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PARTNERING FOR WELLBEING AND ENABLING RECOVERY

Annex 1: Population Mental Health Report



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1.0 Introduction

Mental health is a fundamental component of individual and societal wellbeing. The World Health Organisation defines it as a state in which individuals realise their potential, cope with normal life stresses, work productively, and contribute to their communities (WHO, 2013)¹. Increasingly, this definition underpins a shift from treatment-focused care towards prevention, early intervention, and population health approaches.

Population health emphasises the social, economic, and environmental determinants that shape mental wellbeing across the life course. Clinical interventions alone are insufficient to improve outcomes at scale. As Purtle et al. (2020)² highlight, population-based mental health approaches extend beyond healthcare systems to include non-clinical interventions targeting shared populations. These approaches are essential in addressing structural determinants such as poverty, housing, education, and inequality, which drive disparities in mental health outcomes (Kirkbride et al., 2024)³.

2.0 Global Context

Mental health disorders affect over one billion people globally and remain leading contributors to disability and premature mortality (Rehm and Shield, 2019)⁴. Despite this, systems remain predominantly reactive and focused on acute care rather than prevention.

People with severe mental illness (SMI) experience compounded disadvantage, including poorer physical health outcomes, reduced access to care, and significantly shorter life expectancy (Carswell et al, 2024)⁵. These inequities reflect systemic failures, including fragmented service provision, diagnostic overshadowing, and insufficient integration of physical and mental healthcare (Ashworth et al., 2017)⁶.

¹ World Health Organisation (2013) *Mental health action plan 2013-2020*. Geneva: World Health Organisation

² Purtle, J., Nelson, K.L., Counts, N.Z. and Yudell, M. (2020) *Population based approaches to mental health: History, strategies and evidence*. Annual Review of Public Health, 41, pp. 201-221.

³ Kirkbride, J. B., Anglin, D.M., Colman, I., Dykxhoorn, J., Jones, P.B., Patalay, P., Pitman, A., Sonesson, E., Steare, T., Wright, T. and Griffiths, S.L. (2024) *The social determinants of mental health and disorder: evidence, prevention and recommendations*. World Psychiatry, 23(1), pp. 58-90

⁴ Rehm, J. and Shield, K. D. (2019) *Global burden of disease and the impact of mental and addictive disorders*. Current Psychiatry Reports, 21(2) Article 10

⁵ Carswell, C., et al. (2024) *'The Lived Experience of Informal Caregivers of People Who Have Severe Mental Illness and Coexisting Long-Term Conditions: A Qualitative Study'*, International Journal of Environmental Research and Public Health, 21(6), 793

⁶ Ashworth, M., Schofield, P. and Das-Munshi, J. (2017) *Physical Health in Severe Mental Illness*. British Journal of General Practice, 67(663), pp.436-437



This highlights the need for structural reform, rather than incremental service improvement.

3.0 UK Context

In the United Kingdom, mental illness represents a substantial and increasing burden across health, economic, and social domains. The *Adult Psychiatric Morbidity Survey (2023/24)* (Morris et al., 2025)⁷ reports that over one in five adults experience a common mental health condition, with prevalence rising significantly over time and disproportionately affecting women.

Suicide remains a critical public health concern, with 7,055 deaths recorded in 2023 (ONS, 2025)⁸. The uniquely high rates among men under 50 years old, combined with surging rates of suicidal ideation and self-harm in young women, indicate that current strategies have not sufficiently addressed underlying determinants or access barriers.

Despite policy recognition of prevention and early intervention, service provision remains heavily weighted towards crisis response. This misalignment between policy intent and system delivery continues to drive unmet need and health inequalities.

Despite clear policy commitments in Northern Ireland (NI) such as the *Mental Health Strategy 2021-2031* (DoH, 2021)⁹ and the *Live Better* (PHA, 2025)¹⁰ initiative to prioritise early intervention, health service delivery remains heavily weighted towards crisis response. This ongoing misalignment between policy intent and actual system delivery drives continued unmet needs and exacerbates health inequalities.

4.0 Local Context

NI experiences disproportionately high levels of mental ill health, with prevalence estimated to be 25% higher than in England (DoH, 2022)¹¹. Socioeconomic deprivation, historical trauma, and service access challenges contribute to this burden. Data consistently demonstrates inequalities, with higher mental health morbidity in deprived communities and among women. Suicide remains the leading cause of death among men under 50 years old, accounting for 21.9% of deaths in this group (NISRA, 2025)¹².

⁷ Morris, S., Hill, S. (eds.) (2025) *Adult Psychiatric Morbidity Survey: Survey of Mental Health in England 2023/24*. Leeds: NHS England

⁸ Office for National Statistics (2025) *Suicides in England and Wales: 2024 registrations*. Newport: Office for National Statistics

⁹ Department of Health (2021) *Mental Health Strategy 2021-31*. Belfast: DoH

¹⁰ Public Health Agency (2025) *Live Better*. Belfast: PHA

¹¹ Department of Health (2022) *Health Survey Northern Ireland: First Results 2021/22*. Belfast: DoH

¹² Northern Ireland Statistics and Research Agency (NISRA) (2025) *Health Inequalities Annual Report 2025*



Policy frameworks, including the *Mental Health Strategy 2021–2031* and *Protect Life 2* (DoH, 2019)¹³, set out clear ambitions for prevention, early intervention, and reducing inequalities. Nevertheless, systemic barriers specifically concerning human resource capacity, integrated care pathways, and population-wide interventions continue to impede full implementation.

4.1 Social Determinants and Inequalities

The social determinants of mental health encompass the structural conditions to which people are exposed across their life course, from conception to death, which affect individual mental health outcomes, and contribute to mental health disparities within and between populations. These structural conditions include factors such as income, employment, socioeconomic status, education, food security, housing, social support, discrimination, childhood adversity, as well as the social and physical conditions of the neighbourhoods in which people live, and the ability to access affordable health care (Kirkbride et al 2024)¹⁴.

Extensive research links NI's rising mental health needs to decades of political conflict and socioeconomic disparities. Today, these historical challenges are amplified by shifts in demographics, epidemiology, and digital communication. Compounded by the cost-of-living crisis and the lasting impacts of the COVID-19 pandemic, mental health has become a critical public health emergency that profoundly affects individuals, families, and communities across all age groups.

In overall terms, research estimates that one in five adults, and one in eight children in NI are likely facing mental illness. In the most recent Health Survey (NI), a fifth of respondents had a high [*General Health Questionnaire -12*](#) (GHQ -12) score which is similar to 2022/23 (20%). It also indicates that respondents in the most deprived areas (27%) continue to be more likely to have a high GHQ-12 score than those in the least deprived areas (15%) and potential mental health morbidity is higher among females compared to males (22% vs 18%, respectively for 2023/24). Bunting et al (2012) estimated the lifetime prevalence of a mental disorder among the NI general population was 39.1%.

4.2 Population Health and Suicide

Suicide remains a critical public health concern in NI, reflecting broader patterns in population mental health. Suicide rates are shaped by a range of multiple social

¹³ Department of Health (2019) *Protect Life 2: A Strategy for Suicide Prevention in Northern Ireland*. Belfast: DoH

¹⁴ Kirkbride, J.B., Anglin, D.M., Colman, I., Dykxhoorn, J., Jones, P.B., Patalay, P., Pitman, A., Sonesson, E., Steare, T., Wright, T. and Griffiths, S.L. (2024) *The social determinants of mental health and disorder: evidence, prevention and recommendations*. *World Psychiatry*, 23 (1), pp.58-90.



determinants, including; economic deprivation, social isolation, unemployment and adverse childhood experiences which can adversely affect mental health across the life span (Walsh, et al. 2025)¹⁵. Further information is available within *The Prevalence and Impact of Adverse Childhood Experiences in NI* by Walsh et al (2025). In addition, certain demographics face a higher risk, including men, young people, and individuals with a history of mental illness. Geographic disparities also exist, with some regions experiencing significantly higher rates than others.

NI Statistics and Research Agency (NISRA) reported annual statistics on registered suicides, showing year-to-year fluctuations; in 2024, 290 suicide deaths were registered in NI (NISRA, 2025)¹⁶. As with previous years, suicide remains the leading cause of death in males aged under 50 years in NI. Of all male deaths registered in 2024 where the deceased was under 50 years of age (690), 151 were deaths by suicide (21.9%). 230 (79.3%) of the 290 suicide deaths in 2024 were males and 60 (20.7%) were females. The age-standardised mortality rate for males was 28.0 per 100,000 in 2024, while for females, the equivalent rate was 7.1 per 100,000. The age-standardised mortality rate for suicides in NI has fluctuated since the start of the revised series (2015), ranging from 11.9 per 100,000 in 2016 to 14.3 per 100,000 in both 2018 and 2021, to 17.4 per 100,000 in 2024. The NI 2024 age-standardised mortality rate of 17.4 suicides per 100,000 population was higher than the rate for Scotland (12.7 per 100,000 population) and England and Wales (11.4 per 100,000). It should be noted, however, that cross country comparisons will be affected by differences in data collection and collation processes in the separate jurisdictions.

There are a number of strategies in NI that outline a vision for the promotion of mental wellbeing and suicide prevention: *The Mental Health Strategy 2021–31* (DoH, 2021) and the *Protect Life 2 Strategy* (DoH, 2019)¹⁷.

4.3 Neurodiversity and Mental Health

The term “neurodiversity” refers to natural variation in human cognition and neurological functioning across the population. Individuals whose cognitive functioning differs from neurotypical norms are often described as neurodivergent, a term that encompasses people with recognised neurodevelopmental conditions such as autism and Attention Deficit Hyperactivity Disorder (ADHD) (Morris et al., 2013)¹⁸.

¹⁵ Walsh, C., Bunting, L., Davidson, G., Doherty, N., McCartan, C., Mulholland, C. and Shelvin, M. (2025) *The prevalence and impact of adverse childhood experiences in Northern Ireland*. Belfast: The Executive Programme on Paramilitarism and Organised Crime.

¹⁶ Northern Ireland Statistics and Research Agency (NISRA) (2025) *Suicide Statistics*: Belfast: NISRA

¹⁷ Department of Health, Social Services and Public Safety (2019) *Protect Life 2: A strategy for preventing suicide and self-harm in Northern Ireland 2019-2024*. Belfast: DHSSPS.

¹⁸ Morris C., Janssens A., Tomlinson R., Williams J., Logan S. (2013). Towards Definition of Neurodisability.



Neurodevelopmental conditions typically emerge early in life and can affect motor, cognitive, behavioural and/or language functioning, creating challenges with movement, information processing, self-regulation and communication.

It's estimated that around 15-20% of people in the UK are neurodivergent individuals, including those with autism and ADHD (National Autism Society 2025)¹⁹. Estimates can vary and it is difficult to accurately approximate the prevalence of conditions (Megan et al. Cleaton and Kirby 2018)²⁰. People with a neurodiversity are more likely to experience mental health challenges, with studies showing a high co-occurrence of mental health conditions, such as anxiety and depression, in comparison to the general population (Nikolic et al. 2024²¹ and Doyle, 2020²²). In a study by Nikolic et al., (2024) it was reported that 37.7% of individuals experiencing First Episode Psychosis (FEP) were likely neurodivergent, significantly higher than the previously estimated 9% prevalence. Individuals with neurodivergence use Mental Health Services more frequently and for a longer duration, than non-divergent individuals. Thus, highlighting an urgent need to reassess how these conditions are identified and managed. There is a need for early identification of all neurodevelopmental conditions and the provision of support to help improve their quality of life and reduce the impact of co-occurring mental health challenges.

Similarly, it's estimated up to 50% of ADHD adults also have an anxiety disorder (van der Meer, et al. 2017²³). A prevalence of neurodiversity in a UK High Secure Psychiatric Hospital cohort showed that over one-half (115, 58%) of the men had at least one neurodivergent condition; nearly a third (56, 29%) had more than one form of neurodivergent condition. The most frequently recorded form of neurodivergent condition was general cognitive dysfunction (24%), followed by general language difficulties (16%), ADHD (15%) and autism (14%). It is estimated that this represents 5% of the general population (National Autistic Society 2025, World Health Organisation).

4.4 Co-occurring and Substance Use

¹⁹ National Autism Society (2025) *Predicting attention deficit/hyperactivity disorder severity from psychosocial stress and stress-response genes: a random forest regression approach*. Translational Psychiatry 7, pp.1-9.

²⁰ Cleaton, M.A.M., Lorgelly, P.K. and Kirby, A., 2019. Developmental coordination disorder: the impact on the family. *Quality of Life Research*, 28(4), pp.925-934

²¹ Nikolic, N., Sculthorpe, C., Stock, J., Stevens, D. and Eccles, J. (2024) *Determining unmet need: clinical relevance of suspected neurodivergence in first-episode psychosis*. Cambridge University Press.

²² Doyle, N. (2020) *Neurodiversity at work: a biopsychosocial model and the impact on working adults*. British Medical Bulletin, vol135, pp.108-125.

²³ Van der Meer, D., Hoekstra, P.J., Van Donkelaar, M., Bralten, J., Oosterlaan, J., Heslenfeld, D., Farone, S.V., Franke, B., Buitelaar, and Hartman, C.A. (2017) *Anxiety modulates the relation between attention-deficit/hyperactivity disorder severity and working brain memory-related activity*. The World Journal of Biological Psychiatry, 19(6), pp.450-460.



Co-occurring mental ill health and substance use remains a persistent and complex challenge within NI, where prevalence is shaped by socioeconomic deprivation, trauma exposure and service fragmentation. People with mental illness and polysubstance use (including alcohol, prescribed medication and illicit drugs) often experience poorer clinical outcomes, higher rates of relapse, and increased risk of suicide (Bahji, 2024)²⁴. During the 2024/25 period, 3,889 people accessed substance misuse services. Notably, 28.6% experienced concurrent drug and alcohol dependencies, highlighting an established demographic in need of integrated mental health and addiction care (DoH, 2025)²⁵. The NI Commissioner for Children and Young People (NICCY) reports that a vast majority, between 64% and 88% of young people with substance misuse disorders, suffer from a co-existing mental health condition. This alarming statistic occurs against the backdrop of a wider Northern Irish context characterised by elevated mental health need and profound challenges in accessing holistic, early-intervention support. Furthermore, health inequalities data highlights that drug-related mortality rates are substantially higher in areas of severe socioeconomic deprivation. This underscores a complex interplay between social determinants, substance misuse and mental health (PHA, 2025)²⁶. Collectively, these findings indicate a disproportionate burden of dual diagnosis within NI.

The division between mental health and addiction pathways creates bureaucratic barriers that delay care and exclude vulnerable individuals. Aligning with the *Mental Health Strategy* (DoH, 2021; PHA, 2020), this structural disconnect must be reformed to deliver seamless care especially for service users dealing with fluctuating capacity, co-morbidities, and acute social instability.

A regional coordinated response is essential, including; fully integrated care pathways, workforce training in dual diagnosis and harm reduction measures. The prioritisation of these measures within mainstream provision is necessary to reduce risk, improve engagement, continuity of care and deliver more consistent recovery outcomes for individuals with co-occurring mental health and substance use needs.

4.5 Neighbourhood Model

The Department of Health in NI published a Health and Social Care [*Reset and Recovery Plan 2024*](#), DoH (2024)²⁷ to address financial pressures and stabilise the health system. The plan's key goals are to deliver a neighbourhood-centered model

²⁴ Bahji, A. (2024) *Navigating the Complex Intersection of Substance Use and Psychiatric Disorders: A Comprehensive Review*. Journal of Clinical Medicine, 13(4), 999

²⁵ Department of Health (2025) *Northern Ireland Substance Misuse Database Statistics 2024/25*. Belfast: DoH

²⁶ Public Health Agency (PHA) (2025) *Health Inequalities Annual Report*. Belfast: PHA

²⁷ Department of Health (2024) *Reset and Recovery Plan*. Belfast: DoH



of care, bringing care as close as possible to those who need it, tackling health inequalities, and supporting individuals to improve their own health and well-being. The HSC Reset Plan, recognises that healthcare is only one component of well-being. Improving overall health requires a whole-government approach, relying equally on the broader social determinants of health, such as employment, housing, and education delivered in partnership across the NI Executive.

Registered Mental Health Nurses (RMHNS) undergo a comprehensive education programme underpinned by an integrated bio-psychosocial understanding of mental health epidemiology, which equips them to deliver a wide range of mental health promotion, early intervention, and prevention programmes. Therefore, mental health nurses can play a pivotal role in addressing population mental health needs across a spectrum of settings (public health, primary care, community and family services, crisis and acute and in specialist/condition specific services). This proposed Neighbourhood Model will see Community Pharmacy, GPs and their Federations, Voluntary and Community Organisations, Trusts and Independent Service Providers working closely together, in formal partnerships, to provide integrated care.

5.0 The Role of Mental Health Nurses

Addressing the challenges of mental ill health requires a workforce capable of operating across clinical, community, and population health domains. Mental health nurses are uniquely positioned to fulfil this role due to their biopsychosocial expertise and system-wide reach.

However, current models underutilise this potential, with roles often confined to reactive, episodic care. A strategic shift is required to embed mental health nurses within population health frameworks and integrated care systems.

Embedding mental health nurses within Integrated Neighbourhood Teams would enable:

- Earlier identification of need;
- Coordinated, community-based interventions;
- Targeted support for high-risk populations;
- Improved continuity of care across the life course;
- Decreases avoidable emergency admissions
- Enhanced connections between patients and community support networks



A strategic expansion of specialist, advanced and consultant nurse roles, in line with the [*NI Career and Development Model for Nursing and Midwifery*](#) (NIPEC, 2025)²⁸. This will enable targeted interventions across key priority areas providing a scalable mechanism to operationalise policy objectives.

5.1 Proposed Mental Health Nursing Roles

A population health approach requires a transformation and reconfiguration of mental health nursing roles to provide proactive prevention, early intervention, and targeted support across the life course. To optimise the greatest immediate achievable impact from mental health nursing, the principal focus necessitates a targeted expansion, development and rapid implementation of specialist and advanced nurse led interface roles. Thereby strengthening coordination and integration, working within primary, community, secondary and specialist mental health services. These roles are a key enabler of the Neighbourhood model of care, improving access, continuity, and integration across HSC services.

Achieving this vision will require the development critical specialist, advanced and consultant mental health nursing roles across MDTs, as outlined below:

- **Population-level mental health care** with nurses leading population-level improvement by integrating physical health monitoring into mental health care and leading public mental health initiatives. They would monitor patterns of mental illness and identify high-risk groups within the population. They would design, implement, and evaluate prevention programmes aimed at improving mental health outcomes. They would also lead anti-stigma initiatives to reduce discrimination and promote mental wellbeing. In addition, they would coordinate cross-sector interventions that address wider determinants of mental health, such as housing, employment, and social inclusion.
- **Trauma-informed mental health care** delivered by nurses championing system-wide healthcare strategies. This will enable identification and the effective management of the deep-rooted effects of trauma, guiding the broader healthcare system in implementing trauma-responsive practices as well as developing educational initiatives.
- **Perinatal mental health nurses**, working alongside midwifery and health visiting services, would provide screening, early intervention for common perinatal mental health difficulties, support parent–infant relationships, and proactively engage vulnerable women.

²⁸ Northern Ireland Practice and Education Council (NIPEC) (2025) *NI Career and Development Model for Nursing and Midwifery*. Belfast: NIPEC

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- **CAMHS nurses** embedded within schools and community hubs would provide early intervention through accessible, youth-friendly services, including school-based support, digital and drop-in models, and family-focused care.
 - **Neurodiversity mental health nurses** would support children, young people, and adults through diagnostic assessment, pre-diagnostic support, and coordination of personalised, sensory-informed care pathways, working in partnership with education services, families, and carers to prevent crisis escalation.
 - **Mental health nurses engaging in suicide prevention** would implement targeted, data-driven interventions, including Neighbourhood risk stratification, assertive outreach to high-risk individuals, rapid response services, and postvention support, alongside analysis of suicide trends, clusters, and inequalities.
 - **Nurses working in eating disorder services** would lead integrated, multi-disciplinary care pathways and provide advanced clinical management for eating disorder conditions associated with significant medical and psychiatric mortality.
 - **Nurses working with early intervention psychosis and Severe Mental Illness (SMI)** would deliver assertive, proactive, biopsychosocial care, focusing on early identification, to support individuals experiencing first-episode psychosis, with integrated management of mental, physical, and social needs, health behaviour change, and relapse prevention to reduce hospitalisation and premature mortality.
 - **Co-occurring and substance use mental health nurses** would take a population-based approach to reducing harm by analysing patterns and 'hotspots' of use, coordinating prevention and early intervention strategies, delivering community awareness initiatives, and implementing harm reduction measures to empower patients and their families with the tools needed for sustainable recovery.
 - **Mental health nurses in community forensic services** providing targeted, data-driven interventions to individuals at greatest risk at court or on release from police custody or prison. Using neighbourhood risk stratification, multi-agency intelligence, and a holistic biopsychosocial approach, they work alongside Healthcare in Prison teams, Police Custody nurses and independently within the courts to identify needs early, support transition planning, and coordinate care from court or on release.

- **Later life and dementia-focused mental health nurses**, integrated with MDTs in primary care and community nursing teams, would provide specialised cognitive and emotional support tailored to the elderly, dementia patients, and their families, alongside early identification, community support and care home management of behavioural symptoms, provide carer education, and prevent avoidable hospital admissions.

Maximising the development and scope of mental health nursing roles will strengthen nurse led early intervention, supports proactive prevention and early intervention, and enable more care closer to home. Hereby, reducing existing mental health acute need, secondary care pressures across the system and coordinating with C&V organisations locally, with responsive prevention and recovery focused care.

An ambitious but deliverable transformation model grounded in system priorities and workforce development will help stabilise system pressures to reduce an over reliance on acute and secondary care services through improved flow, decision-making, faster access to evidence-based interventions, coordination of care and sustainable care delivery. Examples of existing pilots and pockets of nursing excellence across the life course for consideration are presented as Appendix 3.

The overall population health recommendations are presented in Table 1.

Table 1: Population Health Key Messages

Population Health Key Messages
Develop a population mental health nursing workforce model that strengthens mental health nursing practice towards prevention, early intervention, and population mental wellbeing, through focusing practice on the four pillars of nursing practice: • Promoting wellness and prevention of ill-health; • Responding to deterioration; and acute needs; • Supporting self-management, anticipatory care and early intervention; • Provide monitoring and treatment for long term conditions, including palliative and end of life care; and • Embed mental health nursing within Neighbourhood MDTs, primary care, community services, coordinating with C&V organisations to deliver accessible, locally responsive mental health support and recovery focused care.

6.0 Conclusion

Mental health is a significant and escalating public health challenge, with clear evidence of rising prevalence, persistent inequalities, and substantial social and



economic consequences across global, UK, and Northern Ireland contexts. While policy frameworks such as the *Northern Ireland Mental Health Strategy 2021–2031* (DoH, 2021) and *Protect Life 2* (DoH, 2019) emphasise prevention, early intervention, and population wellbeing, there remains a clear implementation gap, with services still largely configured around crisis response rather than proactive care.

Addressing this gap requires a system-wide shift towards population health approaches that target the social determinants of mental health, reduce inequalities, and prioritise early intervention across the life course. In this context, Mental Health Nurses represent a critical but underutilised strategic resource. Their biopsychosocial expertise and ability to operate across clinical, community, and public health settings uniquely position them to support delivery of policy objectives at scale.

Embedding mental health nurses within Integrated Neighbourhood Teams provides a practical mechanism to operationalise these approaches, enabling earlier identification of need, targeted support for high-risk groups, improved care coordination, and population-level intervention delivery. A strategic expansion of specialist, advanced and consultant nurse roles, in line with the [*NI Career and Development Model for Nursing and Midwifery*](#) (NIPEC, 2025)²⁹. This will enable targeted interventions across key priority areas providing a scalable mechanism to operationalise policy objectives.

²⁹ Northern Ireland Practice and Education Council (NIPEC) (2025) *NI Career and Development Model for Nursing and Midwifery*. Belfast: NIPEC



For further Information, please contact:

NIPEC

4th Floor James House
2-4 Cromac Avenue
BELFAST
BT7 2JB

Tel: 0300 3000066

Email: enquiries@nipec.hscni.net

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