Evidence to Health Committee 6th November 2025

Professor Siobhan O'Neill, Mental Health Champion

I welcome the opportunity to provide evidence to the Health Committee regarding mental health services and the Mental Health Strategy deliverability review. I provided a full briefing a week ago and I'm now going to speak to the most urgent recommendations, the need for resources for the priority areas, particularly suicide prevention and community crisis and suicide prevention services. I will also discuss the implications of the Health Reset Plan, the emphasis on cross-departmental working, and the need for more cross-departmental work to address poor mental health of young people, especially girls.

Deliverability Plan Mental Health Strategy

Our core mental health services have been underfunded for decades, and we are now seeing the devastating implications of this on the ground. The annual allocation for mental health services per head in NI is only £212, compared with £264 in England. This is unacceptable and runs contrary to the goal of addressing the mental health legacy of the past and investing to save. In addition to core services, we had developed a Strategy to deliver much needed transformation of services. The reality is that the Mental Health Strategy is not going to be fully implemented. The £12.3 million invested represents 16% of that needed in years 1 to 3, but it is only one percent of the total needed over 10 years. One percent.

The funding gaps are significant, with the integration of the Community and Voluntary sector accounting for the largest gap (£12.3 million). Many actions in the Strategy have commenced with working groups, plans and reviews, but the reviews are not being implemented. My view is that continuing this cycle without the realistic prospect of additional funding may be a waste of resources, time and effort. Without investment in infrastructure and staff any expansion in one part of the system will create vacancies and pressure in other parts of the system.

The recent Deliverability Review highlighted crisis services and workforce as priorities. But these "priorities" will only be progressed if there is additional funding, and the

Minister clearly states that no additional money is available. So, the priorities are not going to be treated as priorities and piecemeal work continues across the actions in the Strategy even though it's now impossible for them to be completed.

The situation on the ground is very bleak indeed. There is now a critical overcapacity in mental health inpatient beds. All five Heath and Social Care (HSC) Trusts in Northern Ireland have bed occupancy rates over 100% as of March 2025 (the maximum should be 85%). In a recent survey three quarters of psychiatrists reported daily or weekly delays in admissions and treatment due to capacity issues. Almost 9 in 10 Psychiatrists in that survey experienced or witnessed "moral injury" indicators when making admission or discharge decisions under capacity pressures. They are calling for Improved Inpatient Provision and Resources, as well as actions to address the Mental Health Workforce Crisis. Approved Social Workers are engaged in industrial action because of bed waits and the lack of psychiatric beds.

My view, and this is also what the psychiatrists are saying, that there is a need Greater Provision for Alternative Care Options, including community-based treatments, and also supports in housing as well as support for people with learning disabilities. However, along-side the difficulties in Statutory services we see cuts to the Community and Voluntary sector funding. Morale in the mental health workforce across all sectors is extremely low, and there are stories of groups closing their doors due to the funding crisis on at least a weekly basis. There are debates in the chamber, MLAs highlight their concern, we discuss it in this Committee, but the funding situation never changes.

Our high suicide rates are also always a worry for me, and putting all this together, I believe that there is now an urgent need for delivery of the Regional Mental Health Crisis Service (RMHCS). A recent economic analysis I commissioned from the London School of Economics shows that mental health crises costs at least £45 million per annum in NI, and that's only the very conservative direct cost to health care system, the PSNI and families. The cost in terms of police time is £4 million per year. The Right Care Right Person policy means that PSNI are changing their response to these calls, and we need effective suicide prevention interventions on the ground.

So, to be clear, people with severe mental illness do need specialist mental health services, (e.g. crisis resolution and home treatment teams). However, many people who experience suicidal distress do not have a mental illness requiring treatment, but they still may be at risk of suicide, and they still present at Emergency Departments in NI. Almost a quarter of young people who died by suicide in NI had presented to an Emergency Department with self-harm. People who present to Emergency Department with thoughts of self-harm or suicide are over 10 times more likely to die by suicide. In 2021-22 over half of those who attended with self-harm or suicidal ideation (53%) were discharged without admission. In many cases the help that they need can be provided in the community, by non-clinical staff because the distress is caused by situational crisis or long-term problems such as housing, debt and poverty.

In Scotland crisis services provide a community-based service, with problem-solving and emotional support. It starts the day after a crisis presentation and lasts up to 14 days. This type of intervention should be an important element of our Protect Life 2 (PL2) Suicide Prevention Strategy and the RMHCS model launched in 2021 included this service. However, due to funding restrictions the recent PL2 action plan and implementation plan refers to more general, “community-based suicide prevention services”, and only progress on developing the RMHCS service (which may well refer to the ongoing working groups).

I commissioned a cost effectiveness analysis of this model for NI, and it demonstrates that the cost per contact is £392. This is considerably less than the costs for an individual presenting at an Emergency Departments which we estimate conservatively to be £544 just for the initial service contacts (with no costs of follow up services, including use of specialist mental health care services included). This means that there is return of investment of £1.39 for every £1 invested, and this is likely to be very conservative. If two-thirds of contacts with A&E services could be avoided through the use of DBI then this potentially could avert costs of over £5 million per annum. Of course, the additional benefits, in reducing the suffering of those people who are in distress, who would now receive a more appropriate service to help address the factors that led to the crisis, are immeasurable.

I would also add that we have Multi Agency Triage Teams, Lifeline and the Self Harm Intervention Programme, as well as crisis cafes and walk in counselling services. However, these services need wired into the network of support so that there is no wrong door, and I worry that there are gaps especially in terms of 24hr face-to-face crisis services outside of Emergency Departments, and of course services for young people in crisis.

The Reset Plan

The aspirations set out in the press release for the Health Reset Plan could make a real difference. The "focus on joined up activity at NI and local level" would be positive, however the fear is that this means that they simply plan to increase and streamline signposting to external organisations. There is no guarantee that mental health services will not be cut further as a result of this plan. Staffing is also an issue, the phase one plan includes 76 new Mental Health Practitioners, but only 10 mental health training places, (in mental health nursing). The Plan is also coming at a time when the Community and Voluntary sector are experiencing high volumes of referrals, including self-referrals, and are already treating patients from Statutory services. The integration of the Community and Voluntary sector is not happening in a meaningful way, and whilst the Reset Plan states that they will be key partners, the interpretation is that they are being asked to do more with less.

The Mental Health Strategy

Positive developments include: the development of the Regional Mental Health Service, with notable progress in establishing local and area collaboratives. A cost-neutral three-year implementation plan is underway to standardise services and improve outcomes, however the challenges of system pressures and alignment with community plans and Right Care Right Person structures remain. The standardisation of data and outcomes in each of the Trusts is also being progressed, but again we should be seeing the embedding the Regional Outcomes Framework that was developed as part of the Mental Health Strategy. The Service User Consultant roles have, I feel been a game changer. These staff are driving a focus on compassionate, recovery-oriented care and they must be protected at all costs. The launch of the Psychological Professions Forum for NI is another positive move, however, the lack of

training places and absence of core child and adolescent psychotherapy remain major concerns. I would like to see the Reset Plan prioritising expanding the psychological workforce and ensuring its influence across key Government Departments (especially Education) to reduce the numbers who need specialist services.

Most people with mental health problems are cared for solely within primary care, but resourcing challenges in general practice can be a real barrier. While Multi-Disciplinary Teams (MDTs) are important, referrals to overstretched specialist services remain problematic. However, no clinical service alone can address the deeper societal issues, such as trauma, poverty, and homelessness, that underlie the suffering. This underscores the urgent need for a cross-departmental approach, and in particular Justice and Education. For example, the data shows that two-thirds of young people have low or slight hope and 53% of 16-year-old girls have probable mental ill health. We urgently need Health and Education to work together on the curriculum reform to ensure that young people have a wellbeing education and resilience training. Prevention is a key part of the reset plan, and following the evidence, this should include a commitment to ensure that all young people have access to schools' wellbeing teams.

Finally, our research is showing that 28.3% of 11–19-year-olds had either ASD or ADHD and that these young people have significantly elevated rates of mental health-health and suicidality. This underscores the urgent need to strengthen the early identification of mental health need and neurodiversity affirmative practices. The proposed changes under the HSC Children and Young People's Emotional Health and Wellbeing Framework, (currently at consultation phase, as I'm sure you are aware) provides a more appropriate response to meeting the needs of children and young people with neurodiversity. However, as always, I am concerned that funding pressures will result in this Framework not being implemented.