MENTAL HEALTH CHAMPION

Mental Health in Northern Ireland

Current Services and Strategic Priorities

April 2026

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MENTAL HEALTH CHAMPION

Foreword

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Mental Health Champion

> As I continue my term as Mental Health Champion, I see it as important to provide a comprehensive report on where we are in relation to mental health in Northern Ireland, and the implications of this for our people, services, and policies across the life course.

This report serves as a follow-up from our 2023 report in conjunction with the Mental Health Foundation, "Mental Health in Northern Ireland: Fundamental Facts", with additional information on the policy context. The report provides a high-level overview of Northern Ireland's mental health services, drawing together information about our history and how that has affected the mental health of the population, information about factors affecting mental health services, and future direction.

My hope is that the report will provide an evidence base for departments, arms-length bodies, Health and Social Care Trusts, and community and voluntary partners. It will also be of value for academics, researchers and the media as they report on this topic.

As an academic I have written extensively about the mental health of the population in Northern Ireland. The years of violence and the legacy of the conflict have shaped our society in profound and lasting ways. The population comprises a diversity of transgenerational experiences. The mental health of the population is shaped by a complex interplay of social, economic, historical, and demographic factors which together have led to a population with a high complexity of need.

The divisions rooted in the Troubles continue to cause trauma and contribute to ongoing political instability. Knowledge and awareness of mental health and wellbeing has increased, and people are recognising the impact of trauma and adversity. Demand for support is rising, particularly among children and young people, with more people experiencing distress, situational crises, self-harm and suicidal ideation.

This report takes a life course approach, highlighting how mental health needs and services evolve from early life through older age, and considers the experiences of groups facing particular challenges. This report is a descriptive, evidence-based assessment designed to facilitate informed debate and planning. The findings make clear that mental health is shaped by complex, intergenerational factors, and that effective responses must address wider issues, particularly poverty, education, and inequality.

I encourage readers to use this report to inform decisions and support a more integrated, trauma-informed approach to policies across Government Departments. I hope it also serves as a valuable resource for people with lived experience, carers, and advocates, highlighting both progress, and areas where further change is needed.

Executive Summary

MENTAL HEALTH CHAMPION

Executive Summary

- *The structures of mental health services in Northern Ireland reflects **decades of political change, financial constraint, and social transformation.***
- *Mental health services in Northern Ireland have developed within a distinctive framework **shaped by the enduring impact of past conflict.***
- ***Patterns of need are shifting,** with rising **demand for crisis support,** high levels of **anxiety and depression** managed in primary care, and new challenges emerging across the life course.*

Governance and Systems

Mental health care in Northern Ireland is delivered through a **publicly funded system** that brings together health and social care. The **Department of Health** sets policy and oversees strategy, while five **Health and Social Care Trusts** and the **Northern Ireland Ambulance Service** (NIAS) manage services locally. The **community and voluntary sector** plays a critical role in delivering interventions and advocacy, working in partnership with Trusts to enhance reach and responsiveness. People also access mental health care through the private sector paying directly for assessments and interventions.

Publicly funded mental health care in Northern Ireland faces challenges amid policy shifts and budget pressures

Investment

Mental health **funding** in Northern Ireland continues to lag behind wider health investment trends. Recent analysis shows that mental health services account for around **6% of the overall health** and social care budget. Per capita investment also remains comparatively low: Northern Ireland is the only UK nation spending **under £220 per person** on mental health annually. This limited funding stands in contrast to the scale of need, with 18% of adults recording probable mental ill health in 2024/25.

Mental health funding and spend per person is below other national averages

Strategy

The **Mental Health Strategy 2021-2031** sets out a realistic plan, focusing on prevention, early intervention, improvements to services, and new ways of working. While delivery plans are in place, many actions are dependent on significant additional investment and require sustained, cross-government commitment for successful implementation. Policy decisions across other Departments also have a material impact on population mental health, particularly in areas such as education and early years, poverty, and supports for marginalised groups, where unmet need continues to drive higher rates of poor mental health.

The Mental Health Strategy 2021–2031 sets ambitious goals, but funding allocated up to 2025 was only 1% of the total needed over 10 years.[1]

Executive Summary

- *Mental health outcomes are shaped by multiple influences, requiring **coordinated responses** across health and social systems and Government Departments.*
- ***Service provision remains inconsistent,** with gaps in integration and long-term planning limiting effectiveness.*
- *Persistent **socioeconomic pressures** heighten vulnerability, underscoring the need for proactive and preventive measures.*

Mental Health Across the Life Course

Mental health challenges look **different at each life stage.** Mothers and partners may need support during pregnancy, in the early years, in parenting and through adolescence and beyond. Children and young people face pressures from peers, family and at school as well as online risks. Factors such as trauma, gender, comorbidities, or neurodiversity may impact mental health into adulthood. Older people may struggle with loneliness, bereavement, and health problems. Mental health services must provide early support and treatment for complex needs at every life stage as well as in schools and through community organisations.

Mental health needs change across life stages, from the early years through to old age

Policy and Service Provision

Support for mental health comes from both **statutory, community and voluntary organisations.** Crisis help includes 24/7 helplines and local teams, while community care is organised through stepped pathways and talking therapies. **Specialist services** are available for trauma, forensic mental health, specific mental illnesses and groups with specific needs. The system aims to provide timely, coordinated care, but faces ongoing challenges with capacity constraints.

Supports are available across sectors, but access disparity persists

Socioeconomic and Demographic Factors

Social circumstances such as income, race, disability and economic status strongly influence mental health across the population. People who live in **deprived areas** have a much higher risk of trauma and mental illness and are more likely to have a prescription for medication as a result. **Place-based access factors** (including in rural communities) can also affect help-seeking. **Loneliness** is common among older adults (rising in the 75+ age group), and gender patterns persist: **women are more likely to have mental ill health** more often present with self-harm, while **men** account for a higher proportion of deaths by suicide.

Socioeconomic stressors drive poor mental health, requiring systemic action

Introduction

MENTAL HEALTH CHAMPION

Introduction

Mental health continues to be a critical public health priority in Northern Ireland, with recent survey data highlighting ongoing challenges and inequalities across the population. The Health Survey Northern Ireland 2024/25 provides valuable insights into the prevalence of mental health concerns and demographic variations. The sample size for the survey was 3,243 individuals aged 16 and over. Findings show that 18% of respondents recorded a high General Health Questionnaire -12 (GHQ 12 >4) score, indicating probable mental ill health, a figure broadly consistent with the previous year (19%). Females (20%) were more likely than males (15%) to have a high score, and individuals in the most deprived areas (24%) remained significantly more likely to do so compared to those in the least deprived areas (14%). Furthermore, 38% of respondents reported concerns about their own mental health in the past year (15% 'definitely'; 23% 'to some extent'). According to 2021 results from the Global Burden of Disease (GBD) study, mental health and substance use disorders account for 9.64% of total disease burden in Northern Ireland.[2,3]

Alongside these prevalence figures, service pressures remain a significant concern. The Department of Health's (DoH) 2024 Child and Adolescent Mental Health Services (CAMHS) Waiting Time Statistics show that 52% of children and young people wait longer than the nine-week target for their first mental health appointment.[4] CAMHS has adopted the digital health record system in line with all other Health and Social Care (HSC) services, following a phased rollout from 2024 and wait times have not been published since.[5] Similarly, the Northern Ireland Assembly's 'Public Accounts Committee Report on Mental Health Services' (2024) highlights persistent delays in adult services, where long waits for community and inpatient care contribute to higher clinical risk and repeated emergency presentations.[6] The Public Accounts Committee (PAC) report emphasises that waiting lists are contributing to increased acuity in presentation which in turn make conditions harder and more costly to treat. The report states that there is a need to reduce waiting lists and improve performance in relation to psychological therapies. Timely access to services is critical to preventing deterioration and reducing pressure on acute and emergency pathways, yet anecdotal evidence indicates that in some areas the waiting list targets remain unmet.[6]

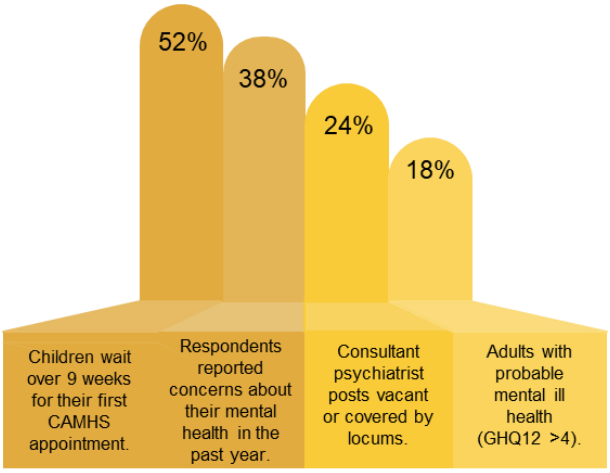
Delays in receiving services are strongly influenced by constraints, with staffing shortages limiting service capacity and contributing to prolonged access times. The Royal College of Psychiatrists in Northern Ireland 2024 press release evidences this challenge, showing that approximately 24% of consultant psychiatrist posts were vacant or covered by locums, coinciding with an estimated 30% increase in mental health waiting lists over the past four years.[7]

These figures highlight the scale and complexity of the region's mental health challenges. This report examines the structural and societal drivers of this challenge and considers how future policy development can address these issues to strengthen mental health provision and improve population wellbeing.

This is further illustrated through examination of funding flows within the community and voluntary sector. The recent Community and Voluntary Sector Review (conducted as part of Action 17 of the Mental Health Strategy) report shows that 35% of organisations reported that they receive less than 10% of their funding or no funding at all from public sector sources.[8]

Northern Ireland's Independent Public Policy Think Tank, Pivotal, has noted how, two years after the restoration of the Executive, Northern Ireland is facing policy crises in many areas. Pivotal report a deterioration of relationships between the political parties and delays in some priority areas. They note that when day to day debate is taken over by party political point-scoring, it is almost inevitable that the focus on improving services for the public is diminished.[9]

Mental health is referenced to a limited extent within the current Programme for Government, Doing What Matters Most Today. The Department of Health's primary focus within this Programme is on reducing health waiting times, and mental health is not included within this initiative. Commitments related to reducing poverty, improving access to childcare, addressing violence against women and girls, and promoting trauma-informed practice have the potential to contribute positively to mental health outcomes, particularly for key population groups. Progress in these areas, however, has been subject to ongoing public and stakeholder scrutiny.[10]



Introduction

The Northern Ireland Anti-Poverty Strategy was subject to public consultation between 17 June and 19 September 2025. Feedback from campaigners, charities and statutory bodies raised concerns regarding the level of ambition within the Strategy, the absence of new or clearly funded actions, and the lack of measurable targets. Stakeholders noted that this largely set out existing actions rather than proposing a transformative approach, with particular concern regarding the absence of new, ring-fenced funding.[11,12,13,14]

The Mental Health Champion had stated that it failed to adequately recognise poverty as an Adverse Childhood Experience (ACE) and the profound consequences this has for mental health and wider life outcomes.[14,15]

Stakeholders also raised concerns that aspects of the proposed actions risked being stigmatising and insufficiently trauma-informed, with an emphasis placed on individual responsibility rather than structural factors. In addition, this was viewed as giving limited recognition to the relationship between mental health and financial deprivation, and as insufficiently addressing the impact of systemic discrimination and ableism on outcomes.

Disability rights campaigners expressed concerns regarding the Disability Strategy 2025–2035 (consultation closed 20 March 2026), indicating that they consider its commitments insufficient to deliver meaningful change or to significantly advance the rights of disabled people.[16]

Key issues identified include the extent to which a human rights-based approach has been applied and the limited incorporation of co-design in the development of the strategy.[17,18]

The strategy was also criticised for its failure to adequately address the causes of poverty among disabled people, barriers to employment, and the disproportionate impact of these issues including violence, against disabled women.[15,16]

While the wider Ending Violence Against Women and Girls (EVAWG) framework includes a focus on promoting understanding of healthy relationships through education, the 2024-26 implementation plan does not set out specific educational actions to ensure that all young people have an understanding of consent. [17,18]

Concerns remain regarding the quality and consistency of relationship and sexuality education in schools, the discretion afforded to schools to deliver the curriculum in line with their ethos, and the availability of parental opt-out provisions.[19,20]

The DOH's recent review of progress made towards actions listed in Northern Ireland's current Mental Health Strategy states that mental health is a priority area for the Minister of Health.[1]

This Review comes at a critical time, as mental health services are under increasing strain and many of the population face barriers to accessing vital services, with prolonged waits affecting both children and adults due to staff shortages and increasing demand. The Review shows how £12.3 million, invested from 2021 up to 24/25 has been utilised across 20 actions. This funding represents 16% of the funding required (£76.93 m) for the Mental Health Strategy by the end of 2024/25, and around 1% of the total needed over the 10 years of the Strategy. As stated in the review, this funding has focused on "enabling processes" and governance structures, developing collaboration across the mental health system itself, and with partners from other government departments, statutory bodies, and community and voluntary sector organisations. There have been numerous quality improvement initiatives on the ground and key reviews have been delivered to pave the way for transformation.

The Review also identified actions to address gaps and challenges within the mental health workforce and crisis services as urgent priorities. This prioritisation reflected prevailing concerns, including the requirement for an estimated 45% increase in the workforce to meet statutory mental health service obligations. The implementation of the Regional Mental Health Crisis Service (RMHCS), launched in August 2021, was also highlighted as a key priority, with its importance heightened by reduced funding for the community and voluntary sector and a recent rise in suicide rates. However, the delivery of these priorities remains contingent on the availability of additional funding.[21,22,23]

This report provides an up-to-date summary of the evidence on the mental health needs of the population and the current services available. It will examine the prevalence of mental health issues across Northern Ireland, driven by complex factors including intergenerational trauma, socioeconomic pressures, structural inequalities, and heightened vulnerabilities among marginalised groups.[24,1]

Introduction

Building on the challenges outlined regarding the high levels of probable mental ill health, persistent inequalities by gender and deprivation, long waiting times, and ongoing service constraints, the government established the post of the Mental Health Champion (MHC). The role is cross-departmental and funded by all government departments. Professor Siobhan O'Neill originally assumed the role on an interim basis, but in 2021, was officially appointed the first permanent MHC for Northern Ireland. Her purpose, alongside her supporting team, is to promote all aspects of mental health for the population of Northern Ireland by advocating for evidence-based supports and services, taking part in public debate and championing mental health issues, contributing to policy development, and engaging with the population in order to maintain a people-centric view of Northern Ireland's mental health services.

The MHC represents the people and the voice of the voiceless in Northern Ireland, working to ensure that policies are reflective of the population's needs and advocating for accessible mental health services for everyone in Northern Ireland. Professor O'Neill and her team focus on various aspects of mental health, such as prevention and early intervention, harmful substance use prevention, and service improvement.[25]

In the years since the establishment of the post, the MHC and her team have been integral to **shaping reform** and **driving awareness of mental health in Northern Ireland**. For example, the Office of the Mental Health Champion (OMHC) played a central role in creating and promoting the Mental Health Strategy 2021 – 2031, which focused on prevention, intervention, and equitable access to services. The OMHC is actively involved in ensuring the delivery of strategy by contributing to the development of annual mental health strategy delivery plans in collaboration with organisations such as the DoH and Public Health Agency (PHA).

The **OMHC have advocated on numerous issues**, including social inequalities, anti-poverty strategies and education guidance. In 2023, the MHC launched the '**We're Better, When We Talk**' campaign to encourage talking about feelings and reduce stigma, while continuing to emphasise schools as a key setting for prevention through support for delivery of the **Children and Young People's Emotional Health and Wellbeing in Education (EHWE) Framework**. In 2024, the MHC launched the **'Take a Moment. Start a Conversation.' Campaign** which encourages the public to have simple, compassionate conversations, aimed at disrupting cycles of distressing thoughts and supporting those who are feeling depressed or suicidal.

In conjunction with raising awareness and contributing to the development of policy and reporting and commenting on issues relating to mental health, the OMHC also publish reports and surveys. Crucially in 2023, the OMHC released the Mental Health in Northern Ireland: **Fundamental Facts report in collaboration with the Mental Health Foundation**. This report was designed to serve as an evidence base, collating up-to-date statistics and evidence on mental health prevalence and social determinants in Northern Ireland. The aim was to aid future policy and service development. It provided data-driven insights into mental health drivers across Northern Ireland and highlighted factors significantly impacting the prevalence of poor mental health. The report also shed light on the needs of vulnerable minority groups such as refugees and ethnical minorities, and highlighted research gaps.[26]

Introduction

Approach and Methods

To examine the factors influencing population mental health and associated service needs, a mixed-methods approach was adopted. This approach encompassed a review of key policy documents and reform initiatives, structured consultations with relevant stakeholders, and an analysis of evidence relating to governance structures, funding mechanisms, and service delivery models. The findings from this research present a policy and service level context to supplement figures presented in the Fundamental Facts report. Relevant datasets and evidence have been referenced throughout to facilitate access. It is advisable to check these referenced sources for updated figures, as those produced by the Northern Ireland Statistics and Research Agency (NISRA), the PHA and various departments will be updated at set intervals.

The following diagram details the process undertaken to identify the principal determinants influencing the current mental health landscape:

01 Research Approach

A mixed-methods approach was employed, encompassing both primary and secondary research to examine historical and contemporary mental health infrastructures across the region. This included mapping of policy frameworks, operational programmes, and service-level provision.

02 Purpose of the Report

This report builds upon the evidence presented in the Fundamental Facts report, advancing its key findings to deliver an overview of Northern Ireland's mental health services. It explores mental health across the life course and highlights population groups at elevated risk such as those residing in rural or socioeconomically disadvantaged settings.

03 Stakeholder Consultations

Primary research comprised consultations with key stakeholders across multiple sectors, including the Strategic Planning and Performance Group (SPPG), the Mental Health Directorate within the DoH, the Public Health Agency (PHA), the Department of Education (DE), the Education Authority (EA), the Department of Justice (DoJ), and the Department of Agriculture, Environment and Rural Affairs (DAERA). Commentary from these consultations is integrated throughout the document.

04 Key Insights

Synthesis of the resulting information allowed for identification of points of strain, trends, and growing areas of concern, and highlighted gaps that impede equitable access to mental health care and treatment across Northern Ireland. The goal of this research was to provide an up-to-date and broad evidence base to inform future policies across departments and foster more resilient, inclusive mental health services in Northern Ireland.

Historical Context and Contemporary Challenges

MENTAL HEALTH CHAMPION

Historical Context and Contemporary Challenges

Northern Ireland's current mental health landscape has been influenced and shaped by decades of political complexity, fiscal constraint, and social transformation. This section explores the governance structures that have influenced service and support delivery, and the funding challenges that have limited progress in this domain. It reviews the historical context of mental health services in Northern Ireland, spanning from the establishment of Health and Social Care in 1948 through to the most recent developments and data in 2026. It also considers the shifting burden of societal need, the enduring impact of trauma and adversity rooted in historical conflict, and inequalities that continue to influence mental health outcomes for members of society.

Together, these forces form a critical backdrop for understanding the historical context and contemporary challenges of today's mental health landscape, a landscape defined by pockets of innovation in the context of sustained socio-political challenges that continue to influence mental health service provision in Northern Ireland.

2.0 | Oversight and Structure

One of nine Executive departments in Northern Ireland, the DoH holds overarching responsibility for the region's HSC system, encompassing three principal domains: Health and Social Care, Public Health, and Public Safety. Its remit includes setting policy and legislation for hospitals, family practitioners,community health and personal social services; developing and implementing public health policy and administrative actions to promote and protect the population's well-being; and overseeing policy and legislation for fire and rescue services.[27]

HSC in Northern Ireland is a publicly funded system that integrates both healthcare and social care services under one framework. It was established in 1948, similar to the National Health Service (NHS) in other parts of the UK, but with a unique structure that combines medical and social services. The region is divided into five HSC Trusts, with the sixth Trust comprising the Northern Ireland Ambulance Service (NIAS), which operates regionally. The five locality Trusts manage hospitals, community health services, mental health services and social services. Each Trust manages its own staff and services and controls its own budget.[28] The community and voluntary sector also play a vital role in promoting mental health and wellbeing across Northern Ireland. Through grassroots initiatives, tailored support services, and collaborative partnerships, these organisations bridge gaps in statutory provision and ensure that individuals and families have access to locally driven care. Their work not only addresses immediate mental health needs but also fosters resilience and inclusion within communities.

2.1 | Governance and Fiscal Constraints/ Considerations

Governance and public finance arrangements in Northern Ireland reflect a distinctive constitutional and political evolution within the United Kingdom. The Good Friday Agreement of 1998 established a devolved Assembly and Executive, designed to ensure cross-community representation through mandatory power-sharing.

This settlement underpins a multi-layered system of public administration, comprising three tiers: the UK Government, which retains responsibility for overarching fiscal policy; the Northern Ireland Executive and Assembly, which set regional priorities and allocates resources; and eleven local councils, which deliver services at community level. Under the Northern Ireland devolution settlement, HSC services are classified as a "transferred matter," meaning that legislative authority and policy responsibility for these services rest with the Northern Ireland Executive and Assembly rather than Westminster. As a result, the Northern Ireland Executive has the autonomy to shape HSC policy to meet regional needs and priorities, whilst Westminster has no direct legislative role in these areas unless specifically agreed otherwise.[29]

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the DoH is charged with HSC funding and policy, while the operational delivery of services is managed by the Strategic Planning and Performance Group (SPPG) and the PHA, working through five trust areas and NIAS. This structure ensures that the DoH provides strategic leadership and governance, while service provision is delegated to specialised agencies.

A report published by the Northern Ireland Fiscal Council in 2021, notes however, that within this framework the Executive's ability to exercise its autonomy is shaped by significant financial constraints. The report states that the Executive has limited discretion over local revenue raising, with most funding coming from the UK Government and only a small proportion raised locally, primarily through Regional Rates. Furthermore, the Executive's borrowing powers are constrained by UK legislation, and its budget process is largely determined by the UK Government's spending reviews.[30]

As a result, the Executive can only make detailed spending plans for the period covered by the UK Government's published plans, which limits its ability to independently fund large-scale, multi-annual transformation initiatives.

Historical Context and Contemporary Challenges

2.1 | Governance and Fiscal Constraints/ Considerations *(cont.)*

Political instability has affected governance in Northern Ireland, resulting in periods without ministerial oversight and contributing to delays in reforms across health, education, and infrastructure. The Executive was suspended from 2002 to 2007 with direct rule reinstated. The Executive collapsed from 2017 to 2020 and again from 2022 to February 2024. In the absence of Ministerial governance during these periods, limited administrative functions were carried out by civil servants.[31] Although officials were granted additional powers to safeguard public services, progress on significant reforms and budgetary decisions slowed. This resulted in limited policy development across health, education, and infrastructure.[32]

Stakeholder commentary;

Periods of political instability have led to delays in policy development and reform, particularly in health and mental health services.

2.2 | The Bamford Review - Prompting Reform

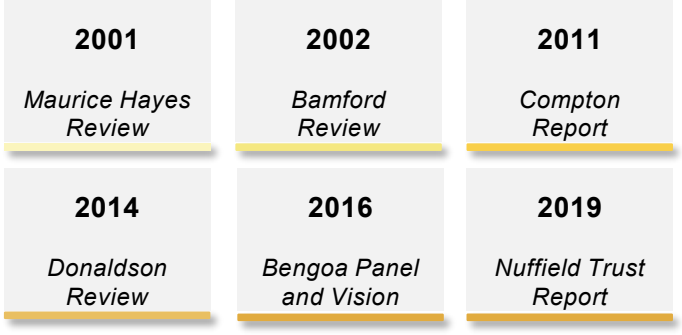
The Bamford Review of Mental Health and Learning Disability was a comprehensive and independent review initiated in Northern Ireland in 2002 by the Department of Health and Social Services and Public Safety (DHSSPS) which later became the DoH.[33] Chaired by Professor David Bamford, its aim was to modernise and reform mental health and learning disability services, law, and policy. It highlighted the need for inclusive, rights-based, recovery-oriented and person-centred care and recommended de-institutionalisation, community-based care, and better integration of services. The review produced several key reports between 2002 and 2007, among them the Mental Health Promotion Report (2006) and the Dementia and Older Age Mental Health Report (2007).[34,35] The Bamford Action Plan (2009–2011) and a follow-up Action Plan (2012–2015) were developed to implement the Review's recommendations.[36,37] These plans emphasised interdepartmental collaboration, service user involvement, and a shift from outputs to outcomes-based evaluation. It led to legislative change with the introduction of the Mental Capacity Act (MCA) (Northern Ireland), which replaced the Mental Health Order. The MCA is being introduced on a phased basis and operates as a two-tier system currently, with the Mental Health Order still applying to under-16 year olds, and across all non-commenced MCA actions for those aged over 18 and over. Importantly, the Review laid the foundation for a 10-15 year transformation of mental health and learning disability services in Northern Ireland.

2.3 | The Bengoa Vision and Implementation Context

Since the turn of the century, three major reviews have been commissioned to seek answers to problems within the wider HSC system in Northern Ireland. Though these reports were not solely focused on mental health, their findings led to reforms that impacted mental health service provision. In 2001, the Maurice Hayes Review recommended the removal of accident and emergency services, from five of Northern Ireland's smallest acute hospitals.[38] In 2011, the Compton Report made 99 recommendations, including decreasing the number of acute hospitals to between five or seven sites.[39] Then, in 2014, the Donaldson Review, reported that there were too many hospitals in Northern Ireland. It argued that elsewhere in the UK, a population of 1.8 m people would likely be served by four acute hospitals.[40] The review, however, recommended convening a panel of international experts to redesign some core elements of the health and social care system.

Building on the ethos of the Bamford Review, in 2016, an Expert Panel led by Professor Rafael Bengoa, an internationally renowned expert on health reform and former Minister of Health in the Basque region, proposed a system-wide shift from fragmented services to coherent, sustainable models of care (the report was formally titled 'Systems, Not Structures: Changing Health and Social Care'). The report outlined a roadmap for reform, including: (i) reconfiguring hospital services to concentrate expertise, (ii) investing in community care, primary care, and integrated multidisciplinary teams, (iii) improving productivity and reducing bureaucracy, and (iv) engaging the public and political stakeholders to support difficult but necessary changes. Overall, the report set out a ten-year vision to shift care "from a series of isolated initiatives" to a coherent, system-wide transformation with ring-fenced transition funding and clear ministerial leadership.[41]

Subsequently, a report carried out by the Nuffield Trust in 2019 highlighted that, while there was determination among leadership and frontline staff to implement the recommendations of the Bengoa review, actual change on the ground remained at an early stage.[42]



Historical Context and Contemporary Challenges

2.3 | The Bengoa Vision and Implementation Context *(cont.)*

Some improvements and initiatives had begun, such as pilot multidisciplinary teams (MDT). £5 million in funding was allocated to each of two pilot sites for multidisciplinary teams in County Down and County Derry/Londonderry. These teams aimed to enhance general practice by integrating physiotherapists and mental health professionals alongside GPs. MDT expansion is anticipated over the next five years. However, expansion has been limited by ongoing challenges within the health service, notably financial constraints, training gaps, and staff turnover. Further discussion and supporting statistics on these challenges are provided in the next section, Mental Health Services.

The Bengoa report envisaged a significantly expanded role for pharmacy and pharmacists, including through medicines optimisation, with the potential to improve safety, efficiency and patient experience, and to release clinical capacity within general practice and other services. Subsequent reviews of implementation found that, while pharmacist-led initiatives demonstrated clear potential, such developments had not been implemented consistently or at scale across the system, with progress varying by region and setting.

Despite ambitions to shift care outside hospitals and focus on prevention, annual accounts from the HSC Board in 2019 showed no increase in spending on primary care or general practice.[43] Trust budgets also showed no shift from acute episodic care to chronic care outside hospitals, indicating that investment priorities had not aligned with reform goals. Underinvestment poses a serious risk to health and social care in Northern Ireland for several interconnected reasons, including deterioration of service delivery, worsening health outcomes and health inequalities, such as the capacity to deliver mental health prevention and early intervention in community settings.[44]

2.4 | The Role of Data Awareness and Reducing Stigma in Advancing Mental Health Outcomes in Northern Ireland

Data awareness plays a pivotal role in shaping mental health outcomes in Northern Ireland by highlighting both the scale of need and the areas requiring urgent intervention. The most recent Health Survey Northern Ireland (2024/25) reports that approximately 18% of adults exhibit probable mental ill health (GHQ12 score ≥4), while around 38% expressed concerns about their mental health over the past year, figures that remain concentrated in deprived and urban communities (Department of Health, 2025).[2]

Awareness of these trends has helped reduce stigma and has coincided with an increase in help seeking. For example, the PHA's Mental Health 2023-24 Survey found that 24% of adults sought support for emotional or mental health issues, and 77% of those would do so again (Public Health Agency, 2025).[45] However, the report found that help seeking stigma was higher for people who had experienced mental ill health.[45]

Despite these advances, significant data gaps remain, particularly in relation to service outcomes and waiting lists, posing ongoing challenges for evaluating service effectiveness. The Northern Ireland Assembly's Public Accounts Committee (PAC) has highlighted the need for urgent improvements in data collection and transparency to address these shortcomings (Northern Ireland Assembly Public Accounts Committee, 2024).[6] Robust data awareness is therefore critical: it supports the identification of areas of greatest need, enables individuals to access appropriate support, informs evidence-based policy development, and highlights weaknesses in service delivery. In this context, improved data awareness is fundamental to addressing unmet need and strengthening mental health services and supports in Northern Ireland.

2.5 | Peace Agreements and Mental Health: Integrating Psychological Recovery into Post-Conflict Policy

The mental health landscape in Northern Ireland is deeply influenced by its socio-political history and the commitments made through peace agreements and policy frameworks. While the 1998 Good Friday Agreement centred primarily on governance, human rights, and institutional reform, it indirectly influenced mental health by creating structures to address the enduring impacts of conflict and the legacy issues that continue to affect communities. The Stormont House Agreement (2014) marked a significant milestone, emphasising long-term peacebuilding and addressing the legacy of conflict (HM Government, 2014).[46] This agreement included provision for victims and survivors, leading to calls for a pension payment for the severely injured and a commitment to the establishment of a dedicated mental health trauma service. In response, the Regional Trauma Network (RTN) was set up under the Department of Health and the SPPG (DoH, Northern Ireland).[47] Currently the RTN provides services to those who meet the legal definition of victim and survivors of the conflict, i.e. those who have been bereaved as a result of the conflict or who have sustained either physical or psychological injury as a result of the conflict.

Historical Context and Contemporary Challenges

The New Decade, New Approach (NDNA) Agreement (2020) further reinforced the commitment to societal wellbeing and reducing inequalities (UK Government & Irish Government, 2020).[48] The agreement referenced these goals multiple times, highlighting the need for collaborative efforts to improve prosperity and wellbeing for all. Key pledges included increasing mental health funding over three years, transforming health and social care systems with a stronger focus on mental health and wellbeing, and publishing a multi-year Programme for Government.

While these plans were published, their implementation has been hampered by funding constraints, leaving many reforms only partially realised. Collectively, these agreements demonstrate a growing recognition that peacebuilding must include sustained investment in mental health to address both historical trauma and future resilience.

Overall, while Northern Ireland has shown a policy commitment to improving mental health services and addressing the legacy of conflict, progress has varied across different areas. Structural challenges, resource limitations, and the complexity of trauma-related needs continue to shape mental health services, underscoring the need for sustained investment and inclusive service delivery to meet the region's long-term wellbeing goals.

2.6 | Underinvestment Risks

Tackling the challenges facing mental health services in Northern Ireland and delivering the long-overdue strategic improvements relies heavily on the provision of sustained additional investment. Historically, however, mental health services and supports in Northern Ireland have received less financial support compared to other regions of the UK.[32]

The Making Parity a Reality report is a major review of mental health policies and services in Northern Ireland, authored by Ulster University academics and widely cited by the DoH, MLAs, and the voluntary sector.[49]

The report evaluated whether mental health services in Northern Ireland are being treated on an equal footing ("parity of esteem") with physical health services. Key findings included that Northern Ireland had the highest mental ill health rates in the UK, linked to trauma, deprivation, and the legacy of the Troubles combined with the longest mental health waiting lists in the UK (at the time, ~120,000 people waiting over 12 months), The report cited the need for a fully costed, 10-year mental health strategy.

In addition, Together for You was a Lottery-funded mental health initiative that brought nine leading charities together to deliver coordinated wellbeing, early intervention, and support services across Northern Ireland. It reached over 52,000 people through psychological therapies, mental health education, prevention, and targeted support for vulnerable groups, significantly improving reported mental health outcomes.[50]

Funding in Northern Ireland continues to lag behind wider health investment trends. Recent analysis shows that services account for approximately 6% of the overall health and social care budget. Per capita investment also remains comparatively low: Northern Ireland is the only UK nation spending under £220 per person on mental health.[6]

The Northern Ireland Audit Office (NIAO) reported in 2022-2023, that a total of £345 million had been allocated for mental health services, representing 5.7% of the overall HSC budget. The report estimated that bringing funding levels into line with elsewhere in the UK would require additional funding, which could be as much as £190 million annually.[51] The Mental Health Strategy 2021–2031, launched by the DoH, sets out a ten-year vision to transform mental health services with costs running to ~£1.2 billion over the decade.[24]

Developed in consultation with service users, clinicians, and stakeholders, the Mental Health Strategy aims to achieve parity of esteem between mental and physical health, improve access to services, and promote prevention, early intervention, and recovery across the lifespan. However, the NIAO warned that these costs "are not available from within departmental resources and will require additional funds to be secured through an Executive".[51]

The Mental Health Strategy was developed in response to the NDNA Agreement, a core element of which was the introduction of a mental health plan. This agreement restored the Executive and set out ambitious commitments for public service transformation generally. As part of NDNA, the UK Government pledged additional funding to support health services, including mental health. However, the resources allocated to the strategy by the DoH have to date fallen significantly short of the Strategy's requirements, as set out in the Strategy Funding Plan.[52] This shortfall highlights the gap between the commitments set out in NDNA and the level of funding currently available to support their implementation within Northern Ireland's mental health services.

Historical Context and Contemporary Challenges

In June 2024 the PAC also recognised that the DoH's existing resources were insufficient to fully implement the plan, urging collective action across the Executive to prioritise mental health in future budget allocations.[6] Historic under-investment in mental health services has had wide-ranging social and population-level implications. The Mental Health Strategy has the potential to address some of these challenges, subject to the provision of sufficient resources.

Stakeholder commentary;

Annual funding cycles have impacted retention, service continuity, and the capacity to plan and deliver longer-term improvements in mental health services.

2.7 | The Changing Complexity of Need

A shift in the scale and complexity of mental health needs across Northern Ireland is evident in both the literature and stakeholder feedback. Together, these sources point to rising demand and increasingly complex presentations of mental ill health across the life course. The Northern Ireland Registry of Self-Harm Regional Report documents these trends and highlights a shifting and complex profile of need across the population. The report notes a marked increase in emergency department attendances related to self-harm and suicidal ideation in recent years, with the burden particularly pronounced among young people. Over the past decade, presentations involving suicidal thoughts have risen substantially and self-harm rates have remained persistently high. It goes on to highlight that patterns of risk differ by age and gender, and that the proportion of self-harm cases involving alcohol has reduced.[53]

Stakeholder Commentary;

Mental health services face capacity pressures, resulting in extended waiting times and difficulties in accessing appropriate support. When community-based care is unavailable, demand on crisis teams and emergency services tends to increase.

The Global Burden of Disease (GBD) study provides internationally comparable estimates of mortality and non-fatal health outcomes across countries, age groups and over time. A core GBD metric is Years Lived with Disability (YLD), which measures the burden of non-fatal conditions by combining prevalence with standardised disability weights reflecting severity. GBD analysis highlights that mental ill-health contributes a substantial share of overall disability, despite relatively low associated mortality.

Mental ill health accounts for a varied share of YLDs across the United Kingdom.[54,3]

Mental ill health ranks as the third highest cause of disease and disability in Northern Ireland. In 2022, economists estimated the cost of mental health across the UK governments, inferring that the estimated mental health costs the Northern Ireland economy £3.4bn annually. This is likely an underestimation as indirect costs, or cost associated with addiction were not considered.[55] These conditions are associated with long-term disability, with potential impacts on daily functioning and participation in work and community life. This underscores a critical policy challenge - while physical health often dominates funding and infrastructure, the hidden burden of mental ill health is eroding capacity, productivity and wellbeing across the region.

2.8 | Trauma and Intergenerational Adversity

As mentioned above, complex mental health issues are increasingly seen across all ages in Northern Ireland, shaped by the enduring impact of trauma unique to the region's history. When trauma is left unaddressed, its effects can persist across generations and reinforce cycles of disadvantage.

The Northern Ireland Study of Health and Stress (NISHS) was the first diagnostic survey of its kind in Northern Ireland and provided the population-level data that enabled examination of the mental health impact of the conflict. The NISHS found that the lifetime prevalence of any mental disorder in the population was 39.1%. People who experienced conflict were more likely to have had an anxiety, mood or impulse-control disorder. Treatment delays were substantial for anxiety and substance disorders.[56]

Drawing from the NISHS, the 2011 'Troubled Consequences' report examined the mental health impact of the Northern Ireland conflict, focusing on trauma-related disorders such as post-traumatic stress disorder (PTSD), depression, and anxiety.[57]

Individuals who experienced any conflict-related traumatic event were more likely to have had any lifetime anxiety, mood, substance or impulse disorder compared to those who experienced a non-conflict-related event and those who had not experienced a traumatic event. Overall, an estimated 53% of individuals who experienced a conflict-related traumatic event had a mental health disorder at some point in their life, while 32% had a mental health disorder in the 12 months previous to the NISHS interview.[57]

Historical Context and Contemporary Challenges

Almost 44% of individuals who experienced a conflict-related traumatic event had a 'post-conflict' disorder following their first experience of conflict (i.e. had a disorder that first developed after their first experience of conflict).

A subsequent report "Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health" warned of how the effects of violence, traumatic experiences and social segregation impact upon parenting practices which affect early attachment and the capacity of the child to self-regulate.[58]

Self-regulation difficulties increase the person's risk of mental disorders, behavioural problems and suicide. They also affect how that person engages with their own children when they become a parent. The accumulation of childhood toxic stress, resulting from negative parenting behaviours, exposure to violence and the use of harsh punishment, is associated with adverse mental health outcomes. Social deprivation and poverty serve to exacerbate the mental health impact of the consequences of the conflict. The 'Towards a Better Future' report sets out recommendations focusing on ameliorating the impact of transgenerational trauma through a focus on ACEs. [58]

A recent representative survey has provided the first comprehensive examination of the links between childhood adversity, conflict related exposures and adult health outcomes in Northern Ireland.[59]

Walsh *et al*. (2025) report that approximately 60% of adults experienced at least one adverse childhood experience (ACE). In practical terms, this indicates that for every 100 people living in Northern Ireland, around sixty are likely to have experienced harm during childhood. More concerningly, 17.6% of adults reported exposure to four or more ACEs (4+ ACEs), a threshold consistently associated in the international literature with substantially elevated risks of adverse outcomes, including mental health difficulties, physical ill health and social disadvantage (Walsh *et al*., 2025). The survey further highlights the distinct post conflict context of Northern Ireland, with almost 30% of respondents reporting conflict specific adversities linked to paramilitarism and community violence. These conflict related exposures were strongly associated with poorer mental and physical health outcomes and other adverse life trajectories. [59]

Importantly, Walsh *et al*. (2025) demonstrate that in Northern Ireland's post conflict setting, childhood adversity is frequently cumulative. Conflict related and extrafamilial harms are often layered onto other forms of deprivation, including poverty and family level adversity. These compounded exposures are particularly prevalent in communities most affected by historical conflict and socioeconomic disadvantage and are strongly associated with poorer adult mental health outcomes.[59]

Taken together, the evidence indicates a deterioration in population mental health alongside a substantial prevalence of childhood adversity. This highlights the need to ensure adequate provision of services for PTSD and complex PTSD, alongside the consistent adoption of trauma-informed approaches across mental health supports and services. This should be supported by the embedding of trauma-informed practice and workforce training across the region. More broadly, the evidence reinforces the importance of preventing childhood adversity. Investment in early intervention, parenting support and the reduction of child poverty represent effective approaches to reducing the long-term burden of mental ill-health within Northern Ireland population.

Stakeholder commentary;

Experiences of trauma and adversity, including conflict-related exposure and social isolation, continue to influence mental health needs.

Historical Context and Contemporary Challenges

2.9 | Social Harms

Social harms are systemic and structural issues which are themselves traumatising and which create environments where individuals are more likely to experience trauma. The relationship between social harms, such as poverty, domestic abuse, gender-based violence, community violence and mental health is complex and deeply rooted in Northern Ireland's social fabric. Similarly to trauma, when social harms are not addressed, their effects can be passed down through generations.

Research suggests 98% of women in Northern Ireland have experienced at least one form of violence or abuse in their lifetime, with half (50%) experiencing this before they were 11 years old.[60] The Police Service of Northern Ireland (PSNI) Domestic Abuse statistics showed that offences reached the highest on record in 2022-23 and remain elevated. Further, while all other crime categories included in the data have reduced in the years since, sexual offences are an exception and remain relatively high.[61]

The persistence of these harms is not only a legacy of conflict, but is also associated with factors including stigma, underreporting, misogyny, bigotry, homophobia, transphobia, limited access to trauma-informed care, institutional abuse, generalised othering and the continued influence of paramilitarism and organised crime. The Executive Programme on Paramilitarism and Organised Crime (EPOC) in Northern Ireland is a cross-departmental initiative launched in 2016 to tackle the harms caused by paramilitary activity and organised crime. Its work is based on a public health approach to violence reduction, aiming both to stop immediate harm and to prevent future exploitation and trauma. More recently, a focus of the programme has been on the areas of coercive control and criminal exploitation, including Child Criminal Exploitation (CCE).[62]

2.10 | Gender-based Violence

Gender-based violence (GBV) has long formed part of the wider social harms shaping Northern Ireland's mental health landscape, with domestic abuse and sexual offences remaining at historically high levels and contributing to enduring trauma across communities. The rate of femicide is stark, 30 women have been murdered since 2020.[63,64]

These patterns are closely linked to structural inequalities, the legacy of conflict, and persistent stigma, all of which limit access to timely, trauma-informed support. In recognition of GBV as both a societal and public health concern, the Executive Office introduced the EVAWG Strategic Framework, a seven year, whole of government policy response launched in 2024, and one of the targeted actions for delivery by 2027.[10]

EVAWG aims to prevent violence by addressing harmful gender norms, expanding healthy relationship and consent education, and strengthening cross sector collaboration at community level. Early implementation activity through the Local Change Fund has focused on awareness raising, school engagement, and professional training, with reported increases in public knowledge of GBV and confidence in recognising harmful behaviours. EVAWG's introduction marks a significant policy shift recognising GBV as a determinant of mental health and provides the institutional framework through which prevention, early intervention, and trauma-responsive services can be more coherently embedded across government. The delivery plan for the first two years of the strategy consists mainly of media campaigns, plans for further engagement with existing groups and more reports. However, there remains no commitment to ensure that all children and young people have access to Relationships and Sexuality Education in schools including education on consent.

2.11 | Mental Health and Intimate Partner/ Domestic Violence in Northern Ireland

Intimate Partner Violence (IPV) and mental health in Northern Ireland are influenced by a range of historical, social, and political factors, and the relationship between them is widely recognised in research and policy discussions. Research spanning several decades highlights the psychological toll of IPV, the influence of post-conflict trauma, and systemic challenges in addressing these problems. Early studies, such as Dorahy *et al*. (2007), found that women in IPV shelters exhibited significantly higher levels of depression, anxiety, dissociation, and guilt compared to controls, with childhood abuse compounding these effects and leading to chronic psychological distress.[65]

Historical Context and Contemporary Challenges

More recent findings indicate that IPV survivors frequently experience PTSD, exhibit self-harm behaviours and experience severe anxiety and depression, with these impacts often extending to children in the form of trauma, fear, and behavioural issues.[66]

Post-conflict dynamics add further complexity; Travers *et al*. (2020) reported that 72.3% of IPV perpetrators had multiple trauma exposures and 63.5% had mental health difficulties, with childhood maltreatment strongly linked to severe IPV outcomes, including injury and sexual violence.[67] Harmful substance use and trauma history were significant predictors of violent behaviour, underscoring the need for integrated mental health and criminal justice interventions. Northern Ireland's social landscape has been shaped by decades of conflict, with longstanding divisions and traditional social structures influencing IPV dynamics and responses. While legislative and policy changes since the 1990s have improved official responses, emotional and psychological abuse continues to receive comparatively limited recognition. Police data show that 30,203 domestic abuse incidents were recorded in the 12 months to 30 September 2025, representing a 2.7% decrease (842 fewer incidents) compared with the previous year.[61,68] In the same period, 18,453 domestic abuse crimes were recorded, a 1.8% decrease (337 fewer crimes). A 2023 Ulster University survey found that 98% of women reported lifetime experiences of violence or abuse, with 70% experiencing it in the past year. Persistent gaps in mental health data collection and quality continue to complicate efforts to assess IPV-related needs.

Individuals with severe mental illness, many of whom report experiences of IPV, have elevated comorbidities and double the mortality risk compared to the general population. Overall, IPV has profound psychological consequences, including depression, anxiety, PTSD, and dissociation, while perpetrator trauma and substance misuse exacerbate IPV severity. Cultural and historical factors shape IPV prevalence and responses, and data gaps hinder effective policy and service planning. Recent studies confirm IPV remains widespread, with significant mental health implications.[69]

In its annual report, published in February 2026, the PSNI reported 30,793 recorded domestic abuse incidents during the 2025 reporting year, alongside seven homicides with an identified domestic abuse motivation (four female and three male victims).[63]

Addressing IPV and mental health in Northern Ireland requires integrated strategies combining trauma-informed care, improved data systems, and culturally sensitive interventions.

In 2024, the Department of Justice and the Department of Health, as lead policy departments for domestic and sexual abuse, have published a new strategy and performance framework for tackling domestic and sexual abuse in Northern Ireland. The vision for the strategy is that Northern Ireland is a place where domestic and/or sexual abuse is not tolerated, and everyone can be safe and free from fear. Domestic and/or sexual abuse is recognised as a cross-societal issue that requires effective partnership working and collaborative approaches to drive sustainable change across communities. A core principle is that the voices of victims, including children and young people, are central to decision-making. This was supported by an accompanying action plan, developed to deliver the outcomes and key priority areas identified under each pillar, and to reflect EVAWG principles where appropriate. However, funding allocations remain unclear, with the majority of actions identified as cost-neutral or subject to confirmation at a later stage.[70]

2.12 | Historical Institutional Abuse

It is important to recognise that while the conflict in Northern Ireland has had a lasting impact on mental health, so too has the legacy of child abuse experienced across multiple residential institutions in Northern Ireland between 1922 and 1995. The Historical Institutional abuse enquiry and the Historical Institutional Abuse Act of 2019 set out the need for a commissioner role.[71,72]

The Commissioner for Survivors of Institutional Childhood Abuse (COSICA) represents and promotes the interests of those abused as children in residential institutions in Northern Ireland between 1922 and 1995. On 11 March 2022, in the Assembly Chamber of Parliament Buildings, Ministers Michelle McIlveen, Conor Murphy, Nichola Mallon, Robin Swann and Naomi Long delivered an apology on behalf of the Northern Ireland government to the victims and survivors of Historical Institutional Abuse. Apologies were also heard from each of the institutions where systemic failings were found in the enquiry report. COSICA's most recent report highlights that 30% of respondents were not able to access the support they need for their wellbeing and 68% said their mental health was poor or very poor.[73]

Historical Context and Contemporary Challenges

Survivors report that traumatic childhood experiences have affected their physical and mental health, and insufficient trauma-informed practice has made it harder for individuals to access support across sectors such as healthcare and housing.[73]

2.13 | Long-Term Gaps in Equity and Inclusion

Gaps in equity and inclusion have historically influenced mental health outcomes in Northern Ireland.[74] While it is well-established that deprivation is closely linked to higher mortality, and mental ill health, less frequently highlighted are the disparities in treatment and diagnosis.[75]

According to the latest Health Inequalities Annual Report (Department of Health, Northern Ireland, 2025) significant gaps persist in premature mortality between the most and least deprived areas in Northern Ireland, with indicators such as suicide and drug-related deaths showing widening inequality. Alcohol and drug-related harms represent some of the largest health inequality gaps recorded, with drug-misuse mortality nearly six times higher in the most deprived communities.[76]

The Strategic Framework to Tackle the Harm from Substance Use (2021-31) was produced in response to commitments in NDNA and takes a prevention approach to treatment and support services.[77]

However, it has been criticised for insufficiently addressing the underlying factors that can contribute to drug and alcohol use, including mental ill-health. Wider evidence indicates that discrimination and socioeconomic inequality are associated with an increased risk of poor mental health and can present barriers to accessing appropriate support.[78]

Stakeholder commentary;

Barriers to accessing support persist for certain groups, including minority ethnic families, members of the Traveller community, and children with disabilities.

2.14 | Discrimination and Marginalisation - The Historical Context of Conflict in Northern Ireland

The relationship between discrimination and the marginalisation of minority communities in Northern Ireland can be better understood when placed within a broader historical context that includes sectarian conflict, periods of limited state support, and the relatively late development of race relations policy.

Although Northern Ireland has often been portrayed as ethnically homogenous, this characterisation does not reflect the region's historical diversity and has contributed to limited recognition of minority ethnic communities. Recent academic commentary states that 'racial discrimination does not, in fact, exist,' a position that contributed to the region's exclusion from the development of UK race relations policy until 1997, more than three decades after Great Britain introduced its first Race Relations Act.[79] This stance meant that minority ethnic communities in Northern Ireland did not benefit from the same legal protections available elsewhere during that period. This historic exclusion had profound consequences.

A 2002 review found that racism in Northern Ireland operates not only at the level of individual prejudice, but is embedded within institutional practices, policies, and the everyday functioning of organisations.[80] His work emphasises that discriminatory outcomes can arise even in the absence of overt intent, underscoring the structural nature of racism and its links to wider patterns of marginalisation. Prior to the introduction of antiracism legislation, these institutional issues persisted, during which time minority communities experienced disproportionately higher levels of disadvantage, limited access to public services, and variable state support.

The intersection of racism with the broader context of conflict related deprivation further intensified these inequalities. Crangle highlights that ethnic minority communities, including longstanding Italian, Indian, Chinese, and later Vietnamese migrants, were often positioned outside the dominant sectarian binary, which did not grant them safety but instead generated new vulnerabilities. Their "foreignness" could allow temporary distance from sectarian divides, but at moments of heightened political tension, such as the Troubles, these communities became more visible and thus more exposed to prejudice, suspicion, or hostility. Meanwhile, Connolly's review situates such experiences within a wider landscape of social exclusion, noting that racism must be understood alongside other forms of structural inequality intensified by conflict, particularly in deprived communities where violence was historically concentrated.[80]

Both bodies of research underscore a shared finding: marginalisation in Northern Ireland has structural roots.

Historical Context and Contemporary Challenges

The prolonged absence of race relations legislation, historical patterns of state neglect, and the assumption of ethnic homogeneity contributed to poor outcomes for minority communities. These dynamics have continued relevance, with more recent evidence indicating that Northern Ireland still experiences comparatively high levels of racism and homophobia, phenomena that remain most acute in areas experiencing deep, conflict-related deprivation.[81]

Together, the literature demonstrates that discrimination and marginalisation cannot be separated from the region's conflict history; instead, they form part of a mutually reinforcing cycle affecting minority groups long after the peace process.

2.15 | The Impact of the UK's Exit from the EU (Brexit) on Mental Health in Northern Ireland

Brexit has had significant and measurable impacts on the funding landscape for mental health services in Northern Ireland, particularly through the loss of major EU structural funds that previously supported community based mental health and wellbeing initiatives and early-intervention programmes. Most notably, the loss of the European Social Fund (ESF) funding that has placed major strain on the community and voluntary mental health sector. While the UK Shared Prosperity Fund provides some replacement support, it falls far short in scale, stability, and equality safeguards.[82] The only substantial EU programme still accessible is PEACEPLUS, preserved due to its peace-process role and now delivering sizeable investment in health and mental health projects, but it does not compensate for the structural loss of ESF and other EU funding streams. The PEACEPLUS programme continues cross-border EU investment in peacebuilding and health, including more than €70 million allocated to mental health and wellbeing initiatives after the UK's withdrawal.[83]

Potential Erosion of Legal Protections

Brexit resulted in EU-derived protections related to services becoming subject to change through domestic political processes, whereas previously they were underpinned by EU legal frameworks. As a result, protections associated with non-discrimination, dignity, and access to services may be more susceptible to amendment or removal. This has potential implications for people with mental illness, including in areas such as detention safeguards, treatment without consent, and disability rights. Equality protections influenced by EU Directives may also be subject to erosion over time, with potential risks relating to workplace discrimination, reasonable adjustments for mental ill-health, and access to services.

However, the Northern Ireland Protocol, introduced to maintain certain EU-aligned rights and standards in Northern Ireland in order to avoid a hard border on the island, provides an additional legal mechanism for challenging rights breaches. This offers a level of legal protection in Northern Ireland that differs from other regions of the UK.[84]

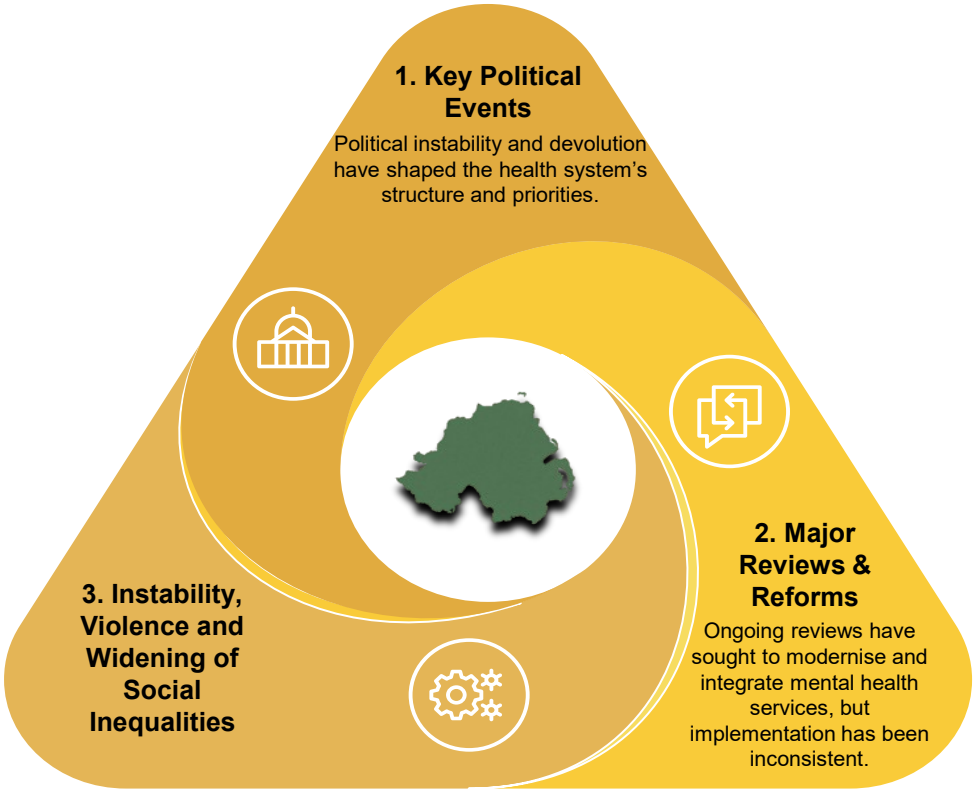
Conclusion

Northern Ireland's mental health needs and services have been shaped over time by a complex interplay of political challenges, financial limitations, and significant social change. Meanwhile, indicators show changes in need, including youth self-harm and disability burden, all within contexts of trauma and inequalities. Audit and parliamentary reports identify the role of sustained investment, improved data, and cross-sector collaboration in supporting the aims of the Mental Health Strategy 2021 - 2031. Achieving meaningful transformation will require sustained ambition and coordinated commitment across all stakeholders to address historical legacies and establish more responsive mental health services.

Historical Context and Contemporary Challenges

2.16 | Historical Context and Contemporary Challenges Summary

The configuration of Northern Ireland's mental health services are the product of prolonged political complexity, successive waves of reform, and limited by the unavailability of updated, community-agnostic, and accurate data. The accompanying graphic provides a consolidated overview of the principal determinants identified, namely political developments, major policy reviews, reform initiatives, and the role of instability, violence and widening of social inequalities, which collectively account for the systemic pressures currently confronting mental health services.



01

- The Good Friday Agreement (1998) established devolved institutions, but **repeated Executive collapses** (2002–2007, 2017–2020, 2022–2024) led to periods of policy stagnation and delayed reform.
- Later political milestones, including the **Stormont House Agreement (2014)** and **New Decade, New Approach (2020)**, reinforced commitments on legacy harms and wellbeing, but delivery has remained vulnerable to instability and constrained governance capacity.

02

- The Bamford Review (2002-2007) called for rights-based, person-centred, community care and led to **new legislation** and **action plans**.
- The Bengoa Vision (2016) proposed system-wide transformation, but **progress has been patchy** and **varies by region and speciality**.

03

- Mental health spending per capita in Northern Ireland (approximately £210–£220) remains lower than in England (around £260), with Northern Ireland **consistently spending less on mental health than other UK jurisdictions**.
- Annual **funding cycles** and **lack of multi-year commitments** have undermined retention, service continuity, and the ability to deliver sustained transformation.

Mental Health Services

MENTAL HEALTH CHAMPION

Mental Health Services

Introduction

Mental health is a complex and multidimensional aspect of human well-being, shaped by biological, psychological, and social factors, with ongoing research continuing to explore these influences.

In this section, we will examine the mental health services available in Northern Ireland through the lens of key life stages, from perinatal through to later years. For each group examined, we will outline the support infrastructures currently in place under the following headings:

- **Policy:** The overarching policies outlining key objectives and goals for mental health.
- **Service:** The operational initiatives supported by 'on the ground' resources planned or currently in place and available to the population.

By mapping the key factors that influence mental health alongside the existing support infrastructure, this analysis aims to provide an overview of Northern Ireland's mental health services. This evidence base can inform the development of a more proactive, integrated, and resilient system of supports and services designed to meet the complex needs of the population.

3.1 | Northern Ireland's Overarching Approach to Mental Healthcare Provision

Northern Ireland's Mental Health Strategy 2021 - 2031 is the most recent policy document that establishes the future strategic direction of mental health services across the country. Launched by the Department of Health on 29 June 2021, it outlines 35 actions across three themes, to be implemented year-on-year through delivery plans led by the Mental Health Strategy Delivery Unit. These overarching themes of the strategy are:

The Strategy establishes the long-term framework for mental health promotion, early intervention, improved service accessibility, and innovative models of care. It was accompanied by a funding plan and its implementation is supported by annual delivery plans that prioritise actions achievable within the constraints of each fiscal year.[52]

On 9 October 2025, Minister Nesbitt published "A Review of the Deliverability of the Strategy's Actions 2026-2029". This comprehensive review involved consultations with over 100 stakeholders and various focus groups of relevance in order to ascertain the progress of the Mental Health Strategy and identify priority areas of focus for the next three years. Despite the Strategy's estimated £1.2bn cost, the review notes that only £12.3m had been allocated to 14 actions by the end of 2024/25 (16% of the funding assessed as needed), limiting what can be delivered. It therefore prioritises two key enablers for 2026/27: strengthening the mental health service (including greater use of community & voluntary capacity) and developing a regionally consistent Mental Health Crisis Service.[1]

The report emphasised the challenging financial context surrounding delivery of the 20 strategic actions that were underway at the time of print, alongside highlighting the Mental Health Workforce and Regional Mental Health Crisis Service (RMHCS) as crucial enablers for broader system improvement going forward. The RMHCS is a new, region-wide initiative which aims to provide consistent, 24/7 crisis support across Northern Ireland. The Minister underscored the imperative of refocusing efforts to achieve optimal mental health outcomes within available resources.[1]

Mental Health Services

3.2 | A Life Course Approach to Mental Health

Patterns of mental health needs and service use vary at each life stage with distinct contributing factors influencing outcomes, such as family of origin, social inclusion, physical and emotional safety, physical health, and inter-generational trauma. In Northern Ireland overall mental health service utilisation is high. However, some groups continue to face significant barriers to timely and appropriate support. This is reflective of challenges faced on a global scale which the World Health Organisation (WHO) has addressed by advocating for a holistic, life course approach to mental health management.[85] This approach places the individual at the centre of service delivery, recognising the unique internal and external factors that shape mental wellbeing. It seeks to ensure that services are responsive to emerging needs across all life stages and promotes proactive prevention, early intervention, and improved outcomes throughout the life course. Our review of Northern Ireland's mental health services will be undertaken within this framework.[85,86]

3.2.1 | Perinatal Mental Health

The early years of life represent a critical period for brain development, where secure attachments and nurturing environments profoundly shape mental health outcomes. Perinatal mental health refers to emotional and psychological conditions that arise during pregnancy and within the first year after birth. These conditions may be new or recurring disorders and can affect not only the mother's well-being but also her relationship with the baby and family.

The PHA reports that around 10 - 20% of women experience some form of mental health problem during pregnancy or in the year after birth, and up to 10% of fathers or partners are also affected.[87,88]

Furthermore, there is an increasing awareness across the medical and scientific communities of the intergenerational transmission of stress and trauma through epigenetics during pregnancy. It has been found that traumatic experiences such as domestic violence, racism, and sexual assault experienced during pregnancy can be "biologically embedded" via epigenetic mechanisms (e.g., changes in DNA methylation that affect how genes are expressed, without changing the DNA sequence), and maternal stress physiology in pregnancy may also shape the developing foetal brain and stress-response pathways.[89]

These inherited genetic alterations can therefore affect the next generation and increase the likelihood of mental health issues and illness for the child later in life. The changes can manifest in a variety of ways including emotional regulation and cognitive function, Major Depressive Disorder (MDD), and heightened stress sensitivity.[90]

In line with National Institute for Health and Care Excellence (NICE) (2014) guidance, midwives in Northern Ireland routinely record a woman's psychiatric history and screen for risk of domestic violence at her first maternity booking.[91] The Northern Ireland Maternity System (NIMATS) is the regional maternity information system used in these instances. Analysis of 140,569 pregnancies in Northern Ireland from 2010 - 2015 found that women who self-reported a history of psychiatric disorder had increased odds of preterm birth, low infant birth weight, and lower Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) scores at delivery.[92]

The Maternal Mental Health Alliance's (MMHA) mapping work indicated that around 80% of women do not have access to a specialist community perinatal team.[93] A comparative review of service provision across the UK revealed significant regional disparities: only 14% of Health Boards in Scotland, 29% of Health Boards in Wales, and 80% of Clinical Commissioning Groups in England met established standards for specialist perinatal mental health services.[94] The established standards for specialist perinatal mental health services in the UK refer to the Perinatal Quality Network (PQN) standards developed by the Royal College of Psychiatrists. These standards are widely used to assess whether services meet best practice requirements. At the time of the MMHA mapping (winter 2019/20), none of Northern Ireland's HSC Trusts met these criteria. Since then, all five Trusts have established community perinatal mental health teams. However, updated PQN assessment is required to confirm current compliance.[94,95]

Mental Health Services

Policy

Recognising the importance of early detection and intervention, the **Regional Perinatal Mental Health Care Pathway**, published by HSC, guides health and social care professionals in Northern Ireland on identifying and treating perinatal mental health conditions.[95] The updated pathway formally embeds newly-funded multidisciplinary community specialist perinatal mental health teams in all five HSC Trusts, shifting from a fragmented model where only one Trust had a dedicated service. This, thereby, enables a consistent "through pregnancy to one year postnatal" care route for women across Northern Ireland.[96] Alongside the development of community-based services, the planned establishment of a regional **Mother and Baby Unit (MBU)** at **Belfast City Hospital** represents a potential advancement in programme delivery. This facility is intended to provide inpatient care for mothers experiencing severe mental illness, ensuring treatment without separation from their infants. Although the site has been designated and construction is anticipated to commence within the current financial year, full capital funding and a definitive implementation timeline remain under negotiation.[97,98,99]

Service

Each of the five HSC Trusts now has an operational community perinatal mental health team, offering specialist support to women in line with the designated care route mentioned above. These multidisciplinary teams include psychiatrists, psychologists, midwives, nurses, and social workers, ensuring holistic care tailored to individual needs.[96]

Mental Health Services

3.2.2 | Children and Young People's Mental Health

Childhood and adolescence are periods of intense change with internal factors such as an increased understanding of the world around us, a developing sense of self, and significant hormonal fluctuations, colliding with external factors such as socialisation, academic pressures and shifting family dynamics. Some individuals enter these stages of life predisposed to mental health challenges due to factors previously discussed, which can be exacerbated during this time. However, even those with no underlying contributing factors can experience significant mental health challenges as they progress through childhood and adolescence.

To provide insight into the prevailing attitudes of young people in Northern Ireland, the Kids' Life and Times (KLT) and Young Life and Times (YLT) surveys collate findings on the stressors they experience and the supports they would like to see implemented, as shown below. These surveys are annually administered by Access Research Knowledge (ARK), a collaboration between Queen's University Belfast and Ulster University. They provide a snapshot of opinions and experiences each year across numerous topics for children (aged 10 – 11) and adolescents (aged 16) in Northern Ireland.[100,101,102]

Stressors

- Academic expectations (pressure to do well at school)
- Relationships (worry about family stability and maintaining friendships)
- Concerns regarding household finances including cost of living expenses
- Online safety (worry about cyber-bullying and negative social media experiences)

Desired Supports

- Better mental health support in schools
- More open conversations
- Reduced stigma
- Social and emotional learning
- Relationships and sexuality education
- Whole school approach to wellbeing

Findings from the 2025 KLT/YLT surveys indicate that 16% of 10/11-year-olds rated their own mental health as fair or poor, with this proportion increasing markedly to 39% among 16-year-olds.[100,101]

Evidence across the life course highlights how adversity and conflict exposure shape mental health outcomes in Northern Ireland. Among children and young people, the Northern Ireland Youth Wellbeing Survey (NIYWS) found that around 11.5% of those aged 2–19 met criteria for a mood or anxiety disorder.[103]

3.2.3 | Vulnerable and Higher Risk Groups

Risk factors associated with poor mental health are often concentrated among young people with early contact with social care services and those experiencing socio-economic pressures. McKenna and Maguire (2025) found that approximately 40.9% of young adults (up to age 18) presenting to emergency departments with self-harm or suicidal ideation had prior childhood contact with social services and that the likelihood of such presentations increased with the level of involvement.[104] The Administrative Data Research (ADR) UK policy brief Self-harm and suicide in Northern Ireland: New evidence from linked administrative data (2025) found that children and young people known to social services, including those who were not taken into care, experience a substantially higher risk of death by suicide compared with those never known to social services.[105]

Other vulnerabilities, especially as individuals approach adolescence, include identity-based risks. These experiences are influenced by broader patterns of discrimination and marginalisation related to gender, sexuality, and identity.[106] A 2021 UK LGBTQIA+ young people's charity found young people who identify as LGBTQIA+ face elevated risks to their mental health.[106] Members of the LGBTQIA+ community are three times more likely to self-harm than their peers and twice as likely to experience anxiety and depression.[106] 68% have experienced suicidal thoughts (compared to 29% of their peers) and only 14% reported feeling relaxed daily (versus 31% of their peers).[106]

Starkly, 10% of LGBTQIA+ youth in the UK reported having never felt any sense of optimism in relation to their future.[106] School is a particular source of distress for young LGBTQIA+ people, with 46% of the cohort having witnessed homophobic bullying (as opposed to 26% of their peers) and only 58% feeling safe in school daily (as opposed to 73% of their peers).[106]

Gender, alongside identity, plays a critical role in shaping mental health during adolescence.

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The developmental stage of childhood and adolescence is marked by challenges related to self-esteem, identity formation, and evolving social relationships as peer networks and environments become increasingly complex.

Additionally, the onset of puberty brings significant physiological and psychological changes, further intensifying the transition from childhood to adulthood. Hormonal shifts and physical changes can cause mental health struggles as individuals adjust while trying to maintain other aspects of their lives, such as academic performance. This stage of life appears to be particularly challenging for young girls in Northern Ireland. In 2021/22 it was reported by the PHA in the 'Northern Ireland Registry of Self-Harm' that females aged 15 -19 had the highest incidence of hospital-presenting self-harm at 1,138 per 100,000.[53]

Emerging evidence also highlights the role of sexism and misogyny in shaping poor mental health outcomes for adolescent girls.[107] Gender-based expectations, policing of behaviour and appearance, and exposure to harassment, both in person and online, can undermine self-esteem and contribute to chronic stress, anxiety, and depressive symptoms. Experiences of misogyny may also discourage help-seeking and reinforce feelings of shame or invisibility, further compounding mental health vulnerabilities during this critical developmental period.[107]

3.2.5 | The Role of Schools and Learning Environments

Schools play a central role in shaping the mental health of children and adolescents.[108] Beyond academic instruction, they provide the primary environment for social interaction, exposure to authority outside the family, and experiences related to peer dynamics and social hierarchies. Schools also impose structured expectations around attention and achievement, often reinforcing harmful societal perceptions of intelligence through performance.[109]

The Northern Ireland Audit Office (NIAO) report Assessing the Quality of Education in Northern Ireland (2026) found that while Northern Ireland performs well in international comparisons, assessment of educational quality remains heavily focused on academic test outcomes. The report highlights significant gaps in system wide performance data, particularly at Key Stages 1–3, meaning that GCSEs are often the first meaningful indication of pupil performance. As a result, opportunities to identify underachievement and intervene to improve outcomes frequently arise very late in a pupil's school journey.[110]

Educational underachievement is further compounded by an education system that can reinforce existing social inequalities, with negative consequences for young people's mental health and self-esteem.[111,112,113]

Since 2018 in Northern Ireland, the performance of the top 10 per cent of high achievers has been maintained but performance of low achievers, the bottom 10 per cent, has deteriorated.[114]

As discussed later in the section on neurodiversity, emerging research highlights that traditional school systems can be exclusionary for students who do not conform to neurotypical norms.[115] For these students, school may be the first setting where differences become apparent, which can have lasting implications for mental health.[116] Children may not attend school because they do not feel safe in the school environment. Conversely, school may be the first safe or stable environment that a student finds themselves in. Students who grow up in challenging home environments, may, for the first time be in the presence of safe authoritative figures who they may open up to about their mental health struggles or home environments.[117] Similarly, school might be the first place that an individual who is coming to understand their sexuality and gender identity might find acceptance amongst peers, particularly if their family of origin has not been supportive.[109]

The overall experience of school, either positive or negative, therefore impacts an individual through the rest of their life and contribute significantly to their mental health and resilience.[118]

Ongoing curriculum reform provides a timely opportunity to transform educational provision by embedding resilience-building education, helping to ensure that young people are better equipped to manage their mental health and wellbeing. Curriculum-based resilience programmes, including Social and Emotional Learning, have been shown to reduce the risk of mental illness later in life by developing young people's emotional regulation, coping, and problem-solving skills.[119]

Other initiatives underway include the Being Well Doing Well (BWDW) toolkit, which offers a structured programme with audits, staff training, and resources to help schools assess and improve their approach to emotional wellbeing. These initiatives are positive steps towards an improved mental healthcare system for the youth of Northern Ireland, though momentum will need to be sustained in the face of increased demand and budgetary restrictions, as evidenced by persistent CAMHS waiting times across NHS Trusts.[1,120,121,122]

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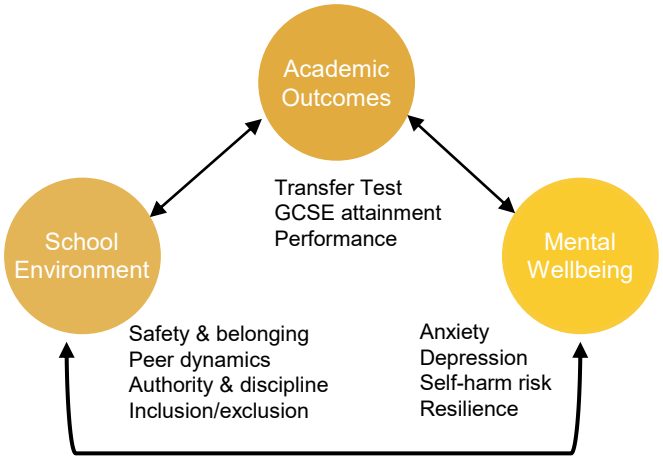

Wellbeing has been identified as a key area for improvement within the education system, as highlighted in Volume 2 of the 'Investing in a Better Future report'. In the report, "wellbeing" refers to strengthening emotional health and inclusion through a whole-school, cross-sector approach, combining universal promotion and early help with targeted supports for learners with complex needs – essentially social and emotional learning, which is shown to strengthen coping and reduce the risk of poor mental health. Published in 2023, the Independent Review of Education positioned wellbeing as a crucial element of a learner-centred system and placed a clear emphasis on inclusion, including moving away from harmful and stigmatising deficit language such as "achieving potential".[123]

The review set out a broad range of proposals aimed at modernising the curriculum to better reflect skills for life, including reconfiguring existing strands under a new learning area entitled Employability and Wellbeing. In its 2025 TransformED NI report, a direct response to the review, the DE announced the establishment of a Curriculum Taskforce to oversee implementation. The Department acknowledged Employability and Wellbeing as vital components but questioned the recommendation to merge them under one stream due to the size of each topic and the limited overlap between them, noting that such a merge could lead to incoherence. The Taskforce is now considering how best to address these areas in the new statutory curriculum.[123,124]

The DoH highlights the need for strong youth mental health support, with Actions 10 and 11 of the Mental Health Strategy focused on improving CAMHS and services for vulnerable children.24 In 2021, the DE and DoH jointly launched the Children and Young People's Emotional Health and Wellbeing in Education Framework and its implementation plan.

The Framework establishes an integrated support network across education, health, and community sectors, embedding a whole-school and community approach to emotional wellbeing. It focuses on universal support, early identification and intervention, and enhanced help for complex needs.

A key component of this framework was a pilot for the Emotional Wellbeing Teams in Schools (EWTS) initiative, which has received extremely positive feedback from teachers and students. EWTS supports schools in Northern Ireland by providing training, resources, and practical guidance to help staff promote emotional health and resilience, and embed the Emotional Health and Wellbeing in Education Framework across the whole school.

3.2.6 | Emotionally Based School Non-attendance

Research indicates that Emotionally Based School Non-attendance (EBSNA) has increased following the COVID-19 pandemic, with BMJ Mental Health reporting "an upward trend in emotionally based school avoidance (EBSA)" post-COVID.[125]

Schools in Northern Ireland are experiencing increasing levels of pupil absence associated with emotionally based school non-attendance (EBSNA), although the precise prevalence is not yet known due to longstanding gaps in formal data collection across the region. While a dedicated absence code is currently under development, the Department of Education is collecting indicative data on absences linked to emotional factors, including anxiety, unexplained physical symptoms, reluctance to leave home, and difficulties with separation or transition into school. Schools are also being asked to report on the number of pupils placed on flexible or reduced timetables as a result of EBSNA, such as attendance limited to specific classes or shortened school days. This information is intended to inform emerging policy and strengthen understanding of mental-health-related attendance challenges. It is important that approaches to EBSNA accurately reflect the scale of the issue without placing disproportionate responsibility on children and young people, and that consideration is given to the role of the wider school environment and how young people's experiences within it may contribute to absenteeism.[126]

Stakeholder commentary;

There is a marked rise in emotionally based school non-attendance, with more investigations and enquiries being initiated in recent years. There is an increase in the complexity of pupils' needs and in the importance of keeping children engaged with learning and in school.

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Stakeholder commentary;

Schools are increasingly supporting pupils with complex needs, while timely access to specialist services remains limited. This has resulted in additional pressure on schools to fulfil both educational responsibilities and provide frontline mental health support.

An important consideration in understanding the mental health of children and young people in Northern Ireland is the influence of technology and social media. It is widely accepted that technology has transformed the experiences of both parenting and teaching, opening multiple new avenues to connect with, monitor and relay information to children and students. The availability of mobile devices, including smartphones, and social media have also facilitated a rapid shift in how children and young people interact with each other and the world around them. It has created a space beyond the oversight of guardians and mentors, and greatly complicated the transition towards adulthood. The rapid and recent nature of technological advances means that today's young people are among the first generations to grow up fully immersed in digital environments. While efforts are underway to create safer systems and platforms, there remains significant uncertainty about the long-term impact of mobile devices and social media on mental health.[127,128,129]

3.2.7 | Digital Pressure and Online Behaviour

Queens University Belfast recently published a study entitled 'Screens, Safety and Social Media' which was based on data collected from the previously mentioned KLT and YLT studies.

- More than 75% of those surveyed spend over three hours daily on social media (with 30% spending over 6 hours).
- There is a correlation between time spent online and poorer mental health.
- Over half of those surveyed had experienced harmful or illegal behaviours (e.g., non-consensual sharing, online stalking).
- Young women, LGBTQIA+ youth, and those with disabilities were disproportionately affected by these negative experiences.

The report explored numerous topics such as children's access to technology, sexual grooming and gender based-violence, online behaviours of adolescents (including cyber-bullying) and exposure to upsetting or explicit content.

Study evidence shows intensive social media use among 16-year-olds in Northern Ireland, with most spending three or more hours per day online; higher use is associated with poorer self-reported mental health. Over half reported experiencing illegal or harmful online behaviours, most often offensive content, non-consensual sharing, or online stalking, with impacts disproportionately affecting young women, same-sex attracted young people, those with disabilities, and those from lower socio-economic backgrounds; notably, most harm came from people known offline.[130]

The most recent iteration of the 'Children's Wellbeing in a Digital World: Index Report' published this year, reported that both parents and children require support in navigating the online world. The central conclusions revolved around the concept of an "Internet of Extremes" wherein the internet is now a vital resource for children and young people, deeply intertwined with modern life that also poses a significant threat to their mental health and wellbeing.[131]

Mental health initiatives for children and young people need to give due consideration to the extent to which the online environment constitutes an integral aspect of their lived experience and is widely regarded as having positive value, including for disabled and marginalised groups. Responses to the mental health impacts of online activity and social media therefore need to take account of this context, rather than relying on restrictive or abstinence-based approaches that may limit young people's rights to participation, access, and autonomy in digital spaces and present significant challenges in practice.

Benefits of the online presence

- Meeting friends
- Staying connected with family
- Increased openness with parents
- Supportive peer interactions

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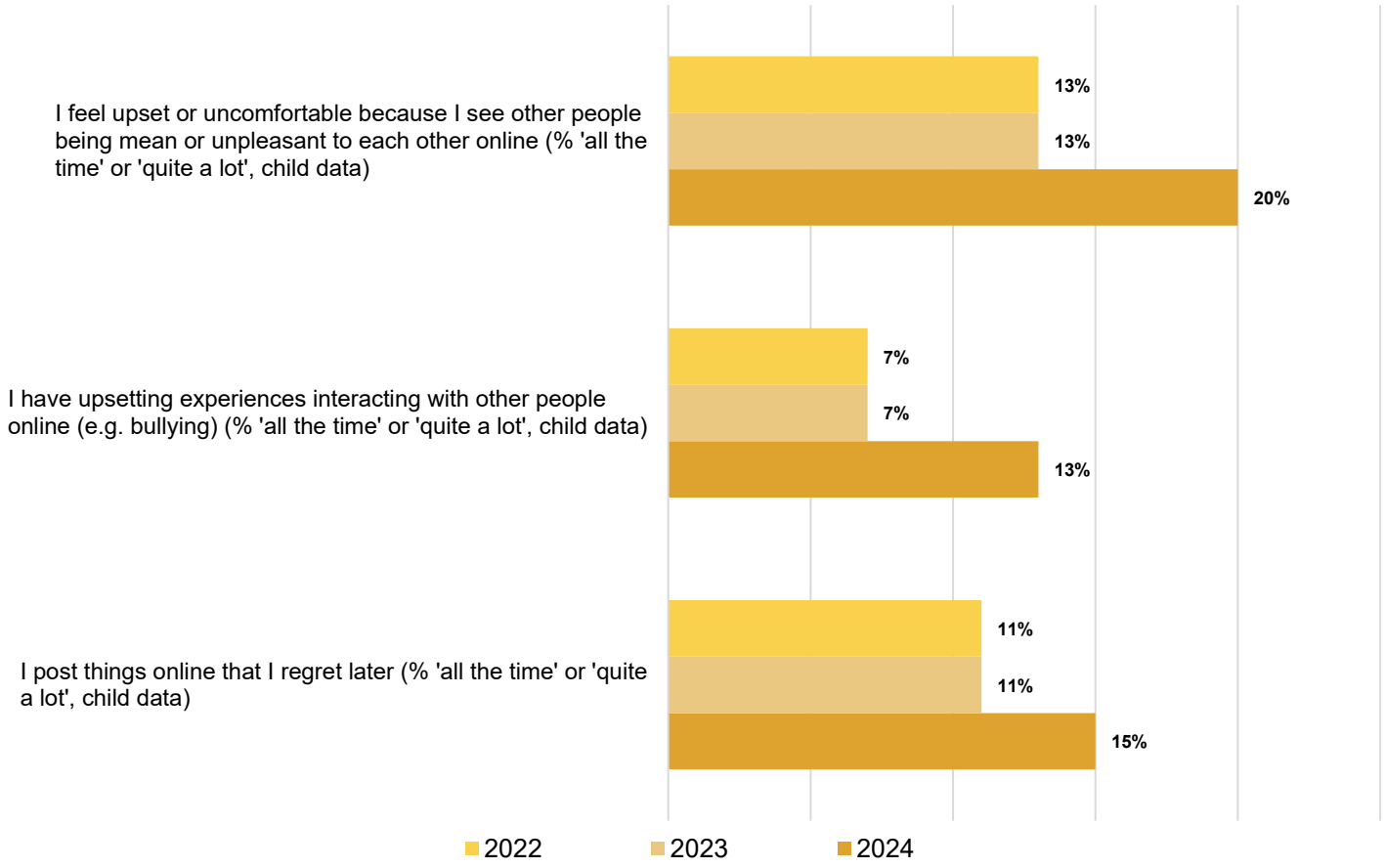
As illustrated in the figure extracted from the 'Children's Wellbeing in a Digital World: Index Report' below, children have self-reported an increasing emotional burden associated with online interactions.[130,131]

Responses by children in relation to the question "How often do these things happen?". Original image from Children's Wellbeing in a Digital World: Index Report (2025) [103]



Stakeholder commentary;

Several digital platforms, such as Youth Wellness Web and Mind Your Head, are available; however, awareness among young people remains limited. The absence of a single, centralised source of information contributes to duplication in signposting and creates navigation challenges for families and schools.

Stakeholders emphasised that although multiple digital platforms exist, the strategy's commitment to developing a single, centralised information hub has not advanced beyond preliminary review and scoping, leaving families, schools, and young people without the coherent, unified resource originally envisaged`.

Mental Health Services

Policy

Northern Ireland has established a comprehensive and multi-layered policy framework to promote the mental health and emotional wellbeing of children and young people, spanning the early years through adolescence and embedding prevention, early intervention, and integrated service delivery. This life course approach is underpinned by the **Infant Mental Health Framework for Northern Ireland** (2016), developed by the PHA, which focuses on promoting emotional wellbeing from birth to age three through a multi-agency, prevention-oriented model. The framework strengthens early-years provision by supporting practitioners across health, social care and community sectors to identify and respond to infant and family needs, with particular emphasis on parent–infant relationships. The **HOPE Counselling service** is an independent counselling service for post-primary schools delivered by Action Mental Health (AMH) in partnership with the Education Authority

Building on this early-years foundation, mental health and wellbeing are embedded as a core outcome within the **Children and Young People's Strategy 2020–2030**, which seeks to reduce inequalities and improve life chances through coordinated action across government departments and statutory agencies. The **Children and Young People's Emotional Health and Wellbeing in Education Framework**, jointly launched by the DE and DoH in February 2021, aims to provide a region-wide, whole-school, tiered approach to emotional health and wellbeing encompassing universal, early and enhanced support. The framework is supported by DE and DoH funding allocated annually and is accompanied by implementation tools, school surveys and guidance on external provision. Most schools report engagement with aspects of the framework, evidence suggests that full implementation of a whole-school approach remains inconsistent across the system.

At the specialist end of the system, **Child and Adolescent Mental Health Services** (CAMHS) represent the statutory secondary and tertiary care offer for children and young people experiencing moderate to severe mental health difficulties. CAMHS in Northern Ireland operates within a stepped-care model, providing multidisciplinary assessment, diagnosis and treatment where needs cannot be met through universal or early-intervention services.

Wider policy alignment is provided by the **Mental Health Strategy 2021–2031**, which prioritises early intervention, investment in Child and Adolescent Mental Health Services (CAMHS), trauma-informed practice, and system-wide reform. Delivery plans and supporting measures, including regional CAMHS pathways and the **Safeguarding Board for Northern Ireland Mental Health Learning and Development Framework** (2024), aim to improve access to specialist support and strengthen workforce capability. In education, the **'A Fair Start'** programme integrates emotional health and wellbeing into efforts to address educational underachievement among disadvantaged children and young people, implementing 47 actions focused on early intervention, school-based mental-health support, and stronger collaboration between education, health and community services. Progress reports highlight advances in whole-school wellbeing approaches, teacher training, and access to counselling and pastoral care.

Across these initiatives, the **Children and Young People's Strategic Partnership** (CYPSP) provides a critical coordination mechanism, bringing together statutory, voluntary and community partners to support outcomes-based planning and local delivery. CYPSP locality planning structures support the translation of policy into practice, particularly for vulnerable children and families, and reinforce the system-wide emphasis on prevention, early identification and joined-up responses. Taken together, Northern Ireland's policy framework aspires to deliver a coordinated, preventative and responsive mental health services for children and young people.

Mental Health Services

Service

On 23 May 2024, the DE issued a Written Ministerial Statement confirming Executive approved **Early Learning and Childcare** (ELC) measures for 2024/25. These measures form part of a £25 million package designed to stabilise the childcare sector, expand provision, and support affordability for families. Central to the programme is the introduction of a funded preschool entitlement of 22.5 hours per week for all children in their final preschool year. Standardisation of delivery is being phased, with implementation cohorts covering 105 approved childcare providers from September 2025 and further settings scheduled to join from 2026.

In addition, on 10 March 2025 the DE announced the continuation and expansion of the **Childcare Subsidy Scheme**, supported by a £55 million funding package. From 1 September 2025, the expanded scheme complements Tax Free Childcare and increases the number of children who will benefit from the scheme from approximately 15,000 to 24,000, strengthening financial support for working parents and enhancing access to early years provision. Alongside ELC measures, a range of emotional health and wellbeing services form part of the Children and Young People's Emotional Health and Wellbeing in Education Framework.

REACH (Resilience, Emotional Health and Wellbeing, and Access to Support) and **RISE NI** (Regional Integrated Support for Emotional Health and Wellbeing NI) are key intervention based services delivered within schools and local communities. REACH supports schools to embed a whole school approach to emotional wellbeing, providing staff training, targeted interventions, and pathways to additional support. RISE NI delivers early intervention mental health support through locally based, multidisciplinary teams, offering therapeutic input, group work, and advice for children and young people experiencing emerging emotional and behavioural difficulties.

The **Emotional Wellbeing Team Service** (EWTS) further complements this offer by delivering direct support to schools, parents, and pupils. EWTS focuses on early identification of need, building emotional literacy, and strengthening protective factors before difficulties escalate.

For children and young people with more complex or acute mental health needs, **CAMHS** provide specialist, multidisciplinary assessment and treatment. CAMHS operates as a regional health service, delivering clinical interventions for moderate to severe mental health conditions, including anxiety disorders, depression, neurodevelopmental presentations, and crisis support.

The **Community and Voluntary** (C&V) sector plays a significant role in delivering children and young people's services across Northern Ireland. C&V organisations provide a wide range of accessible, locally grounded supports, including counselling services, mentoring programmes, group based emotional wellbeing interventions, youth work, and outreach to marginalised or high risk groups. Examples of C&V initiatives include AMH's **Healthy Me** programme delivers mental health education in schools, aiming to build emotional resilience and promote positive mental health.

In addition to services directed at children and young people, a number of programmes are delivered directly to families. **Family focused services** include family support hubs, parenting programmes, family support interventions, psychoeducation, and advocacy, all of which aim to strengthen parental capacity, improve family functioning, and support children's emotional development within the home environment. Collectively, these statutory, community, and voluntary services form an integrated system of support, with families, schools, and communities playing a central role in promoting positive emotional health and wellbeing outcomes for children and young people.

Mental Health Services

3.2.8 | Adult Mental Health

Northern Ireland's population experiences ongoing mental health challenges, shaped by a complex interaction of social, economic and biological determinants. Based on 2024 GHQ12 figures, around a fifth (19%) of the Northern Irish population have probable mental ill-health (a GHQ score of 4 or more). The rate in Northern Ireland was 27% in 2021/22 and 21% in the 2022/23 fiscal year. Mental illness is a leading cause of disability in Northern Ireland and the Global Burden of Disease study estimates indicate that mental illness accounts for 9.64% of Northern Ireland's total disease burden, higher than the UK average (7.95%), with depressive and anxiety disorders contributing substantially to YLDs.[54]

Data from the Northern Ireland Registry of Self-Harm and Northern Ireland Statistics and Research Agency (NISRA) show that in the period 2021 to 2022, 13,804 attendances were recorded at emergency departments for patients presenting with self-harm or suicidal ideation. Adults aged 18 to 64 accounted for the majority of these presentations. Among males, self-harm incidence rose most in the 25-34 age group from April 2012 to March 2022.[53,132] Demonstrated below, the same dataset shows that women aged 18 to 64 more often present with self-harm, while men account for most deaths.[53,132]

Gender differences persist: women more often present with self-harm, men with fatalities.[51,132]

*Adults aged 18–64

Over 1 in 5 people in Northern Ireland had an anti-depressant prescription in 2024/25 and increase of 1.5% compared to 2023/24, 26% of women and 16% of men. This rose to 40% of women in the 45-64 year age group. According to the NIAO's report 'Mental Health Services in Northern Ireland' (2023) prescribing volumes of antidepressants have steadily increased for adults (ages 18 and over).[133,134] Data from the Business Services Organisation's 'Prescription Cost Analysis' shows that in 2023/24, 45.4 million prescription items were dispensed (an increase of 1.7% on the previous year), and antidepressants, like sertraline, were among the ten most commonly dispensed medications, with over 1,003,530 items issued.[135]

The legacy of the Troubles remains one of the most significant determinants of mental health in Northern Ireland, representing a unique factor within the UK context. The region's history of civil conflict has left a profound and enduring impact on the adult population, contributing to elevated rates of PTSD and other trauma-related conditions compared to other UK regions.

The Northern Ireland Study of Health and Stress found that the 12-month prevalence of PTSD in Northern Ireland was approximately 5.1% of the adult population, with elevated rates attributed to widespread exposure to conflict-related traumatic events.[136]

As discussed earlier, more recent research indicates the situation may have worsened: an updated study reported approximately 1 in 16 adults live with trauma-related mental health conditions. Findings from a 2023 Northern Ireland survey indicate that 30% of respondents reported experiencing a conflict-related traumatic event personally, notably high prevalence, while 29.9% acknowledged that the Troubles had adversely affected their mental health.[137] These findings highlight the enduring psychological legacy of conflict and the ways in which past trauma continues to shape mental health outcomes across adulthood.

For many individuals, the impact of trauma is further compounded by experiences in adulthood that affect their position in society. Experiences related to employment and economic participation can have significant and enduring implications for mental health, particularly where they intersect with broader socio-economic disadvantage. A body of longitudinal evidence by Bruggeman *et al*. (2024) demonstrates that employment status is closely linked to mental health outcomes, with unemployment and economic inactivity consistently associated with higher rates of common mental health disorders. Importantly, this relationship does not operate in a single direction. Poor mental health can limit an individual's capacity to enter or remain in employment, while prolonged exclusion from the labour market can, in turn, further erode psychological wellbeing.[138]

Educational attainment plays a central role within this dynamic. As demonstrated in the "A Fair Start" report, educational outcomes influence access to stable and secure employment, shaping exposure to economic uncertainty, social participation, and daily routine, factors that are closely connected to mental health. Together, education, employment, and mental health interact in a reinforcing cycle across adulthood, contributing to persistent inequalities in mental health outcomes at the population level.[138]

A combination of social stigma, discrimination, and historical legal and cultural barriers have resulted in poorer mental health in LGBTQIA+ adults in Northern Ireland. The Rainbow Project's 'Through our Minds' report (2013) found 35.3% of LGBTQIA+ people in Northern Ireland had self-harmed, 25.7% had attempted , 46.9% had suicidal ideation, and 70.9% had experienced depression.[139] The Report further added that nearly 60% of those who had attempted did so before turning 24, and called for targeted mental health services and early intervention strategies for LGBTQIA+ individuals.[139]

Mental Health Services

3.2.8 | Adult Mental Health (cont.)

These findings underscore how identity-based discrimination compounds mental health vulnerabilities, and similar patterns emerge when considering other adverse experiences, particularly those that lead to harmful coping mechanisms such as harmful substance use.

3.2.9 | Harmful Substance Use Trends and Treatment Demand in Northern Ireland

Harmful substance use remains a major public health concern in Northern Ireland, with the most robust prevalence data now drawn from the Northern Ireland Substance Misuse Database (SMD) and associated Department of Health monitoring surveys.[140] Recent SMD findings show that 3,889 people accessed substance use disorder services in 2024/25, with 38% presenting for alcohol misuse only, 33.4% for drug misuse only, and 28.6% for combined drug and alcohol misuse. Cannabis (49.4%) and cocaine (48.8%) continue to be the most commonly reported drugs among treatment entrants, and nearly 60% of those seeking drug misuse support reported daily use.

Complementing this data, internal analysis highlights the growing burden of dual diagnosis (DD), noting increased psychological vulnerability among people with co-occurring mental ill health and harmful substance use. DD is recognised in Northern Ireland as a growing challenge. The Northern Ireland Assembly's 2021 research paper 'Mental ill health and substance misuse: Dual Diagnosis' notes that individuals with such DD experience higher risks of homelessness, and contact with the criminal justice system.[141] Together, these datasets illustrate escalating complexity in the harmful substance use landscape and reinforce the need for integrated, trauma informed approaches across mental health and addiction services.

3.2.10 | The Mental Health Impacts of Physical Ill health

Adults living with long-term medical conditions or disabilities are far more likely to experience depression or anxiety. In Northern Ireland, census data shows that among adults who have a long-term physical health problem that limits daily activities, over 27.5% also have a long-term mental health condition (more than double the rate in the general adult population).[142] Likewise, survey data revealed that nearly 40% of adults in Northern Ireland with a chronic condition (e.g. diabetes, heart disease) reported struggling with anxiety and their mental health.[142]

In summary, varied and complex determinants remind us that mental health is not solely about external circumstances; an adult's physical health and personal lived experience are all influencing factors. In Northern Ireland, addressing these factors holistically, through healthcare, trauma-informed services, community reconciliation efforts, mental health supports and early intervention, will be key to supporting and improving the overall mental health picture of the adult population.

3.2.11 | Primary Care Integration of Mental Health Services: The Multi-Disciplinary Team Model in Northern Ireland

Mental health conditions in Northern Ireland are increasingly managed within primary care settings, reflecting a strategic shift towards early intervention and community-based support. GPs remain the initial point of contact for most patients, but the traditional model, where GPs alone address mental health concerns, has evolved. The introduction of Mental Health Practitioners (MHPs) into GP practices as part of newly established MDTs represents a transformative approach to service delivery.[143]

Within these MDTs, MHPs provide more timely access to mental health expertise, offering initial assessment, short-term therapeutic interventions, and practical support for common conditions such as anxiety, stress, bereavement, depression, suicidal ideation, and addiction. Where necessary, they facilitate onward referral to specialist secondary care services, ensuring continuity and suitability of care. This model aims to reduce delays in treatment, mitigates the escalation of mental health issues, and promotes recovery within the community.

Launched in 2018, the MDT initiative now spans over 115 GP practices across Northern Ireland, employing approximately 360 full-time staff. MDTs are not limited to mental health professionals; they also include social workers, physiotherapists, health visitors, and district nurses. This integrated structure enables holistic care, addressing both physical and psychosocial needs within a single, accessible setting.

The MDT model has delivered measurable benefits. In 2023-24 alone, MDTs facilitated approximately 301,000 additional consultations, contributing to hundreds of thousands annually since inception. Coverage has expanded to reach roughly 36% of Northern Ireland's population, with plans for further growth. Evidence suggests that this approach alleviates GP workload, reduces unnecessary referrals to secondary care, and enhances patient outcomes through timely, person-centred interventions.

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The integration of mental health services into primary care via MDTs reflects a broader policy commitment to community-based, holistic healthcare. By embedding mental health expertise within GP practices, the model supports early intervention, improves equity of access, and fosters collaborative working across disciplines. This aligns with international best practice and responds to rising demand for mental health support in Northern Ireland, where prevalence rates are the highest in the UK.[144]

Despite its success, the MDT model faces challenges, including recruitment, training, and sustaining funding to meet growing demand. Continued evaluation will be essential to ensure scalability, maintain quality standards, and address regional disparities in access. Future developments may include digital integration, enhanced data sharing, and expanded roles for allied health professionals to further strengthen the model's impact.

3.2.12 | Digital Mental Health: Technology-Enabled Approaches to Wellbeing and Treatment

Digital mental health refers to the use of technology, such as smartphone applications, online platforms, telehealth services, and wearable devices, to support mental wellbeing, promote self-help, and augment clinical treatment.

These solutions range from wellness apps for mindfulness and mood tracking to clinically validated digital therapeutics that complement traditional therapy or medication. On 16 October 2024, the Digital Adult Mental Health and Wellbeing Campaign was launched to provide self-help resources and tools for individuals seeking mental health support.[145]

This initiative, supported by the DoH in collaboration with Digital Health & Care NI, offers a curated selection of mental health and wellbeing apps through the HSC Apps Library.[146] This library enables individuals to access tens of thousands of apps, view key information, and download apps reviewed and evaluated by the Organisation for Review of Care and Health Apps (ORCHA). These apps provide valuable information and advice on topics such as anxiety, depression, stress, sleep, and meditation. At the launch, Health Minister Mike Nesbitt emphasised the importance of digital innovation in mental health care, stating that these technologies offer increased choice, availability, and access alongside traditional service delivery.

He highlighted that transitioning from an analogue to a digital health and social care system represents a major shift in healthcare delivery, aimed at producing better outcomes for all. This campaign aligns with Action 30 of the Mental Health Strategy, which commits to developing and implementing a comprehensive digital mental health model.[24]

The goal is to provide digital delivery of mental health services across all steps of care, thereby increasing access to digital solutions and supporting traditional services with innovative methods. Digital mental health tools enhance accessibility by offering flexible, user-driven options that complement in-person services. They help reduce barriers such as stigma, long wait times, and travel requirements, providing timely and targeted mental health support for diverse needs.

3.2.13 | Older Adult Mental Health

Mental health challenges in later life are shaped by a range of interconnected risk factors, including social isolation and loneliness, bereavement, chronic physical illness, functional decline, and increased vulnerability to abuse or neglect. Collectively, these factors can undermine psychological resilience and increase the risk of anxiety and depressive symptoms among older adults (World Health Organisation [WHO], 2025).[147]

These individual-level risk factors are further compounded by structural pressures within health and social care systems, particularly where access to timely and appropriate services is constrained. This dynamic is clearly reflected in the 'Voices of Concern: The Reality of Health and Social Care for Older People in Northern Ireland' report, in which the Commissioner for Older People for Northern Ireland highlights that many older people feel increasingly excluded from the health and social care system. The report documents widespread difficulty accessing GP, hospital, and social care services, alongside pervasive uncertainty about service availability. Beyond the direct physical health consequences of declining service capacity, older people report a significant mental health impact, with many experiencing ongoing anxiety related to accessing healthcare and fears about being unable to obtain necessary care when needed (Commissioner for Older People for Northern Ireland [COPNI], 2026).[148]

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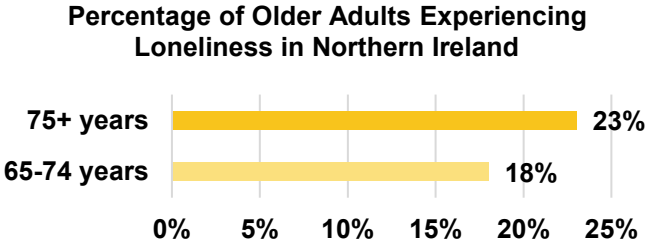
Loneliness is a significant and growing public health issue in Northern Ireland, with multiple recent reports showing clear and consistent links between loneliness and poorer mental health outcomes. Recent reporting in Northern Ireland demonstrates that loneliness remains a major determinant of mental health and overall wellbeing, with newer surveys and wellbeing analyses offering updated, population-level data. The Individual Wellbeing in Northern Ireland Report 2023/24 (published March 2025) positions loneliness as one of four core wellbeing indicators for adults, providing current estimates of how often people feel lonely and linking these patterns to broader personal wellbeing metrics such as anxiety, happiness, and life satisfaction.[149] Data from the 2023/24 Wellbeing Report, shows that 18% of adults aged 65-74 are lonely at least some of the time. This increased to 23% for those aged 75 and older.[149]

The impact of loneliness is particularly significant for older adults, as it is associated with increased risks of anxiety, depression, and greater use of health services.[149] Alongside this, NISRA's ongoing loneliness monitoring outlines how loneliness is measured through national surveys, such as the Continuous Household Survey and the Annual Health Survey and confirms that loneliness has measurable negative impacts on health, wellbeing, and quality of life.[150]

Mental health challenges are increasingly recognised as a major component of wellbeing in older age. The WHO (2025) reports that among adults aged 70 years and over, mental ill health accounted for around 6.8% of all YLDs in this age group, with depression and anxiety the most common conditions. These difficulties often occur alongside chronic physical and neurological illnesses such as dementia, compounding cognitive decline and care needs.[147] According to Parkinson's UK, there are approximately 4,400 people living with Parkinson's in Northern Ireland, with advancing age being the strongest risk factor for developing the disease. Parkinson's UK notes that anxiety and depression are among the most common non-motor symptoms of Parkinson's disease, affecting nearly half of those diagnosed. These mental health challenges arise from both psychological stress and neurochemical changes in the brain, reflecting the complex interaction between neurodegenerative conditions and mental health in later life.[151]

Finally, recent research also shows that the impact of conflict-related trauma remains visible into later life. A Queen's University Belfast led analysis of the Northern Ireland Cohort for the Longitudinal Study of Ageing (NICOLA) ageing cohort reports that current PTSD among adults aged 50+ is approximately 4.74% (almost 1 in 20), and nearly 60% of those with PTSD identify the Troubles as their worst traumatic event in their lifetime. These findings highlight the importance of trauma informed, age appropriate mental health services that recognise the long term and cumulative effects of historical violence on older populations in Northern Ireland.[152]



3.2.14 | Dementia and Cognitive Impairment

Epidemiology and emerging data resources

Northern Ireland is building a robust evidence base on later life cognition through the NICOLA study and its Harmonised Cognitive Assessment Protocol (HCAP). The NICOLA HCAP sub study is assessing people aged 65+ to estimate the prevalence of cognitive impairment and dementia in Northern Ireland and harmonise findings with sister cohorts in Ireland, England and the US, thereby enabling cross national comparisons and longitudinal follow up of cognitive trajectories.[153,154] The broader NICOLA platform (Wave 1 health assessment) integrates objective measures of physical function, sensory health and cognitive function, positioning Northern Ireland within international ageing research networks (e.g., DPUK and the Gateway to Global Ageing).

Lived experience: capability, not disability

Public engagement in Northern Ireland indicates a preference for approaches that emphasise capability rather than disability, address stigma, and support everyday autonomy.

Mental Health Services

Qualitative work in Northern Ireland (and the wider literature) shows that living well with dementia depends on positive public attitudes, supportive environments, and practical facilitators (e.g., accessible information, technology, transport), while barriers include ageism, service fragmentation, and inconsistent post diagnostic support. Complementary global syntheses argue that a "positive psychiatry of ageing", strengthening resilience, wisdom and prosocial behaviours, can counter ageist narratives and improve outcomes for people with neurocognitive disorders.[155]

Psychiatry of Old Age: Current Debates and Service Design

Age based cutoffs and crossover at 65

In Northern Ireland and across the UK and Ireland, 65 remains a common service demarcation between "general adult" and "old age" mental health services, often creating a crossover that can reduce autonomy and funnel older people into pathways dominated by physical health priorities. The Commissioner for Older People for Northern Ireland (COPNI) warned during the Mental Health Strategy consultation that the pandemic intensified isolation and health inequalities for older adults and urged investment to prevent reiterations of age-based inequity.[156] The Royal College of Psychiatrists (RCPsych) has similarly documented age inequality and called for removal of upper age barriers, arguing that older people must not be denied care "simply because they are 'too old'," and that needs (frailty, multimorbidity, cognitive issues) should drive access to specialist support.[157]

In considering the implications for Northern Ireland, where upper age cut-offs continue to apply, it is important that transitions at age 65 are needs-led and explicitly integrated across mental and physical health services, social care, and the voluntary sector. This approach would align with NHS England's position that specialist older people's mental health support should be determined by clinical complexity rather than age, and that adult services should remove upper age thresholds.

Scope and competencies of old age psychiatry

Contemporary geriatric psychiatry spans neurocognitive disorders, depression, schizophrenia, and substance use, typically in the context of multimorbidity and polypharmacy. Best practice emphasises MDT care, comprehensive assessment, liaison between mental and physical services, and family-centred approaches (including carer wellbeing). RCPsych guidance further stresses integration with geriatric medicine to manage falls, delirium, cerebrovascular disease, frailty and end of life care, key comorbidities that shape psychiatric presentation and treatment tolerance in later life.[158]

Current discussions within the field point to the persistence of age-related biases in mental health commissioning and service delivery, where generic "all adult" models may not adequately meet the more complex needs of older people unless specifically adapted. There is broad clinical support for integrated care pathways linking memory services, community mental health teams, liaison psychiatry, primary care and social supports; however, implementation remains variable and capacity constrained. In Northern Ireland, these issues are being addressed through the development of a regional pathway and associated project board. In parallel, a balance is required between ensuring timely and accurate diagnosis, particularly in the context of emerging disease-modifying therapies and avoiding over-medicalisation. This highlights the importance of proportionate post-diagnostic support and life-course approaches that emphasise capability, participation and quality of life.

Looking ahead, research agendas call for trials and services that better account for moderators and mediators of treatment response, emphasise tolerability across metabolic, cardiovascular, and neurological domains, address later life risk, and promote positive ageing to counter pervasive stigma.

Accelerated delivery of the Regional Dementia Care Pathway in Northern Ireland remains necessary, supported by protected funding and expanded specialist capacity, in order to meet assessment targets and address regional inequities. This requires the embedding of a "capability-first" approach, with outcome monitoring extending beyond biomedical indicators to reflect functional ability, quality of life, and independence.[159]

Mental Health Services

The removal of age-based thresholds in favour of needs-led access would enable older adults to utilise mainstream mental health services, supported by clearly defined pathways to specialist teams where required. Strengthened integration between physical and mental health services remains a critical consideration, including expanded liaison psychiatry provision, greater geriatric expertise within psychiatric inpatient settings, and shared protocols for the management of common comorbidities. In addition, the use of NICOLA Health and Care Professional Assessment (HCAP) data offers an opportunity to inform prevalence estimation, service planning, and longitudinal monitoring. Priority may also be given to embedding training in the positive psychiatry of ageing within professional standards and audit frameworks, incorporating principles relating to anti-ageism, resilience promotion, and support for carers.

3.2.15 | Intersecting Risks, Barriers, and Mental Health Needs of Older Adults Across the Justice, Care, and Community Environments

Gendered risks persist in older age, with some experiencing domestic abuse and coercive control for the first time later in life. The COPNI 'Growing Concern' report found that 21% of the victims of domestic abuse in Northern Ireland are aged 60 or over.[160] Older adults are particularly vulnerable to crime due to physical frailty, cognitive decline, and social isolation. Incidents such as burglary, fraud, and physical assault can lead to severe psychological distress, including heightened anxiety, depression, and loss of trust in the community. Fear of repeat victimisation often results in reduced mobility and withdrawal from social activities, exacerbating loneliness and health deterioration.

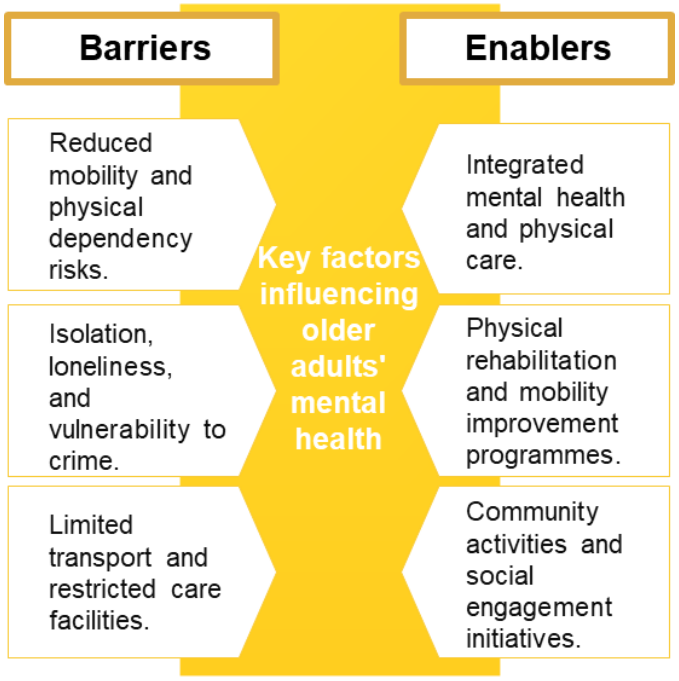
The Criminal Justice Inspection Northern Ireland (CJI) report 'Vulnerable Older People in the Criminal Justice System' (2023) highlights that mental ill health acts as a barrier to people over 60 years of age participating in and seeking criminal justice outcomes in Northern Ireland.[161] There are also considerations for the care of elderly prisoners in police custody, such as prison inmates, whose day-to-day needs might be more complex than their younger counterparts.

Stakeholder commentary;

Environments for older people in custody are adapted because their needs are different and often complex. These adaptations include dementia-friendly units, therapeutic gardens, and dedicated supports for those aged 55 and over. Such measures are due to the growing number of older adults in custody, many of whom have dementia or other age-related health challenges.

There are also challenges in terms of the physical and built environment for this cohort. In residential and home care environments, mental health challenges among older adults are often compounded by mobility limitations. Restricted movement can lead to feelings of dependency and helplessness, increasing the risk of depression and anxiety.[162]

Such issues can be addressed with the provision of integrated mental health support, physical rehabilitation programs, and social engagement initiatives to maintain quality of life as a person ages. An additional compounding factor can be limited access to reliable public transport, which can significantly affect older adults' ability to participate in community life. A lack of mobility fosters social isolation, which is strongly linked to cognitive decline and mental health disorders such as depression. Investment in age-friendly transport systems and community outreach programs is essential to reduce isolation and promote mental well-being.[163] These insights are summarised visually in the graphic below.



Finally, from a societal perspective, the demographic shift toward an aging population places increasing demands on mental health services. Care providers require specialised training in geriatric psychology, dementia care, and trauma-informed practices to effectively support older adults. Continuous professional development and expansion of capacity are critical to meet future needs of this segment of Northern Ireland's population.[163]

Mental Health Services

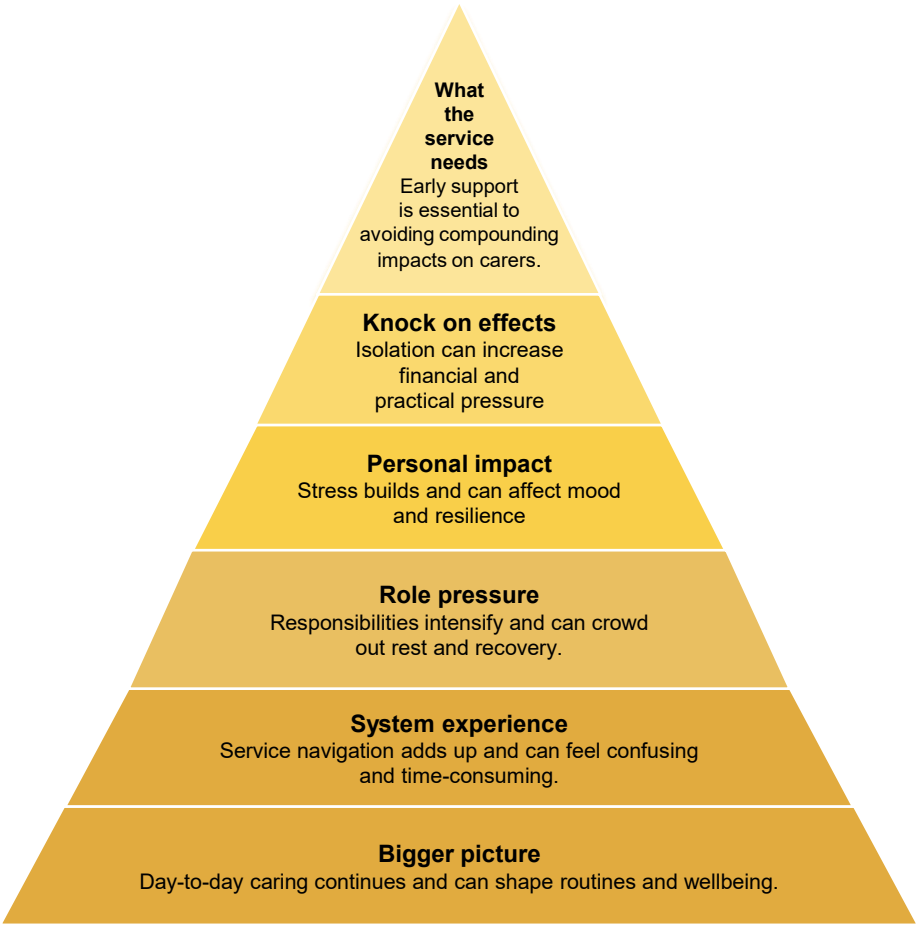
3.2.16 | Social Care and the Mental Health Burden on Carers in Northern Ireland

Caring roles sit at a critical intersection within the wider adult and older-adult mental health services, yet their impact is often overlooked. Carers play a central part in supporting individuals with chronic and complex conditions, frequently stepping in to bridge gaps where services are limited or fragmented. In doing so, they shoulder substantial emotional, practical, and psychological burdens that can significantly affect their own wellbeing.

Carers of individuals with mental illness in Northern Ireland face significant adverse health impacts. According to Carers UK's 2023 State of Caring survey,[164] 1 in 4 carers report experiencing mental ill health, while two-thirds report a negative impact on their mental wellbeing, 25% describe it as "very negative" and 41% as "slightly negative". Symptoms commonly include anxiety, depression, burnout, and even post-traumatic stress, often exacerbated by long hours of unpaid care and insufficient respite and support.

Around half of carers report frequent loneliness, and over one-third have delayed seeking health treatment for themselves due to caregiving responsibilities. Longitudinal research from the Northern Ireland Longitudinal Study confirms elevated levels of stress, fatigue, anxiety, and depression among informal caregivers compared to non-carers, with increased prescription rates of anxiety medication and antidepressants.[165,166] Together, evidence underscores a profound mental and physical health burden on carers, highlighting an urgent need for improved support, access to services, and respite provisions.

The AMH Impact Report 2024/2025 outlines a year of service expansion and rising demand for mental health support across Northern Ireland.[167] AMH strengthened partnerships, expanded school based and community programmes, and adapted to service changes amid increasing economic pressures. The report highlights growing reliance on community based services and the vital role of families and carers, as demand places greater strain on social care systems and informal support networks.



Mental Health Services

Policy

Northern Ireland's adult and older adult mental health system is underpinned by a set of inter-related strategies, statutory frameworks and regional care pathways that shape commissioning, access, and delivery of services. At the core of this framework is the **Mental Health Strategy 2021–2031**, which sets out a ten-year vision for transforming mental health services across the life course.

The **Regional Mental Health Service Model (RMHS)** is an action of the Mental Health Strategy at a regional level, providing a consistent structural framework across Health and Social Care Trusts. There have been proposals to establish a standalone Mental Health Trust in Northern Ireland. However, the Minister chose to progress an alternative approach through the development of a regional mental health service structure, designed to operate across existing Health and Social Care Trusts and to integrate primary care and community and voluntary sector provision.

The **You in Mind** Regional Mental Health Care Pathway is also referenced as a structured, region-wide pathway designed to support timely access to appropriate levels of mental health care, aligned with recovery and continuity principles.

For older adults, the Mental Health Strategy is reinforced by the **Early Intervention and Prevention Action Plan (2022–2025)**, which targets health inequalities linked to ageing and cognitive decline.

Loneliness and social isolation are recognised as significant determinants of poor mental health in later life. Although a statutory Loneliness Strategy has not yet been implemented, there is sustained policy consensus across the Assembly, Executive Office and age-sector organisations for a cross-departmental response. Current responses are delivered through **Age-Friendly Community** initiatives and PHA funded wellbeing programmes.

Dementia policy is guided by **Improving Dementia Services in Northern Ireland – A Regional Strategy**, focusing on early diagnosis, post-diagnostic support, carer involvement and enabling people to remain living at home where possible. The **Regional Dementia Care Pathway** supports integrated provision across health, social care and the voluntary sector. Dementia policy is increasingly rights-based and co-produced, recognising the strong interaction between dementia, depression, anxiety and social isolation in later life.

Older people's mental wellbeing is closely linked to justice and safeguarding. Policy is shaped by adult safeguarding frameworks and equality and human rights duties under **Section 75 of the Northern Ireland Act 1998**, with oversight by COPNI. Evidence highlights older adults' heightened vulnerability to abuse, neglect, financial exploitation and barriers to accessing justice, particularly for those with cognitive impairment or care needs.

Northern Ireland policy places a strong emphasis on care in the community, reinforced by reforms such as **Health and Wellbeing: Delivering Together** and the **Neighbourhood Model of Health and Wellbeing**, which prioritise integrated, locality-based teams. While adult social care reform is ongoing, carers remain central to support in later life, underpinned by the **Caring for Carers Strategy**, with increasing attention to the mental health impact of caring, particularly in dementia.

Mental Health Services

Service

Adult and older adult mental health services in Northern Ireland are delivered through a combination of statutory and community and voluntary (C&V) provision, structured under the **Regional Mental Health Service Model** spanning primary, community and specialist care.

Health and Social Care (HSC) services form the core statutory framework, with General Practitioners acting as the primary point of access for assessment and referral. **Primary Care Talking Therapies** provide counselling and wellbeing support, while **Community Mental Health Teams** (CMHTs) across all Trusts support people with severe or enduring mental illness.

For older adults, **Community Mental Health Teams for Older People** (CMHTOP), including **Psychiatry of Old Age** services, provide specialist support for those aged over 65 and people living with dementia, offering memory assessment, home-based care and carer support.

Complementing statutory services, the C&V sector plays a critical role in prevention, early intervention and recovery. Organisations such as **AWARE NI**, **Action Mental Health**, **Inspire Wellbeing**, **MindWise**, **Age NI** and **UHub Therapy Centre** deliver counselling, education, advocacy, housing support, resilience programmes and befriending services, including tailored provision for older adults. Together, these services form a comprehensive, integrated system addressing mental health needs across the adult life course.

Mental Health Services

3.3 | Severe Mental Ill Health

While mental health needs and challenges evolve across the life course, some individuals experience severe and enduring conditions that require specialised, long-term support. Severe mental ill health refers to mental health conditions that cause substantial impairment in daily functioning and work or social life. These include schizophrenia, and bipolar, borderline personality and other affective disorders, which are characterised by significant and enduring symptoms requiring ongoing treatment and support.[168]

People living with these conditions experience complex challenges within the care system. Their care needs can be multi-faceted and long-term, requiring close coordination across health, housing, and social supports. As a result, delivery of care provision for this group often exposes system strain in relation to capacity, continuity, and specialist availability. This is further compounded by the nature of these conditions which typically lead to periods of unpredictable or sporadic behaviour, including mental ill health crises such as suicidal distress, making it difficult for patients to adhere to treatment plans or medications.[168]

The Mental Health Strategy highlights that people experiencing severe mental illness often need continuous, comprehensive support that goes beyond clinical care, encompassing physical health, housing, and social assistance.[24]

Stakeholder commentary;

Flexible engagement models may be needed to improve access for high-risk cohorts. Current Did Not Attend (DNA) policies and rigid appointment systems can disproportionately affect individuals with unstable or unpredictable circumstances, including those experiencing severe mental ill health.

While severe mental illnesses are relatively low in prevalence across the population, they are associated with high individual, service and system-level costs, reflecting the complexity, intensity and duration of support required from health, social care and wider public services.

Stakeholder commentary;

People with severe and complex mental ill health need coordinated, multi-agency support. Pressures are at their greatest when capacity is limited and clinical risk is high.

3.3.1 | Personality Disorders and Other Severe Mental Illnesses

Personality disorders represent an important and often under-recognised aspect of Northern Ireland's mental health landscape. A rapid review commissioned by Health and Social Care Research & Development and associated agencies found elevated rates of personality disorders across community, clinical, and forensic settings, highlighting both their prevalence and the complexity of associated care requirements.[169]

The impact of personality disorders is particularly profound: individuals often experience more severe functional impairment and greater social and occupational disruption compared to those with other mental health conditions. These challenges are further intensified by early life adversity, trauma, and socioeconomic deprivation, all recognised risk factors for personality disorders. Taken together, these findings point to an urgent need for strengthened trauma-informed services, specialised therapeutic interventions, and integrated support pathways capable of addressing the complex, long-term needs of people living with personality disorders across Northern Ireland.[170,59]

Severe mental illness encompasses a range of conditions, including schizophrenia and related psychotic illnesses, bipolar disorder, treatment-resistant depression, and eating disorders. Schizophrenia and related psychotic illnesses are typically long-term conditions characterised by profound disturbances in perception, thought, and functioning, often requiring sustained specialist community and inpatient support. Bipolar disorder is marked by recurrent episodes of mania and depression, with significant impacts on social, occupational, and physical health outcomes. Treatment-resistant depression, while less prevalent, is associated with high morbidity and service use due to persistent symptoms despite multiple treatment attempts. Eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and avoidant/restrictive food intake disorder (ARFID), are increasingly recognised across the life course, including among males, and are associated with high medical risk, complex psychological need, and elevated mortality, necessitating coordinated, multidisciplinary care.

Mental Health Services

In Northern Ireland, the Early Intervention in Psychosis Network (EIPN) supports the quality improvement of early intervention in psychosis teams. The NHS Long Term Plan reconfirmed the commitment to the EIPN access and waiting time standard, ensuring that 60% of people with a first episode of psychosis start treatment within two weeks of referral. The services provide a full range of NICE recommended treatments and are evidence-based, cost-saving, and preferred by service users and carers over generic services.[171,172]

3.3.2 | Crisis Intervention and Suicide Prevention; Distinguishing Between Severe Mental Ill Health Driven Crises and Situational Crises

In order to understand the demands on mental health services it is essential to distinguish between clinically driven crises, which are related to aspects of mental illness, and situational crises that arise from acute external stressors. The Protect Life 2 strategy emphasises that crisis responses are proportionate, trauma-informed, and tailored to the underlying cause of distress.[173] The Mental Health Strategy's prioritisation of a regionally consistent Mental Health Crisis Service reflects an understanding that individuals experiencing acute episodes linked to conditions such as psychosis, severe mood disorders, suicidal distress require specialised, clinically led interventions, often involving coordinated input from crisis resolution teams and inpatient services.

In contrast, situational crises, such as those related to bereavement, relationship breakdown, or sudden socioeconomic pressures, typically necessitate rapid stabilisation, psychosocial assessment, and short-term practical or emotional support, delivered in a way that prevents escalation and reduces reliance on clinical pathways.

Understanding these distinctions in crisis presentation naturally leads to consideration of how inpatient mental health services must be equipped to respond appropriately when crises escalate beyond what community based or situational supports can safely manage.

3.3.3 | Inpatient Care

Inpatient mental health care in Northern Ireland includes mainstream acute psychiatry wards and secure forensic units. Mainstream inpatient care provides short term treatment for individuals experiencing acute episodes of mental illness who cannot be safely supported in the community.

These admissions are primarily for people with severe mental health needs, and this approach ensures that individuals in crisis receive intensive, structured care in a safe environment until they are stable enough to transition back to community based support.

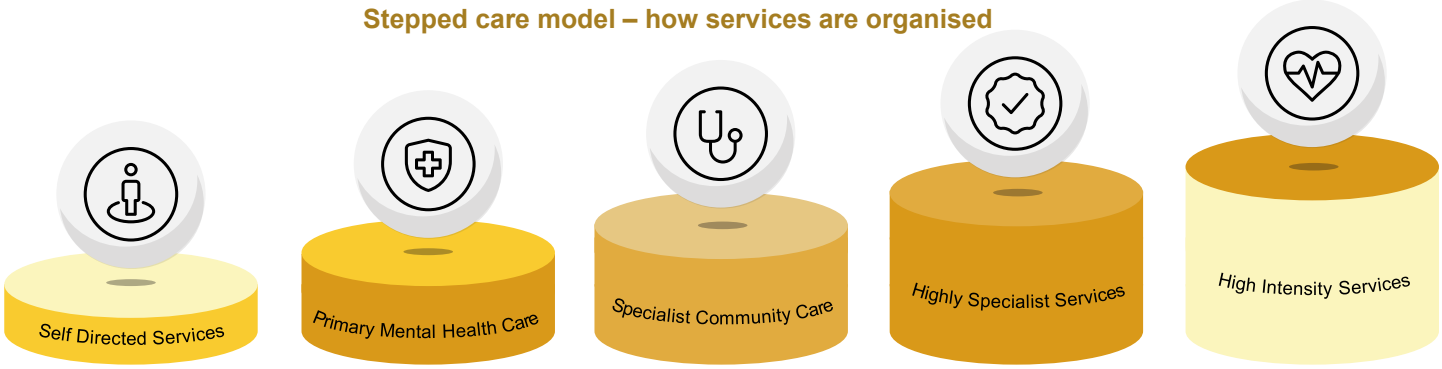
The Royal College of Psychiatrists has highlighted that around 1 in 10 people who present with a first episode of psychosis will require longer-term rehabilitation services, and that inpatient stays in these units may last several months or longer.[174] Limited step-down and community options contribute to delayed discharges and increased reliance on acute beds.

Stakeholder commentary;

The system operates on a stepped care model, with universal supports and regionally defined care pathways. Resource constraints, including funding limitations and shortages, present challenges to sustaining consistent support for individuals with higher levels of need.

The graphic below illustrates the stepped care model referenced above, showing how mental health support for mental ill health is delivered across settings.

Stepped care model – how services are organised



Support involving responding to stress and mild emotional difficulties	Supports involving responding to mental health and emotional difficulties such as depression and anxiety	Supports involving responding to mental health problems which are adversely affecting quality of life	Supports involving providing care in response to complex specific mental health needs	Supports involving the delivery of intensive recovery focused support

Mental Health Services

3.3.4 | Secure Care

Forensic mental health care operates as a distinct pathway within the wider inpatient system, designed for individuals whose mental illness is associated with significant risk or involvement with the criminal justice system. Unlike mainstream acute wards, which admit people experiencing severe mental illness for short-term stabilisation, the forensic pathway manages patients who require secure environments due to public safety concerns or court directed treatment. Decisions about care and treatment in these settings are guided by the principles of the MCA (NI) 2016, which establishes safeguards for people who may lack capacity.[175]

A 2024 Northern Ireland Assembly research paper, 'Mental Health and the Criminal Justice System: Overview,' reported that, of a sample of people arrested between 2017 and 2018, 64% had a mental health issue at the time of arrest. Furthermore, 45% of offenders in Northern Ireland assessed by the Probation Board during that same time period presented with mental health issues. Repeat offending is common, and access to rehabilitation and post-release support is constrained by under-funding, insufficient integration between services, and breakdowns in collaborative working across the forensic mental health care pathway. The Royal College of Psychiatrists noted that following the closure of the dedicated healthcare wing in HMP Maghaberry, transfers to the regional secure unit increased fourfold. This shift indicates that, in the absence of an in-estate therapeutic alternative, acutely unwell individuals are being diverted into already limited specialist beds rather than receiving stabilisation and care on site.[176,177]

The same report notes that secure hospital bed provision in Northern Ireland stands at 0.2 beds per 100,000 population compared with 0.8 per 100,000 elsewhere in the United Kingdom, a gap that lengthens waits for appropriate admission and sustains pressure on acute wards, which were not designed for prolonged or medically complex cases.[177] This example illustrates how limited secure provision beds and the absence of alternative facilities can influence patient pathways.[174,177]

Stakeholder commentary;

There are extended waiting times for psychological assessment in custody, and the requirement for self-referral adds further barriers to access. A business case for a secure mental health facility has been developed but remains unfunded.

Stakeholders highlighted that people in custody often wait for psychological assessment and that current pathways can make it challenging to access support when it is most needed. They also noted that the lack of a funded secure mental health facility leaves a clear gap in appropriate assessment and care.

3.3.5 | Deprivation of Liberty and Safeguards

The MCA (NI) 2016 introduced a unified legal framework for decision-making for individuals aged 16 and over who lack capacity to make decisions for themselves, supporting legal protections and decision-making for matters of health, welfare and finances.[175] Deprivation of Liberty (DoL) is one of the most serious interventions under this Act, as it involves restricting a person's freedom for their care or safety. It must therefore be lawfully authorised and carried out in accordance with strict safeguards to protect human rights under Article 5 of the European Convention on Human Rights.

DoH guidance, drawing on the MCA (NI) 2016 and relevant case law, states that a person is considered deprived of their liberty where they are under continuous supervision and control and are not free to leave. Any deprivation of liberty must be necessary, proportionate and in the person's best interests, be formally authorised in accordance with statutory safeguards, and be subject to regular review.[178]

Since DoL provisions commenced in December 2019, activity across HSC Trusts has continued to grow. Between April 2023 and April 2024, 2,350 Trust Panel applications and 3,900 extension authorisations were processed, with overall activity rising compared to the previous year.[179] The departmental update also notes ongoing use of short-term detention authorisations, reflecting the steady expansion of formal safeguards.[179] There remain a number of challenges in this area, including delays in authorisations and resource constraints, leaving some individuals without full protection. Older adults, particularly those in care homes, are disproportionately affected. Full implementation of the Act across all settings is required and greater public awareness of rights and safeguards encouraged.

Mental Health Services

3.3.6 | Right Care, Right Person

The Right Care, Right Person (RCRP) model is a policing and mental-health framework being introduced in Northern Ireland to ensure individuals in crisis receive support from the most appropriate professionals rather than by default from the police.

The approach, already implemented in parts of England, focuses on reducing unnecessary police involvement in mental health and welfare related incidents by directing cases to health or social care services unless there is an immediate risk to life, serious harm, or a crime involved.

In Northern Ireland, the PSNI's planned adoption of RCRP has prompted sector-wide discussion, including concerns about the timing and readiness of local services to support the new model. Overall, RCRP aims to improve outcomes for vulnerable individuals while allowing police resources to be focused on core public-safety responsibilities.[180]

Work has been undertaken to develop a proposed Regional Crisis Intervention Service (RCIS) for Northern Ireland, as identified in Actions 12 and 27 of the Mental Health Strategy. The associated policy sets out an expectation of collaboration across statutory and partner agencies, including the Police Service of Northern Ireland (PSNI), which participated in the policy's development.

The proposed model outlines more coordinated working between emergency services and existing crisis-related supports, such as triage initiatives, crisis cafés and other community-based services, with the intended objective of providing a consistent and responsive approach to people experiencing mental health crisis across all geographical areas.

Although the policy was launched in August 2021, funding to support implementation of the Regional Crisis Intervention Service has not been allocated to date. The Terms of Reference for relevant regional crisis governance and programme structures do not explicitly reference delivery of the RCIS as set out in the Mental Health Strategy. In parallel, work is ongoing within relevant Departments to assess the operational impact of the policy.

At present, crisis intervention services, inclusive of pilot project operating across different Trusts continue to operate alongside established emergency services. During RCRP implementation, clarity regarding future funding, commissioning and delivery arrangements for alternative crisis responses is still emerging. This may contribute to continued pressure on existing services until new crisis models are fully embedded.[21]

Mental Health Services

Policy

Policy for crisis intervention and suicide prevention in Northern Ireland is anchored in the Mental Health Strategy. Regional care pathways, including those for crisis care, are designed to support stepped-care, continuity, and timely escalation and de-escalation based on clinical need. **Protect Life 2** explicitly highlights the role of primary care in proactively identifying and intervening with patients showing signs of suicidal behaviour, reinforcing the importance of strong primary care linkages within urgent pathways.

Prevention activity is delivered through a combination of strategic leadership, standardised clinical pathways in statutory services, and population and community-based measures. Protect Life 2 was first published in September 2019 and has been extended until the end of 2027. Following an independent review of the action plan, the updated Protect Life 2 Action Plan and Implementation Plan were published on 1 July 2025, setting out over 80 measures and confirming the Chief Medical Officer as Chair of the Protect Life 2 Steering Group.[173,181]

Within statutory mental health services, a region-wide **Prevention Care Pathway** was launched in 2021 under **'Towards Zero ',** as part of the Protect Life 2 strategy, standardising identification, safety planning and care management across Trust services.[182] At community and population level, Protect Life 2 positions prevention as a whole-of-society effort, including support for community and voluntary organisations and workforce skills development across sectors. Furthermore, the PHA has set tiered standards and routes for prevention. The PHA also delivers large-scale training in prevention and mental health awareness, such as **Applied Suicide Intervention Skills Training** (ASIST), **Mental Health First Aid NI** (MHFA) and **safeTALK**, an alertness training programme.[183]

Right Care, Right Person (RCRP) is a cross-agency operating model that ensures individuals experiencing mental health needs in Northern Ireland are supported by the most appropriate health or social care service at the right time, reducing reliance on police intervention where there is no primary policing requirement.

Mental Health Services

Service

Crisis support services in Northern Ireland are delivered through a combination of 24/7 helpline provision and local HSC Trust crisis teams, forming the frontline of the region's mental health emergency response system.

The **Lifeline Service**, commissioned by the PHA, operates as Northern Ireland's dedicated crisis helpline, providing round-the-clock free and confidential telephone support for anyone experiencing distress, suicidal thoughts, or mental health crisis. It offers immediate de-escalation, emotional support, safety planning, and referral to local services for ongoing care. Lifeline counsellors can arrange follow-up contact and liaise with HSC Trusts, primary care, or community providers where further intervention is required, ensuring continuity between crisis and recovery support pathways.[184]

Alongside Lifeline, each HSC Trust operates a **Mental Health Crisis Response** or **Home Treatment Team**, available 24 hours a day, seven days a week.[185,186] These multidisciplinary teams, comprising of psychiatric nurses, social workers, and support staff, provide rapid assessment and intensive short-term intervention for people in acute mental distress. They are accessible via Lifeline, GP referral, emergency departments, and urgent care routes, ensuring crisis support is locally responsive and integrated with the community.[186]

Complementing statutory provision, the **Samaritans** provide an all-Ireland, 24/7 confidential listening service for anyone struggling to cope or experiencing emotional distress. The service operates by freephone (116 123), online chat, and in-person branches across Northern Ireland, offering non-judgemental support that complements clinical crisis care. Samaritans volunteers also collaborate with public bodies and local partners to promote prevention awareness and build community resilience.[187]

The DoH intends to strengthen the crisis response through the launch of the **Regional Mental Health Crisis Service**, designed to provide a consistent, region-wide model of care and reduce reliance on emergency departments.[21] This service builds on the **Prevention Care Pathway**, introduced in 2021, to ensure that anyone presenting with suicidal ideation receives timely assessment, safety planning, and coordinated follow-up across Trusts and community settings.[182] However, the service has not been fully funded or implemented, therefore is not currently regionally operational. Building on these core crisis pathways, multi-agency and emergency response models have been introduced to provide faster, more coordinated support for people in mental health crisis. The **Multi-Agency Triage Team** (MATT) pilot, established in partnership between the PSNI, NIAS, and HSC Trusts, enables joint response to mental health-related 999 and 101 calls.[188]

The **Early Intervention in Psychosis Network** (EIPN) supports the quality improvement of early intervention in psychosis teams. The **Regional Care Pathway for Personality Disorders** sets out a stepped-care model and standards for assessment, treatment and recovery-focused support across services. In parallel, the **NIAS Hear and Treat** model allows trained clinicians in the ambulance control centre to triage and manage non-life-threatening or mental health-related calls remotely, ensuring callers are safely redirected to mental health or community services without unnecessary ambulance dispatch.[189]

Mental Health Services

3.4 | Physical Comorbidities

Reflecting the WHO's position outlined in section 3.2, a holistic approach, centered on treating the individual rather than solely the illness, has become a foundational principle of contemporary healthcare. Advances in biomedical science increasingly reveal intricate interconnections between physiological and psychological processes, such as the role of stress-induced inflammation in linking trauma and chronic disease, and the influence of the gut microbiome on neurochemistry and mental health. These insights highlight the need to view individuals holistically, considering internal and external factors that shape their physical and mental health. Crucially, medicine is shifting from reactive to proactive care, equipping people with knowledge and resources to maintain health rather than waiting until they become unwell. This approach recognises that physical and mental health are deeply intertwined. While comorbidity traditionally refers to multiple conditions in one person, in practice every individual has overlapping factors influencing wellbeing. When we discuss comorbidity, we are considering a broader medical commitment to treating the whole person. This approach allows for a more informed and proactive healthcare system, where multiple dimensions of the patient must be considered simultaneously. [190,191,192,193,194,195]

In line with this approach, The European Psychiatry study by McCarter *et al*. (2023) analysed hospital data for over 900,000 adults in Northern Ireland and found strong links between mental illness and physical health problems, including higher rates of cardiovascular disease, diabetes and respiratory illness.[194]

Evidence from Administrative Data Research UK (2024) further showed that people with co-existing mental and physical health conditions face markedly higher emergency-admission rates and are more than twice as likely to die from physical causes than the general population.[195] The Northern Ireland Assembly's research paper 'Mental Health in Northern Ireland' (2017) reported that young people with learning disabilities (36%) have higher levels of psychiatric disorders compared with those without a learning disability (8%).[196] More recently, the NIAO's report 'Mental Health Services in Northern Ireland (2023)' acknowledges a continuing rise in demand for services to treat harmful substance use and associated mental health problems.[133]

These findings underline the importance of integrated approaches recognising the interdependence of physical and mental health. It recognises that comorbidities increase the complexity of presentations across all sectors, statutory and voluntary.

3.4.1 | Rare Diseases/ Conditions

People living with rare diseases/conditions (e.g. cystic fibrosis, muscular dystrophy, epidermolysis bullosa) often experience emotional strain alongside the challenges of managing complex illnesses. A disease/condition is considered rare if it affects fewer than 1 in 2,000 people, with 80% of such rare conditions being genetic and often present from birth. Many are life-threatening or chronically debilitating, compounded by a lack of treatment options.[197,198]

Recent UK and Northern Ireland evidence highlights the mental health toll of these diseases/conditions, the limited integration between physical and psychological care, and the urgent need for more coordinated, multidisciplinary support. According to Rare Disease UK's report 'Living with a Rare Condition (2018)', over 90% of adults living with rare diseases reported feeling worried, anxious or low in mood, and 36% had experienced suicidal thoughts.[199]

The UK-wide survey by Spencer-Tansley *et al*. (2022) gathered responses from 1,231 adults living with rare diseases/ conditions and 564 carers of such adults. Although most participants described significant emotional strain linked to their physical illness and care experiences, only 23% felt that healthcare professionals considered mental and physical health as equally important.[200]

The DoH's 'Northern Ireland Rare Diseases Action Plan 2022/23' emphasises the need for better coordination between specialist physical health and mental health services, improving access to multidisciplinary care and ensuring that people with rare diseases/ conditions receive timely, integrated seamless support across the system.[201]

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3.4.2 | Multifactorial Influences on Mental Illness - Infectious Etiologies

Whilst rare diseases represent an under recognised challenge in Northern Ireland's mental health service, evidence of infection-related neurobiological effects underscores the complex interplay of psychosocial and biological factors in psychiatric illness.[202] A range of infections have been linked to mental illness through mechanisms such as neuroinflammation, immune activation, and direct brain involvement.[203] Bacterial infections like *Borrelia burgdorferi* (Lyme disease), *Treponema pallidum* (syphilis), and Group A Streptococcus can lead to depression, anxiety, and obsessive compulsive symptoms. Viral infections, including herpes simplex, Epstein-Barr virus, influenza, and SARS-CoV-2 are associated with mood disorders, psychosis, and bipolar disorder. Parasitic infections such as *Toxoplasma gondii* have been linked to cognitive impairment and psychosis, while fungal infections like Cryptococcus may cause mood changes and cognitive decline. Even common acute infections, such as urinary tract or respiratory infections, increase the risk of mental illness, with meningitis and encephalitis showing the strongest association.[204] These findings underscore the importance of infection prevention and integrated physical and mental health care.

Increasing attention is also being paid to the role of the gut microbiome as a potential mediator between infection, immune dysregulation and mental health. Alterations in microbial composition have been associated with depression, anxiety, psychosis and neurocognitive disorders, with emerging evidence suggesting bidirectional interactions between the gut, immune system and brain. This has prompted interest in microbiome-informed approaches, including dietary interventions, probiotics and related therapies, as potential adjuncts to established treatments.[193]

3.4.3 | Neurodevelopmental Conditions and Mental Health Needs

Neurodivergence, in itself, is not a determinant of mental distress; rather, it reflects natural variation in cognitive functioning, information processing, and interaction with the environment. Neurodiversity is an umbrella term that covers a range of cognitive differences including Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia and Dyspraxia.

These differences are inherent to the individual's physiology and are present throughout life. Awareness of neurodiversity has grown significantly in recent years due to factors such as the rise of social media, improved diagnostic tests, and a shift towards a medical system that is less gender biased. Traditional testing criteria for many neurodivergent conditions were based on how they present in young boys, yet it is increasingly clear that young girls and women often present differently.[205]

Challenges relating to neurodivergence typically emerge when individuals encounter circumstances that induce distress or sensory overload, conditions that are prevalent in environments primarily structured for neurotypical needs. While modern life imposes stressors on all individuals, neurodivergent people often experience heightened vulnerability due to persistent demands for social engagement, performance, and adaptability across personal and professional domains. These pressures can contribute to mental health difficulties and recurrent episodes of burnout.[206]

Emerging evidence indicates that generations of individuals, mainly women, have lived with undiagnosed neurodivergence, often resulting in chronic mental health difficulties and misdirected medical interventions. Many have undergone prolonged treatment for conditions such as depression and anxiety, when the underlying issue was neurodivergence. Enhanced awareness and support could significantly improve quality of life for these individuals. While early recognition and intervention during childhood are critical, the provision of robust services for adults remains equally essential.[207,208]

3.4.4 | Autism and ADHD

Autism and ADHD represent two prevalent forms of neurodiversity with a sharp rise in diagnosis for both in recent years. Changes to diagnostic guidance in recent years (including DSM-5/DSM-5-TR and ICD-11) have clarified how autism and ADHD can present across the life course, particularly in adults, which is likely contributing to increased identification alongside improved awareness and research. This is due to progress in research which has improved understanding of both conditions, in particular for late-diagnosed adults. An emerging body of research shows that these conditions often present together, a co-occurrence informally known as 'AuDHD'.[209]

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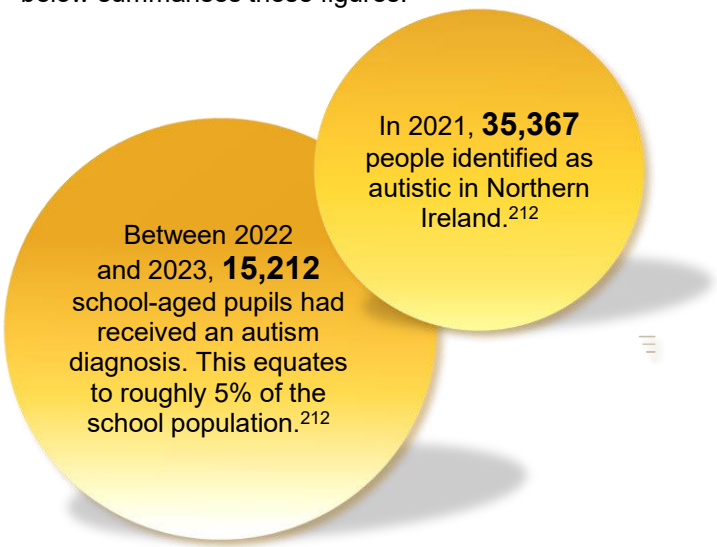
There is also emerging evidence that both conditions may have a genetic component, which means that some parents of diagnosed children could themselves be neurodiverse. There is a rising trend of parents being diagnosed in tandem with their children as they recognise their own traits and behaviours during their child's assessment process.[210,211]

Recent Census data provides insights into the scale of need in Northern Ireland, indicating notable numbers of children and adults identified as autistic. The graphic below summarises these figures.[212]



The DoH's 'Autism Strategy 2023–2028' advises that rising referrals and lengthy diagnostic waits are driving heightened demand for emotional well-being and mental health support among autistic people and their families. As previously mentioned, rising awareness around different representations between genders and differing representations of ASD, ADHD and combined presentations will likely lead to an even greater demand for diagnosis and supports in coming years. With ADHD, medication is often initiated by a specialist team and, once it's settled, day-to-day prescribing and monitoring tends to move to GPs under shared care. In Northern Ireland, shared care guidance is available for ADHD medicines, however people report difficulties accessing shared care on the ground and this can impact adherence to treatments.[212]

Stakeholder commentary;

In identifying the limitations of the present service model and the requirements for future planning stakeholders noted:

A regionally commissioned adult ADHD service is not currently in place, and provision varies across Trusts. Work is ongoing to assess demand and inform future service planning.

Stakeholder commentary;

Stakeholders from across the sector reported shared experiences and challenges, highlighting that:

Approximately one third of pupils in Education Otherwise Than at School (EOTAS) are autistic or undergoing assessment, and reintegration into mainstream education is infrequent. Current arrangements present challenges in meeting the needs of autistic learners.

As discussed, trying to function in a neurotypical world as a neurodiverse person can put intense strain on an individual's mental health. A Northern Ireland study by McNulty *et al*. (2025) found that neurodivergent young people had significantly higher levels of anxiety and more frequent suicidal thoughts than their neurotypical peers. They were also more likely to experience cyberbullying, suggesting heightened vulnerability to online harassment.[213]

Recent UK research by Jonathan Green indicates a significant overlap between neurodevelopmental conditions and mental-health needs. Green (2023) reports that referrals for neurodevelopmental conditions, particularly autism, now make up an increasing proportion of CAMHS caseloads, with waiting times stretching to several years, in some cases "equivalent to the whole length of a child's life up until that point."[214]

In adulthood, without sufficient supports, issues continue to persist and worsen, drastically affecting the individual's quality of life. For example, ASD and ADHD individuals are vulnerable and high risk of periods of burnout driven by the pressure put on them to suppress their needs to fit into environments designed for neurotypical people (also known as "masking"), cope with sensory overload and processing differences, and deal with stigma. The resulting burnout is a state of profound physical, mental and emotional exhaustion that often results in a reduced capacity to function and the need for extended sick leave.[215] The 2024 Chartered Institute of Personnel and Development (CIPD) Neuroinclusion Report found that burnout is a major risk for neurodivergent employees in the UK.[216,217]

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3.4.5 | Burnout in Northern Ireland and Implications for Mental Health

This elevated risk among neurodivergent employees mirrors a broader pattern seen across Northern Ireland, where burnout has become an increasingly common response to sustained stress, overload, and unmet support needs. Beyond its occupational framing, burnout affects emotional regulation, cognitive functioning, and help-seeking behaviour, often contributing to worsening mental-health outcomes. Given its growing prevalence and impact, it warrants focused attention as a distinct and emerging challenge.[218]

Recent evidence underscores that poor mental health at work is widespread across the UK, with significant implications for productivity, wellbeing, and economic stability.[219] Nationally, an estimated 15% of workers live with an existing mental health condition, and work-related stress, depression, and anxiety accounted for 875,000 affected workers and 17.1 million lost working days in 2022/23. These trends reflect substantial structural pressures within workplaces that directly contribute to burnout.

Burnout and Economic Insecurity

The Joseph Rowntree Foundation's Poverty in Northern Ireland 2025 report highlights a crucial social determinant of burnout: financial insecurity.[220] Most people experiencing poverty in Northern Ireland now live in working families, and nearly half of all workers have experienced low pay within the last five years. Importantly, the report emphasises that employment alone is no longer a reliable route out of poverty, with a population equivalent to the size of Belfast living in poverty, including 110,000 children.

This persistent economic strain significantly heightens stress levels, undermines wellbeing, and increases susceptibility to burnout among low income workers. The combination of rising living costs, insecure work, and inadequate social supports exacerbates chronic stress for thousands of households. These pressures translate into emotional exhaustion, reduced coping capacity, and greater vulnerability to workplace mental health difficulties, particularly in sectors characterised by low pay and limited job security.[218]

Burnout Among Mental Health Professionals

Burnout is particularly acute within the NHS mental health workforce, where emotional and psychological demands are high and staffing pressures are ongoing. The impacts are profound for the individual staff member and also for recipients of mental health services.

According to Sideri's 2025 systematic review, focused on NHS workers UK wide, burnout among mental health professionals (MHPs) is highly prevalent, with pooled estimates showing: 42% experiencing emotional exhaustion; 22% experiencing depersonalisation; 19% reporting low personal accomplishment.[221] These rates reflect both individual and organisational risk factors, including excessive workload, insufficient staffing, and high-intensity clinical environments. The review also highlights that burnout is shaped by systemic issues within NHS mental health services. Organisational contributors, such as workload pressures, inadequate supervision, and emotional strain inherent to therapeutic roles, create sustained stress that undermines resilience and long-term workforce stability. Sideri notes the need for further research, particularly regarding the experiences of clinical psychologists, who were underrepresented in the evidence base but face significant pressures in frontline roles.

Implications for Service Delivery and Workforce Sustainability

The combined insights from workplace statistics, poverty research, and NHS staff wellbeing point to a multidimensional burnout crisis in Northern Ireland. The convergence of economic insecurity, workplace stress, and systemic pressures within healthcare services creates conditions that undermine mental health at population and workforce levels. For Northern Ireland, this has several implications: higher burnout risk among low-paid and insecure workers, who face persistent financial pressures and limited access to support; ongoing workforce challenges in the NHS, where elevated burnout rates threaten retention, service continuity, and quality of care, and finally, greater demand on mental health services, as both workers and clinicians experience increased psychological strain.[6]

Addressing burnout in Northern Ireland therefore requires coordinated action across employment policy, poverty reduction, and health service workforce planning. Strengthening financial security, improving working conditions, and investing in staff wellbeing supports are essential steps in mitigating the growing burden of burnout across sectors.

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Policy

Northern Ireland's **Mental Health Strategy 2021–2031** recognises the bidirectional relationship between mental and physical ill-health, particularly in the context of deprivation, long-term conditions, disability and trauma. Policy intent is to achieve parity of esteem through integrated, person-centred care, improved coordination between primary, community and acute services, and earlier intervention across the life course.

Northern Ireland implements a **Rare Diseases Action Plan** aligned with the UK Rare Diseases Framework, overseen by the **Northern Ireland Rare Diseases Implementation Group** (NIRDIG). The Plan focuses on four priorities: faster diagnosis; increased professional awareness; better coordination of care; and improved access to specialist treatment and research. Current provision includes development of regional rare disease care pathways, expanded genomic diagnostics, specialist clinical leadership, and targeted carer supports.

The **Autism Strategy 2023–2028** is a statutory, cross-departmental strategy, mandated under the **Autism Act (NI) 2011** and strengthened by the **Autism (Amendment) Act (NI) 2022**. The Strategy commits to improving: regional health and social care pathways; education and life-stage transitions; employment inclusion; housing; and autism-inclusive communities. Delivery is supported by a phased Delivery Plan and annual monitoring, with enhanced oversight through the appointment of an **Independent Autism Reviewer**.

Service

Autism services are delivered across health, education and social care, with access routes differing for children and adults. Health services include **autism assessment services** within **HSC Trusts** (children and adults).

Burnout is managed within workplace mental health, occupational health and stress management frameworks, led primarily by employers rather than health services. Relevant service provision includes PHA led workplace wellbeing guidance and support, which informs the design and delivery of preventative and early-intervention services for work-related stress and additionally, the Health and Safety Executive for Northern Ireland's application of the **HSE Management Standards for work-related stress,** and voluntary initiatives such as the **Mental Health Charter**.

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3.5 | Socioeconomic and Demographic Factors

Socioeconomic and demographic factors are recognised as important influences on mental health outcomes. Factors such as poverty, deprivation, unemployment, education and geographic location can influence both the risk of developing mental ill health and the ability to access appropriate support.

3.5.1 | Poverty, Employment and Education

Poverty is widely acknowledged as a significant determinant of mental health outcomes, and Northern Ireland continues to experience persistently elevated poverty rates. Approximately, 16% of individuals (roughly 300,000 people) in Northern Ireland were in relative income poverty in 2021/22. Among children, 18% were living in relative poverty.[222] According to the 'Northern Ireland Poverty and Income Inequality Report 2023/24' (Department for Communities), the proportion of individuals in relative poverty decreased from 18% in 2022/23 to 17% in 2023/24, however, the percentage of individuals in absolute poverty increased from 14% in 2022/23 to 15% in 2023/24,[223] indicating that a substantial proportion of the population lacks resources to meet basic living standards. Economic hardship creates chronic stress, financial insecurity, and reduced access to resources, all of which elevate the risk of depression and anxiety.

The Anti-Poverty Strategy for Northern Ireland, originally proposed in 2006, has advanced in response to statutory requirements and subsequent political consensus and aims to provide a long-term framework for reducing poverty and its associated harms across Northern Ireland. The strategy public consultation closed in September 2025 and the strategy for 2025 - 2035 adopts a cross-departmental approach to tackle poverty through three core pillars: including a 'Minimising Impacts' pillar which is aimed at reducing the negative effects of poverty on health and wellbeing. However, this has been heavily criticised for not addressing the drivers of poverty.

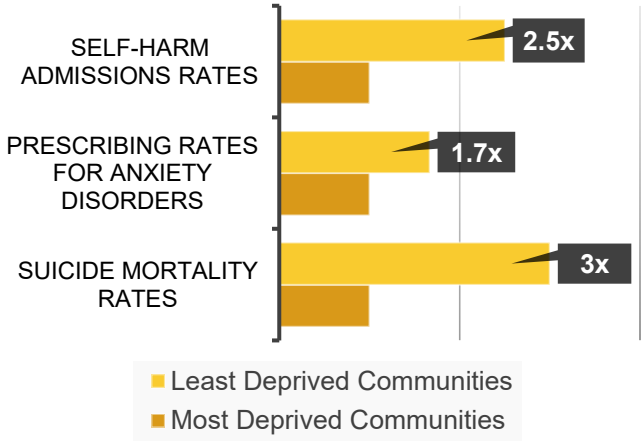
For adults scoring above the General Health Questionnaire -12 (GHQ12) threshold for probable mental ill health, those living in the most deprived areas most affected (27% compared to 15% in the least deprived areas). The DoH's 'Health Inequalities Annual Report 2025' demonstrates that inequality exerts a significant influence on adult mental health. Wellbeing indicators such as anxiety and loneliness follow a clear socioeconomic gradient, reflecting the structural determinants that shape mental health outcomes.[74]

Stakeholder commentary;

Economic pressures, including reduced public spending and rising household costs, are associated with increased mental health challenges across communities.

Between 2021 and 2023, the most deprived areas in Northern Ireland had a mortality rate nearly three times higher than in the least deprived areas. The Health Inequalities Annual Report 2025 also indicates that prescribing rates for mood and anxiety disorders are two-thirds higher in the most deprived communities and have continued to rise over time, as shown below.[74] While overall self-harm admissions have declined, the gap between the most and least deprived remains substantial.[74]

Demonstrating inequalities in mental ill-health indicators



Employment status and job conditions also significantly influence mental health. Being unemployed or economically inactive is associated with higher rates of mental health problems. Northern Ireland consistently has a higher economic inactivity rate than the UK overall, with particularly high inactivity among women. The latest labour market data shows an employment rate of 71.6% and an economic inactivity rate of 26.7%, with long-term sickness and disability being the largest reasons for inactivity.[224] Educational attainment constitutes a fundamental social determinant of health, influencing both employment trajectories and mental health outcomes. Gaps in qualifications and vocational skills represent substantial structural barriers to labour market participation. Furthermore, education is a key predictor of health literacy; lower levels of educational achievement are strongly correlated with diminished health literacy, which constrains individuals' capacity to effectively manage chronic conditions, including mental disorders and to engage with preventive health services.[225]

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3.5.2 | Housing as a Social Determinant of Mental Health

Secure housing underpins stability and wellbeing. Housing demand and supply trends shape many aspects of health and living standards, as demonstrated by the figures below. Housing stress is perceived when housing costs are burdensomely high relative to income.

In 2025, NISRA's 'Northern Ireland Housing Statistics 2024-25' listed that 49,083 households were on the social housing waiting list, with 37,635 assessed as being in "housing stress". In 2024-25, 10,855 applications for statutory homelessness were accepted by the Housing Executive.[226]

Annual targets for new social housing starts were met in 2024-25 (1,504 starts), but the Chartered Institute of Housing Northern Ireland argues the target itself falls short of the >2,200 homes per year estimated to be needed.[227]

A 2017 report by the UK Charity Shelter stated that around one in five adults (21%) report experiencing long-term stress, anxiety, or depression as a direct result of housing problems over the past five years, with some cases severe enough to involve suicidal thoughts.[228]

Stable, secure housing is fundamental to mental wellbeing. Between October 2024 and March 2025, the Department for Communities' Northern Ireland Homelessness Bulletin reported that 7,637 households presented as homeless, with 'accommodation not reasonable' cited most often (24.8%). Within this category, mental ill health was a contributing factor in 12.8% of cases, second only to physical health/disability.[229] The experience of homelessness is associated with the loss of stability and security, which can exacerbate mental health difficulties for individuals and families.

A 2023 survey by the Simon Community and the DePaul Northern Ireland Charity, 'Mental Health and Homelessness', found that among 170 people experiencing homelessness across Northern Ireland, 70% were reported to have high support needs in relation to their mental health.[230]

Survey findings also show that 40% of participants rated their mental health as 'poor', while only 14% described it as 'very good' or 'excellent'.[230]

3.5.3 | Psychosocial Determinants of Mental Health in Farming Communities

Farmers in Northern Ireland face unique challenges that significantly affect mental health. Isolation is a major factor as many farms are located in remote rural areas with limited social interaction, poor transport links, and inadequate broadband connectivity. This geographical and social isolation often leads to loneliness, which research links to increased risk of depression and anxiety. Farmers report feeling disconnected from wider society and undervalued, which compounds emotional distress.[231]

Additionally, farmers often work non-traditional working hours, which can exceed 15-18 hours per day during peak harvesting and livestock birthing seasons. Long hours reduce opportunities for rest, family time, and social engagement, while financial pressures and unpredictable conditions (weather, market fluctuations) heighten stress. Studies show that extended working hours correlate with poor sleep quality, higher anxiety, and depressive symptoms. In farming, this is intensified by lone-working and the cultural expectation of resilience.

The PHA identifies the farming population as particularly susceptible to poor health and stress and other mental health problems are also recognised by the Agency as occupational hazards of farm work.[232,233]

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3.5.3 | Psychosocial Determinants in Farming Communities (cont.)

A survey by the charity Rural Support (2016) consisting of 199 rural respondents found that a significant percentage scored in the domains of "concerning" or "very concerning" mental health impacts of the agricultural downturn in Northern Ireland.[234]

Furthermore, a Northern Ireland Assembly Research blog (2019) noted that while there is a lack of comprehensive data, rural Northern Ireland, including farming households, shows elevated risks of, self-harm hospital admissions and high prescribing rates for mood and anxiety drugs.[235]

UK-based research has shown that farmers have one of the highest suicide rates among occupational groups. A Scottish qualitative study explored how to engage farmers in shaping mental health interventions. Supporting farmers with mental health issues will require better engagement, including using appropriate communication and recognising that farmers tend to turn to those in their own community for help. Also noted was the need for increased training to recognise and support mental health issues.[236]

Stakeholder commentary;

In rural areas, there is significant engagement from the community and voluntary sector; however, unique barriers to access persist. The sector is heavily relied upon, and the withdrawal of EU funding presents substantial risks to the sustainability of rural mental health supports.

Farmers in Northern Ireland face distinctive mental health challenges driven by economic uncertainty, social isolation, and the demanding nature of agricultural work. Elevated rates of, self-harm, and prescriptions for mood and anxiety disorders point to a systemic vulnerability within rural communities.[237] These patterns indicate a need for tailored interventions that extend beyond generic mental health strategies. This includes the adoption of culturally sensitive approaches, the removal of structural barriers to care, improved access to services in remote areas, and proactive outreach to farming households. Addressing these issues is important not only for individual health and wellbeing, but also for sustaining the resilience and long-term viability of the agricultural sector and rural communities more broadly.

3.5.4 | Psychosocial Determinants in Minority Ethnic and Refugee/ Asylum Seeker Communities

There is a significant lack of research on the mental health of Black, Asian, and Minority Ethnic (BAME) communities in Northern Ireland, meaning our understanding of this group's mental health needs remains limited.[238]

Evidence suggests that BAME communities are generally at higher risk of experiencing poor mental health outcomes. According to Census 2021, 3.4% of the population, approximately 65,600 people, identified as belonging to minority ethnic groups. This represents a notable increase from previous census figures: 1.8% (32,400 people) in 2011 and 0.8% (14,300 people) in 2001.[239] This figure includes the Irish Traveller population (0.1%). It is widely acknowledged that this is likely an underestimate. Despite a growing Traveller population, data on this group remains limited, and the Northern Ireland government has taken little action to address this gap. The 2021 Northern Ireland Census allowed respondents to report an emotional or mental health condition expected to last 12 months or more. Among 2,610 Irish Traveller respondents, 24.25% reported such a condition. The All-Ireland Traveller Health Study highlights that poor mental health within this community is strongly linked to experiences of discrimination and recent bereavement. The study also found that the prevalence of Frequent Mental Distress (12.9%) among Travellers is more than two and a half times higher than that observed in a sample of the general Irish population.[240]

Asylum seekers and refugees in Northern Ireland face significant mental health challenges due to complex stressors and trauma, making them more vulnerable to conditions such as PTSD, depression, and anxiety. In 2023, around 3,030 people received asylum support, representing 2.7% of the UK's asylum seekers. A 2020 review investigated the prevalence of mental illness in refugees and asylum seekers. Common mental illnesses include PTSD (31%), depression (31.5%), anxiety disorders (11%), and psychosis (1.5%), with high rates of distress and grief also reported among children affected by war and displacement.[241] The 'Make My Voice Heard' report shines a light on the experiences of women seeking international protection in Northern Ireland, highlighting the barriers they face when accessing HSC services and offering recommendations to improve equity and inclusion. Published in May 2025 by the DoH, the report was developed through a Personal and Public Involvement project led by a regional steering group with representation from all five HSC Trusts, the PHA, and the OMHC. Over 167 women from 15 nationalities participated in 19 engagement sessions, sharing challenges related to maternity care, mental health, public health nursing, and social services.[242]

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3.5.4 | Psychosocial Determinants in Minority Ethnic and Refugee/Asylum Seeker Communities (cont.)

Key findings from the Make My Voice Heard' report include: [242]

1 Barriers and Needs
Language barriers, cultural differences, and difficulties navigating a fragmented healthcare system.

2 Considerations
To reduce health inequalities and improve integration for those who have chosen Northern Ireland as their home, steps must be taken to improve interpreting and translation services, create a standardised support model across Trusts, embed cultural competence in everyday practice, develop a central navigation resource for newcomers, and commission community-based health education programs.

A regional UNHCR analysis (January 2025) notes that Mental Health and Psychosocial Support (MHPSS) remains a top priority for Ukrainian refugees across Europe.[243]

The Ukrainian refugee community in Northern Ireland has grown steadily since the start of the Russian invasion of Ukraine in 2022, with over 3,000 arrivals in Northern Ireland reported by early 2024 under schemes such as Homes for Ukraine and the Ukraine Family Scheme. Many refugees are hosted by local families, supported by government initiatives that include financial assistance, housing help, and access to healthcare, education, and employment. Dedicated Ukraine Assistance Centres provide practical and emotional support, while recent policy updates allow visa extensions for those wishing to remain longer. Access to safe, stable accommodation is widely recognised as a key protective factor for refugees and minority ethnic communities, underpinning both psychosocial wellbeing and the ability to engage with support. The community is gradually settling, with strong local engagement and ongoing efforts to address challenges like housing and integration.[244]

The growing diversity within Northern Ireland's population, including ethnic minorities, refugees, asylum seekers, and the recent influx of Ukrainian refugees, has created challenges for healthcare providers.[245]

Language barriers often hinder effective communication between patients and medical staff, impacting diagnosis, treatment, and overall patient safety. To ensure equitable access to care and uphold clinical standards, the provision of translation and interpretation services in hospital and healthcare settings is essential. These services support informed consent and accurate medical decision-making but also foster trust and inclusivity within the health system. However, traditional interpreter services are not always immediately available, particularly in urgent situations or outside regular hours. In the absence of such services, situations can arise where minors are stepping in to relay sometimes complex and sensitive medical information to parents and guardians, which can lead to misunderstandings, and increased stress for both patients and healthcare staff.[246,247]

To address these issues, AI-powered translation devices have emerged as an innovative solution, offering real-time multilingual support and improving accessibility in emergency settings. AI-powered translation devices are currently available in some Northern Ireland emergency departments, but only as part of a pilot scheme. If pilots are deemed successful, this could pave the way for a wider rollout across Northern Ireland, significantly enhancing equity and safety in emergency care for minority communities.[248]

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Policy

Mental health outcomes in Northern Ireland are strongly influenced by socioeconomic and demographic determinants. Policy frameworks increasingly recognise that mental health cannot be addressed in isolation from structural inequalities. The **Mental Health Strategy 2021–2031** adopts a whole-system approach, emphasising prevention, early intervention, and collaboration across health, education, housing, and justice sectors. It acknowledges that mental health cannot be improved without addressing structural determinants such as poverty, unemployment, and housing insecurity. These disparities are monitored through the **Health and Social Care Inequalities Monitoring System** (HSCIMS). Annual reports by NISRA and the DoH track inequality gaps in mental health indicators, ensuring evidence-based policy adjustments. Funding schemes under the **'Making Life Better' framework** support grassroots projects aimed at resilience and health equity.

The PHA's **'Building Sustainable Communities'** programme promotes place-based wellbeing and cross-sector collaboration under the Mental Health Strategy prevention theme, incorporating commissioning standards and evaluation frameworks to ensure that community design and regeneration initiatives deliver tangible mental health gains.[249]

Service

The **Rural Support** charity provides a dedicated mental health and wellbeing service for farmers and rural families across Northern Ireland, recognising the pressures of isolation, financial stress, and changing agricultural policy. Its confidential support line and one-to-one mentoring service offer early intervention, stress management, and signposting to professional counselling or business advice. Operating province-wide, **Rural Support** also delivers outreach programmes and resilience training in collaboration with the PHA and DAERA, helping address mental health stigma and risk in rural communities.

PHA's initiatives such as the **Farm Families Health Checks Programme**, which brings mobile health services to rural areas to address these challenges. The **Rural Health and Care Toolkit** in Northern Ireland is a practical resource designed to help HSC planners, policy makers, and service providers address the specific needs of rural populations when developing strategies, initiatives, and service delivery plans. **Ukraine Assistance Centres** have been set up to support people arriving under the Homes for Ukraine Sponsorship Scheme or the Ukraine Family Scheme. Centres in Belfast and Newry provide health assessments, education support, employment and benefits advice and housing assistance among other services.

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Conclusion

Mental health services in Northern Ireland reflect a complex interaction of social, economic, historical, and demographic factors, with patterns of need and service use changing across the life course. The region's mental health services strive to address these needs through a mix of statutory and voluntary provision, innovative crisis support pathways, and targeted programmes for vulnerable groups, while also managing systemic pressures that affect capacity, timeliness, and inclusivity. Socioeconomic and geographic determinants, such as deprivation, housing stress, and rural isolation, further reinforce barriers to access and exacerbate mental health disparities.

Delays in accessing care can increase the risk of unmet needs and place additional pressure on emergency and intensive services. While timely access is widely recognised as essential, challenges in service availability and capacity persist. These constraints make it difficult for providers to respond effectively, and individuals may experience extended periods without appropriate support. Addressing these systemic issues will require sustained investment, improved pathways, and a commitment to equitable provision to achieve better mental health outcomes.

Taken together, the evidence indicates that mental health needs in Northern Ireland are shaped by both individual life circumstances and wider systemic factors. Poverty, trauma, housing pressures, discrimination, and timely access to support interact in complex ways, underscoring the need for progress to be driven through coordinated action across multiple domains.

There is also a realistic basis for optimism. As prevention and early intervention approaches expand, and as wider pressures affecting people's lives are progressively alleviated, services are better positioned to intervene earlier and respond more consistently. The development of clearer care pathways, stronger system coordination, and structured involvement of people with lived experience can support a more navigable system over time, with the potential for gradual and sustained improvements in outcomes.

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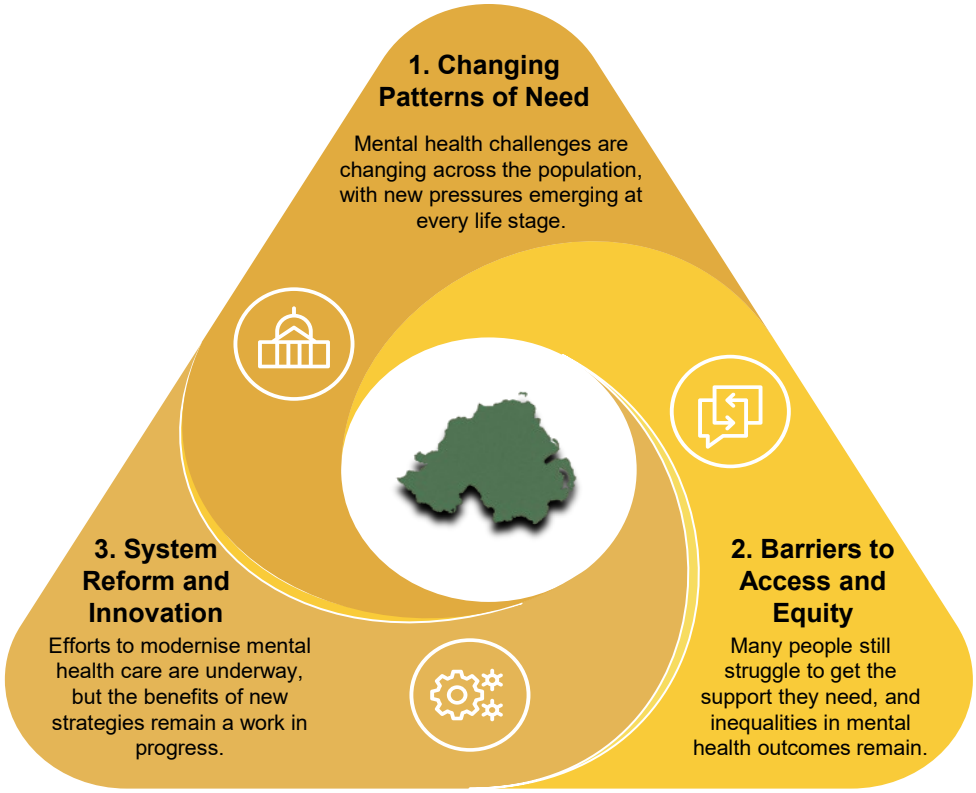
3.6 | Mental Health Services Summary

Northern Ireland's mental health services face significant challenges, including rising needs, shortages and gaps in access, yet it is also poised for meaningful transformation. Recent strategies emphasise prevention, early intervention and integrated, person-centred care, offering a clear vision for progress. Achieving this will require sustained investment, strong collaboration and an unwavering commitment to equity, ensuring that every individual and community can access the support they deserve.



01

- **Children and young people** are increasingly affected by academic stress, social media and identity issues, while **adults and older people** face the ongoing impacts of trauma, economic hardship and social isolation, parental mental illness/trauma and neurodiversity.
- **Complexity of need** is increasing, with more people experiencing overlapping challenges such as the presence of comorbidities or severe mental ill health, making it harder for services to **respond effectively**.

02

- Access to timely care is limited by **shortages, long waiting lists** and **regional disparity** in service availability, leaving some groups at risk of falling through the cracks.
- **Socioeconomic disadvantage** and **social exclusion** continue to contribute to poor mental health.

03

- Recent policies and programmes prioritise **prevention, early intervention** and more joined-up, trauma-informed care, with a growing focus on **collaboration** between statutory, voluntary and community sectors.
- However, the pace of change is slowed by **funding constraints**, **short-term planning cycles** and the need for **sustained investment** in development and service integration.

Looking Forward

MENTAL HEALTH CHAMPION

Looking Forward

The research, evidence and data presented in this report demonstrate that mental health in Northern Ireland is shaped by a complex interplay of social, economic, historical, and demographic factors. While there have been significant advances in policy, service provision, and public awareness, persistent challenges remain, particularly in access, equity, and the ability to respond to evolving patterns of need across the life course. Northern Ireland's levels of ill-health, and the systems that support mental health, are at a pivotal point. Recent years have seen the launch of ambitious strategies and a growing recognition of the need for holistic, life course approaches. These achievements provide a strong foundation for the next phase of transformation. While there is clear demand for further reform, several risks and opportunities must continue to be navigated. Ongoing shortages, annual funding cycles, and persistent inequalities, particularly for deprived and marginalised groups, pose risks to service continuity and equitable access. Proactive, cross-sector and cross-Executive collaboration will be essential to overcome these barriers.

Mental health outcomes are also strongly influenced by wider social determinants, including poverty, housing insecurity, education, employment, and experiences of inequality and discrimination. Exposure to adverse childhood experiences (ACEs), gender-based violence, including violence against women and girls, and structural exclusion faced by disabled people and LGBT+ communities significantly increase mental health risk across the life course. Addressing these drivers requires robust, aligned anti-poverty, disability and LGBT+ strategies, alongside trauma-informed, preventative approaches that extend beyond health services alone. While there is clear demand for further reform, several risks and opportunities must continue to be navigated.

A resilient mental health service depends on two foundational pillars, a sustainable workforce and a robust crisis response infrastructure. Both are critical system enablers for achieving timely, equitable, and person-centred care. Therefore, a focus for 2026/27 will be on strengthening the Mental Health Workforce and developing the Regional Mental Health Crisis Service. Both are identified as essential facilitators for broader system improvement, supporting the delivery of high-quality, accessible mental health services across Northern Ireland.

Current challenges, such as shortages of qualified professionals, uneven distribution across regions, and rising demand, pose significant risks to system performance. Addressing these gaps will require focus on recruitment and retention which can be enhanced via incentive programmes, enhanced mental health training offerings, clear career pathways, provider well-being initiatives and competitive compensation to attract and retain talent. Crisis services form the front line of urgent intervention, preventing escalation and reducing reliance on emergency departments or police services. These services divert individuals from inappropriate settings, provide rapid stabilisation, and connect them to ongoing care. When crisis services are effectively deployed the result is significant reductions in hospital admissions and justice system involvement. Investing in the above areas has enormous potential to strengthen the entire continuum of mental health care in Northern Ireland, improve outcomes, and enhance system efficiency.

This report considers the adoption of a whole system, life course approach that addresses challenges and risk factors at every stage. Prevention and early intervention are vital, with targeted programmes for perinatal mental health, early years, and school-based supports. Reducing waiting times and tackling persistent inequalities is essential to ensure access and equity, particularly for deprived, rural, and marginalised groups. Integrated, person-centred care should link physical and mental health, address comorbidities, and enable seamless transitions between services. Future investment must prioritise innovative models, including digital mental health solutions, to improve access and navigation. Strengthening cross-Executive leadership, embedding mental health as a Programme for Government priority, and securing multi-year funding will support long-term planning and continuity. Enhanced data collection, outcome measurement, and research will inform policy and practice. While progress has been made, Northern Ireland's mental health services face historical and emerging pressures. Bold leadership, sustained investment, and a relentless focus on equity and inclusion are essential to build a resilient, responsive, and person-centred system fit for the future.

Closing Vision

Together, we aspire to create a mental health service that not only responds to need but actively nurtures wellbeing for every person in Northern Ireland, across all life stages and communities. By sustaining ambition, investing in people, and fostering collaboration, we can shape a future where mental health is a shared priority. Central to this vision is prevention and early intervention, empowering individuals and communities before challenges arise, reducing suffering, lowering long-term costs, and unlocking greater potential and productivity. With courage and commitment, we can build a legacy of lasting change and improved mental health wellbeing in Northern Ireland for generations to come.

Closing Remarks

MENTAL HEALTH CHAMPION

Note from the Mental Health Champion

As I write this note, in what is my final year as Mental Health Champion for Northern Ireland, I am struck by both the progress we have made and the challenges that remain. This report offers an updated view of current mental health services and supports across our communities, drawing together evidence to help leaders and stakeholders understand where our efforts are most needed going forward.

The findings are clear: mental health is shaped by the accumulation of experiences and circumstances throughout life. Pressures are mounting, especially for children and young people, who face increasing distress and too often struggle to access timely support. Adults continue to feel the weight of adversity, economic uncertainty, and trauma, while older people and marginalised groups encounter persistent barriers to care.

Yet, there is much to acknowledge. The momentum behind the Mental Health Strategy, the dedication of healthcare professionals, community volunteers, and the vital role of prevention and early intervention initiatives all offer hope. Still, demand for mental health services and supports outpace capacity, and inequalities persist.

Looking ahead, our priorities must be clear: invest in early intervention and prevention, advocate for sustainable and longer-term funding, build a stable, highly trained workforce, and ensure compassionate, accessible mental health services and support for all members of our community. Above all, we must listen to those with lived experience and keep their voices at the heart of reform.

I encourage you to use this report as a tool for action. Together, through sustained commitment and collaboration, we can create a mental health service that truly serves everyone in Northern Ireland.

Professor Siobhan O'Neill
Mental Health Champion

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MENTAL HEALTH CHAMPION

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Appendix: Acronyms

MENTAL HEALTH CHAMPION

Appendix: Acronyms

The below provides a list of acronyms mentioned throughout the report

Acronym	Definition
ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ADR	Administrative Data Research (UK)
AMH	Action Mental Health
APGAR	Appearance, Pulse, Grimace, Activity, and Respiration
ARFID	Avoidant/ Restrictive Food Intake Disorder
ARK	Access Research Knowledge
ASD	Autism Spectrum Disorder
ASIST	Applied Suicide Intervention Skills Training
BAME	Black, Asian, and Minority Ethnic
BWDW	Being Well Doing Well
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCE	Child Criminal Exploitation
CHOICE	Challenging Health Outcomes/Integrating Care Environments
CIPD	Chartered Institute of Personnel and Development
CJI	Criminal Justice Inspection Northern Ireland
CMHTOP	Community Mental Health Teams for Older People
CMHTs	Community Mental Health Teams
COPNI	Commissioner for Older People for Northern Ireland
COSICA	Commissioner for Survivors of Institutional Childhood Abuse
CYPSP	Children and Young People's Strategic Partnership

Appendix: Acronyms

The below provides a list of acronyms mentioned throughout the report

Acronym	Definition
DAERA	Department of Agriculture, Environment and Rural Affairs
DD	Dual Diagnosis
DE	Department of Education
DHSSPS	Department of Health and Social Services and Public Safety
DoH	Department of Health
DNA	Did Not Attend
DoJ	Department of Justice
DoL	Deprivation of Liberty
EA	Education Authority
EHWE	Emotional Health and Wellbeing in Education
EIP	Early Intervention in Psychosis
EIPN	Early Intervention in Psychosis Network
EOTAS	Education Otherwise Than at School
ELC	Early Learning & Childcare
EPOC	Executive Programme on Paramilitarism and Organised Crime
ESF	European Social Fund
EVAWG	Ending Violence Against Women and Girls
EWTS	Emotional Wellbeing Teams in Schools
GHQ	General Health Questionnaire
GHQ12	General Health Questionnaire -12
GBD	Global Burden of Disease
GBV	Gender-based Violence

Appendix: Acronyms

The below provides a list of acronyms mentioned throughout the report

Acronym	Definition
HCAP	Harmonised Cognitive Assessment Protocol
HSC	Health and Social Care
HSCIMS	Health and Social Care Inequalities Monitoring System
IPV	Intimate Partner Violence
KLT	Kids' Life and Times
KPI	Key Performance Indicator
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, and Asexual, with the Plus representing other identities.
MATT	Multi Agency Triage Team
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MHC	Mental Health Champion
MHFA	Mental Health First Aid
MHP	Mental Health Professional
MHPSS	Mental Health and Psychosocial Support
MMHA	Maternal Mental Health Alliance
NDNA	New Decade, New Approach
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NICE	National Institute for Health and Care Excellence
NICOLA	Northern Ireland Cohort for the Longitudinal Study of Ageing
NIMATS	Northern Ireland Maternity System
NIRDIG	Northern Ireland Rare Diseases Implementation Group

Appendix: Acronyms

The below provides a list of acronyms mentioned throughout the report

Acronym	Definition
NISHS	Northern Ireland Study of Health and Stress
NISRA	Northern Ireland Statistics and Research Agency
NIYWS	Northern Ireland Youth Wellbeing Survey
OMHC	Office of the Mental Health Champion
ORCHA	Organisation for Review of Care and Health Apps
PAC	Public Accounts Committee
PHA	Public Health Agency
PSNI	Police Service of Northern Ireland
PQN	Perinatal Quality Network
PTS	Psychological Therapies Services
PTSD	Post Traumatic Stress Disorder
RCIS	Regional Crisis Intervention Service
RCRP	Right Care, Right Person
REACH	Resilience Education Assisting Change to Happen
REULA	Retained EU Law (Revocation and Reform) Act
RISE NI	Regional Integrated Support for Education in Northern Ireland
RMHS	Regional Mental Health Service
RMHCS	Regional Mental Health Crisis Service
RTN	Regional Trauma Network
SMD	Substance Misuse Database
SPPG	Strategic Planning and Performance Group
SSPS	Social Services and Public Safety

Appendix: Acronyms

The below provides a list of acronyms mentioned throughout the report

Acronym	Definition
WHO	World Health Organisation
YLD	Years Lived with Disability
YLT	Young Life and Times

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