HSC Public Health Agency

Mental Health Strategy 2021-2031

Early Intervention and Prevention

Overview of At-Risk Groups

Prepared on behalf of the Data & Outcomes Group

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Improving your health and wellbeing

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1. Background

Everyone has mental health and everyone is able to experience mental ill health. In Northern Ireland, the lifetime prevalence of experiencing a mental health disorder is 39.1% [1]. However, the risk of developing mental ill health is not evenly distributed throughout the population. Certain sub-populations within society have an increased level of risk compared to the general population, this may be due to an increased risk of adverse life experiences or belonging to a social exclusion group. The World Health Organization defines these 'vulnerable groups' as "*individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness or lack or capacity)*[2]". The World Health Organization advocates for the practice of proportionate universalism, which combines universal prevention aimed at the whole population, with targeted and/or selective prevention to focus on those who experience inequalities. Consideration of these at-risk groups is therefore important for any effective preventative strategies for mental illness.

The Mental Health Strategy 2021–2031 for Northern Ireland was published by the Department of Health on 29th June 2021. The Strategy outlines 35 actions to improve the mental wellbeing of the population in Northern Ireland. The Public Health Agency (PHA), has been tasked with forwarding Actions 1 and 2 of the strategy which focus on early intervention and prevention:

- **Action 1:** Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging the public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

- **Action 2:** Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

The aim of this report is therefore to outline what specific groups within the Northern Ireland population have an increased risk or are vulnerable to developing mental ill health. This will help inform the Public Health Agency's ongoing efforts to meet Action's 1 and 2 of the Mental Health Strategy which focus on early intervention and prevention.

2. Methodology

Initial scoping searches were conducted to identify reviews which outlined the main groups within the population who are at risk of developing mental ill health. Broad search terms including 'at-risk' 'vulnerable,' 'population,' and 'mental health' were run through several bibliographic databases (Medline, PubMed). However, it was evident that there was a lack of publications discussing these vulnerable and at-risk groups at the population or national level. Therefore, we focused on supplementing the original list of at-risk groups identified in The Mental Health Strategy 2021–2031, with those identified by key organisations such as the Mental Health Foundation and the public health bodies of neighbouring countries. An overview of these sources can be found in Appendix 1. The groups identified were collated, focusing on those who were consistently highlighted as vulnerable. In addition, feedback on the list was provided from experts in mental health in Northern Ireland through the Data and Outcomes Sub Group to provide information Northern Ireland specific groups such as those who have exposure to paramilitary violence.

Once the list of at-risk groups was collated, individual searches were conducted to find the most up to date evidence of this group in Northern Ireland. Where Northern Ireland specific background information was not available, evidence sought from the UK or Ireland and presented alongside the best available data for the Northern Ireland population. For each included group, the following information is presented:

- A definition or criteria for inclusion in the group.
- Evidence of the risk of developing mental ill health for the group and influencing factors. However, the mental health conditions included in this report are not intended to all-inclusive and represent only the key evidence identified.
- The most up to date data available for the group in Northern Ireland, both in regards to the prevalence within the Northern Ireland population and any mental health outcome data available.

The list of at-risk groups presented in this report is not intended to be exhaustive and does not include all risk factors for mental ill health. We have focused on specific minority groups within the population and excluded groups which would result in the inclusion of large sections of the Northern Ireland population. It is for this reason that all of those living in urban or rural areas were excluded from consideration. We have also not included children and young people, pregnant and post-natal women or older people in this report. However, we acknowledge that the risk of mental ill health varies across the life course and recognise in the considerations section that age and gender may intersect with many of these groups to increase risk. Intergenerational trauma was also highlighted as a Northern Ireland specific issue, but it was unclear how we would feasibly capture the group experiencing this phenomenon within the population.

3. At-Risk Groups

3.1. Domestic Abuse and Intimate Partner Violence

In Northern Ireland, domestic abuse is defined as: ‘’threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member’’[3]. Intimate partner violence (IPV) is a type of domestic violence that specifically occurs between current and former intimate partners only. There is clear evidence of the long-lasting impact of domestic abuse and intimate partner violence on the mental health of survivors. Women with intimate partner violence exposure are at three times greater risk of developing depression and had a two-fold risk of developing anxiety [4]. In men intimate partner violence has been associated with depression, anxiety, PTSD and suicidal ideation [5]. Children may be direct survivors of domestic abuse themselves, or be secondary victims who have witnessed intimate partner violence of a parent or care-giver. Exposure to these kinds of domestic violence have been found to cause both short-and long-term mental health complications for children including depression and PTSD [6].

Not all domestic abuse incidents meet the criteria to be recorded as a crime, so the Police Service of Northern Ireland report statistics on both domestic abuse incidents, and domestic abuse crimes. These show that in the 12 months from 1st April 2023 to 31st March 2024, there were 32,763 domestic abuse incidents in Northern Ireland, with 19,954 domestic abuse crimes, relating to 17 domestic abuse incidents and 10 domestic abuse crimes per 1,000 of the population [7]. However, it must be noted that not at all domestic violence incidents are reported to the police, so in fact these numbers likely underrepresent the prevalence in Northern Ireland. Findings from the Northern Ireland Safe Community Survey in 2018/19, showed that the police were unaware of the majority of incidents reported by participants, with only a quarter (24.9%) indicating that the police knew about their experience [8]. In this survey 18.8% of respondents (aged 16-74) reported experiencing at least one form of domestic violence or abuse, with one in eight (12.3%) having experience in the previous three years. To the best of our knowledge there is no data on the mental health outcomes of survivors of domestic violence and abuse collected currently in Northern Ireland.

3.2. Ethnic Minorities

3.2.1. Black and Minority Ethnic Groups (BAME)

Certain minority ethnic groups are at an increased risk of mental illness. For instance, people from ethnic minorities have increased risks of schizophrenia, especially individuals who are Black African and Black Caribbean [9]. It is thought that the key influencing factors in mental health risk are experiences of racism, inequality and stigma as well as barriers to support including a lack of literacy around mental health, not knowing where or what help is available, language or financial barriers [10]. Compared to the other nations of the UK there has traditionally been a very low number of individuals from the BAME community in Northern Ireland. The proportion of the population who are part of a minority ethnic group has increased from 1.8% in the 2011 census to 3.4% in the 2021 census [11]. Despite this, there is still a significant gap in our understanding of mental health within the BAME

community of Northern Ireland. The 2021 census did include some information on mental health, showing that 2.7% of Asian respondents, 3.1% of Black respondents and 6.5% of mixed ethnicity respondents reported an emotional or mental health condition expected to last 12 months or more [11]. In addition, a project called 'Hearing Our Needs' was conducted by Counselling All Nations Services (CANS) in 2020. Although the sample size was relatively small (45 BAME individuals), They found that racism and hate crime was a significant issue in Northern Ireland, with 42% stated that they had experienced racism or hate crime in Northern Ireland [12].

3.2.2. Irish Travellers

Irish Travellers are recognised as an ethnic minority on the island of Ireland, described as an indigenous group who are distinct in their history, culture, traditions and customs including a traditionally nomadic way of life. The majority of the Traveller community live in the Republic of Ireland, however there remains a smaller community of Travellers who reside in Northern Ireland. The most up to date figures on these populations can be found in the census of both countries. There were 32,949 individuals identifying as an Irish Traveller in the 2022 Census of the Republic of Ireland, and 2,609 in Northern Ireland's 2021 Census [13, 14]. However, as Irish Travellers have been historically less likely to respond to the census, these figures likely underestimate the size of the population.

Irish Travellers have been consistently found to have poor mental health. The All-Ireland Traveller Health Study represents the most comprehensive research on the Irish Traveller community to date, as it contacted every identifiable traveller family on the island of Ireland with a response rate of 80%. In this study, over half (57%) of Irish Travellers aged 15 and over reported that their mental health was not good in the past month [15]. More recently in the Northern Ireland census, around one quarter of those who identified as Irish Travellers reported an emotional or mental health condition in the previous 12 months [14]. Furthermore, 90% of Travellers agree that mental health problems are common in their community, with suicide being the cause of 11% of Traveller deaths [16]. There is evidence that this is due to increased experiences of discrimination and bereavement [17]. To the best of our knowledge there is no data on the mental health outcomes of Irish Travellers currently collected in Northern Ireland.

3.2.3. Refugees and Asylum Seekers

An immigrant is someone who chooses to move to another country to settle permanently, looking for better opportunities such as work or education. Asylum seekers however flee their home due to conflict and persecution. In Northern Ireland the term asylum seeker refers to those who are seeking sanctuary, including both those who have travelled to the UK by their own means and requested asylum, and those who were brought to the UK through 'safe and legal routes' such as refugee resettlement programs. A refugee is an asylum seeker who has had refugee status granted and are allowed to stay in the UK. Refugee status lasts for five years, after which they are offered to apply for permanent settlement and eventually are able to apply for British citizenship. The term migrant has no universally accepted or legal definition. As of March 2024, there are 2,748 people receiving asylum support in Northern Ireland, with the vast majority living in Belfast [18].

Common mental disorders such as anxiety and depression, affect one out of three asylum seekers [19], with recent pooled estimates suggesting that the prevalence of major depressive disorder is 32% and post-traumatic stress disorder is 31% [20]. A 2018 survey of the asylum seeker community in Belfast found that 79% of people stated that they experienced anxiety, depression, isolation or felt they could not cope with daily activities [21]. The increased risk of mental ill health may be due to the range of stressors refugees face throughout the migration process, including exposure to conflict, violence and persecution pre-migration and the potentially life-threatening experience of migration travel itself [22]. However, the post-migration and settlement periods are equally important to mental health with post-migration stressors also potentially affecting recovery from premigration trauma [23]. These post-migration and settlement stressors include but are not limited to poor living conditions, separation from family, uncertainty regarding asylum process, poor working conditions or unemployment, assimilation difficulties, racism and social isolation [22]. Research with asylum seekers, refugees and service providers highlighted that the specific post-migration stressors faced by refugees and asylum seekers settling in Northern Ireland include poor housing, the long process of trying to claim asylum and the health system not being well equipped to handle the specific needs of those who have underwent the migration process (such as torture recovery) [24].

3.3. Farmers and Their Families

A study of 450 farmers aged under 50, found that 95% said that poor mental health is the biggest hidden problem facing the farming industry today [25]. Farmers have been found to have significantly higher psychological morbidity compared to the non-farming population, and have one of the highest rates of suicide of any industry [26, 27]. The four most cited risk factors that affect farmers mental health are pesticide exposure, financial difficulties, climate variabilities/drought and poor physical health/past injuries [28]. However, there is an extensive range of drivers which affect farming mental health including personal/social reasons (such as loneliness, isolation), farm related issues (including weather, financial issues, farm accidents, tenancy issues), policy related concerns (such as paperwork and inspections) and issues with the public/media (such as rural crime and media criticism) [29]. Moreover, the interrelationship between work and home life for farmers may exacerbate the impact of these stressors, as any problem in one area will likely affect both their personal and professional life [30].

The Agricultural Census shows that there were 26,131 farms in Northern Ireland in June 2023, and 40,585 farmers, partners/spouses or directors [31]. A recent report in Northern Ireland found that members of the farming community score significantly higher on measures of stress, loneliness, depressed and anxious affect and lower on wellbeing [32]. Similarly, the Farm Support Survey in 2023 by Rural Support NI found that 67% of participants had a wellbeing score below the population average [33].

3.4. Homelessness

As they are the most visible group, ‘rough sleepers’ or those staying on the streets, are often what is thought of when describing homelessness. However, homelessness refers to a much broader group. In Northern Ireland, homelessness is the responsibility of the Northern Ireland Housing

Executive (NIHE). The NIHE define homelessness as sleeping on the streets but also include those who are living in poor conditions that are damaging their health, staying in a hostel, at risk of violence if they stay in their home, live in overcrowded conditions, are staying in a bed and breakfast, staying with friends and family or living in a house that is unsuitable [34]. However, for much of the data available in Northern Ireland, 'homelessness' refers to anyone who is undergoing or has passed the NIHE's homelessness assessment. The most recent NIHE homelessness bulletin states that there were 8,452 households who met this criterion in March 2024 [35]. Those sleeping on the streets are not included in this estimate, with the NIHE instead conducting rough sleeper audits of Belfast, Newry and Derry/Londonderry. In the most recent count, there were 45 people rough sleeping across Northern Ireland [36].

It is well established prevalence of mental illness is higher in those who are homeless, compared to the general population. For the vast majority of individual's, these mental health issues pre-date homelessness. For instance, in a 2023 survey from Simon Community NI and DePaul, 68% of respondents reported a mental health disorder diagnosis, of which 84% were prior to becoming homeless [37]. However, the relationship between homelessness and mental illness is bidirectional. Mental illness is not just a factor which may contribute to homelessness, but those individuals who are experiencing homelessness with no previous mental illness are also at an increased risk of developing mental ill health. This could be due to their social and material needs not being met, experiences of discrimination and violence and the stress of homelessness. However, there is a gap in information in terms of prevention of mental ill health and those who developed mental ill health as a result of being homeless.

3.5. LGBTQIA+

The term LGBTQIA+ refers to those who identify as lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, non-binary or as a part of other minority sexuality and gender identity groups. There is strong evidence that members this community are at a higher risk of developing mental ill health compared to the general population. A recent meta-analysis of people with minority sexual-orientations showed that lesbian, gay and bisexual people had significantly higher risk of depression, anxiety, alcohol use disorder and suicidality when compared to heterosexuals [38]. Similar findings are found for gender identity. A 2018 report on LGBT health by the Stonewall charity, found that two thirds of trans people (67%) and seven in ten (70%) of non-binary people had experienced depression in the past year [39]. Similarly, 80% of non-binary people and 71% of trans people had experienced anxiety in the previous year. It is not sexual orientation or gender identity itself which causes increased risk of mental ill health, but the unique challenges that groups within this community may face such as discrimination and stigmatisation, prejudice (homophobia or transphobia), victimisation, violence and hate crimes, unequal access and barriers to healthcare and difficult experiences of coming out [40, 41].

Sexual orientation was included in the Northern Ireland census in 2021, as such we can estimate that there are 31,600 people aged 16 or over identifying as lesbian, gay or bisexual in Northern Ireland (2.1% of the population) [42]. However, no questions about gender identity were included in the most census, so there are currently no population level figures for this group in Northern Ireland. Moreover, no consistent and specific indicators of mental health within this community are currently collected in Northern Ireland. The most comprehensive information available to date is a report by

the Rainbow Project in 2013 which found that LGBT individuals reported poorer mental well-being than their heterosexual peers [43]. Moreover, in the previous 12 months two thirds (64.7%) of LGBT people reported having experienced personal, emotional, behavioural or mental health problems for which they required professional help, with a significantly higher proportion experiencing a mental illness and not seeking help. More recently, the 2021 census showed that 26.6% of LGB individuals reported an emotional or mental health condition expected to last 12 months or more [42].

3.6. Long-term and Chronic Conditions

3.6.1. Physical Conditions

Long-term physical conditions or chronic conditions are those which are not curable but can be managed such as diabetes or arthritis. There a wealth of evidence linking physical health and mental health. Having a chronic condition such as asthma, diabetes, cholesterol disease, kidney disease or coronary heart disease have been linked to mental ill health and the prevalence of depression and anxiety [44, 45]. In fact, evidence shows that those with long-term conditions are three times more likely to experience mental health problems [46]. Moreover, having more than one long-term health condition increases this risk, with one study finding that those who have two or more conditions are seven times more likely to have depression than those with no long-term condition [47]. Contributing factors may include pain, increased worry and stress, low self-esteem, social isolation or stigma.

In the 2021 census, 11.5% of the population indicated that they had a long-term health condition which limited their day-to-day activities a lot, with a further 12.9% whose activities were limited a little [48]. Of those who were limited a lot, over a third (35.5%) also reported an emotional or mental health condition. For those who were limited a little, the rate was 18.6%. In the 2022/23 Northern Ireland Health Survey, 40% reported having a physical or mental health condition or illness expected to last 12 months or more and 30% have a long-standing illness that reduces their ability to carry out day-to-day activities [49].

3.6.2. Learning Disability

NICE suggest that a learning disability can be defined by the presence of three core criteria: lower intellectual ability (IQ less than 70), significant impairment in social or adaptive functioning and an onset in childhood [50]. The term intellectual disability is often used interchangeably with learning disability. According to the 2021 census, 16,921 people or 0.9% of the Northern Irish population live with a learning or intellectual disability [51]. It is widely accepted that those living with a learning disability experience higher rates of mental ill health compared to the general population. Prevalence estimates vary due to methodological differences, but pooled prevalence estimates report that around one third of adults with an intellectual disability (33.6%) have a co-occurring psychiatric disorder [52]. A similar prevalence of 36% is found for children, with children with learning disabilities accounting for 14% of all children with a mental health problem and being six times more likely to have a diagnosable psychiatric disorder compared to their peers [53]. Of the 16,921 individuals living with a learning disability in the 2021 census, a quarter (24.8%) also reported having an emotional or mental health condition [51]. This may be due negative attitudes from others such as stigma and discrimination, the biological and genetic risk factors involved in learning disability also increasing

the risk of a mental illness, those with a learning disability having a higher likelihood of experiencing negative life events such as deprivation, poverty, abuse, or having access to fewer resources and coping skills such as lack of social support [54].

3.6.3. Neurodivergence

Neurodivergence is an umbrella term that refers to people whose brains function differently to what is considered 'normal' and can include a range of conditions such as autism, ADHD, dyspraxia, dyslexia, and dyscalculia. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), defines Autism Spectrum Disorder as a neurodevelopment disorder which is characterised by deficits in social communication and interaction, restricted and repetitive behaviours and interests [55]. ADHD or Attention-Deficit Hyperactivity Disorder is a neurodevelopmental disorder which is characterised by a mix of hyperactivity, inattention and impulsivity [56]. Both conditions have onsets in childhood, however, the previous two decades have shown significant increases in diagnoses of autism and ADHD in adults [57, 58].

The National Autism Society suggest that one in every 100 people in the UK are autistic [59]. In Northern Ireland 1.9% of the population were identified as having autism or Asperger syndrome during the 2021 Census [60]. Co-occurring mental health conditions are more prevalent in those with autism compared to the general population [61]. Of the 35,367 who had autism in the census, 7,036 or one fifth also indicated that they had an emotional, psychological or mental health (19.9%) [60]. According to the Mental Health Foundation, there is a gap in knowledge as to why those with Autism have a high prevalence, however they suggest that contributing factors may include struggles to fit in or make sense of the world, stigma and discrimination and a lack of available support that is specifically for those with autism [62].

In the UK the prevalence of ADHD in adults is estimated to be between 3-4%, with a ratio of 3:1 males to females [63]. In the 2021 Northern Ireland Census, ADHD was included in 'learning difficulty' along with dyslexia and dyspraxia. The proportion of a learning difficulty was 3.1% [64]. There is evidence that ADHD is more predictive of conditions such as anxiety and depression than autism [65]. Indeed, of the 59,889 who identified as having a learning difficulty, almost a third of which also reported an emotional or mental health condition (31.5%) [64].

3.6.4. Sight and Hearing Loss

Hearing loss, including deafness and partial hearing loss, is experienced by 5.8% of the Northern Irish population [66]. Diagnoses rates for anxiety and depression are higher, and occur earlier, in deaf adults compared to hearing adults [67]. Of the 109,459 who have deafness or some form of hearing loss in Northern Ireland, 13.8% also reported having an emotional or mental health condition [66]. There are significant individual differences in this group based on severity and time when hearing loss was acquired. For instance, many deaf people do not consider themselves to have a disability, with many speaking British Sign Language and being active members of the deaf community. However, those with acquired deafness who lose their hearing when already an adult tend to see

deafness as a purely negative condition, are less likely to learn sign language or join a deaf community and experience a bereavement reaction to losing their hearing [68].

Approximately 1.8% of the Northern Ireland population are blind or have partial sight loss [69]. The emotional distress of losing sight, fear and anxiety over future sight loss, feelings of loss, stigma and functional limitations all contribute to an increased risk to mental health in those with visual impairment [70]. There is much research on the link between visual impairment and depression, with pooled survey data estimating that one in four of those with visual impairment also have depression (pooled proportion 0.27) [71]. In Northern Ireland, of the 33,957 living with blindness or sight loss, almost one fifth (18.9%) also reported having an emotional or mental health condition [69]. However, similar to hearing loss this group is varied depending on severity of their condition (i.e., blind versus partial sight loss) and when this was acquired (born blind versus, sudden sight loss or a gradual decline).

While both impairments individually impact on communication, mobility, ability to access information and independence, it is suggested that those living with both visual and hearing impairment (deafblindness or dual sensory loss) are particularly vulnerable due to the extra difficulties this group face. In a specially adapted survey of 2717 Deafblind UK members, 61% reported experiencing psychiatric problems [72], with a particularly strong relationship being found between dual sensory loss and depression [73]. In Northern Ireland there are 12,783 people who reported having both sight and hearing loss, 18.6% of which also reported having an emotional or mental health condition [74].

3.6.5. Unpaid Carers

A carer refers to both children and adults who provide unpaid help to look after a family member, partner or friend who needs support due to an illness, frailty, disability, mental health problem or addiction. There is overwhelming evidence that unpaid caregiving is detrimental to the mental health of working age adults [75], and is consistently shown to be associated with poor mental health in young carers (those aged 25 and under) [76]. A survey in November 2023 by CarersUK found that 27% of carers reported their mental health as bad or very bad, with over three quarters (79%) saying they were anxious or stressed and half reporting feeling depressed (49%) or lonely (50%) [77]. Compared to non-carers, both full-time and part-time carers have been found to have significantly higher scores of psychological distress [79]. The increased risk may be due to a combination of stigma, financial difficulties, social isolation and reduced time to participate in leisure activities [76, 79].

The 2021 census showed that 11.7% of the Northern Irish population provided at least one or more hours of unpaid care per week [80]. Carers NI found that 1 in 4 surveyed described their mental health as bad or very bad, and that this was greater in those who had been caring for a longer amount of time (10+ years) [81]. The NI Census showed that of the who 222,219 people who provide at least one hour of care, 11.2% also reported having an emotional or mental health condition. However, there is evidence of a gradient increasing with the number of hours of care provided with 8.5% of those caring 1-19 hours, 11.8% of those caring 20-49 hours and 14.8% of those caring 50+ hours also reporting having an emotional or mental health condition [80].

3.7. Looked After Children and Care Leavers

A child is considered 'looked after' if they are in the care of an Authority or are provided with accommodation for a continuous period of more than 24 hours, as of March 2023 there were 3,801 children and young people who met this definition in Northern Ireland [82]. A report by the Department for Education in 2014, which looked at outcomes for looked after children found that only half (50.4%) had emotional and behavioural health that was considered 'normal' [83]. Whilst the likelihood of mental ill health is highest for those who have experienced care or been 'looked after', all children who have had previous contact with social services have an increased risk [84]. In Northern Ireland equates to approximately 1 in every 6 young people, but accounts for half of children who have experienced mental ill health [84, 85].

When looked after children and those in care grow and reach adulthood, they have to leave care. In 2022/23 there were 365 care leavers aged 16-18, and 242 aged 19 in Northern Ireland [86]. For many this is a difficult time, as they must transition to adulthood 'whether they are ready or not', with most feeling that they do not have the skills needed to do so [87]. This makes this group particularly vulnerable with a report by Barnardo's in 2017 showing that 1 in 4 of the cases of these care leavers involving a mental health crisis after leaving care [88]. The Department of Health in Northern Ireland report annually on the number of care leavers, their accommodation and employment status, but do not include any data on their mental health outcomes.

3.8. Paramilitary Harm

Paramilitary groups continue to have a significant presence in certain areas across Northern Ireland, despite the Good Friday Agreement in 1998. Paramilitarism is a complex phenomenon, and can cause a range of harms to the communities in which they are embedded. In 2023 18% of respondents to the Northern Ireland Life and Times Survey agreed that paramilitary groups create fear and intimidation in their area, with a further 15% agreeing that they have a controlling influence [89]. In their 2024 report on the connection between paramilitarism and mental health in Northern Ireland, the Executive Programme on Paramilitarism and Organised Crime (EPPOC) outlined the range of harms that paramilitaries can cause [90]. These range from gatekeeping, coercive control, treats intimidation, extortion, grooming and child exploitation, to serious personal/interpersonal violence and violence against the state. EPPOC also acknowledged the lack of data available on the impact of 'hidden harms' such threats, intimidation, extortion, exploitation and coercive control as focus has traditionally been more focused on the impact of serious violence. Interviews with young people in Northern Ireland who have exposure to paramilitarism have described their individual stories of the impact to their mental health [91], and qualitative work with young men at risk of paramilitary related harm has found that symptoms described by respondents could be considered as consistent with the DSM-V criteria for PTSD [92]. However, this evidence is anecdotal and to the best of our knowledge there has been no empirical data collected on the mental health outcomes of those exposed to paramilitary harm in Northern Ireland.

3.9. Poverty and Deprivation

The Joseph Roundtree Foundation define poverty as when an individual's financial resources are well below their minimum needs, meaning that they are unable to heat your home, pay rent, or buy essentials [93]. In Northern Ireland an individual is considered to be in relative poverty if they are living in a household with an equivalised income below 60% of UK median income in the year in question and absolute poverty if they are living in a household with an equivalised income that is below 60% of the UK median income in 2010/11. In 2022/23, the proportion of the population in relative poverty was 18%, absolute poverty was 14% [94]. Furthermore, a quarter of children were found to be in relative poverty (24%) and one fifth in absolute poverty (19%). The link between poverty and mental health is well established, with living in poverty being considered one of the key social determinants of mental health and poverty alleviation one of the key interventions [95]. It is estimated that those with the lowest incomes are 1.5-3 times more likely to experience depression or anxiety compared to the richest [96]. Moreover, recent research by the Mental Health Foundation has highlighted the importance of poverty stigma, with experiences of poverty stigma being positively associated with higher levels of anxiety and depression irrespective of the level of economic hardship experienced [97].

Deprivation offers a method of measuring the wider living standards of an individual. People are considered to be living in poverty if they lack the financial resources to meet their needs, but they can be considered deprived if they lack any kind of resources, not just income [98]. Deprivation therefore offers a way to measure an individual's unmet needs, whereas poverty refers to the lack of resources required to meet those needs. In Northern Ireland, deprivation is captured using the Northern Ireland Multiple Deprivation Measure 2017 [99]. This measure ranks areas in Northern Ireland from most deprived to least deprived using 38 indicators across seven deprivation domains including income, employment, health, education skills and training, access to services, living environment and crime and disorder. Using the NIMDM, findings from the Health Survey show a gradient in the proportion of people with potential psychiatric problems (GHQ12), rising from 17% in the least deprived areas to 28% in the most deprived areas [100].

3.10. Prisoners and People in Contact with the Justice System

It is challenging to get an accurate count of the prison population in Northern Ireland, as the number of people within the justice system fluctuates regularly, with the Chief Inspector of Criminal Justice calling it a ''revolving door'' [101]. As such the clearest figure we have is an average daily prison population, which in 2023/23 was 1,685, 78 of which were female and 1,428 were male [102]. However, this figure also includes those who are on remanded into custody to await their trial. These individuals make up a large proportion of the prison population in Northern Ireland. In fact, Northern Ireland has one of the highest rates of remanding in custody in Europe, with 80% of all committals to prison being on remand and 40% of the overall prison population being unsentenced [101].

In Northern Ireland, over a third (36%) of prisoners were already in contact with mental health services at the time of their committal [103]. Many of the discussions surrounding mental health and prisons often focus on the services and care available to this group of prisoners who present with pre-existing mental illness diagnoses. However, the prison environment itself also poses a

significant risk to mental health as it inevitably involves a loss of freedom as well as removal from society and social support groups. Despite this the NI Audit Office's review found very little information in regards to early intervention or prevention in the prison population, which focus more on the management and treatment of existing mental illness [103].

3.10.1. Children and Families of Prisoners

In addition to prisoners themselves, the families of those imprisoned are also at increased risk of mental ill health. Children with parents, care-givers or other close family members who are imprisoned are especially vulnerable. Parental incarceration in particular is considered an Adverse Childhood Experience (ACE), a traumatic event in a young person's life that causes long-term harm [104]. From 2010-2012 the COPING study gathered evidence from over 1500 children, care-givers, imprisoned parents and stakeholders across four countries (UK, Germany, Romania, Sweden) and found that children with an imprisoned parent had significantly higher risk of mental health problems compared to the general population [105]. This may be due to a number of factors including break-up of the family, financial difficulties and stigma. However, there may be significant differences in the impact on mental health depending on a myriad of factors including the nature of the offence, pre-existing difficulties and family dynamics, and social support systems. Recent data linkage in England and Wales suggests that there are 192,912 children with a parent in prison [106]. Unfortunately, the number of children with parents or family members in prison in Northern Ireland is not routinely recorded. In their 2016 policy briefing NIACRO estimate this number to be around 2,400, with 1,500 working with their family links service [107].

3.11. Substance and Alcohol Use Disorders

Substance Use Disorder (SUD), refers to drug addiction and an individual's inability to control the use of drugs. The DSM-5 criteria for a substance use disorder includes 11 criteria ranging from drug cravings to continuing to use despite negative consequences, wanting to stop but not being able to [108]. It further recognises that these can result from a range of drug classes including hallucinogens, opioids and stimulants, as well as substances such as tobacco and caffeine. Statistics from the Drug Misuse Database [109], show that there are 1,818 clients having presented to services for drugs misuse in 2022/23. There were 154 drug misuse deaths in 2022, defined as drug-related deaths where the underlying cause is drug abuse or dependence, or where any of the substances controlled under the Misuse of Drugs Act 1971 were involved [110]. The link between drug use and mental illness is well established with dual diagnosis (the co-occurrence of a diagnosed mental illness and alcohol/substance abuse) being a prevalent health and societal issue [111]. However, relationship between drug use and mental health is complex and may differ depending on the substance used. Generally, the risk of mental ill health in substance use may be due to common risk factors for both conditions such as an individual's environment, adverse childhood experiences and stress or may be a direct effect of substances changing the brain to increase risk or unlock a predisposition to mental illnesses [112].

Alcohol Use Disorder (AUD), encompasses a range of conditions referred to as alcohol abuse, dependence, addiction or alcoholism. According to the most recent Health Survey, 16% of people in Northern Ireland drink above their weekly limits [113]. In April 2019, there were 2560 clients in treatment for problem alcohol in Northern Ireland [114]. There were 356 alcohol-specific deaths

registered in 2022, accounting for 2.1% of the overall number of deaths that year [115]. Those with common mental disorders have been found to be twice as likely to report alcohol use disorder compared to those without [116]. However, a particularly strong link between alcohol use disorder and depression [117]. Alcohol can affect mental health indirectly by causing challenges to one's family or work life or as a result of repeated hangovers and feeling unwell [118]. However, as a depressant alcohol also directly impacts an individual's brain chemistry by altering its neurotransmitters (chemical messengers). To the best of our knowledge there is no data collected on the mental health outcomes of those with substance use disorder or alcohol use disorder in Northern Ireland.

3.12. Veterans

In the UK a veteran is defined as someone who served in the Armed Forces for at least one day and is no longer serving. There is no reliable estimate of the number of veterans living in Northern Ireland, however, it is suggested to be around 110,000. The Northern Ireland Veteran Health and Wellbeing Study (NIVHWS), of 1267 veterans living in Northern Ireland showed high prevalence's of mental ill health with 39.9% met the criteria for depression, 36.8% for PTSD and 32.3% for anxiety [119]. Stressors pose a risk to the mental health of veterans include the stressful and often traumatic nature of their job, the potential of working away from family and support networks, physical injuries and the difficulties of returning to civilian life after service.

Approximately 300,000 veterans served on Operation Banner during the Troubles in Northern Ireland, of which 40,000 served in home service regiments who were recruited locally and in many cases on a part-time basis. There is evidence that this sub-population may be especially vulnerable. In the NIVHWS, the prevalence of depression (47.8% vs 33.9%), PTSD (46.7% vs 29.0%) and anxiety (40.5% vs 26.0%) was significantly higher for those who were home service veterans compared to those who were in general service. Moreover, there is evidence that these groups stressors are exacerbated by security concerns and ongoing worries of their safety and that of their families, as they live in the same area as they served [120].

4. Considerations

4.1. Intersectionality

While these groups are presented as separately in this document, it must be noted that these issues are often intersectional and compounded. People often experience more than one inequality with these determinants tending to cluster together into multiple disadvantage. This means that individuals can belong to one or more of these at-risk groups. For example, a recent report called 'We Are Getting Hurt' by the Migration Justice Project, the Law Centre NI and Rainbow Refugees NI shows the unique challenges faced when the vulnerabilities of sexuality and refugee status intersect, resulting in increased rates of self-harm and suicide ideation [121]. Moreover, we know that risk varies across the life course and that age and gender likely impact the risk of developing mental ill health for each of these groups. For example, the youngest or oldest of each group may be more at risk. Consideration and care should therefore be given to not reduce any individuals to one aspect of their identity, experience or condition [122].

4.2. Individual Differences

Experiencing one of the inequalities or belonging to one of the groups presented in this report also does not necessarily mean that an individual will go on to develop a mental illness. There are individual differences in the risk of mental ill health which this report does not include. This includes the various protective factors which may buffer the increased risk experienced by these groups such as social support or positive parenting.

4.3. Innate Characteristics

It must also be recognised that some of the groups presented are considered at-risk due to fixed innate characteristics such as ethnicity, whereas others are due to situational factors which are modifiable and potentially preventable such as homelessness or problematic substance use.

4.4. Data Availability

One consistent finding throughout this report is the lack of mental health outcomes data collected for these at-risk groups. The scarcity of data population level mental health is well acknowledged in Northern Ireland. It has been outlined by the Mental Health Champion and the Mental Health Foundation in their Fundamental Fact's report for Northern Ireland, stating that ''population-level data, capturing the prevalence of mental health problems among people who experience inequalities and who are considered to be more at risk, needs to be collected' [123]. There are also significant issues with the mental health data that is available. For instance, where population and programme level mental health data is collected and reported on by statutory organisations, it often cannot be routinely broken down into the minority groups identified in this report. This was highlighted by the Office for Statistics Regulation's 2021 review of mental health statistics in Northern Ireland, which emphasised the lack of data collected around at-risk groups and Section 75 indicators [124]. For the

majority of groups outlined in this report, the best available data was sourced from the 2021 census. However, there remain significant caveats in the feasibility of using census data for indicators of mental health outcomes given the length of time between data collection points (10 years). Caution is also required when considering data on these at-risk groups which is collected via large nationally representative social surveys. These surveys typically have large sample sizes and are able to provide estimates generalisable to the wider population. However, given that these at-risk groups are mainly minority groups within the population, there are likely not enough respondents from each group included within the sample of these surveys to be able to conduct subgroup analysis or have enough statistical power to make any reliable estimates.

5. Summary

Table 1: Summary of at-risk groups, definitions and availability of mental health related data in Northern Ireland

At Risk Group	Definition	Examples of Mental Health concerns identified	Available Data
Domestic abuse & intimate partner violence survivors	Threatening, controlling, coercive behaviour, violence or abuse	Assoc with depression, anxiety, PTSD, suicidal ideation	No data relating to MH outcomes but some incidence data available from PSNI statistics
Ethnic minority groups	BAME, Irish Travellers, Refugees & Asylum Seekers	Schizophrenia, MDD, PTSD, Anxiety, Suicide	Population data, likely to under-represent groups No data relating to MH outcomes
Farmers & farm families	40.585 farmers, partners or directors in NI June 2023	Stress, loneliness, depression, anxiety, suicide, lower wellbeing	No data relating to MH outcomes
Homelessness	Rough sleepers, living in poor conditions, unsuitable housing, hostels, overcrowded dwellings, B&B, staying with friends/family.	Increased likelihood of diagnosis of mental illness	Some under-represented prevalence data No data relating to MH outcomes
Long-term chronic conditions	Physical conditions, People with Learning Disability (PWLD), neurodivergent (autism, ADHD, dyspraxia, dyslexia, dyscalculia), Sight/hearing loss	Depression, anxiety	MH concern reported by 36% of those with long-term physical condition 34% PWLD, 20% those with autism, 19% sight loss, 19% deaf/blind (Census) MH data limited
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, non-binary or other minority sexuality or gender identity groups	Depression, anxiety, alcohol use disorder, suicidality	LGB estimated at 2.1% population (Census) 65% had mental, emotional, personal or behavioural problem requiring professional help (Rainbow)

			27% emotional or mental health condition expected to last 12+ months (Census)
Carers	Children/adults providing unpaid care for family member, partner or friend who needs support due to illness, disability, frailty, MH problem or addiction	Psychological distress, isolation	1 in 4 have ‘very bad’ MH (Carers NI) MH data limited
Looked after children/ Care leavers	In the care of an Authority for continuous period of 24 hours or more	Not defined	Approx. 50% have poor MH (DE) 1 in 4 care leavers have MH crisis after leaving care (Barnardo’s)
Paramilitary harm	Those exposed to paramilitary harms	Not defined	Anecdotal evidence only
Poverty & deprivation	Poverty is when an individual’s financial resources are well below their minimum needs, meaning that they are unable to heat your home, pay rent, or buy essentials (JRF) NI Multiple Deprivation Measure (NISRA)	Depression, anxiety	Potential psychiatric problem rises from 17% in general population to 28% in deprived areas (Health Survey)
Prisoners & people in contact with Justice	Those in the Justice system, children and families of prisoners	Not defined	36% prisoners were already in contact with MH services prior to incarceration (NIAO) No MH outcome data collected for those without pre-existing MH concerns
Problematic substance use	Those who meet the criteria for substance use disorder	Dual diagnosis, depression	No MH data outcome data collected

Veterans	Someone who served in the Armed Forces for at least one day and is no longer serving	Stress, PTSD, depression, anxiety	No MH data outcome collected but some survey data indicates 40% have depression, 37% PTSD, 32% anxiety (NIVHWS)

Appendix 1: Sources of At-Risk Groups

NI Mental Health Strategy Early Intervention and Prevention Action Plan	Homeless Leaving care Offenders in prison or in the community Those living on low incomes People with problem debt LGBTQ+ Substance users
Mental Health in Northern Ireland: Fundamental Facts	Black, Asian and Minority Ethnic Communities including Irish Travellers Refugees and asylum seekers People with long-term health conditions LGBTQIA+ Carers
ScotPHO:Public Health Information for Scotland	Substance users (alcohol and drugs) Ethnic minority groups Homeless people Prisoners/offenders People with learning disabilities Refugees LGBTQIA+
Public Health England	Black and minority ethnic groups (BAME) People living with physical or learning disabilities People with alcohol and/or drug dependence Prison population, offenders and victims of crime LGBT people Carers People with sensory impairment Homeless people Refugees, asylum seekers and stateless persons
Connecting the dots: tackling mental health inequalities in Wales	People from socioeconomically-disadvantaged backgrounds, or who are living in poverty Ethnic minority communities Older people Children with experience of care, school exclusion or adverse childhood experiences ("ACEs") Neurodivergent people People with a learning disability People with sensory impairment or loss LGBTQ+ people Pregnant women and new mothers Disabled people People living with a chronic health condition or with serious mental illness. Carers People with substance misuse issues Refugees and asylum seekers Homeless people People who have experienced trauma, including sexual violence or domestic abuse Offenders The health, care and education workforces

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