Royal College of Psychiatrists in NI (RCPsychiNI) Response to: DfC Consultation on NI Executive's Anti-Poverty Strategy (2025-2035)

1.0 Introduction about RCPsych in NI:

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has approximately 450 Members in Northern Ireland (including Doctors in training) who provide the backbone of the local Psychiatric service, offering acute and community treatment, as well as specialist care and consultation across a large range of settings.

This response is submitted on behalf of the Devolved Council of the Royal College of Psychiatrists in Northern Ireland.

2.0 General Comments

Poverty has a complex relationship with Mental Illness/Disorders, Learning Disability and Substance Misuse.

This range of disorders can lead to people falling into poverty through impact on their functioning at work, maintaining relationships and also on Childcare, which in turn leads to sowing the foundations for poverty in the upcoming generation.

On the other hand, poverty can contribute as a causal/aetiological factor to the development of these conditions, as well as impact on the effectiveness of interventions and treatment.

Suicide rates are higher in populations with socio-economic disadvantage.

From a Substance Misuse perspective, we strongly support the emphasis on addressing poverty as a key social determinant of health. Poverty is both a driver and a consequence of addiction, and we would stress:

- The importance of accessible, joined-up addiction and mental health services, particularly for individuals and families experiencing poverty
- The need for early intervention and prevention strategies, including education and community-based supports, to reduce the intergenerational cycle of deprivation and substance use
- Recognition of the links between housing insecurity, unemployment, poverty and addiction - and the value of integrated policy approaches across health, social care, housing and justice
- Ensuring that people with lived experience of addiction and poverty are included in shaping and evaluating this Strategy

Overall, the complexity of relationships is not well identified in the 2025-2035 Anti-Poverty Strategy.

The Actions that will be required to address this are not well identified and the entire document is too high level to such an extent that it is unclear what the intended outcome is.

3.0 Substantive Response/Specific Comments:

3.1 The Vision: To talk of eradicating Poverty in a 10-year Strategy seems disconnected from reality. The stated Vision needs to be relevant to the Strategy and the outcomes. The Vision should be reviewed.

3.2 The Three Pillars: This is a good structure for looking at the issue of Poverty, but there should be more about the interfaces between these Pillars. Tackling these interfaces is key to addressing and seeking to break the cycle of poverty.

Pillar 1- Minimising Risks: The headings in this section are reasonable, but lack information and detail.

One of the major issues that is not highlighted is the provision of mental health services as envisaged by the Mental Health Strategy, which has not been funded.

When a person develops a mental disorder/illness or substance use issue, there needs to be a prompt involvement with mental health services, not merely support. This will reduce the impact on their functioning and roles in life, including their working roles.

Also prompt intervention with children who are showing signs of mental disorder will reduce the impact on them and their family, that if not addressed in

a reasonable time frame may lead to a long-term mental disability and an impact on poverty.

This also applies to people with a learning disability where the impact of the disability can be mitigated through interventions.

Many families who care for children with disability are unable to work due to shortened school days because of lack of staff/unsuitable provision, lack of extra social outlets/respite provision and lack of school transport. Prioritising funding education and social care for these children may enable parents to be in employment.

Vocational rehabilitation needs to be further developed and underpinned with appropriate funding and appropriate expertise. This would be an effective way for people with disabilities to get back to work.

It is difficult to know what type of "good family structure" is to be promoted. This is often something that lies out with control. The emphasis should be on the education and training, if needed, of those who are responsible for children or who have key roles in their lives.

The topic of Debt and Financial Management should be introduced in the school curriculum.

Pillar 2 - Minimising Impacts: Appropriate and effective financial support is important for people who are socio-economically disadvantaged and those who have disabilities that affect their ability to work.

In addition, people with a mental disability or recovering from a mental disorder should have flexible availability of benefits on returning to work.

There needs to be specific programmes for housing and fuel poverty, especially in households with children.

We support the important need for financial support to access education for children from socio-economic disadvantaged families.

The physical health morbidity and raised mortality in people with severe mental illness, learning disability and substance misuse are well documented. Many of these physical health disorders could be identified early and their impact could be prevented. The physical health disorders can lead to an ongoing impact on functioning after the mental disorder has been treated. This combination of physical and mental health is clearly exacerbated in socio-economic disadvantaged populations.

It is simply not enough to say that everyone will be helped to improve their mental and physical wellbeing.

What is needed is appropriate funding of mental health services that will provide treatment for the mental disorders and prevention of associated physical health disorder.

Pillar 3 - Exiting Poverty: More work placements for people with a mental or learning disability with appropriate support for both the employee and the employer should be established.

Young adults with a mental disorder need to have appropriate availability of flexible mental health services in Higher and Further education, especially for those who are living away from home. This is not just during their time in the educational institution itself, but also during their transition to and transition from it into employment.

4.0 Monitoring, Reporting and Governance:

As there is overlap between the roles of the three Pillars, procedures would need to be incorporated into the functioning and terms of reference for each of the three Pillar Sub-Committees, in order to ensure that they communicate with one another on the overlaps and do not operate in silos.

The membership of the three Pillar Sub-Committees should be expanded upon.

The suggested measures and outcomes are very high level and would take time to register change. Much more sensitive measures and outcomes must be developed.

A much more detailed Action Plan needs to be developed.

5.0 Summary:

There needs to be a concerted drive to fund the Mental Health Strategy 2021-2031, Substance Use Strategy 2021-2031 and the Learning Disability Service Model (currently under Consultation within DoH).

One inevitable and significant consequence of their current underfunding will be these population groups falling further into poverty.

Dated: 19th September 2025

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