risk of long-term morbidity (Kessler et al., 2017; Roberts et al., 2019).

At the same time, the evidence is unequivocal that delays in accessing psychological support—often reflected in prolonged waiting times—are associated with increasing clinical complexity, higher crisis presentation, and poorer outcomes overall (Murphy et al., 2019; NICE, 2011). This reinforces the need for sustained investment in specialist psychological therapy capacity; however, it also highlights the limits of a predominantly downstream, secondary-care-focused response to demand.

A complementary and equally critical priority is to build psychological capability and capacity earlier in the stepped-care pathway. This is particularly important within Primary Care Multidisciplinary Teams and neighbourhood-based community and voluntary sector provision. Strengthening psychologically informed practice, formulation skills, and therapeutic interventions at Steps 1 and 2 enables earlier identification of, and response to, psychological, emotional, and common mental health distress. It also supports more effective MDT decision-making and improves the management of need across the system.

Alongside the strengthening of social prescribing and lifestyle interventions, this approach explicitly recognises the interdependence between early intervention and specialist psychological services. By reducing avoidable escalation, it ensures that specialist expertise is deployed where it adds the greatest clinical value, while simultaneously strengthening the effectiveness of both early-stage and specialist care.

Within the context of the Reset agenda, the neighbourhood model provides a critical catalyst for rebalancing psychological care across the system. Embedding the full spectrum of evidence-based psychological therapeutics across neighbourhood, core, and specialist services enables a shift away from a predominantly reactive, referral-driven model towards one that prioritises prevention, early intervention, and psychologically informed core practice. In this way, the development of clinical psychology and full spectrum of psychological therapies becomes a reinforcing component of a coherent, population-based mental health system.

As a practical enabling measure, updating and further embedding the *Working Together, Learning Together* Framework provides a strategic mechanism for delivering a shared, whole-system approach to psychological care. Adapting the framework to support a whole system approach has the potential to enable alignment across community, primary, secondary, and specialist mental health services.

Priority 3: Cluster of Third-Level Priorities

Substance Misuse Services

The demand for substance misuse treatment continues to rise, but investment has continued to lag behind need. Expansion of clinical expertise and intervention capacity is necessary to meet growing needs, reduce the burden on psychiatry, and improve outcomes. Evidence from the UK (NICE Guidelines CG120, 2011; Murphy et al., 2019) shows that untreated co-occurring substance misuse and mental health disorders result in poorer health outcomes, higher hospitalisation rates, and increased healthcare costs. Integrated treatment approaches can mitigate these risks and reduce expenditures. Developing multidisciplinary teams and a public health approach, with collaboration across neighbourhoods and sectors, is essential for effective substance misuse services.

Personality Disorder Services

Personality disorder services were also noted as a third-level priority, reflecting significant underinvestment. Trusts recognise the need for robust multidisciplinary responses to address complex needs, ensure safety, de-escalate crises, and support community mental health teams in collaborating effectively with specialist psychological services.

Priority 4 Cluster Eating Disorders and Acute Inpatient Services

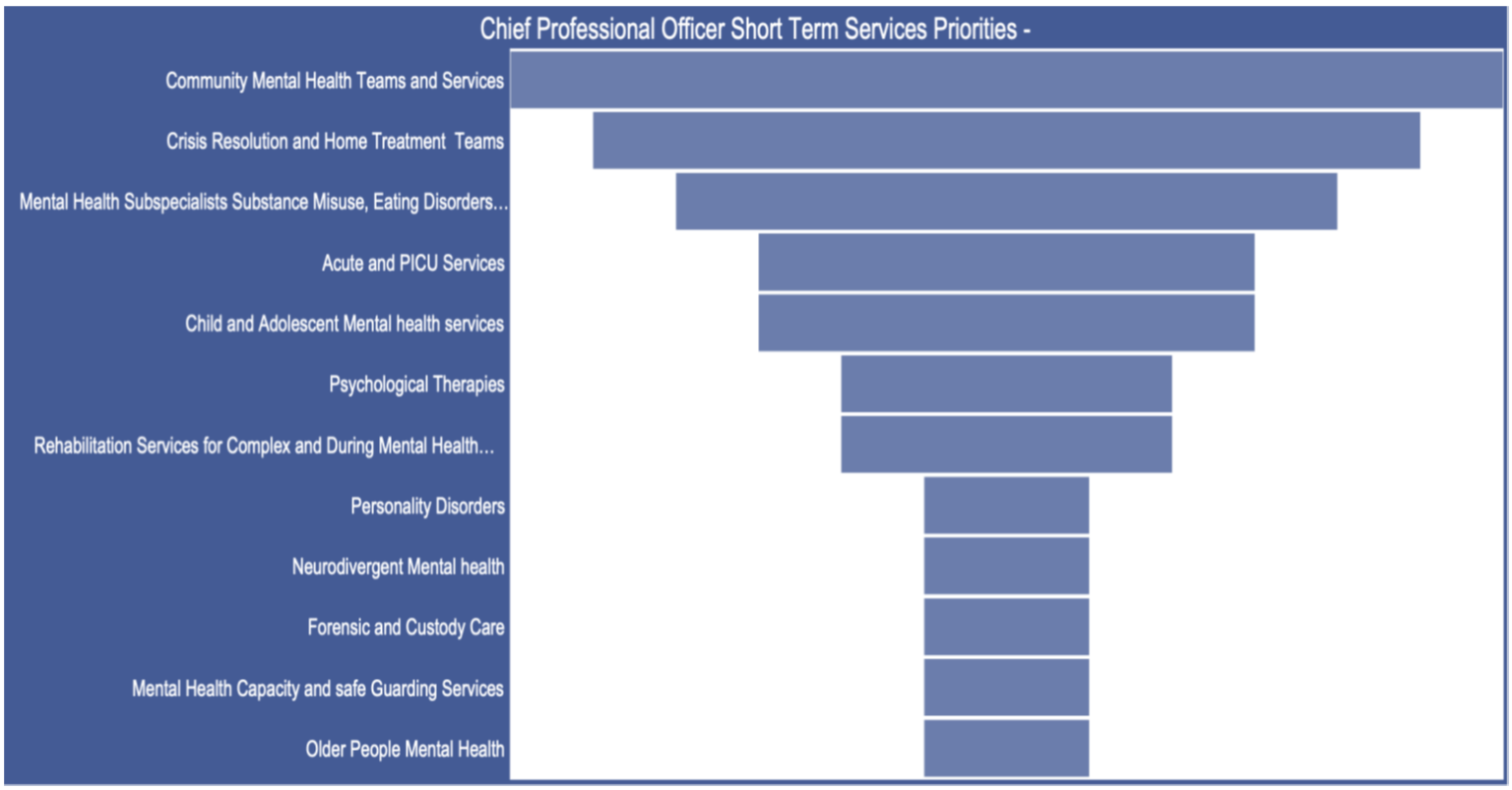
Eating disorders and acute inpatient services were identified as the fourth priority. Increasing referrals highlight a growing need for accessible, evidence-based treatment. Ensuring smooth transitions from youth to adult services is vital for continuity and effectiveness. The focus is on reducing morbidity risks and providing intensive therapeutic care, supported by comprehensive multidisciplinary teams.

Priority 5: Neurodivergent Mental Health and Forensic Services

The fifth priority is neurodivergent mental health, an area currently under review through a separate exercise led by the Department of Health Mental Health Directorate. The emphasis is on diversifying mental health responses and, through a stepped care approach, strengthening core services while developing specialist clinical and care teams.

One Trust also highlighted the need to develop forensic care, particularly by enhancing clinical psychology within medium secure services. Building capacity in psychological and occupational therapy, as well as providing staff training for medium secure environments and community forensic services, will improve service delivery and safety. Strengthening custody care and implementing the RCRP model will support better planning and enable delivery under the Mental Capacity Act and adult safeguarding.

4.4 Chief Professional Officer-Led Mental Health Services Key Priorities



Key Priorities for Mental Health Service Development

As indicated above, CPOs, like the Trusts, identified investment and development in community mental health services, crisis resolution and home treatment teams, and psychological therapeutic services as key priorities. This reflects a clear recognition of the importance of providing the right care, at the right time, in the right place.

Emphasis on Prevention and Early Intervention

Chief Professional Officers particularly emphasised the vital role of prevention and early intervention, recognising that developing service responses which enable evidence-based therapeutic recovery is essential for sustainable recovery for individuals and communities. In this context, they were unequivocal about the need to advance the 'reset agenda', advocating for this agenda to guide the ongoing reform of mental health care delivery—especially through the development of neighbourhood-based mental health responses.

Population Health Approach and Workforce Optimisation

Their position highlights the significance of embedding early intervention and prevention within a population health approach, while simultaneously optimising the existing workforce to meet evolving

needs. Additionally, chief professional officers highlighted the risks associated with complex mental health needs such as personality disorders, eating disorders, and substance misuse. They emphasised the necessity of building capacity to deliver therapeutic responses and support sustainable recovery.

Innovative Service Delivery and New Roles

There was a clear and consistent emphasis on the importance of adopting innovative ways of working to improve how demand is managed within mental health services. This focused largely on developing and prioritising new roles, which enhanced the overall impact, effectiveness, and productivity of services.

4.5 Section Two: Priorities for Action

Priority for Action 1: Prioritise Service and Workforce Stabilisation

Analysis clearly demonstrates a critical shortage of workforce capacity to meet current and projected demand, compounded by persistent vacancies in essential roles. Addressing these gaps must be the immediate priority, through the systematic development and delivery of robust three-year implementation plans aimed at filling existing vacancies. This also involves restructuring the number of undergraduate and postgraduate training positions to support the growth of key professions over the next three years. By increasing training opportunities, the supply of core professionals will expand, helping to stabilise services and fill critical vacancies more effectively.

Workforce stability is the cornerstone of sustainable service reform. A stable, adequately resourced workforce not only ensures the continuity and quality of care but also creates the necessary conditions for innovation and transformation. When staffing levels are secure and core roles are filled, teams are better equipped to embrace new models of care, respond effectively to evolving needs, and drive the reset agenda. Ultimately, investing in workforce stabilisation lays the foundation for meaningful change, empowering services to move beyond crisis management towards proactive, evidence-based improvement and recovery for individuals and communities.

Priority Action 2 – Implement a Whole-System Approach to Managing Workforce Movements

To mitigate the risks associated with unplanned and uncoordinated workforce movements, a whole-system approach to workforce stewardship is required. This should move beyond service-by-service responses towards system-level planning that enable right place, right expertise workforce deployment. This should include establishing clear oversight arrangements, supported by routine monitoring of vacancies, workforce flows, and staff transitions across the system. This alongside integrating service and workforce planning enable early identification of workforce destabilising patterns and unintended consequences associated with siloed planning. With in this context this report advocates for system-wide workforce management approach to actively balance service development with workforce sustainability, ensuring that career progression and service redesign are planned within an agreed framework that protects core capacity. In doing so, this approach aims to promote stability across mental health services, minimise displacement and service fragility, and safeguard the continuity, quality, and safety of care delivery.

Priority for Action 3: Optimise the Existing Workforce

Maximising the potential of the current workforce is essential for delivering effective, sustainable mental health services, particularly in the context of persistent staffing shortages and increasing service demand. A robust approach to workforce optimisation requires a thorough understanding and appreciation of the unique contributions of each team member. By mapping individual skills and fostering a culture of shared professional development and multidisciplinary collaboration, organisations can ensure that expertise is both recognised and strategically deployed to where it is needed most.

Evidence shows that upskilling, reskilling and, where appropriate, redeploying staff not only enhances workforce flexibility but also improves service resilience and quality of care. These strategies enable teams to adapt swiftly to changing population needs, implement innovative models of care, and address gaps in service provision without the delays associated with external recruitment. In addition, updating frameworks such as ‘Learning Together and Working Together’ will provide structured opportunities for continuous professional development, supporting an agile, responsive, therapeutically attuned workforce.

Introducing proven workforce and workload management frameworks, such as the Choice and Partnership Approach, can further enhance efficiency by ensuring that staff are supported to work at the top of their licence, reducing bottlenecks and streamlining care pathways. Strengthening clinical mentorship and embedding robust outcome evaluation processes will support ongoing skills development, improve job satisfaction, and ensure that service improvements are evidence-based and measurable.

In summary, optimising the existing workforce is not simply a matter of filling gaps; it is a strategic imperative that underpins the effective transformation of mental health services. By investing in skills, fostering collaboration, and implementing supportive frameworks, organisations can build a workforce that is both adaptable and equipped to deliver high-quality, person-centred care—now and in the future.

Priority for Action 4: Drive Service Transformation through Co-Design and Rapid Adoption of Innovative Practices

To achieve meaningful transformation in mental health services, it is essential to embrace a co-design approach and swiftly scale up new ways of working. This involves systematically leveraging proven innovations and fully integrating enabling technologies into everyday practice. By expanding advanced practice roles, services can enhance clinical decision-making and ensure that expertise is used to its fullest potential. In particular, the introduction of new outreach models will allow services to manage demand and waiting lists more effectively, moving beyond traditional approaches to care delivery.

Robust evidence supports the value of collaborative co-design, where service users, carers, clinicians, and partners from the primary care and community voluntary sectors work together to develop solutions tailored to local needs. Such partnerships facilitate the sharing of resources, knowledge, and expertise, resulting in more responsive and sustainable neighbourhood-based mental health responses. Furthermore, the adoption of advanced practice roles and innovative models has been shown to improve access, reduce bottlenecks, and enhance service quality, particularly when implemented alongside technologies that support streamlined communication and data-driven decision-making.

By prioritising co-design and the rapid scaling of evidence-based innovations, mental health services can become more adaptable, person-centred, and capable of meeting complex and evolving

population needs. This strategic approach not only addresses current challenges with demand and waiting times but also lays the groundwork for the development of an integrated approach to workforce and service planning.

Priority for Action 5: Integrate Service and Workforce Planning and Design

Further Developed in Section three of this paper.

5. Section 3 – Integrating Workforce and Service Planning: A Structured Approach

Section 3: Integrated Workforce and Service Planning Framework:- Introduces a structured framework that aligns service design with multidisciplinary workforce planning. It establishes an evidence-based decision-making approach to ensure workforce development is systematically linked to population need, service priorities, and sustainable models of care.

Integrating Workforce and Service Planning in Mental Health Care

This section presents a comprehensive analysis of the pressing need for integrated workforce and service planning within mental health care. It outlines the limitations of current fragmented approaches and proposes a Multi-Criteria Decision-Making Analysis (MCDMA) framework to enable effective prioritisation, resource optimisation, and sustainable service delivery. Key recommendations include the establishment of multidisciplinary standards, evidence-based decision-making platforms, and collaborative governance structures. The proposed framework aims to support healthcare leaders and policymakers in achieving resilient, equitable, and high-impact mental health services.

Introduction

Building on the analysis presented in Sections 1 and 2, it is evident that a structured, integrated approach to workforce and service planning is fundamental to enable the effective prioritisation of the mental health care workforce. The current approach to service and workforce planning is disconnected, leading to fragmented decision-making between policy, system, and operational functions. Evidence from recent workforce rebasing exercises highlights considerable variation in the composition of mental health service teams, largely due to the lack of a comprehensive multidisciplinary workforce plan. This underscores the need for integrated mechanisms that facilitate the development of multidisciplinary workforce plans, ensuring that the right professional roles and combinations are available to meet the population's needs for both core and specialty services.

The Role of Workforce Policy in Strategic Planning

Although workforce policy plays a pivotal role in setting the strategic vision for workforce development—such as establishing targets for undergraduate and postgraduate training as well as driving overall workforce reform—it’s true impact can only be realised when workforce planning is seamlessly woven into the fabric of service planning. Embedding workforce planning within service design and delivery is essential to proactively shape a mental health system that is responsive, equitable, and capable of meeting both present and future demands.

Adopting this integrated approach not only facilitates the engagement of professional expertise in service planning and decision-making but also ensures that this expertise is utilised in formulating the optimal multidisciplinary composition of mental health teams. This not only fosters robust multidisciplinary team (MDT) collaboration, encourages consensus-building, and promotes shared

decision-making but also enables the translation of evidence-based practice guidelines and specialised professional competencies/knowledge to be seamlessly incorporated into service design as well as service/workforce development priorities. This approach ensures that mental health services are provided by teams that possess the optimal combination of skills and expertise necessary to deliver the best possible outcomes for people, families and the broader community.

Historical Workforce Planning and the Need for Integration

Historically, workforce planning in mental health has trended along unidisciplinary/professional lines. Although each profession brings valuable insights and expertise, workforce planning largely remains disconnected across disciplines, and there is currently no formal mechanism for integrated professional workforce planning in mental health care.

While the distinct ideologies of each profession are vital in shaping their unique contributions to mental health care, it is crucial to recognise the significant interdependence among professions. With the emergence of new models of working and the development of advanced practice and other therapeutic professional roles, developing an integrated, multidisciplinary approach to workforce planning in mental health has become increasingly important. Data from workforce rebasing, as outlined in Section 1, highlight substantial variation in the composition of mental health service teams. These differences are largely attributable to the lack of a standardised multidisciplinary workforce model for core mental health services and their subspecialties.

Key Priorities for Multidisciplinary Workforce Planning

Whilst recognising the value and importance of professional ideologies, there is a need, as part of multidisciplinary workforce planning, to:

1. ***Develop a fuller understanding*** of how each profession's scope of practice and unique contributions can be maximised across the delivery of mental health care.

2. ***Systematically evaluate,*** using realist evaluation methodology, how these professional contributions can be optimised and/or developed for greater impact.

3. ***Establish mechanisms that integrate*** both professional and workforce policy leadership into the strategic co-design and prioritisation of mental health services.

4. ***Formulate multidisciplinary workforce standards*** for each mental health service and its teams, defining the optimal skill mix and specific professional roles required from each discipline, while also identifying and promoting the development of coworking practices and shared competencies needed for the effective delivery of both core and specialised mental health services.

5. ***Safer Staffing.*** Safer staffing is a fundamental enabler underpinning the strategic, integrated, and multidisciplinary workforce planning approach set out throughout this paper. Within the context of mental health services, safer staffing is not defined solely by staffing numbers, nor by profession-specific ratios alone, but by ensuring that teams are configured with the **right mix, level, and deployment of professional expertise and competencies** to deliver safe, high-quality, equitable, and person-centred care across the continuum of need. Embedding safer staffing principles into service and workforce planning enables the **proactive identification and mitigation of system risks** associated with understaffing, skill gaps, inappropriate role substitution, or imbalanced team configurations.

   Left unaddressed, these risks can compromise patient safety, service quality, continuity of care, and workforce wellbeing, while also reinforcing unwarranted variation across services and settings.

   While several individual professions have developed — or are progressing — profession-specific safer staffing models, this paper emphasises that **mental health care delivery is inherently multidisciplinary**. As such, safer staffing must be conceptualised and operationalised within a **whole-team and whole-system framework**, rather than through isolated professional lenses. It is within this wider context that safer staffing considerations must be integrated into both the **Mental Health Multi-Criteria Decision-Making Analysis (MCDMA) framework** and the development of **Multidisciplinary Team (MDT) composition standards**.

   The MCDMA framework provides the structured mechanism through which safer staffing considerations — including risk, deliverability, skill mix, and system resilience — can be consistently assessed alongside population need, evidence of impact, and value. In parallel, MDT composition standards provide the practical means to translate safer staffing principles into **clear, service-specific guidance on optimal team design**, defining the appropriate balance of professions, grades, competencies, and advanced practice roles required within different mental health settings and service clusters.

Challenges in Current Approaches and the Need for an Integrated Framework

One of the fundamental issues facing the effective delivery of mental health service and workforce prioritisation is the absence of an integrated framework which enables workforce and service planning. This inevitably contributes to ongoing inconsistencies in workforce composition and the allocation of professional roles within and across mental health services. This, in turn, creates structural disconnects and inequities in the scope and range of services provided across different mental health settings. The challenge of aligning service priorities with the diverse array of professional expertise highlights the urgent need for a clearly defined, consensus-driven framework that addresses these interconnected aspects of mental health care. Without a systematic and coordinated approach, mental health services will continue to face difficulties in prioritising service development and in forward-planning for the workforce needed to meet current and future needs.

Purpose of the Multi-Criteria Decision-Making Framework

A central aim of this section is to propose the establishment of a multi-criteria decision-making framework for mental health, designed to support the seamless integration of service and workforce planning. At the core of this framework is the principle of connecting ‘mental health systems to more of itself’ both within and across statutory mental health care services and, importantly, including those provided by primary care and partner organisations, particularly those in the community and voluntary sectors.

Rationale for a New Approach

The analysis presented in this paper clearly demonstrates that rising mental health needs and the persistent gap between capacity and demand—including workforce vacancies and significant staffing challenges—require a new approach. While the necessity for additional investment in mental health remains paramount, the proposed framework fundamentally calls for a shift, over time, away from traditional transactional referral and waiting systems, towards a more proactive primary, secondary, and tertiary public mental health approach.

Framework Principles and Alignment with Recommendations

In this context, this section builds upon the foundational principles of multi-criteria decision-making analysis models as the cornerstone enabling effective multidisciplinary service design and workforce planning in mental health care. By adopting a systemic model, it aims to provide a coherent platform

for translating the 2022 Mental Health Workforce Review recommendations into realistic and actionable plans aligned with service priorities.

Enabling Systematic Evaluation and Collaboration

Through this process, the framework seeks to facilitate transparent evaluation and systematic prioritisation, enabling decision-makers to identify optimal skill mixes, define essential professional roles, and foster collaborative practices across multidisciplinary teams. By harmonising workforce and service planning under a consensus-driven methodology, this approach directly addresses structural disconnects and inequities, ensuring that resources are allocated and optimised where they will generate the greatest impact for both service users and the broader community.

Facilitating Transformation and Sustainable Outcomes

Ultimately, the framework has been designed to serve as an enabler in mental health system transformation—one that is capable of navigating complexity, promoting excellence, and delivering sustainable outcomes, thereby enabling mental health services to be responsive to current requirements and to support the development of workforce resilience.

Multi-Criteria Decision-Making Framework for Mental Health Services: A Structured Approach to Service and Workforce Planning

The development of a mental health multi-criteria decision-making framework was undertaken through task group discussions involving representatives from the mental health planning and delivery system including Department of Health/Health and Social Care Strategic Planning and Performance Group (SPPG), Chief Professional Officer Teams, Public Health Agency, Director of Mental Health and Regional Professional Leads This model has been designed to facilitate evidence-based decision-making, support the integration of service and workforce planning, and enable the objective prioritisation of the mental health workforce as part of service planning. It also aims to facilitate the formulation of mental health workforce team composition standards. Fundamentally, the MCDMA model aims to support mental health leaders, workforce and service planners, and professional leads to collaborate in the proactive feed-forward co-design of service and workforce models.

Framework Structure and Function

The multi-criteria decision-making analysis (MCDMA) framework is a structured approach that enables systems to evaluate complex options by considering multiple, often competing, criteria. In the context of mental health services, this framework systematically weighs factors such as population needs, professional expertise, clinical effectiveness, deliverability, and value for money. By using transparent and objective criteria, MCDMA facilitates the comparative analysis of proposals, service models, and workforce configurations in a balanced and evidence-based manner.

This framework is particularly valuable for integrating service and workforce planning in mental health because it creates a unified platform for aligning strategic objectives, professional roles, and resource allocation. It encourages collaboration among leaders, planners, and professional groups, making it possible to formulate workforce composition standards that optimise skill mix. As a result, MCDMA facilitates the prioritisation of both services and workforce development, ensuring decisions are needs-driven, outcome-oriented, and responsive to evolving community requirements. Ultimately, it supports the creation of resilient, equitable, and sustainable mental health systems that can adapt to future demands.

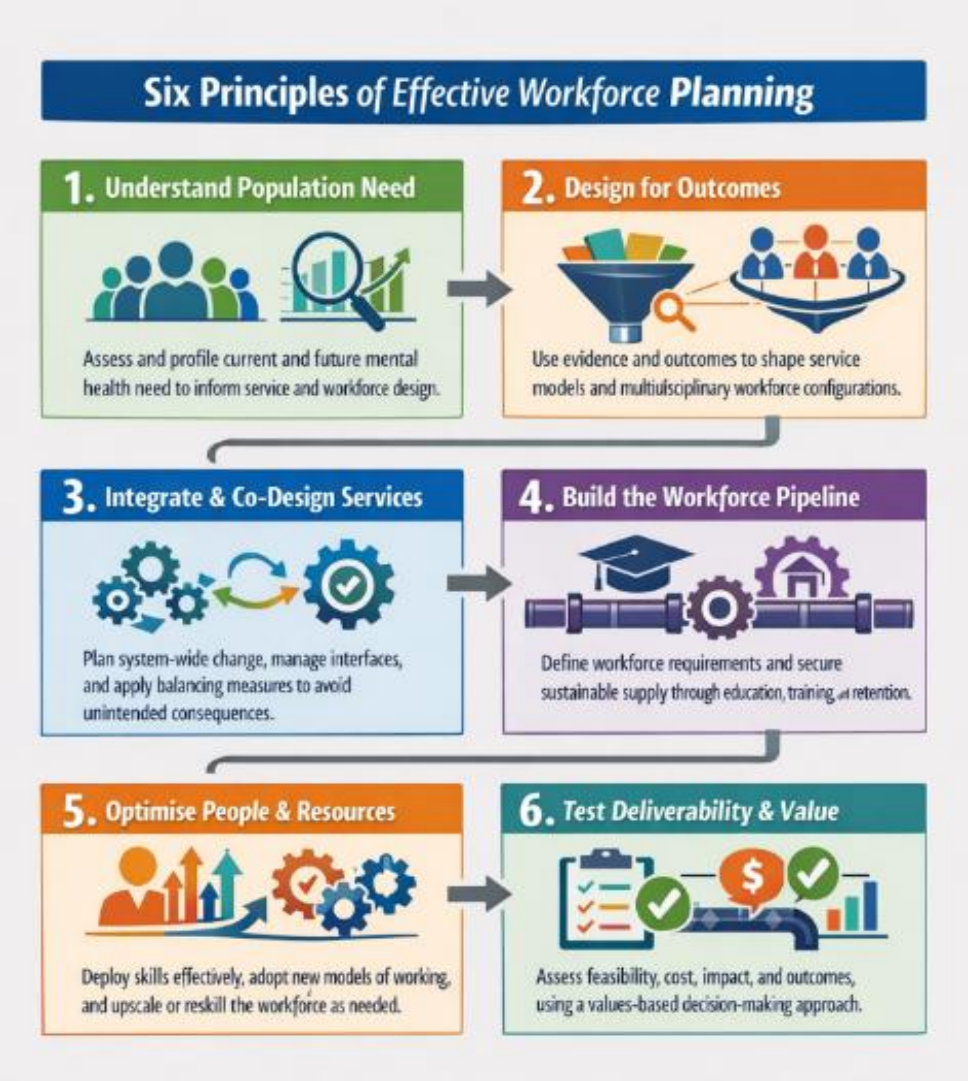
As outlined above, service planning and workforce planning currently operate as largely discrete processes, progressing in parallel rather than as an integrated system. This fragmentation, compounded by sustained resource constraints, limits the system's ability to align service ambition with workforce deliverability. The introduction of a Multi-Criteria Decision-Making (MCDM) framework provides a critical structural intervention by establishing a single, coherent mechanism through which service priorities and workforce requirements can be jointly assessed, balanced, and sequenced. By embedding shared criteria, evidential reasoning, and collective ownership into decision-making, the framework enables coordinated, system-level planning and mitigates the risks associated with siloed investment and unaligned service development.

Evidence-Based Decision-Making

The framework is designed to ensure that planning decisions are firmly rooted in robust evidence, with the primary goal of improving service design, strategic workforce planning, and the effective allocation and optimisation of resources across mental health services. At its core, the framework centres on evidential reasoning, providing a solid foundation for decision-making and priority setting. In the context of mental health, this means establishing a systematic process that integrates research evidence, clinical expertise, and real-world data to identify which services and workforce

priorities should be addressed. This approach moves away from decisions based on assumptions and instead promotes a data-driven process, ensuring resources are used effectively, services are tailored to actual population needs, and the workforce is equipped with the necessary skills and capacity.

Developing a rational, evidence-based foundation for decision-making aligns with the six principles of effective workforce planning These six principles form the **core analytical bridge** between the opening theory of change, the subsequent driver diagram, and the design and formulation of the four Mental Health Multi-Criteria Decision-Making Analysis (MCDMA) platforms. Together, they provide the **evidential reasoning architecture** required to prioritise mental health services and the workforce needed to deliver them in a way that is coherent, transparent, and implementable. Rather than functioning as a linear checklist, the principles operate as an interdependent decision-logic, ensuring that service and workforce planning is consistently anchored in population need, evidence of impact, deliverability, and value.



By structuring planning decisions around these principles, the MCDMA framework connects strategic intent to operational design. It ensures that choices about service models, workforce configuration, and investment are not abstract or aspirational, but are grounded in robust data, explicit assumptions, and tested feasibility. In this way, the principles directly inform the weighting, scoring, and trade-off decisions that underpin the four MCDMA platforms and shape the system-level prioritisation of services and workforce growth.

1. *Determine, Assess and Profile Population Need and Demand*

The first principle establishes the population-level evidence base for planning by systematically assessing current and projected mental health need. Drawing on epidemiology, demand patterns, inequalities, and lived experience, this step ensures that service and workforce planning is explicitly needs-led, rather than driven by historical service configurations or existing workforce supply. It clarifies the scale, complexity, and distribution of need across neighbourhood, core, and specialist services, directly informing service design, safer staffing requirements, and multidisciplinary workforce planning.

2. *Translate Evidence and Outcomes into Service and Workforce Design*

Building on assessed population need, the second principle translates evidence-based practice and agreed outcomes into effective service models and workforce configurations. This includes defining the right care, delivered at the right time, by the right professional or multidisciplinary team, in the right place, and at the right level of intensity. Crucially, outcome ambition is explicitly linked to workforce capacity, skill mix, seniority, and safer staffing requirements, creating a clear line of sight between evidence, service design, and workforce composition.

3. *Map Required Service Change and System Integration*

The third principle focuses on system coherence and the management of interdependencies. Required service changes are mapped across pathways and organisational boundaries, with particular attention to interfaces between primary and secondary care, core and specialist services, and statutory and community or voluntary sectors. Co-design and integration are central at this stage, alongside the use of balancing measures to mitigate unintended consequences such as workforce displacement, service destabilisation, or unmanaged demand shift. This principle reinforces whole-system stewardship, rather than isolated service- or profession-specific decision-making.

4. *Define Workforce Requirements and Secure the Workforce Pipeline*

The fourth principle translates agreed service models into clear, multidisciplinary workforce requirements aligned to emerging Mental Health MDT composition standards. It emphasises the development of sustainable education, training, recruitment, and retention pipelines, recognising professional lead-in times, supervision capacity, and the interdependencies between workforce growth, service stability, and system resilience. This step ensures that strategic ambition articulated through the theory of change is matched by a realistic and deliverable workforce supply.

5. *Optimise People and Resources through New Models of Working*

The fifth principle focuses on maximising the contribution of the existing workforce. It prioritises skill-mix optimisation, role redesign, advanced practice, and the upskilling or reskilling of staff in evidence-based therapeutic approaches. By enabling staff to work to the top of their scope within multidisciplinary teams, this principle directly supports safer staffing, strengthens workforce resilience, and enables the adoption of new and more effective models of care without destabilising core services.

6. *Test Deliverability, Value and Impact*

The final principle closes the planning loop by testing deliverability through structured assessment of feasibility, cost, workforce availability, infrastructure, and implementation readiness. It evaluates net effectiveness and value through a values-based lens, considering impact on outcomes, experience, equity, staff wellbeing, and system sustainability. Learning from this evaluation feeds back into ongoing refinement of service models and workforce assumptions, ensuring that planning remains adaptive, proportionate, and outcome-focused.

Importantly, these six principles provide the **analytical scaffolding** through which Mental Health Multidisciplinary Team (MDT) composition standards are developed and applied in practice. By anchoring service design and workforce decisions in population need, evidence of impact, deliverability, and value, the MCDMA-aligned framework establishes a coherent and repeatable logic for defining and prioritising the optimal mix of skills, roles, and competencies required within different mental health settings. This ensures that MDT standards do not default to static workforce

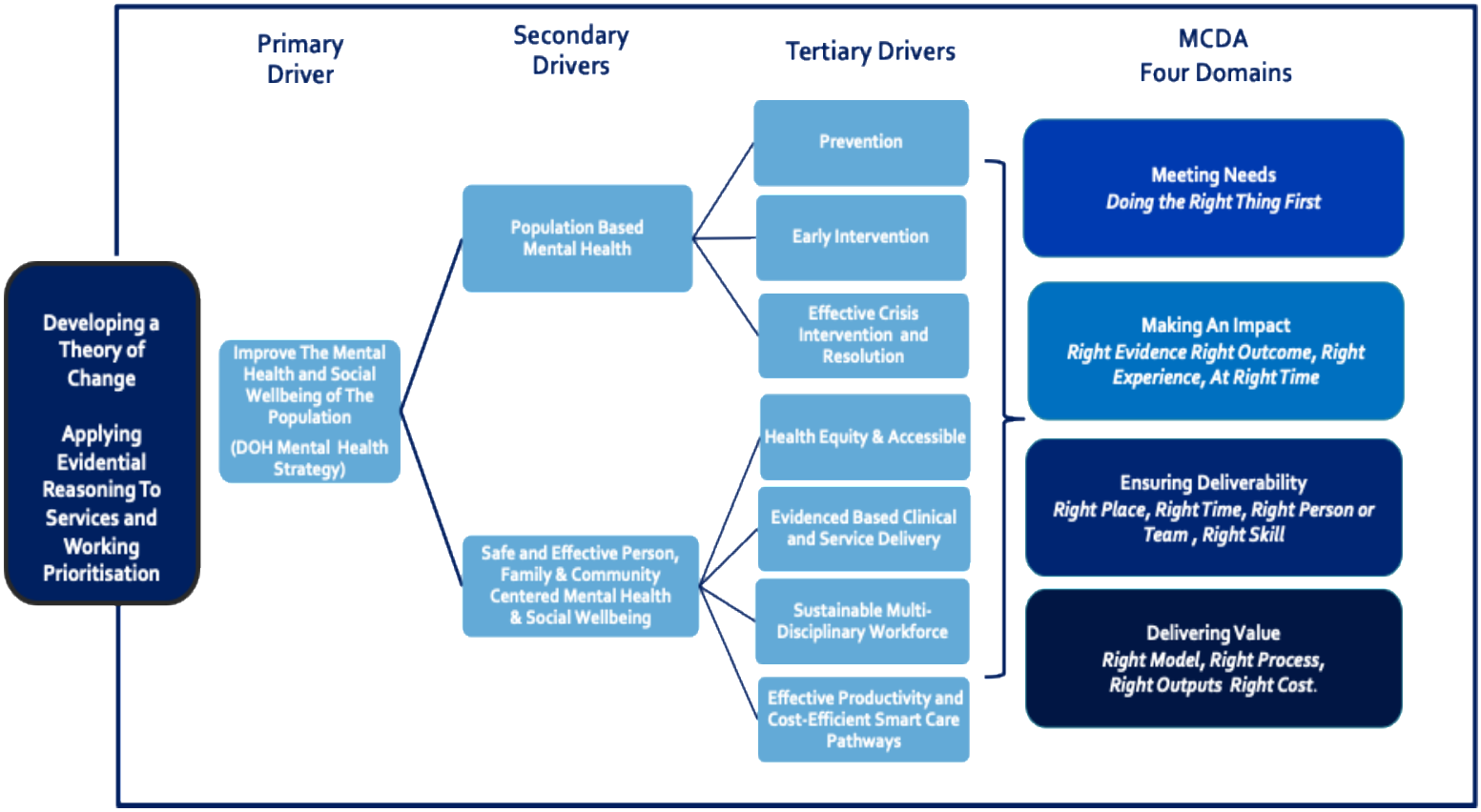
planning templates, but instead operate as dynamic and adaptive frameworks, enabling the translation of population need and system priorities into safe, effective, and sustainable models of care.

Theory of Change and Framework Architecture

Adopting a MCDMA approach that emphasises evidential reasoning is fundamental to developing a robust theory of change. In integrating service and workforce planning, it is essential that this integration is based on a strong theory of change, which in turn should guide the prioritisation of both services and the workforce needed to deliver them. The model proposed in this paper is intended to support and facilitate this objective.

The framework's architecture is depicted in a driver diagram below which sets out a clear theory of change and seeks to organise mental health services and workforce decision-making around four interrelated platforms closely aligned with the regional mental health strategy, Health and Social Care Workforce strategy, and the Department of Health Reset Plan.

Alignment with Strategic Direction – Mental Health Multi-Criteria Analysis Framework Driver



Diagram

The framework is intentionally aligned with the strategic direction articulated in the Department of Health Reset Plan, which emphasises prevention, early intervention, and innovative practice. The Reset Plan calls for the remodelling of access to care and the introduction of neighbourhood-based, integrated models. Achieving these ambitions requires fundamental rethinking of team configuration, workforce deployment, and investment in evidence-informed professional development. The framework supports these aims by promoting distributed decision-making, local empowerment, and adaptability across the entire care continuum.

Distributed, Collective Decision-Making

Central to the framework is the principle of distributed, collective decision-making. Evidence demonstrates that shifting authority to those with direct knowledge and experience—namely, multidisciplinary teams (MDTs) at the point of care—enhances service effectiveness, optimises resource use, and yields better outcomes for both staff and service users. Distributed MDT decision-making improves responsiveness, encourages experimentation, and generates innovative solutions by leveraging local knowledge. This not only improves efficiency across professional, team, and organisational boundaries but also enhances professional engagement and ownership. By drawing on this expertise, the four platforms provide a structured approach to ensuring decisions are effective, sustainable, and enable teams to adapt models of care which stabilise, reform, and deliver better outcomes.

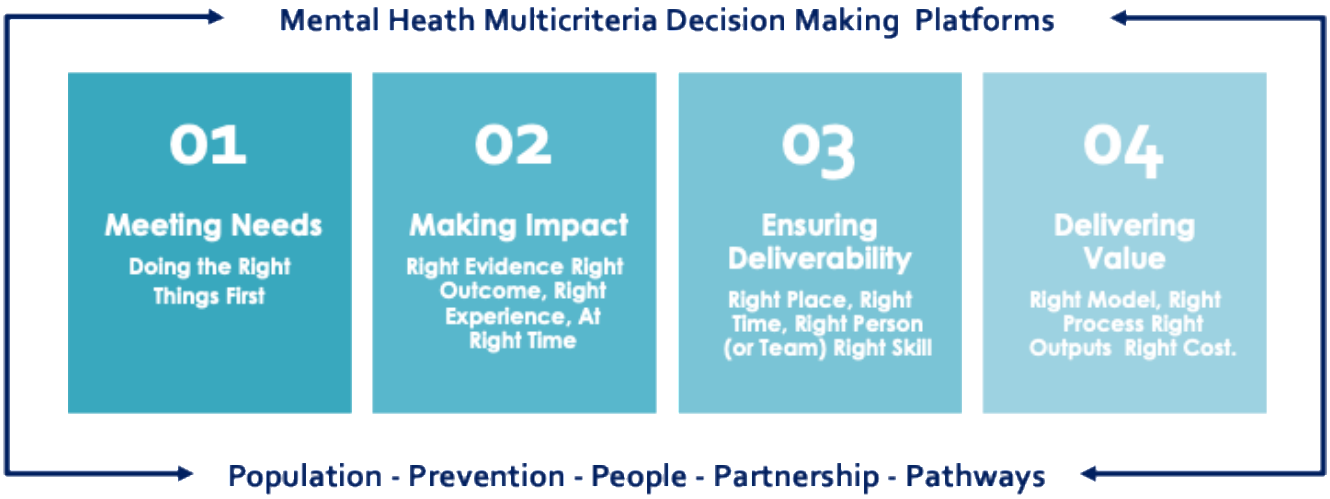
Adopting a Population-Based Approach

The driver diagram above provides a visual and conceptual representation of the framework's theory of change underpinning the drive to integrate service and workforce planning. It clearly outlines the primary, secondary, and tertiary drivers necessary to achieve the ambitions detailed in the mental health strategy and the 2022 mental health workforce review. Central to the framework is the overarching goal of improving the mental health and social well-being of the population in Northern Ireland. Achieving this objective depends on adopting a population-based mental health approach and designing authentic, safe, and effective services that are centred around individuals, families, and communities.

This approach inherently requires prioritising prevention, early intervention, and the capacity for effective crisis intervention and resolution. By focusing on these areas, the system can better respond to needs as they arise and, crucially, prevent escalation in need.

The delivery of safe and effective mental health care is fundamentally supported by the promotion of health equity and improved access. This means ensuring that all current service models and care pathways are grounded in solid evidence, with a strong focus on ensuring care is delivered through mental health teams with the right composition of disciplines. The overarching objective is for mental health services to reliably deliver care that is safe, effective, high-quality, and optimises the value for the resources being deployed. Within this context, the use of primary, secondary, and tertiary drivers has been instrumental in shaping the multi-criteria decision-making platforms as detailed in Figure below.

The Four Mental Health Service and Workforce Planning and Decision-Making Platforms



These four platforms have been thoughtfully developed to support and embody both strategic priorities and the evidence required for informed decision-making in mental health service development and workforce planning. It is intended that these four platforms will be utilised systemically in shaping and in the co-design of services, as well as in the optimisation of existing resources and/or in the allocation of any new resources which might become available. These platforms underscore the importance of adopting a comprehensive, population-based planning approach in mental health and the centrality of place-based prevention. Equally, they emphasise the critical need to create the right conditions for the people who staff services to make the impact and difference they believe in.

The development of a systemic approach to mental health care provision and workforce planning is interdependent on fostering strong partnerships among professionals, across disciplines and

organisational boundaries. This is essential for co-designing and implementing system-orientated integrated mental health care pathways. The objective is clear: to ensure that every person has access to care through a “no wrong door” approach, which consistently delivers the right care, at the right time, by the right person or team, in the right place, with the right skills, delivering the right experience for people, families, and communities, while maximising the value, impact, and effectiveness of mental health services.

Medium- to Long-Term Planning and Consistency

The mental health multi-criteria decision-making framework has been developed to support medium- and long-term planning. The framework aims to create a unified approach to decision-making across regional, local system (Trust Catchment Areas), and neighbourhood levels. It provides a foundation for service planning, service design, enabling service reform, prioritisation, and the evaluation of service performance aligned with the regional mental health outcomes framework.

Alignment with the Quintuple Aim

The decision-making platforms are grounded in the principles and disciplines of the Institute for Healthcare Improvement’s Quintuple Aim. Within this context, the multi-criteria decision-making framework is designed to ensure that people in Northern Ireland receive the right care, in the right place, at the right time, delivered by the right person or team with the right skills, resulting in the right outcomes.

5.1 Health Multi-Criteria Decision-Making Analysis MCDMA – Platforms Overview

Platform 1: Meeting Needs – Doing the Right Thing First

MCDA Platforms	Sub-Criteria/Focus	Indicative Decision-Making Indicators (illustrative)
Meeting Mental Health and Social Needs Doing the right things first. Weighted Score 35%	Robust Population Needs Assessment	Draws on epidemiological data, qualitative insights, including lived experience.
	Mental Health Policy Alignment	Aligns with legislative mandates, mental health strategies, and promotes cross-sector collaboration.
	Public Mental Health Approach	Prioritizes primary secondary and tertiary public mental health interventions, clearly addresses the wider social determinants of health Including physical health and lifestyle as well as enabling the co-design of preventive interventions in partnership neighbourhoods and local communities.
	Safety Promotion and Risk Mitigation	Enables rapid crisis response, risk reduction, early intervention pathways, advanced care planning, and inter-agency cooperation.
	Support for At-Risk Populations	Promotes social inclusion and this intentional about reaching out to vulnerable communities and ensures services responses are culturally inclusive and tracks equity-focused outcomes.
	Innovative and people centred solutions	Focuses on innovation and introducing new models which reimage capacity, improve mental health literacy and the makes full use of access enabling technologies to promote self-care, self-management and enables help-seeking behaviours.

Foundational Focus: Meeting the Needs of Individuals, Families, and Communities

The first and foundational decision-making platform focuses on meeting the needs of individuals, families, and communities by adhering to the principle of “doing the right things first.” Table 1 above summarises the sub-criterion and the indicative indicators underpinning this platform. This approach places clear emphasis on prevention and reducing the risks associated with mental ill health across the population, with early intervention as a central pillar. Critically, this platform also provides a primary benchmark for assessing service developments or service reform proposals, against their capacity to identify and address the most pressing mental health needs in the population.

Systematic Identification and Differentiation of Population Needs

The platform requires service/workforce proposals to demonstrate:

- The systematic identification and differentiation of population needs at regional, local system, and neighbourhood levels.
- How epidemiological and population health data has been used to formulate the approach and how a public health approach to mental health has been incorporated into the model and/or professional practice.

- How it will address the diverse and varying needs of different communities.
- Alignment with broader public health objectives and the reduction of health inequalities, and how wider social determinants have influenced and shaped the approach.

Assessment Criteria: Building Capacity and Accessibility

In practice, this means that assessment criteria include an analysis of how the service or workforce design:

- Builds population health capacity and capability within neighbourhoods, ensuring the model of delivery is informed by locally grounded and real-world experiences.
- Ensures the delivery of timely, accessible, effective, and evidence-based interventions that meet the specific mental health needs of the local population.
- Enables effective cross-sector collaboration and co-design, including evidence of joint planning, shared goals, and coordinated delivery of care.
- Measures and assesses the achievement of quantifiable improvements in mental health and well-being at the local level, using robust indicators to track progress and impact.

Promoting Public Health Approaches and Health Equity

This platform is fundamentally rooted in promoting primary, secondary, and tertiary public health approaches, and requires clear evidence of how the service advances health equity—particularly in meeting the needs of marginalised groups, as well as individuals and communities who may encounter barriers to accessing conventional services.

Alignment with Policy and Innovation

As a core criterion for assessing the merits of any service development proposal, this platform also evaluates the extent to which service development and workforce priorities are aligned with legislative and policy mandates, as well as broader mental health strategies. This includes how workforce/team practice will be reconfigured to align with these policy mandates.

Driving Innovation and Expanding Access

Ultimately, this platform challenges proposals to be truly innovative, demanding new solutions that fundamentally transform and expand access to mental health care. This includes reimagining how

and where people receive support—leveraging community partnerships, outreach initiatives, utilising enabling technologies, boosting mental health literacy, and promoting self-care and self-management. Furthermore, integrated, population-based approaches that prioritise prevention and early intervention help to decrease overall service demand, improve service flow, ensure equitable access, and contribute to better recovery rates and outcomes for individuals and communities. These strategies are also crucial for ensuring effective capacity flow and efficient resource use.

Summary: The Benchmark for Needs-Driven and Prevention-Oriented Services

In summary, this platform is the most influential of the four, underscoring the critical importance of population health in determining service priorities. It serves as a rigorous benchmark to ensure that service proposals are truly needs-driven, prevention-oriented, and capable of enabling early intervention. The platform evaluates service development or reform proposals based on their potential to enhance population mental health outcomes, reduce inequalities, and deliver sustainable, community-focused mental health and wellbeing solutions.

Platform 2: Making an Impact – Delivering the Right Evidence, Experience, Outcome, and Timing Translating Evidence into Effective Practice

MCDA Platforms	Sub-Criteria/Focus	Indicative Decision-Making Indicators (illustrative)
Making an Impact	Improved access, equity and inclusivity,	Reimagines waiting management approaches, Redesigns pathways that promote integration and improve access as well as providing tailored support outreach support to unrepresented communities.
right evidence, right experience right outcome, right time.	Clinical and Care Effectiveness	Demonstrates that care interventions and pathways are evidence based. That models of care embedded routine outcomes analysis focus on getting it right first time every time. The model of care ensure effective prevention of relapse and effective follow up, including person-centred transition across ages, and/or services pathways.
Weighted Score 30%	Person-Centeredness and Shared Decision-Making	Collaborates with service users and carers in the co-design of pathways. Clear evidence that a person-centred framework and personalized care model. Provides clear evidence of shared decision making and dynamic risk management including advanced safety planning and the development wrap around models that comprehensively meets the rehabilitative need, particularly of people with complex and enduring mental health needs.
	Outcome Measurement	Provides clear evidence of the embedding of the regional mental health outcome's framework in practice, including the routine evaluation and monitoring of outcomes. Demonstrates how outcome analysis is used to improve service -user experience, care practice and service delivery.

The second key decision-making platform is focused on ensuring that mental health services consistently translate evidence into practice, delivering the right outcomes and experiences for

individuals in the right place and at the right time. Table 2 above summarises the sub-criterion and the indicative indicators underpinning this platform.

Prioritising High-Impact Services and Interventions

Central to this platform is the prioritisation of services and interventions that deliver the greatest impact, guided by the application of robust, evidence-based care. As a result, prioritisation decisions are focused on those service, teams, and workforce who can demonstrate their respective ability to achieve significant and impactful change.

Alignment with the Mental Health Outcome Framework

A critical component of this platform involves the systematic evaluation of how well service developments align with the Mental Health Outcome Framework and whether care systems and procedures are designed to ensure service gets care right, right time, every time. This involves a thorough assessment of whether care models are built upon the most current and robust evidence, as well as whether the workforce possesses the necessary competencies to provide effective, evidence-based interventions.

Optimising Therapeutic Interventions and Resource Allocation

Optimising the use of therapeutic interventions to achieve the best possible outcomes for individuals, families, and communities is essential. The platform requires clear demonstration of how resources are allocated effectively to achieve the greatest impact in terms of measurable improvements in mental health and overall well-being.

Addressing Socio-Economic Impacts through Evidence-Based Practice

Research consistently demonstrates that mental ill health carries substantial and enduring costs for individuals, families, public services, and the wider economy. In Northern Ireland, the estimated annual economic burden of mental ill health—approximately £3.4 billion—significantly outweighs current expenditure on mental health services. This disparity highlights a long-recognised strategic tension: the imperative to respond to immediate and rising demand, alongside the need to invest in prevention and early intervention in a resource-constrained environment.

Where capacity is predominantly absorbed by acute and downstream pressures, opportunities to prevent escalation and reduce future demand are necessarily limited. Over time, these dynamic risks entrenching a cycle in which unmet or delayed need generates higher downstream costs, reduced system efficiency, and avoidable pressure on scarce specialist expertise. Strengthening the consistent application of evidence-based practice—particularly prevention-oriented, early intervention, and integrated models of care—is therefore central not only to improving outcomes for people who use services, but also to optimising the impact and sustainability of the mental health workforce as a whole.

Emphasis on Outcome Measurement, Research, and Workforce Development

This platform emphasises the importance of outcome measurement, research, and development to ensure that care interventions deliver the right results. There was significant agreement, as outlined in section two, about the need to upskill and reskill the workforce. Therefore, this platform seeks clear evidence of robust action to upskill and reskill the mental health workforce, with a particular focus on equipping staff to deliver evidence-based psychological and recovery-oriented therapies. Proposals must provide compelling evidence that workforce development initiatives are grounded in the latest research and best practices.

The Role of Evidence-Based Interventions and Training

Numerous studies underscore that prioritising evidence-based interventions—delivered by practitioners with specialised, up-to-date training—leads to significantly improved clinical results, reduces both the severity and duration of mental health episodes, and greatly enhances the prospects for sustained recovery (NICE Guidelines on Therapeutic Intervention in Mental Health).

Collaborative Decision Making and Lived Experience Partnerships

This platform prioritises high-quality shared decision-making and partnerships with those who have lived experience of mental health issues. This includes seeking clear evidence of active collaboration with service users and carers in designing care pathways. The platform looks for robust evidence of the adoption of person-centred frameworks and personalised care models, and patient and family reported outcomes.

Dynamic Risk Management and Holistic Care

It will assess whether dynamic risk management strategies—such as advanced safety planning and the development of comprehensive wraparound support—have been designed in the service and practice models. The platform also seeks evidence of how the rehabilitative needs of people with complex and enduring mental health conditions are addressed as part of the care model. Proposals should adopt a holistic approach, particularly in addressing the unique physical health implications associated with mental health challenges, including the optimisation of pharmacological regimens and the management of polypharmacy. Pharmacy has therefore been identified as a core priority.

Protecting Psychological Therapies and Workforce Collaboration

Numerous NICE guidelines highlight the significant role of psychological therapies in supporting mental health recovery. Protecting the integrity of these therapies and embedding them within core service delivery is critical. Optimising the workforce also involves refreshing and expanding the scope of the "Working Together and Learning Together" Framework to support ongoing workforce development and best practice. Proposals should demonstrate how this framework has been applied.

Conclusion: A Platform for Evidence, Outcomes, and Sustainable Impact

In conclusion, the second decision-making platform is pivotal in ensuring mental health services are grounded in evidence-based practice, with a strong focus on delivering the right care, in the right way, at the right time and place. The seminal points of this platform include the prioritisation of interventions that demonstrate measurable impact, rigorous alignment with the Mental Health Outcome Framework, and systematic upskilling of the workforce to deliver evidence-based and recovery-oriented therapies. It emphasises the importance of resource allocation based on robust evidence, collaborative partnerships with those with lived experience, and the adoption of holistic and person-centred care models. Additionally, it highlights the need to address both mental and physical health needs, protect the role of psychological therapies, and ensure ongoing workforce development through frameworks such as "Working Together and Learning Together."

Platform 3: Ensuring Deliverability – Right Place, Right Person, Right Skill

MCDA Platforms	Sub-Criteria/Focus	Indicative Decision-Making Indicators (illustrative)
Ensuring Deliverability Weighted score 25%	Service Delivery Feasibility	Demonstrates that the proposed service delivery models are feasible with supporting evidence of how capacity has been modelled based on need to ensure successful implementation.
	Credible Timelines	There is robust implementation plan, detailing time bounded implementation steps, including supporting evidence of plan actions to be taken.
	Services and Workforce Readiness	The service design include detail of the necessary multidisciplinary workforce composition, with a comprehensive assessment of workforce capacity and advance roles/upskill/reskill has been analysis to deliver maximum benefit . It clearly outlines all measures taken to ensure an adequate supply of staff and demonstrates recruitment preparedness to effectively deliver the required services and interventions.
	Infrastructure and Technology	The essential infrastructure requirements have been clearly identified, with supporting evidence that both physical and digital components have been thoughtfully planned to enable efficient service delivery. Comprehensive management strategies are in place to address system and service interdependencies, including thorough analysis of key balancing factors that could potentially affect how services are provided.
	Service Stabilization	The service model is structured to provide consistent, stable, and sustainable delivery. It incorporates an evaluation process aimed at minimizing workforce displacement, while also encouraging service integration and the sharing of skills.

The third decision-making platform is grounded in the principle of deliverability, emphasising that mental health services must be provided in the right place, at the right time, by the right person with the right skill set, and supported by a robust implementation plan. Table 3 above summarises the sub-criterion and the indicative indicators underpinning this platform. Achieving this balance requires not only a commitment to effective service delivery but also a rigorous assessment of what can realistically be achieved.

Addressing Historical Challenges

Historically, persistent vacancies and delays in appointing key roles have hindered the planning and delivery of mental health services. These recurring challenges stem from short-term workforce planning and a structural disconnect between service planning and workforce development, creating barriers to change, reliability, and service quality. Given these persistent issues, the platform underscores the importance of thoroughly testing deliverability when setting and refining service and workforce priorities.

Integrating Workforce Planning with Service Reform

Effective mental health service delivery depends on integrating workforce planning with multi-year service reform, ensuring that the right professionals and skills are available to meet identified needs. This integration involves developing multidisciplinary workforce standards tailored to specific mental health domains, which supports team design, targeted training, and effective recruitment. Collaborative planning across sectors—particularly between primary care and community services—enhances the alignment of services with community needs, reduces fragmentation, and optimises resource utilisation.

Forward-Looking Strategies for Deliverability

Forward-looking strategies, such as robust training programmes, targeted supervision, and clear governance structures, are essential for maintaining service deliverability and workforce resilience. Integrating specialist expertise into core services strengthens adaptability and long-term sustainability. Extensive research indicates that care based on interdisciplinary cooperation and collaborative multidisciplinary working is associated with increased patient safety, better outcome system efficiency as improving the access to care and experience of care. In addition, the careful balancing of core and specialist roles, supported by joint planning and robust counterbalancing measures, are crucial for preventing workforce displacement and service instability.

Systematic and Collaborative Workforce Planning

Ultimately, systematic and collaborative workforce planning ensures that individuals receive the right care at the right time from the right professionals, thereby maximising positive outcomes and strengthening system resilience. Within this context, the platform establishes a clear framework for assessing and evaluating service development and workforce proposals, structured around the following key criteria:

- Feasibility of Delivery: Proposals must present compelling evidence that the proposed service models are practical and achievable. This includes a thorough demonstration of how service capacity has been modelled to meet identified needs, ensuring a realistic and successful implementation.

- Realistic Time Scales: Each proposal must include a robust implementation plan with clearly defined steps and timeframes. Supporting evidence should be provided for all proposed actions, guaranteeing that each phase is attainable within the specified timelines.

- Service and Workforce Readiness: The design should outline the required multidisciplinary workforce composition, assess workforce capacity, and detail advanced roles and upskilling initiatives. Proposals must demonstrate preparedness for recruitment and the effective delivery of services and interventions.

- Infrastructure Requirements: Essential physical and digital infrastructure must be identified, with evidence showing thoughtful planning to enable efficient service delivery. Management strategies should address system and service interdependencies, incorporating analysis of key balancing factors that may influence service provision.

- Stability and Sustainability: Service models should be structured to ensure consistent, stable, and sustainable delivery. An embedded evaluation process must minimise workforce displacement, promote integration, and encourage the sharing of skills across teams and disciplines.

Conclusion

Fundamentally, deliverability means that individuals with mental health needs receive the right care, at the right time, from the right people, in the right place—ensuring the best possible outcomes through coherent and sustainable service models.

Platform 4: Delivering Value for People, Families, Communities, and Mental Health Systems of Care

MCDA Platforms	Sub-Criteria/Focus	Indicative Decision-Making Indicators (illustrative)
Delivering Value Right model right processes right output right cost Weighted score 15%	Financial Planning	The service redesign proposal includes a sound financial plan that clearly shows cost-effectiveness and delivers value for money in relation to the main outputs and activities.
	Value for Money	A comprehensive cost-benefit analysis has been carried out, which accurately benchmarks service cost/impact against of comparable care models.
	Added Value	The available evidence demonstrates that current resources have been optimized, and right model of care/pathways including new ways of working have been develop supported right workforce composition and skill mix
	Productivity and Quality Improvement	There is a strong commitment to ongoing quality and productivity enhancements, ensuring that specialized skills are applied efficiently—by the appropriate person in the right place, and at the right time
	Clinical Governance	Comprehensive multidisciplinary case management frameworks are established. There is effective arrangement for clinical/professional leadership and governance., including robust assurance mechanisms that continually incorporate lessons learned from patient safety incidents and clinical outcomes to drive ongoing improvement.

Overview of the Fourth Decision-Making Platform

The fourth decision-making platform focuses on delivering value across all aspects of mental health services. Table 4 above summarises the sub-criterion and the indicative indicators underpinning this platform. Value is defined by care that is accessible, safe, reliable, effective, and efficient. This platform emphasises evaluating the resilience of mental health systems, service models, and care pathways by identifying and addressing potential single points of failure while eliminating duplication and inefficiencies within interconnected systems.

Financial Planning and Cost-Effectiveness

A key aspect of this platform is the assessment of service redesign proposals to ensure they are supported by robust financial plans. These plans must demonstrate clear cost-effectiveness and value for money, directly linked to primary outputs and activities. Comprehensive cost-benefit analyses are required to benchmark service costs and impacts against comparable care models. Proposals should provide evidence that existing resources have been fully optimised and that the chosen model of care—including innovative pathways and new approaches to service delivery—is supported by the appropriate workforce composition and skill mix.

Quality, Productivity, and Governance

To drive quality and productivity improvements, the platform examines approaches to multidisciplinary case management, clinical and professional leadership, and details of clinical governance and assurance mechanisms. It also assesses how lessons learned from patient safety incidents and clinical outcomes are leveraged to foster ongoing improvement. Evidence shows that, even with limited resources, mental health services can enhance performance through service redesign, the adoption of new working models, and the use of emerging technologies.

Commitment to Innovation and Rigorous Evaluation

Delivering value for individuals, families, communities, and the broader mental health system requires a commitment to innovation and service reconfiguration. This involves subjecting existing practices to transparent and rigorous evaluation, questioning the rationale behind current approaches, and assessing outcomes—especially regarding socio-economic impact.

Optimising Service Interfaces and Resource Allocation

Strategically reducing unnecessary handoffs and embedding specialist expertise within core services leads to more accessible, efficient, and person-centred mental health care. Optimising the interfaces between core and specialist services minimises duplication and complexity, ensuring resources are allocated where they have the greatest effect. This results in more coordinated, reliable care delivery and smoother pathways for individuals and families, with fewer transactional referrals.

Driving System Change and Service Improvement

The principle that repeating the same actions yields the same results underpins the four decision-making platforms, which are designed to encourage a ‘shift left’ mindset. This involves reimagining access to services and tackling the negative impact of waiting lists on mental health and well-being. Achieving this requires remodelling service practices to align with the ambitions outlined in the Department of Health Reset Plan, particularly through the development of neighbourhood-based models that reach people where they are. By strengthening capability, capacity, and specialist skills within core services, the mental health system can deliver better outcomes using existing resources. Ultimately, this ensures value for people, families, and the wider system through streamlined, collaborative, and effective practices.

Service Prioritisation and Resource Optimisation

These platforms are designed to facilitate the prioritisation of both services and workforce at the regional, local, and neighbourhood levels. The overarching aim is to establish a model of service prioritisation based on population needs. This approach will lead to the creation of service clusters that reflect the needs of specific subpopulations and support the development of multidisciplinary plans. Such plans will ensure that the right professional/team or services—including those provided by community and voluntary sectors—are available in the right places. Additionally, the framework incorporates a focus on resource optimisation and the strategic deployment of expertise, ensuring that services are both effective and sustainable.

MCDM Domain Proposed Weighting and Rationale

A multi criteria decision making analysis framework is dependent upon a structured scoring system and, following discussions with the multi criteria analysis design group and steering group, the following scoring system has been developed as a guide for effective service and workforce planning decision as outlined in table 4 below.

Scoring level	Scoring Description
1- low evidence	Minimal evidence supplied; No connection made with population need/evidence and fails to substantiate claims or define impact across any domains. The submission is largely anecdotal or unsupported by data, with significant limitation in identifying benefits, cost effectiveness or outcomes.
2 – limited evidence	Limited evidence provided; though some relevant findings exist, these are sporadic, inconsistent, or weakly substantiated across domains. Services development remains preliminary, and there are clear gaps in the robustness, depth, and generalizability of the evidence.
3 – Moderate Evidence	Moderate evidence supplied; a reasonable degree of support is shown with consistent findings in several domains, but notable weaknesses or omissions persist. The evidence is credible and relevant, although several domains require stronger, more comprehensive substantiation.
4 – Good Evidence	High-quality evidence presented; the submission is well-supported across all domains, with strong, reliable, and relevant data. Minor limitations may exist, but they do not substantially detract from the overall robustness, consistency, and applicability of the evidence.
5 – Excellent Evidence	Exceptional and comprehensive evidence provided; the submission demonstrates exemplary rigor, substantiation, and impact with no discernible gaps or weaknesses. All domains are thoroughly addressed with conclusive, generalisable, and actionable findings, setting a benchmark for best practice.

In the application of these score parameters, the following weightings have been attributed to reflect the decision-making priorities in mental health service planning:

When applying these scoring parameters, the following weightings table 5, have been assigned to reflect the key priorities in mental health service planning.

MCDMA-Platform Criteria Weighting (100%)	Criterion Descriptor
Meeting Needs – 35%	Evaluates how effectively the service addresses the specific mental health requirements of the target population, including the qulaity of accessibility, equity, and cultural relevance.
Making Impact -30%	Assesses the demonstrable outcomes achieved by the service, focusing on the extent to which it improves mental health and well-being, reduces disparities, and achieves positive change based on available evidence
Deliverability – 25%	Considers the practicality of implementing and sustaining the service, considering factors such as available resources, workforce capacity, and the ability to adapt to changing circumstances.
Delivering Value -15%	Examines the overall benefit provided relative to the investment, including considerations of cost-effectiveness, integration with other services, and long-term sustainability.

The purpose of this scoring and weighting matrix is to support balanced decision-making. It is designed to anchor decisions in both person-centred and system-level realities, offering a structured approach for identifying which combinations of services and workforce deliver the greatest impact and foster sustainable, reliable service models.

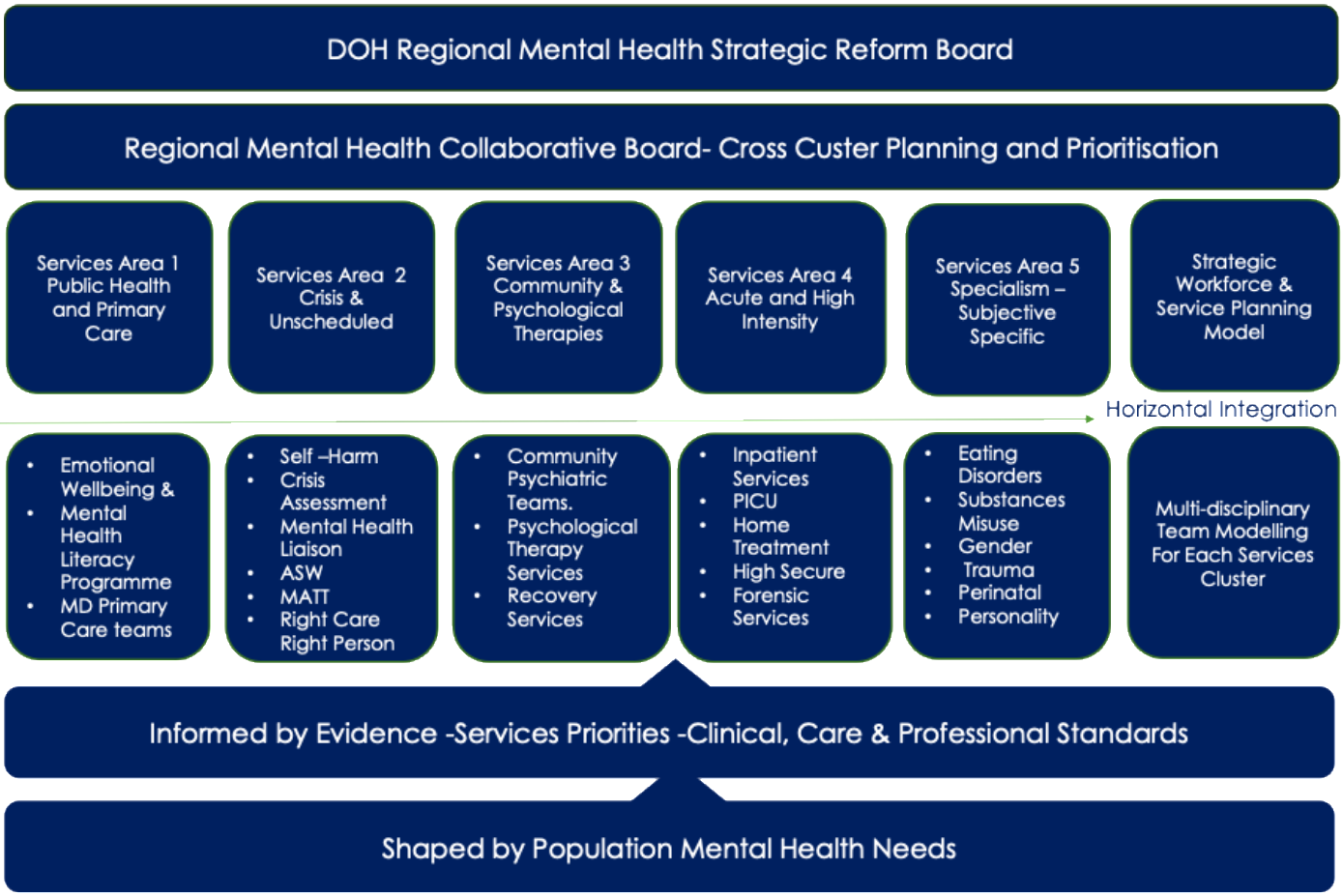
Balancing considerations: The Multi-Criteria Decision-Making (MCDM) criteria provide a structured framework for planning and prioritisation; however, like all frameworks, they must be applied alongside appropriate balancing measures. It is also recognised that emerging or novel models of care may not yet have a fully developed evidence base. In such circumstances, a proportionate and pragmatic approach may be required. Importantly, the MCDM domains provide a consistent structure through which new, novel, and evolving models can be systematically assessed, tested, and refined over time.

Multi Criteria Decision-Making Analysis Implementation Process

Effective leadership and strong system ownership are essential for the successful implementation of multi-criteria decision-making (MCDM) frameworks in mental health service planning. Achieving this requires the establishment of robust regional and local mechanisms to support the co-design of mental health team composition standards. These mechanisms should draw on the four foundational platforms outlined in this design. Central to this process is the creation of service clusters, which not only facilitate the development of tailored team composition standards for each

distinct mental health service area, but also enable the prioritisation of service development and identification of key workforce needs across different areas of expertise. Figure below provides an illustrative example.

5.2 Service Clusters and Workforce Planning Model Illustrative



https://www.transformationpartners.nhs.uk/wp-content/uploads/2017/11/Building-Workforce-Models-A-Brief-Introduction.pdf

Strengthening the Role of Service-Cluster Models in Service and Workforce Prioritisation

Service-cluster models provide a critical analytical and structural foundation for aligning service design and workforce planning in a coherent, evidence-based, and deliverable way. Rather than viewing workforce requirements in isolation or along single-professional lines, the cluster approach frames workforce planning around **functions, activities, and pathways of care**, enabling services and the workforce required to deliver them to be modelled together as an integrated system. This approach reflects established best practice in workforce modelling, which emphasises the need to test different service scenarios, explore alternative models of care, and understand the dynamic interactions between workforce supply, demand, and system capacity.

Within this model, each service cluster is responsible for producing a workforce plan that accurately reflects the specific needs of its population and the functions the service is required to perform. These plans must be shaped by relevant policy and statutory requirements, strategic objectives, and the best available intelligence on population need and service demand. In line with the six workforce modelling principles highlight earlier cluster-level plans are grounded in robust baseline data, make explicit assumptions, and test alternative scenarios—such as new models of care, role redesign, or the introduction of enabling technologies—to understand their workforce implications and feasibility. This ensures that both service and workforce priorities are not only aspirational, but realistic, evidence-informed, and deliverable over time.

A defining strength of the service-cluster approach is its emphasis on **joint ownership and co-production**. Workforce plans developed at cluster level are not owned by a single function or profession but are co-designed by clinical and professional leads, workforce planners, service planners, and operational service leads. This collaborative process is essential to ensuring that modelling assumptions are credible, that professional roles are appropriately understood, and that proposed workforce configurations reflect how care is delivered in practice. Critically, this joint ownership also strengthens alignment between service ambition and workforce reality, reducing the risk of unintended consequences such as workforce displacement, service fragility, or over-reliance on limited specialist roles.

Cluster Interdependencies and System-Level Leadership

While each service cluster establishes its own priorities and workforce requirements, effective cluster-based planning depends on explicit recognition of **interdependencies across the system**. Individuals and families may move between, or receive support from, multiple clusters across the continuum of care. Workforce decisions taken within one cluster therefore have the potential to create impacts elsewhere—both positive and negative. NHS workforce modelling guidance highlights the importance of system-level oversight to manage these interdependencies, ensuring that changes in one part of the system do not inadvertently destabilise another.

System-level (regional) leadership plays a pivotal role in this regard. At regional level, oversight is required to ensure that service-cluster workforce plans are aligned, that common assumptions and data sources are used, and that cross-cluster risks and dependencies are actively managed. This includes supporting the consistent application of multi-criteria decision-making approaches, testing

deliverability at scale, and ensuring that prioritisation decisions across clusters collectively optimise outcomes for the population, rather than maximising performance in isolated service areas.

5.3 Governance, Oversight, and Strategic Alignment

Given its remit for standardisation and system coherence, the Regional Mental Health Service (RMHS) Collaborative Board—working in close partnership with Chief Professional Officers and their respective leads—is well positioned to provide the necessary governance and oversight for service-cluster-based workforce planning. This governance role extends beyond assurance; it encompasses setting expectations for modelling quality, facilitating shared learning across clusters, and arbitrating where priorities or workforce demands compete across the system. By overseeing aggregated priorities across clusters, the Board can ensure a unified strategic direction for service development and workforce investment, consistent with population needs and system capacity.

Benefits of Service- and Workforce-Planning Clusters

A key advantage of service-cluster models is their ability to support **multidisciplinary workforce planning** through the development of cluster-specific MDT composition standards. Workforce composition planning within clusters provides a structured method for determining the optimal mix, number, and distribution of professional roles required to deliver defined service functions safely and effectively. This aligns with workforce modelling principles that emphasise matching skills and capacity to service activities, rather than planning around existing roles or organisational boundaries.

Through this approach, cluster-specific MDT standards can be explicitly linked to population need, evidence-based practice, models of care, resource availability, and safe staffing requirements. This strengthens consistency, reduces unwarranted variation, and supports equitable access to high-quality care across the system.

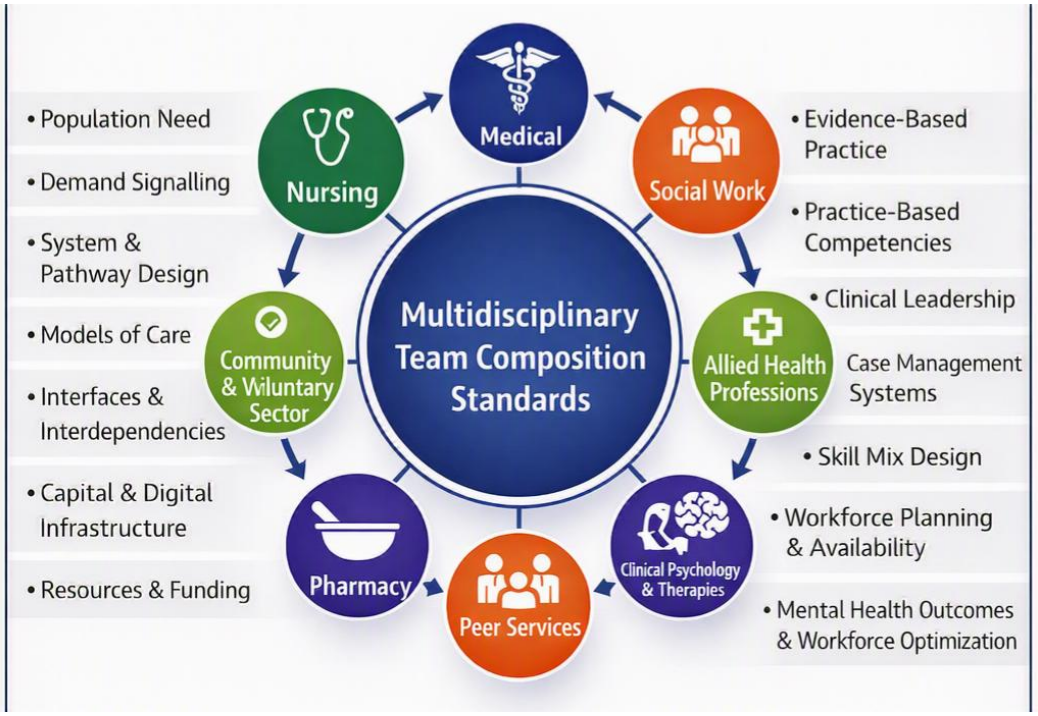
Integration and Adaptability in Workforce Planning

Finally, service-cluster models enable workforce planning to function as a **dynamic and iterative process**, rather than a one-off exercise. As service models evolve, demand patterns shift, or new evidence emerges, clusters provide a clear locus for reviewing assumptions, updating scenarios, and adjusting workforce configurations accordingly. Supported by clear governance and system-level coordination, this approach allows workforce planning to remain responsive, integrated, and aligned with service transformation—ensuring that workforce investment supports sustainable, safe, and person-centred mental health services over the medium and long term.

Formulating Workforce Composition Standards/Framework

The service-cluster model set out in the preceding section establishes the essential structural logic for organising mental health services around coherent groupings of need, function, and pathway. Building on this foundation, the development of multidisciplinary team (MDT) composition standards provides the practical mechanism through which service clusters are translated into safe, deliverable, and effective models of care. MDT composition standards therefore act as the critical bridge between service intent and operational reality, ensuring that each cluster is supported by the right balance of professional expertise, skill mix, and leadership capacity.

The infographic below brings together the principal component parts and influencing factors that must be considered in the formulation of MDT composition standards. It illustrates that effective team design is inherently multi-dimensional, requiring the deliberate integration of core professional groups—including nursing, medical, social work, allied health professions, clinical psychology and therapies, pharmacy, peer services, and the community and voluntary sector—within a shared system architecture. These component



parts should not be viewed as interchangeable or additive, but as complementary contributors whose combined impact depends on how they are configured, supported, and enabled to work together.

Central to this model is the requirement that MDT composition standards are **co-produced**, drawing on the expertise of service users, carers, frontline practitioners, professional leadership, and system planners. Co-production is essential to ensure that standards reflect real-world practice, lived experience, and the complexities of delivery across different service clusters and local contexts. This collaborative approach strengthens legitimacy, supports trust and ownership, and helps ensure that standards are both aspirational and implementable.

The formulation of MDT composition standards must also be **explicitly evidence-informed**. Decisions about team configuration, skill mix, and role delineation should be grounded in the best available evidence on clinical effectiveness, population need, safe staffing, and workforce sustainability. This includes consideration of statutory and regulatory requirements, current and projected demand, models of care across the stepped-care continuum, and the interdependencies between professional roles, services, and pathways. Evidence-based practice, practice-based competencies, and clinical leadership capacity are therefore not secondary considerations, but foundational elements in determining how teams are structured and how care is delivered.

Safe staffing is a critical organising principle within this framework. MDT composition standards must ensure that teams are configured with sufficient depth, seniority, and resilience to provide safe, timely, and effective care, particularly within high-risk or high-intensity service clusters. This requires alignment between workforce planning and availability, case-management systems, supervision arrangements, and clinical governance structures. Without this alignment, service models risk becoming fragile, overly reliant on individual roles, or unsafe in the face of rising demand and workforce pressures.

Equally important is the recognition that MDT composition standards must be **dynamic rather than static**. The influencing factors represented in the infographic—such as population need, demand signalling, system and pathway design, capital and digital infrastructure, and available resources—highlight that team design must be responsive to change. As service clusters evolve, new models of care emerge, and innovation is introduced, MDT standards should provide a structured yet adaptable framework that supports continuous review, learning, and workforce optimisation.

In this way, service-cluster models and MDT composition standards are mutually reinforcing. Clusters provide the structure for prioritising services and understanding demand; MDT composition

standards provide the mechanism for configuring the workforce to meet that demand safely and effectively. Used together—and supported by the influencing factors set out in the infographic—they enable a coherent, system-wide approach to service and workforce prioritisation that is evidence-led, co-produced, and responsive to population need, while maintaining flexibility to adapt as service models as needs evolve.

6. Section Four Toward Implementation - Priorities for Action

Section 4: Priorities for Action: - Translates the analysis and findings into a clear, deliverable, and action-oriented roadmap. It defines practical, system-wide priorities to stabilise services, optimise the workforce, and enable phased implementation of strategic objectives.

Introduction

This section centres on the implementation of Recommendations 1 and 2 from the Mental Health Workforce Review, presenting a concise yet comprehensive summative analysis of the critical challenges affecting mental health service delivery and workforce capacity. By drawing together the key insights from previous analyses—including persistent workforce gaps, data limitations, structural disconnects between service and workforce planning, professional silos, and historical underfunding—it articulates the pressing issues that must be addressed to ensure safe, equitable, and sustainable mental health care. The focus is distinctly action-oriented, outlining targeted priorities designed not only to stabilise and optimise services and workforce but also to foster innovation, improve data intelligence, and embed integrated planning frameworks. Through this approach, the section establishes a clear pathway for immediate and strategic improvements, ensuring that the mental health system can respond effectively to rising demands while safeguarding quality and outcomes for service users.

Analysis of Mental Health Workforce Gap

Section one of this paper provided a comprehensive analysis of the gap between the current mental health workforce and the projected requirements outlined in the 2022 mental health workforce review. Based on the updated 2025 workforce rebasing data, the current workforce gap is approximately 2,300 positions. Bridging the identified gap will necessitate an investment of roughly £150 million over the next decade, equating to an annual allocation of £15 million for each of the next ten years.

Current Expenditure and Vacancy Rates

At present, total expenditure on mental health services is estimated at £450 million, with workforce-related costs constituting around 68% of this amount—approximately £308.5 million. Of particular concern is a substantial overall vacancy rate of nearly 16%, with certain professional groups experiencing vacancy rates as high as 25%. It is conservatively estimated that these vacancies represent a financial impact of approximately £48 million. However, it is important to interpret this figure with caution, as a significant proportion of these resources is currently directed towards temporary, locum, and agency staffing solutions.

Workforce Data Challenges

Analysing workforce data trends within mental health services is inherently challenging due to ongoing issues with data integrity and the data returns demonstrate substantial variation in the professional roles, functional responsibilities, and team structures across various Health and Social Care Trusts. These data limitations underscore the critical need for enhanced workforce intelligence to inform prioritisation, resource allocation and long-term service planning.

Service and Workforce Priorities

Section two of the report delineates both service and workforce priorities yet does so in the context of an absence of a formalised, systematic prioritisation framework. In this environment, Health and Social Care Trusts, alongside Professional Officers, have collectively identified several core priorities that predominantly target the immediate alleviation of workforce pressures and the stabilisation of existing service delivery structures.

The analysis of the workforce priorities for development and investment over the forthcoming three-year period reveals a strategic focus on enhancing capacity and expertise in key disciplines. The top five workforce development priorities are as follows: consultant psychiatry, pharmacy (new roles), psychology, advanced nurse practitioners, approved social work, and peer support workers. It is noteworthy that, although not explicitly ranked within the top five, there was substantive discussion regarding the imperative to mainstream a broader array of Allied Health Professional roles. This underscores a recognition of the evolving complexity of mental health service demands and the necessity for a multidisciplinary approach that leverages diverse professional skill sets. This prioritisation reflects a pragmatic approach focused on stabilising the workforce and addressing immediate challenges in service delivery, while also recognising the importance of investment in expanding core roles and building capacity across the entire system.

Service Development Priorities

There was broad agreement regarding service development priorities. Foremost among these was the imperative to invest in and enhance the role, scope, and capacity of community mental health services, which was equally prioritised alongside the need to strengthen crisis resolution and home treatment services. In joint second position were Child and Adolescent Mental Health Services (CAMHS) and psychological therapies, with a distinct emphasis on prevention and early intervention initiatives. Additional priorities included expanding services for people with substance misuse and

eating disorders, as well as strengthening acute mental health services. Collectively, stakeholders advocated for reinforcing and expanding the core mental health service infrastructure to more effectively address the increasingly diverse and complex needs within the population.

Constraints and Opportunities for Innovation

As indicated, a significant constraint in the current process is the absence of a structured framework that facilitates the integrated prioritisation of both workforce and service developments. Consequently, the resulting priorities may be perceived as perpetuating established operational models rather than fostering innovation. However, this must be understood in the context of escalating mental health needs that continue to exceed available capacity, compounded by a historical pattern of underinvestment. Within this context, there was widespread recognition of the necessity for mental health services to explore innovative approaches to emerging needs. At the same time, there was pragmatic acknowledgment that, while additional resources remain unlikely given the current fiscal position, optimising the deployment and effectiveness of existing resources is essential in the immediate term.

6.1 Key Planning Challenges and Next Steps

In light of these considerations, establishing the key priorities for action requires a clear articulation of the primary planning challenges identified throughout the gap analysis and prioritisation process presented in this report.

Summative Analysis of Key Planning Challenges

Reflecting on the findings across sections 1 and 2 and discussions regarding the need for an integrated approach to workforce and service planning, it is important in framing priorities for action to summarise some of the key radical issues that require further action.

1. ***Improve the Integrity of Workforce Data: - The Impact of Data Limitations on Mental Health Workforce Planning***

As highlighted in this report, limitations in mental health workforce data have a significant negative impact on mental health service delivery. Inaccurate or incomplete workforce data undermines strategic planning and resource allocation, leading to difficulties in identifying workforce gaps and forecasting future needs. This uncertainty hampers efforts to prioritise service areas and optimise professional roles that could most effectively address rising demands in mental health care. Furthermore, without reliable data, evaluating the outcomes of workforce decisions and measuring

multidisciplinary impact becomes challenging, which can result in fragmented care and reduced effectiveness of service delivery. Ultimately, the absence of robust workforce data threatens the sustainability, composition, and overall performance of mental health teams.

Systemic Evidence Supporting the Need for Reliable Workforce Data

This concern is also reflected in wider systemic research, which highlights that the absence of reliable and comprehensive workforce intelligence impedes the ability to plan, deliver services effectively, address workforce shortages and skills, or deploy resources to meet changing population/service demands (Centre for Mental Health 2022). As stated succinctly, “robust workforce data is foundational for building sustainable teams and ensuring high-quality mental health care.” – King’s Fund report, Addressing the Mental Health Workforce Crisis (2021).

2. Shift the Focus from Transactional Models of Care

There is an overreliance on transactional models of care, which typically follow traditional referral and wait models of care. While the design and delivery of mental health care services is inherently complex, it is crucial to examine how the interfaces between different parts of the system could be better integrated to improve care. Too often, when a new unmet need or specialised service/professional role is identified, there has been a trend to establish a new specialist team in response. This approach often overlooks the opportunities to enhance existing core services by building their capacity, skills, and competencies to address a wider range of mental health needs.

Evidence indicates that transactional referral-based models in mental health care—characterised by traditional pathways where individuals are referred and placed on waiting lists for specialist services—can contribute to several systemic challenges. These models often result in increased waiting times and create hidden delays as service users transition between different levels of care, such as moving from primary to secondary care or between core and specialist services. This compartmentalisation can lead to fragmented care, where the multifaceted needs of individuals, especially those with comorbid or co-occurring mental health conditions, are not adequately addressed. As a result, care becomes less responsive and less effective, with individuals potentially falling through the cracks or receiving services that do not fully match their needs.

Studies also consistently demonstrate that transactional, referral-based models contribute to fragmented care pathways. Research from the King’s Fund and the Centre for Mental Health

underscores that transactional models tend to prioritise process over person-centred outcomes, exacerbating service bottlenecks and undermining the flexibility required to respond to need. These models are associated with increased administrative burden, duplication of assessments, and inefficient resource allocation, all of which diminish the overall effectiveness and sustainability of mental health services. By contrast, integrated, multidisciplinary, and needs-based approaches have been shown to deliver more responsive, coordinated, and effective care, supporting better outcomes for individuals and communities. (King's Fund, Addressing the Mental Health Workforce Crisis, 2021; Centre for Mental Health, 2022)

The evidence base strongly supports a shift away from rigid, transactional models toward more agile, collaborative frameworks that prioritise seamless service integration, multidisciplinary teamwork, and personalised care planning. The multi-criteria decision-making analysis framework outlined in this paper is designed to enhance integrated service planning and promote stronger cross-boundary collaboration. By embracing a multidisciplinary and multisectoral approach, the framework harnesses the unique strengths of each profession and service area, shifting away from traditional transactional case management toward a more person-centred and community-focused model of mental health and well-being. This transition is critical for ensuring that care is more responsive, effective, and holistic, particularly for people, families and communities and ultimately the framework lays the foundation for a more cohesive and sustainable mental health system.

3. Professional Identity and Ideologies

The Importance of Articulating Professional Contributions

Clearly articulating the contribution of each profession is essential for effective workforce development. However, without established mechanisms to support multidisciplinary integration, strong professional identities may inadvertently become barriers. This can result in fragmented workforce priorities and impede collaborative approaches to care, reducing the overall effectiveness of service delivery. The unique strengths of each profession, harnessed by multidisciplinary planning, diminish competition among professional ideologies for priority and resources, ultimately supporting more comprehensive care.

The Positive Role of Strong Professional Identities

Strong professional identities can contribute positively by clarifying the unique roles, skills, and contributions of each discipline, which is essential for effective workforce development and ensuring

that the distinct needs of people with mental health needs are met. When harnessed through multidisciplinary planning, these diverse professional strengths can promote comprehensive care, reduce competition for resources, and foster collaborative practices that improve service outcomes.

Risks Associated with Professional Silos

However, without robust mechanisms for multidisciplinary integration, well-defined professional boundaries may inadvertently create silos, leading to fragmented workforce priorities and impeding collaborative approaches. This fragmentation can significantly diminish the effectiveness of service delivery, as it may lead to competition among professions or teams for priority and resources or result in the reallocation of resources between professions rather than focusing on the fundamental roles and collaborative functions needed to address the full spectrum of mental health needs. As previously referenced, research published in the British Journal of Psychiatry and policy reports acknowledge the distinct value of each professional role, while also emphasising the potential risks associated with rigid adherence to professional boundaries and ideologies (Royal College of Psychiatrists, Workforce Planning in Mental Health Services, 2018).

Balancing Professional Ideologies Within Multidisciplinary Teams

Systemic review research also highlights the critical importance of achieving a balance between distinct professional ideologies and ensuring the optimal blend of professions within multidisciplinary mental health teams (Cantaert et al., 2022; APPG 2021). Studies emphasise that, while strong professional identities contribute unique perspectives and specialised expertise, it is the deliberate integration and collaboration across disciplines that leads to more comprehensive, effective, and person-centred care. The authors argue that fostering mutual respect and understanding among different professions, rather than rigid adherence to professional boundaries, is essential for delivering responsive and equitable mental health services (Academy of Medical Royal Colleges, 2020). This balanced approach supports the development of teams that leverage the strengths of each discipline whilst achieving the optimal blend of roles and protects the primary key worker's relational role with the person receiving care.

Integrating Generalist and Specialist Contributions

It is equally important to emphasise that this principle is not a choice between generalist and specialist—as all mental health systems need both—nor is it about replacing one professional role with another, but rather about acknowledging the unique contributions each profession brings. The focus is on integrating these distinct professional roles in a way that enhances care delivery and

supports the cultivation of specialised skills and knowledge, ultimately leading to more effective outcomes. The World Health Organisation points out that transforming mental health starts with building the foundations for well-functioning mental health systems and services, which is interdependent on a competent and motivated workforce—a vital component of a well-functioning health system (WHO Report 2022).

4. Disconnect Between Service and Workforce Planning

Structural Disconnect Between Service and Workforce Planning

As highlighted in this report, the ongoing misalignment between mental health service planning and workforce planning represents a substantial and ongoing challenge in prioritising the Mental Health Workforce recommendations outlined in the 2022 review. This structural disconnect often leads to an uncoordinated approach, resulting in a mismatch between the services planning and the workforce required to deliver services effectively. Multiple UK studies and policy reports underscore the critical importance of integrating workforce and service planning in mental health care and highlight that disjointed workforce and service planning has contributed to inconsistent team compositions and inequalities in service provision.

Embedding workforce planning into the design of mental health services is essential for building resilient teams capable of meeting the needs of the population. This also includes consider the workforce requirements of adjacent service developments, that often draws staff from core AMH/CAMHS workforce. Achieving this integration requires the development and implementation of standardised multidisciplinary workforce models, ensuring that teams have the right composition of disciplines and mix of skills to address their population needs. This also includes developing talent pipelines and projecting workforce requirements being cognisant of the workforce requirement across the spectrum of primary care, core and specialist mental health services and those of the community and voluntary sectors. For this to be effective this will require collective leadership, whole system planning and regional co-ordination.

Learning from UK Systems

At a systems planning level, Scotland, England, and Wales have all recognised the necessity of establishing mechanisms to align mental health service design and workforce planning. This alignment is vital to ensure services are appropriately staffed to meet local population needs, reduce fragmentation, and improve outcomes. Developing a needs-based workforce planning model means

prioritising the health needs of the population rather than centring on the priorities of individual professional groups in isolation. Adopting a population-focused approach is foundational for effectively integrating service and workforce planning.

Adopting a Population-Focused Approach

Transitioning to this model requires intentionally moving beyond traditional organisational and professional boundaries, planning mental health services based on neighbourhood and community needs. This approach includes redesigning the workforce to address the full range of needs across community and voluntary sectors, primary care, core mental health services, and mental health subspecialties. It relies on implementing a balanced care model that ensures the right person with the right skills is available in the right place at the right time, delivering the most appropriate care response.

Embedding Workforce Planning into Service Design

Furthermore, embedding workforce planning into service design inevitably requires the development of standardised multidisciplinary workforce models that foster interprofessional collaboration and use evidence-based decision-making frameworks to align workforce and service priorities.

Enabling Responsive and Equitable Services

This integration is particularly important for supporting the development of new roles and collaborative practices necessary to deliver responsive, equitable, and resilient mental health services. The central finding of this report is that integrating workforce planning with service design will enable more effective prioritisation, planning, and translation of the 2022 workforce recommendation into a realistic delivery model.

5. Variation in Service Models and Team Composition

During the workforce re-basing exercise described in Section One, and in the process of establishing both workforce and service priorities, clear differences in team composition emerged. These variations reflect the diverse service models in place, much of which stem from historical decisions regarding service planning and delivery. While such differences may have been designed to meet specific local needs, they have led to inconsistencies in service access, care pathways, and overall

service capacity. The absence of a standardised approach to mental health service planning and workforce composition has made it challenging to define optimal team structures. Without agreed-upon standards for service and workforce composition, delivering equitable care becomes more difficult, and building resilient, effective, and responsive mental health services across all Trusts is significantly hindered.

6. Resourcing and Historical Underfunding

Finally, it is crucial to acknowledge that the persistent underfunding of mental health services over many years has significantly impeded the development and sustainability of effective long-term workforce planning. The well-documented funding gap when Northern Ireland is compared to other regions of the UK, poses a considerable challenge, particularly considering current fiscal constraints. As detailed in section one of this report, the estimated workforce funding gap of £150 million would require £15 million each year for the next ten years to address the identified workforce gap. Whilst adopting a realist perspective, it is important to highlight that without additional investment, progress in implementing the 2022 Workforce Review recommendations will be severely limited, directly affecting the ability of mental health services to meet both current and emerging needs.

Optimising Resource Deployment

Given these financial limitations, it is equally important to focus on how existing resources are deployed and utilised. Workforce expenditure accounts for approximately 68% of total mental health funding, highlighting the critical need to strategically repurpose and optimise available resources. This involves implementing innovative service models that enhance productivity and maximise the impact of current investments. Such an approach is not about working harder or compromising on quality, but rather about developing new, creative methods to make the most of existing workforce capacity and expertise. This includes rapidly adopting new ways of working, leveraging person-centred and staff-enabling technologies, and partnering with the wider system—including community and voluntary sectors, as well as primary care—to explore how the value of current expenditure can be optimised.

Reimagining Service Delivery and Referral Pathways

Inevitably, this will require reimagining referral pathways, expanding neighbourhood psycho-social mental health and well-being programmes at scale, increasing opportunities for social prescribing, and utilising public health resources to address lifestyle factors that place individuals, families, and

communities at risk of developing mental health problems. It also means developing a robust pre-habilitative model of care. As part of adopting a population health approach in mental health, a pre-habilitative mental health care approach shifts the focus proactively on developing interventions designed to strengthen people's psychological resilience, coping skills, and social supports before the onset or escalation of mental health issues. The evidence base for such pre-habilitative approaches is steadily growing, with research demonstrating that early, preventative strategies can reduce the severity, duration, and recurrence of mental health crises.

Prevention, Early Intervention, and Community Engagement

Prevention and early intervention are well supported by epidemiological studies, which show that population-level pre-habilitative interventions—such as mental health literacy campaigns and community-based psychoeducation resilience programmes—can reduce stigma, improve self-help, self-management, and help-seeking behaviours, as well as decrease the overall burden of mental illness within communities. Many of these interventions are delivered through group therapy, peer support, or local neighbourhood initiatives, all of which have the potential to extend service capacity.

Upskilling the Workforce and Recovery-Oriented Care

Additionally, it is essential to intensify efforts to upskill and reskill the workforce in evidence-based therapies, and as a priority, to adopt a progressive rehabilitative and recovery-oriented model of care that better supports individuals with complex and enduring mental health needs. Scaling up these approaches will enable a more effective response to demand, potentially reduce waiting lists, and allow mental health services to focus their expertise on both direct treatment provision and supporting public health and primary care interventions at scale.

Section 4: Priorities for Action: - Implementing Recommendations 1 and 2 of the Mental Health Workforce Review

This section sets out the **system priorities for action** required to implement **Recommendations 1 and 2** of the *Mental Health Workforce Review 2022*. The priorities are directly derived from the gap analysis, service and workforce prioritisation exercise, and the integrated planning framework outlined in Sections 1–3 of this report.

Each priority is grounded in the imperative to ensure patient safety, enhance service capacity, and build a sustainable, high-performing mental health workforce. The evolving landscape of mental

health services underscores the urgent need to develop robust, evidence-based workforce composition standards and integrate these into service planning. Persistent vacancies, service and workforce variation, and rising service demands highlight critical gaps that are undermining the stability, effectiveness, and equity of mental healthcare delivery. To effectively address these pressing challenges, a series of targeted priorities have been formulated to close critical gaps, strengthening professional development, and ensuring the mental health system is equipped to meet demand while maintaining safety and service quality. Collectively, these priorities for actions are intended to stabilise services, optimise the existing workforce, and establish the enabling architecture required to support a phased, multi-year approach to mental health service reform and workforce development.

6.2 Priority Action 1 – Stabilise Services and the Mental Health Workforce Development

There is a clear and urgent need to take decisive action to stabilise both service delivery and workforce capacity as a prerequisite for sustainable reform and future growth. Persistent vacancies across key professional groups represent a critical risk to service quality, safety, and accessibility. Addressing these gaps must therefore be treated as an immediate system priority.

Key actions may include:

- **Developing and implement a system-wide, multidisciplinary vacancy improvement strategy**, focused on stabilising high-risk and high-pressure services while protecting the integrity of core mental health provision.

- **Utilise recurrent vacancy funding strategically** to upskill and reskill the existing workforce and accelerate the development of new and advanced practice roles, including Advanced Nurse Practitioners, Pharmacy, Clinical Psychology (&Psychological Therapies) Approved social Work, and Allied Health Professional roles.

- **Address regional disparities in distribution of key clinical roles**, particularly in psychiatry—by establishing formalised mutual aid arrangements to ensure consistent clinical cover in high-risk areas. In parallel, develop longer-term, system-level agreements to

optimise the deployment of specialist expertise across services and geographies, drawing on managed care network models to support coordinated workforce utilisation, improve resilience, and to reduce unwarranted variation in access to specialist care.

- **Develop, at a regional level, a vacancy improvement and workforce supply plan** in partnership with all five Health and Social Care Trusts, with a specific focus on increasing undergraduate and postgraduate or professional training places for psychiatry, nursing, psychology, psychological therapies, social work, pharmacy, and key Allied Health Professional roles.

- **Systematically increasing undergraduate** and post graduate training places across nursing, medicine, social work, psychology, and allied health professions over the next three years, with dedicated funding to support these increases.

- **Transition away from annualised workforce planning** by expanding undergraduate and postgraduate training capacity over the next three years, supported by dedicated and ring-fenced funding, recognising the long lead-in times required to deliver a sustainable workforce pipeline.

- **Develop Whole-System Approach to Managing Workforce Movements:** This action advocates for the development of a coordinated, system-level strategy to oversee workforce movements between primary care core and specialist mental health services. Rather than relying on isolated, service-specific planning this approached reinforces the need for the development integrated planning mechanism and oversight to ensure that staff are deployed effectively, with the right expertise in the right places.

6.3 Priority Action 2 – Expand the Workforce and Standardise Services (Enabling Services and Workforce Optimisation)

In the context of ongoing financial constraint, expanding capacity must be achieved alongside more effective use of existing resources. Stabilisation must therefore be accompanied by focus on

workforce optimisation and service standardisation to maximise clinical impact and system resilience including reconfiguring service provision to ensure the relevant expertise and clinical leadership is in the right places.

Key actions may include:

- **Strategically redeploy regional underspends** to relieve immediate workforce pressures, prioritising roles that can be mobilised quickly while safeguarding essential professional posts and stabilising core services.

- **Commission a three-year mental health workforce development programme** to accelerate upskilling and reskilling in evidence-based psychological and recovery-oriented therapies, particularly within therapy-focused roles and Allied Health Professions.

- **Develop and implement a comprehensive, system-wide multidisciplinary clinical (case) management framework**—aligned with the Mental Health Outcomes Framework—to standardise and optimise care delivery across pathways. This should incorporate structured models such as the *Choice and Partnership Framework (CAPA)*, or equivalent approaches, to strengthen shared MDT clinical leadership, clarify roles and accountability, and support collective decision-making. The framework should embed flexible, person-centred pathways, facilitate multidisciplinary case review and strengthen MDT communication mechanisms, and robust clinical and quality performance indicators, enabling timely intervention, early escalation of complexity, effective use of specialist expertise, and continuous learning and optimisation across the mental health system.

- **Prioritise the Integration of Value-Adding Clinical Roles: including Accelerate the expansion and strategic integration of roles that augment clinical capacity. (e.g. - Advance Practice models)** enabled through planned and targeted training and agreed MDT career pathways.

- Develop the business case to secure a **£50m workforce development fund with a view to planning and recruiting over the next three years** at least one-third of the 2022 workforce recommendations. These actions recognise the scale and urgency of workforce pressures facing mental health services, while also acknowledging the practical and fiscal constraints within which the system must operate.

  Persistent vacancies, service instability, and escalating demand require do require **immediate stabilisation**, yet this report is equally clear that sustainable recovery and reform cannot be achieved through short-term measures alone. A pragmatic phased approach is therefore required—one that stabilises services in the short term while **progressively expanding capacity and capability over time** in a planned, evidence-led, and deliverable manner.

  Within this context, the development of a **£50m Mental Health Workforce Development Fund** represents a necessary and proportionate enabling investment. Rather than attempting to deliver the full scale of the 2022 workforce recommendations at once—an approach which be challenging to deliverable, —this proposed action is designed to provide planning certainty (subject to approval and resource being available) supported a **managed, three-five-year implementation phase** to **plan and recruit at least one-third of the recommended workforce expansion**. This approach balances ambition with realism, ensuring that investment is sequenced in line with workforce supply, training pipelines, and service readiness.

  Crucially, this proposed phased investment is not intended to operate in isolation. It is explicitly aligned to the development and implementation of **mental health multidisciplinary team (MDT) composition standards**, which will provide the authoritative framework for determining the **right mix of roles, skills, and seniority required to deliver agreed service models safely and effectively**. By anchoring recruitment and workforce growth to these standards—rather than to single-discipline or service-specific pressures—the fund ensures that expansion directly supports **policy objectives, service priorities, and population need**, while reducing the risk of unintended workforce displacement or service fragility elsewhere in the system.

  In parallel, the fund enables targeted investment in **training, upskilling, reskilling, and advanced practice development**, addressing both immediate gaps and longer-term capability requirements. This includes strengthening value-adding roles that enhance system

resilience, reduce pressure on highly constrained professions, and enable mental health services to respond more flexibly to prevailing and emerging demand. Importantly, this approach supports a transition away from reactive, annualised workforce responses towards **integrated, multi-year workforce and service planning**, consistent with Recommendations 1 and 2 of the 2022 Mental Health Workforce Review.

In summary this proposed £50m Workforce Development Fund provides a **credible bridge between stabilisation and transformation**. It creates the conditions to secure early gains in service stability, while establishing the structural, professional, and planning foundations required to scale delivery over time. By progressing approximately one-third of the 2022 workforce recommendations over the next three years—within the context of agreed MDT standards and service priorities—the system could make tangible, measurable progress towards closing the workforce gap, without compromising safety, deliverability, or long-term sustainability.

6.4 Priority Action 3 – Strengthen Services and Workforce Intelligence

As detailed in this report accurate, standardised, and accessible workforce data is foundational to effective planning, prioritisation, and delivery. Current limitations in workforce intelligence undermine Mental Health Services ability to quantify gaps, forecast demand, and evaluate the impact of workforce investment.

Key actions may include:

- **Establishing clear, standardised workforce definitions and naming conventions** across mental health services to enable reliable benchmarking, trend analysis, and comparative planning.
- **Developing a centralised mental health workforce registry and dashboard**, enabling real-time monitoring of workforce supply, demand, deployment, and vacancy patterns.
- **Utilising the development of a centralised registry to drive regional standardisation of key roles**, support routine workforce monitoring, and inform system-wide action planning and investment decisions.
- **Building on the 2025 workforce database** to support the development of a minimum mental health workforce dataset, underpinning future gap analysis and multi-year planning.

6.5 Priority Action 4 – Fully Integrate Service and Workforce Planning

A central finding of this report is the persistent disconnection between service planning and workforce planning. Fully integrating these functions is essential to delivering Recommendation 2 and to ensuring that workforce investment is aligned with population need and service priorities.

Key actions may include:

- **Adopting a phased, multi-year workforce planning model**, explicitly incorporating primary care and the community and voluntary sector.

- **Implementing the Mental Health Multi-Criteria Decision-Making Analysis (MCDMA) framework** as the system standard for prioritising service development and workforce investment.

- **Developing multidisciplinary team (MDT) composition standards**, organised around service and needs-based clusters, to guide service design and workforce configuration.

- **Establish robust, system-wide shared decision-making mechanisms** between regional service planners (SPPG), Chief Professional Officers' teams, and Departmental workforce policy and service leads to address the current variation and siloed approaches to workforce and service prioritisation. These mechanisms should support **collective leadership, transparency, prioritisation equity and accountability** in determining both service development and workforce priorities. This may include the introduction of **formal shared decision-making councils or equivalent multidisciplinary forums**, bringing together service, professional, and workforce leadership to jointly agree priorities, test deliverability, and manage competing priorities in in a constrained system. Such models provide a structured means of aligning workforce decisions with agreed service priorities and emerging population need, reducing unwarranted variation, avoiding uncoordinated workforce movements, and ensuring that decisions about investment, role expansion, and service development are taken coherently and consistently at system level.

6.6 Priority Action 5 – Standardise, Integrate, Develop and Adopt Innovative Systems/Models of Care Delivery

Stabilisation and optimisation must create the conditions for reform. Mental health services must move beyond predominantly transactional models of care and adopt approaches that better manage demand, strengthen prevention and early intervention, and improve outcomes at scale.

Key actions include:

- **Design and implement a population-based mental health model of practice**, aligned with emerging neighbourhood health and wellbeing frameworks and *explore the Integration of* community mental health teams, primary care, and community and voluntary sector partners in a single system approach.

- **Rethink how demand is met** by shifting towards neighbourhood-based models of care that emphasise prevention, early intervention, continuity, and shared responsibility across the system.

- **Systematically evaluate, adapt, and scale effective innovations** to stimulate continuous service improvement within and across mental health services in Northern Ireland. This should include a structured scoping and appraisal of emerging models, innovations, and best practice—testing clinical impact, deliverability, and alignment with service priorities—to identify approaches with the greatest potential for regional adoption. Particular emphasis should be placed on innovations that improve access, flow, and outcomes, including the appropriate use of digital, virtual, and technology-enabled therapies.

- **Update and extend the "Working Together, Learning Together" framework** to support neighbourhood mental health teams, strengthen psychologically informed practice across all levels of care, and improve coordination, access, and continuity for people, families, and communities.

- **Use workforce intelligence to inform ongoing service redesign**, ensuring that innovation strengthens system resilience rather than displacing capacity from core services.

- **Rebuild, extend and diversify the scope of core services** by embedding a boarder range of skills expertise and/or strengthen interface with specialist service/clinical expertise.

7. Conclusion

From Analysis to Action Through Integrated Decision-Making, Team Design, and Service Configuration

This paper has set out a clear case for moving beyond fragmented, profession-specific or service-by-service approaches to mental health planning. The accompanying infographic provides a unifying visual representation of the core proposition: that **effective service prioritisation and sustainable workforce planning must be addressed together**, through an integrated, system-level framework that explicitly connects **multi-criteria decision-making**, **multidisciplinary team (MDT) composition standards**, and **service cluster design**. At the outer level, the multi-criteria decision-making framework establishes a transparent and consistent basis for prioritisation. By explicitly balancing *meeting population need*, *making a demonstrable impact*, *ensuring deliverability through testing feasibility*, and *delivering value in terms of the right cost, model, and outcomes*, the framework provides a disciplined method for determining *what* services should be prioritised and *why*. This directly addresses **Recommendation 1**, which calls for a structured, evidence-based approach to identifying and prioritising mental health service developments aligned to population need and system capacity.

At the core of the model, MDT composition standards translate strategic intent into operational reality. The infographic demonstrates that MDTs are not static or generic entities, but core capabilities that must be deliberately designed, balanced, and flexed across contexts. By making explicit the contribution of medical, nursing, social work, allied health professions, clinical psychology and therapies, pharmacy, peer services, and the community and voluntary sector, MDT

composition standards provide a practical mechanism for determining *how* services are delivered safely, effectively, and equitably. This directly supports **Recommendation 2**, which emphasises the need to align workforce development with service priorities and to move away from ad-hoc or siloed workforce decisions.

Critically, the representation of **service clusters as connected applications around the MDT core** reinforces a whole-system view of mental health care. Clusters such as CAMHS, primary care, crisis intervention, community mental health services, psychological therapies, acute, high-intensity mental health care, and subject-specific specialist mental health care are shown not as linear steps or isolated services, but as **interdependent contexts** that draw on shared MDT capability in different ways. This reinforces the reality that workforce supply, skills, and experience are shared across the system, and that decisions in one cluster inevitably have consequences elsewhere. The infographic therefore helps decision-makers to identify both **service priorities** (where investment or redesign will have the greatest impact) and **workforce priorities** (which skills, roles, and capacities are most critical to deliver those priorities safely).

Adopting this integrated approach is fundamental to delivering the ambition of this paper because it moves planning from abstraction to action. The framework does not simply describe principles; it provides **pragmatic levers for implementation**. It enables mental health system to

- apply a common decision logic when assessing competing service proposals.
- design MDTs intentionally, based on function and context rather than historical configuration.
- test feasibility early, including workforce availability, training pipelines, and system readiness.
- ensure that investment decisions deliver value over time.

In summary, integrating workforce and service planning through a structured, evidence-based framework is essential for building a resilient, equitable, and effective mental health care system. The combined use of multi-criteria decision-making, MDT composition standards, and service cluster modelling provides a coherent architecture for translating strategic priorities into deliverable action. By fostering shared leadership, co-production, and disciplined decision-making, this approach strengthens service design, supports sustainable workforce development, and ensures that mental health services remain responsive, person-centered, and aligned to long-term population need—ultimately improving outcomes for individuals, families, and communities

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