Health Committee
Briefing Paper

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I welcome the opportunity to provide evidence to the Health Committee regarding mental health services and the Mental Health Strategy deliverability review. I will also discuss the implications of the Health Reset Plan, crisis services and particularly their role in suicide prevention. Finally, I also wish to highlight the concerning data on the mental health and wellbeing of children and young people, especially girls, people with neurodiversity and young people who are leaving care. I have provided recommendations, many of which are cross-Departmental, regarding what we need to do to alleviate suffering, reduce expenditure on mental health services, and support the population to flourish.

Deliverability Plan MH Strategy

I wish to start by highlighting again the very serious funding deficit for mental health services in Northern Ireland (NI). Whilst health expenditure is higher in NI, than in UK and Ireland, mental health expenditure is lower[1]. For example, the annual allocation for mental health services per head of population NI is only £212, compared with £264 in England. This is despite the fact that successive Executives and MLAs agree that we need to fully address the mental health legacy of the past, and the solid evidence that spending on mental health, particularly early intervention, will lead to savings.

The transformation plan, the Mental Health Strategy was costly financially, and in terms of the time and effort, and the goodwill of people with lived experience of poor mental health, and staff from the Community and Voluntary (C&V) Sector. The reality is that this Strategy is not going to be fully implemented. It has received only 16% of the funding needed to date, and we are around a third of the way through the Strategy's 10-year term. Whilst the £12.3 million invested represents 16% of that needed in years 1-3, it is only one percent of the total needed over 10 years. Most of the £5- £6 million invested annually (£12.3 million overall) has gone to Child and Adolescent Mental Health Services (CAMHS) at just over £4 million, perinatal services (almost £3 million), and Early Intervention and Prevention (£2.2 million). The funding gaps are significant, with the integration of the C&V sector accounting for the largest gap (£12.3 million). Many actions in the Strategy have commenced with working groups, plans and reviews, which was necessary preparation for the expansion of services on the ground, but the increase in funding to provide training places and improve services was not provided, so the reviews and plans are not being implemented. The only reference within the Programme for Government to the Mental Health Strategy is its "continued implementation"[2]. This suggests a continuation of the repeated reviews and plans. My view is that continuing the cycle of reviews and plans without the realistic expectation of additional funding will lead to wasted resources, time and effort. Without investment in the infrastructure, any expansion in one part of the system will create vacancies and more pressure in other parts of the system.

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[1] The Northern Ireland Mental Health Strategy A Review of the deliverability of the Strategys Actions 2026-2029 - FINAL.pdf (page 19) NHS England £264, NHS Wales £256, NHS Scotland £234, Ireland £236

In the recent Deliverability Review crisis services were identified as a priority and a focus on workforce is needed to address retention difficulties and high numbers of vacancies, and commence the 45% increase recommended by the Statutory Workforce Review. However, the Review is clear that these "priorities" will only be progressed if there is additional funding, and to date the Minister has stated that no additional money has been made available. The Mental Health Strategy Unit is now trying to identify cost-neutral actions that will make a difference to service users. Had the Strategy been funded in full, from year one, we would already be benefiting from savings in the whole system with more streamlined services, and fewer people needing welfare payments in the future because their poor mental health.

My fear is that staff feel that they are continually being asked to do more with less resources. I hear about the distress they feel when they cannot provide the service that they know their patients need. The Royal College of Psychiatrists recently reported that 89% of psychiatrists experienced or witness moral injury by being forced to make decisions that conflict with their clinical judgment because of system limitations. Cuts to the fund available for core grants has resulted in morale in the C&V sector being at an all-time low. There are debates in the chamber and MLAs highlight their concern, but the funding situation does not change.

Crisis Services

The delivery of the Regional Mental Health Crisis Service (RMHCS) is particularly urgent given the introduction of Right Care Right Person, leading to changes to how PSNI will be responding to mental health calls, and the importance of suicide prevention interventions on the ground. The RMHCS would result in a joined-up responsive service for people in crisis for both people who have self harmed, and those who have thoughts of suicide or self-harm regardless of whether they present in the community, at EDs, via PSNI or ambulance, in Primary Care or via a rescue organisation. It is important to add that many people who experience suicidal distress and crisis do not have a mental illness requiring treatment by statutory mental health services and the majority of those who die by suicide are not in contact with statutory services[2]. Interventions to address suicidal thoughts and behaviours, and to address the factors which led to the suicidal crisis are very beneficial and they need to be delivered in a range of settings.

A recent ADRNI research briefing highlights that almost a quarter of young people who died by suicide in Northern Ireland had presented to an emergency department (ED) with self-harm. Additionally, individuals who present to EDs with thoughts of self-harm or suicide are over 10 times more likely to die by suicide. Around 4 in 10 people who present with self-harm (38% or suicidal ideation) to an ED have consumed alcohol around the time of the attendance, which influences their subsequent care. In 2021-22 over half 53% were discharged from ED without admission to either general or psychiatric wards. Of those discharged, only 43% received a mental health assessment prior to discharge, whereas another 43% were referred for mental health assessment after discharge[3]. There is no data collected on how many of those referred received a mental health assessment. The Towards Zero Suicide Programme has led to the widespread delivery of patient safety, suicide prevention interventions and care pathways in Statutory services. The commitment in the PL2 Action Plan is to continue this work and embed consistency of safety planning interventions and follow-up across HSC Trusts (including healthcare in prisons, and progress

[2] 74% UK wide and 70% in Northern Ireland (2012-2022)

[3] PHA is due to publish 23/24 and 24/25 self-harm registry figures in the coming weeks, preview of the data was not available

on sharing plans across sectors). This is the right approach to increase suicide prevention interventions for people who are in contact with statutory services[4].

It's important to highlight that many crisis services are available. The current system[5] now includes Multi Agency Triage Teams in some parts of NI who provide de-escalation and an appointment "card before you leave". Lifeline provides 24/7 telephone support, follow-up calls and short-term counselling if necessary. The SHIP service supports people aged over 11 years who have engaged in self-harm and takes referrals from statutory mental health professionals or MDTs. Other C&V sector models include crisis cafes and walk in counselling services. Despite these positive and welcome developments, I am concerned that gaps may remain, for example in relation to face-to-face crisis services outside of EDs in some parts of NI, and for young people aged under 18 years who are in crisis. In Scotland, crisis services operate within the DBI Scotland Connected Compassionate Support model, which provides an evidence based, follow-up, face to face service for people aged over 16 years. This includes community-based support service from third sector organisations offering problem-solving and emotional support for up to 14 days after a crisis. This type of intervention should be an important element of our PL2 suicide prevention strategy and the RMHCS model launched in 2021 included this service. However, due to funding restrictions the recent action plan and implementation plan for the PL2 Strategy the commitment is more general, to "community-based suicide prevention services", and progress on developing the RMHCS service. I would like to see faster progress, as I have highlighted, many of the components are already in place, however not all regions of NI are covered, and accessing services can prove difficult. We still do not have the "no wrong door" approach, and no sign of funding to address the gaps. Four years after the RMHCS was announced, this is far from ideal.

The recent ADRNI report also highlighted how young adults with care experience, and contact with social services, are at a higher risk of self-harm and suicide, and they have a 25 times higher rate of self-harm. This is a relatively small group proportionally[6], and they are most likely to be affected by the forthcoming welfare reforms (especially the removal of the health uplift element of universal credit) which may leave them without resources at a time when they are leaving the care system. Whilst the Dept. for Communities policies sate that care experienced young people are signposted to appropriate services and supports. It is my view that this group should be offered additional support and services given the nature of the risk.

The Reset Plan

The Reset Plan, described as, the most ambitious efficiency programme in HSC history, has significant implications for mental health. Firstly, despite the underfunding of mental health services for years, there is no guarantee that mental health services will not be cut further as a result of this plan. The plan states that the £300 million of savings are set to be achieved by a further expansion of multi-disciplinary teams (MDTs). I have however heard anecdotally

[4] Data from the National Confidential Inquiry shows that most are at home at the time of death, a third (35%) missed their last appointment in the previous month, a third had contact at the time of death, and whilst three quarters had a history of self-harm, the vast majority were assessed as low risk in the short -term (89%) and long term (63%).

[5] Details are available in the PL2 Progress Report: https://www.health-ni.gov.uk/publications/protect-life-2-suicide-prevention-strategy

[6] Numbers are rising, as per the Children and Young People's Strategic Partnership Report

that many of the mental health posts in these teams have recruited staff from statutory mental health services leaving vacancies. The phase one plan includes the creation of 90 training places, 10 of which are mental health nursing post through the university. It also allows for the additional recruitment of 290 staff, 76 of which are Mental Health Practitioners, with little information on where these staff will come from[7]. Mental Health Practitioners are also referring people to Statutory and C&V sector services, and staff report that this can create a further burden on those services[8].

The Reset Plan is also coming at a time when the C&V sector are experiencing high volumes of referrals, including self-referrals, and are already treating patients referred and signposted to them from statutory services. The core grant funding available has been maintained at the same level as last year (£1.8m) but capped for each applicant at £50k. While this allows more groups to avail of the limited resources, it also means that groups who require a higher amount of funding may close or use their reserves (if they have them). The integration of the C&V sector is not happening in a meaningful way and whilst the Reset Plan states that they will be "*key partners in the planning and delivery of social care and mental health services, working alongside other partners in the statutory and independent sectors*" the interpretation is that they are being asked to do more with less. The C&V sector feel that they are at the bottom of the pecking order when it comes to mental health services and claim that they do not get the recognition that they deserve for their role.

Despite these difficulties, the Reset Plan has several admirable aspirations which if enacted would make a real difference. For example, it refers to a "much greater focus on joined up activity at NI and local level". I don't want to pre-judge this but without having the detail about how this will happen, however I so fear that in practice this means that they simply plan to increase and streamline signposting to external organisations. I hope that the reference to *"enhanced support from DoH for such programmes as: tackling poverty and improving early years of life for children; and reducing offending and reoffending*" means that there will be funding support from DoH for these programmes, because they really do make an enormous difference.

The Mental Health Strategy

The Strategy includes the vision of a Regional Mental Health Service, and despite the pressures, structural changes are progressing. I am contributing to the work to establish the service, and some important progress has been made regarding the local and area collaboratives. A three-year cost neutral implementation plan for the RMHS is currently under development and this represents a real effort to standardise services to achieve changes for service users. The focus on the neighbourhood model, emphasising local need, is the right direction. The first Area Collaborative Board has been established in the in Southern Trust, and other Trusts are making significant progress in engaging the C&V sector and establishing vital relationships. This work faces challenges, not least due to pressures, but also in relation to the alignment with the community plans and Right Care Right Person structures.

In relation to Right Care Right Person, officials from the Depts of Health and Justice, alongside PSNI, have agreed governance structures to support a coordinated approach to implementing the model. Nine subgroups will explore the implications and prepare for roll-out. Key milestones include finalising interagency Memorandums of Understanding for

[7] The MDT Implementation Plan 01.07.25.pdf phase 1 includes recruitment and training of new staff. 90 training places have been agreed annually for 24/25 and 25/26, 10 are in Mental Health Nursing, however the plan is to recruit 76 Mental Health Practitioners.
[8] The Implementation Plan states there are lower numbers of referrals in practices with MDTs.

Welfare Checks, Gaining Entry, Articles 129/130 of the Mental Health (NI) Order 1986, and Conveyance, as well as a protocol for patients who leave healthcare settings or go absent without leave while detained. The work of other subgroups will identify necessary changes within the HSC system and assess the costs associated with implementation. It remains essential that RCRP is introduced at a pace that safeguards the most vulnerable individuals. The system is complicated and even the work to untangle the different groups and bodies and connect them is very much welcomed. The much-needed standardisation of data and outcomes in each of the Trusts is also being progressed, but again if full funding were available, we would be seeing progress towards embedding the Regional Outcomes Framework that was developed as part of the MH Strategy.

The development and inclusion of service user consultant roles in the planning of the Regional Mental Health Service is particularly welcome. Their voice makes a real difference in the planning and decision making for the service and helps orientate the groups towards the establishment of the compassionate services that we know will promote recovery. The launch of Psychological Professions Forum for NI is another welcome development, and work to embed psychological knowledge and expertise is throughout health and social care system is very much needed. However, the lack of resources for training places for psychologists and the continuing absence of core child and adolescent psychotherapy remains hugely disappointing. The Reset Plan should involve maximising the current psychological workforce to expedite the expansion of psychological therapies and ensure that psychological expertise influences work across Government Depts, particularly Education, Communities, and Justice.

Finally, it is important to note that the majority of people with mental health problems receive care from primary care alone. The resourcing challenges in general practice will invariably result in people with poor mental health having difficulty accessing services. Mental Health practitioners in MDTs are very welcome and can help differentiate physical and lifestyle factors leading to poor mental health, but the difficulties remain when people are referred to stretched and under-resourced mental health services. A quarter of women and 16% of men currently receive an antidepressant prescription for their poor mental health. Many would prefer a psychological therapy or face to face support. However, none of these services can change or fix the cycles of trauma, poverty and structural inequalities that lead to poor mental health. These are the issues that need to be addressed and why a cross Departmental approach to mental health is necessary.

Children and Young People

It's important that I highlight the data regarding the mental health of children and young people, particularly girls, in NI. The 2022 Young Persons Behaviour and Attitudes (YPBA) Survey found that wellbeing in year 10-12 pupils (14-16yr olds) had declined to its lowest ever level since 2016, and again girls had a lower mean wellbeing score than boys. The 2025 Life and Times Surveys showed that 15% of 11year olds described their own mental health as fair or poor, and that % rose to 39% of 16 year olds. When we consider the screening questions (GHQ caseness), the actual rates are even higher, with 45.4% of 16-year-olds in NI having probable mental ill-health; over half of girls (53.7%) and a third of boys (31.9%)[9]. The gender differences are also reflected in the self-harm registry data[10] with the highest rate of self-harm in 15–19-year-old females (1,138 per 100,000) (followed by 20-24 yr old males, 748 per 100,000). Males are more likely to have suicidal thoughts (261 per

[9] Women in NI have much higher rates of poor mental health than men (1 in 4 women and 1 in 5 overall)
[10] From the PL2 Progress Report 2023-2024

100,000 vs for females 184), however the female rates of self-harm are higher (343 per 100,000 vs 280 for males).

Poverty, inequality and pressure at school are key contributors, and other Depts can play a crucial role. Our society is also characterized by systemic gender bias, women and girls feel threatened, and there is pressure on young men to engage in, or condone, abusive behaviours. This culture also perpetuates negative narratives of masculinity that inhibit emotional awareness and promote emotional suppression. Mental health and wellbeing (social and emotional learning) in schools is fundamental to addressing this and is now a core part of the English and Welsh curricula. It is demonstrated to lead to a cost effective reduction in depression (£5 for every £1 spent). Our young people have been calling for this education [11],[12],[13]. However, the Curriculum Review's recommendations regarding wellbeing education have not been accepted, and we will be engaging with the review team to help ensure that the new NI curriculum includes these vital components. Action in schools and relationships education (including anti-sexism and gender equality education, and education in consent) is a fundamental component of our Ending Violence Against Women and Girls Strategic Framework (EVAWG) but it is not included in the delivery plan for the first three years of the programme. NI is behind the UK regions in relation to mental health programmes in schools generally. In England for example over 600 Mental Health Support Teams (MHST) are operational, providing support to 52% of pupils, and this will rise to 60% by April 2026. Each MHST offers psychological interventions, supports schools in creating positive cultures, provide staff advice and training, and coordinates with external services. The Welsh Government introduced statutory guidance in 2021 making it a requirement for all schools to adopt a whole-school approach to mental health and emotional wellbeing.

The delivery mechanism for wellbeing programmes in schools in NI is the Children & Young People's Emotional Health and Wellbeing in Education Framework**.** There are over 1000 schools in NI and the Being Well Doing Well (whole school approach) programme was only operational in 170 schools in 25/26 year. Reach (for ages 6-19) operated in 107 schools in 23/24). Emotional Wellbeing Teams were in most (166) post primary settings and does operate regionally since its start in 2023. The p5-7 RISE NI programme was in 242 schools in 23-24. The numbers of schools in receipt of specific programmes therefore remains very low. To reduce the burden on mental health services in the future these interventions need to be expanded and adequately resourced as part of the Reset Plan.

Benevolent Childhood Experiences, Hope and Wellbeing

Analysis of a study we conducted as part of the 2025 Kids Life and Times (KLT) and Young Life and Times (YLT) surveys reveals that wellbeing in NI's young people declines markedly from childhood to adolescence: while nearly three-quarters of Primary 7 children report moderate to high wellbeing (73.5%), fewer than half of 16-year-olds do so (41.1%) and almost one in four adolescents have possible depression (23.9%). Hope levels follow a similar trajectory. Younger children show relatively balanced distributions across moderate and high hope categories (Low, 2.8%; Slight, 38.4%; Moderate, 35.8%; High, 23.1%). In contrast, adolescents overwhelmingly report slight hope, with only a small proportion indicating high hope **(**Low, 6.6%; Slight 58.2%; Moderate, 23%; High,12.2%). This decline in hope coincides with reduced endorsement of

[11] 'My generation has been completely failed by our LLW education' says Youth MP Lauren Bond as survey finds teaching on consent is inadequate – The Irish News
[12] Elephant-in-the-Room-Young-Peoples-Report.pdf
[13] Me4mental

positive early life experiences, suggesting that perceived relational and environmental supports diminish as children age. Exposure to Benevolent Childhood Experiences (BCEs) is as a critical protective factor. Two-thirds of younger children report high BCE exposure compared to just over half of adolescents. Low hope and low BCE exposure dramatically increase the odds of poor wellbeing and possible depression. For example, among children, low BCE exposure is associated with nearly 29 times higher odds of depression, while low hope increases odds by 14 times. Similar patterns hold for adolescents, though effect sizes are slightly smaller[14]. Gender differences amplify these risks. Girls consistently show higher vulnerability when hope and BCEs are low, reinforcing the need for gender-sensitive interventions[15]. Collectively, these findings highlight the intertwined roles of psychological resources and positive early experiences in shaping mental health trajectories and underscore the urgency of embedding hope-enhancing and BCE-informed strategies within policy and practice frameworks, especially the current Reset Plan. The findings demonstrate the need for early intervention and the establishment of safe spaces across sectors (and particularly in education) for children to reduce the impact of childhood adversities on wellbeing. It remains concerning that the use of force by adults continues to be permitted in NI's schools for "maintaining good order and discipline". The Dept. Health needs to continue to work to ensure that our schools are a safe, trauma-informed environments for young people.

Neurodiversity

The language used regarding neurodiversity and neurodivergent children continues to concern me. The Reset Plan states: "*working with education to address the rise in SEN and other children's problems such as ADHD".* The continuing references to children with neurodiversity as a problem is deeply inappropriate and conflicts with rights-based and trauma-informed approaches. Neurodiversity refers to the range of differences in individual brain function and behavioural traits. These variations are the natural variation and differences in brain processing styles present in the human population, and they also include clusters of traits which represent conditions such as autism and ADHD. Whilst the traits that people with neurodiversity exhibit are normal and natural, some of these conditions are disabling because the structures and attitudes of society create barriers to participation.

The 2019 prevalence study showed that 7.74% of young people[16] potentially met the criteria for a diagnosis of autism[17] and 14.7% have hyperactivity symptomatic of ADHD. Together they represent 28.3% of the population of 11–19-year-olds. Our initial analyses show that together they have elevated rates of anxiety (16.3% vs 6.8%), depression (17.8% vs 7.3%), self harm (16% vs 7.2%), suicidal ideation (23.7% vs 9.4%) and disordered eating (22.3% vs 13.1%). These risks exist regardless of formal diagnosis and underscore the urgent need to strengthen the early identification of mental health need. We should be promoting neurodiversity affirmative practices to improve the experience of these young people [18].

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[14] BCE Exposure
KLT (P7): Low (8%), Moderate (24.1%), High (67.9%)
YLT (16yrs): Low (18%), Moderate (29.9%), High (52.1%)

[15] Predictive Strength (Odds Ratios)
KLT: Low Hope → Depression (OR = 14.01), Poor Wellbeing (OR = 5.76)
Low BCEs → Depression (OR = 28.68), Poor Wellbeing (OR = 5.41)
YLT: Low Hope → Depression (OR = 11.26), Poor Wellbeing (OR = 3.79)
Low BCEs → Depression (OR = 12.53), Poor Wellbeing (OR = 2.87)

[16] 11-19 years

[17] 9.8% in the most deprived and 5.2% in the least deprived areas

[18] Neurodiversity-affirmative education: why and how? | BPS

Teachers should be prepared to respond to neurodiversity rather than relying on specialist services. We should also be viewing all health policies through a neurodiversity informed lens. For example, ADHD would not be a “problem” if there was a service to provide shared care to people with ADHD, and neurodiversity affirmative environments across society. There are certainly high levels of diagnosis of neurodiversity in NI, but this may well reflect the inequalities and scarcity of resources.

The proposed changes under the HSC Children and Young People’s Emotional Health and Wellbeing Framework, (currently at consultation phase) provides a more appropriate response to meeting the needs of children young people with neurodiversity. It sets out a trauma-informed approach to inform assessment, treatment and support in keeping with a neurodevelopmental model of care, reflecting development through childhood of neurological pathways that influence functioning and experience. It also promotes a neurodiversity-affirmative approach in which natural differences and the range of function and experiences across the population are considered and the overall approach centres individuals’ experiences and includes parents and carers in an integrated system providing wraparound care. This Framework is strong, but it could be developed further to include culturally competent care as well as procedures to ensure that the system is easily accessible to newcomer children, asylum seekers and refugees. As always, I am concerned that funding pressures will result in this Framework not being implemented in full.

Recommendations

Whilst a robust Anti-Poverty Strategy, and full implementation of the Mental Health Strategy, the EVAWG Strategic Framework, and the Children & Young People's Emotional Health and Wellbeing in Education Framework are necessary, I have identified some specific immediate recommendations, many of which are cross-Departmental, which would make the most difference currently:

- The Dept. Health should consider a more radical recalibration of the Mental Health Strategy, with all possible resources pushed into the completion of the priority areas. This should include actions to address workforce vacancies in statutory services and staff for MDTs. It should also include funding to accelerate the RMHCS and C&V sector suicide prevention services.

- The Depts of Health and Communities should undertake a rapid review of the mental health and financial supports in place for care leavers. They should take action to address the risk posed by the proposed welfare reforms. They should act to ensure that care experienced young people have resources to live independently with dignity and have easy access to mental health services when necessary.

- The Dept. Health should continue to work with the Dept. for Education to repeal Article 4(1c) of the Education (NI) Order 1998 which currently permits the use of force by adults against children in education settings for the purpose of “maintaining good order and discipline”.

- The Dept. Health should also work with the Dept. for Education to ensure that the new NI curriculum includes a strong social and emotional learning programme as part of the Reset Plan.

- The jointly funded Children & Young People's Emotional Health and Wellbeing in Education Framework should be expanded as part of the Reset Plan. The goal

should be to increase the number of children and young people who have access to support and interventions and move towards the full implementation the “whole school approach” in all NI’s schools.

- The Dept. Health should work with the Depts of Justice and Education to ensure that the new curriculum includes social and emotional learning (including anti-sexism and gender equality education, and education in consent) in all NI schools (as part of the EVAWG Strategic Framework).

- Hope-enhancing and BCE-informed strategies and programmes should be included in the Dept. Health’s Reset Plan. There should be a strong focus on parents and young people, and the work should be undertaken in collaboration with the Depts for Education and Communities.

- Neurodiversity awareness and the importance of neurodiversity affirmative environments should be promoted across Government Depts, in line with the proposals in the HSC Children and Young People’s Emotional Health and Wellbeing Framework.