**Mental health disorders in Northern Ireland: the economic imperative**

Western societies in general have high levels of mental disorder and an increase in rates in the past three decades, and NI is no exception. However, there is evidence that the years of violence associated with the Troubles in Northern Ireland have been an additional burden and have contributed to high rates of chronic and severe mental health problems and substance abuse. Bunting et al.1, based on epidemiological study of mental health in NI, found significantly elevated rates of mood, anxiety and substance disorders among men and women who had experienced conflict-related trauma.

The impact of the Troubles on mental health is complex and cyclical. It is characterised by the interactions between the effects of parental mental health on attachment and parenting, exposure to traumatic life events, poverty, and social and cultural factors as well as ongoing sectarianism and community violence. The high rates of mental disorders are reflected in the high usage of psychotropic medication in NI. One in five of those with direct experience of the Troubles had used psychotrophic medication in the past year, and the rates of medication use for mental disorders are higher in NI than in other parts of the UK and Europe2.

The impact of the Troubles on mental health cannot be considered in isolation, however. There is a clear link between mental health and social and economic issues in NI, and deprivation is a key variable dictating the degree to which the Troubles impacts upon childrens’ mental health3,4. McLafferty and colleagues’5 analysis of the NISHS data reveal that the social and economic legacy of the Troubles and deprivation has disproportionately impacted upon those who have been exposed to the violence, constituting an additional stressor increasing the risk of adverse mental health outcomes.

One of the most concerning aspects of the high rates of mental disorders and trauma exposure in NI is the impact that it might have on future generations. There is much evidence to indicate that the interactions and attachments formed in the first few years of a child’s life are crucial to the healthy brain and behavioural development and that attachment patterns are passed to subsequent generations6 Hypervigilance and emotional numbing, characteristics of PTSD and trauma exposure, may limit a parent’s capacity for the synchronous interactions which are fundamental to infant attachment7.

Furthermore, NI has the highest rates of suicide in the UK, suicide remains an important cause of mortality, and the figures have shown an increase in the past 15 years8. In addition to the loss of life and suffering of those touched by suicide, each suicide is estimated to cost the economy over £1.4 million9. A recent study reported an association between the experience of conflict related events and both suicide ideation and plans10. It suggested that those at highest risk, who experienced conflict related events, may be more likely to complete suicide on their first attempt because their exposure to violence increases their capability for suicide. An analysis of events prior to death by suicide reveals that increasing social isolation, and loss of identity and purpose, in combination with social, political and economic difficulties, may also account for the increased rates in recent years8.

There are significant economic costs to mental disorders and consequently, massive economic benefits to providing treatments and interventions to those affected. The Northern Ireland Association for Mental Health (NIAMH), found that the annual direct costs of medication and treatment associated with mental health conditions in NI in 2003 for example was in the region of £372 million11.

Cost-of-illness studies of mental health however, have consistently shown that the largest proportion of the overall economic burden is accounted for by indirect costs in the form of lost productivity11. Mental health disorders limit productivity in the home and in the workplace, and people with mental illnesses are more frequently absent from the workplace on both a short-term and long-term basis. Once again highlighting the additional mental health burden of the Troubles in economic terms, Ferry and colleagues12 estimated that the annual costs associated with PTSD in NI were in the region of £173 million, with service costs accounting for 19% and productivity losses 81% of this total figure. The economic implications of suicide has been alluded to earlier, and this constitutes a substantial proportion of the indirect costs associated with mental illness. In NI there already exists a range of statutory and non-statutory services that are capable of addressing a range of mental disorders. However these services are often under resourced and poorly integrated, resulting in many of those with mental disorders not receiving treatment that would be beneficial.

There is unequivocal evidence of the high levels of chronic and serious mental health disorders in the NI population, in comparison with other western countries. This undoubtedly has a significant economic impact and the failure to adequately address these mental health issues has clear consequences for the economy for future generations. We recommend the following:

1. Current services should be further developed and integrated to deliver state-of-the-art, evidence-based interventions for individuals with mental disorders.
2. Policy makers should adopt a strategic, two-generation approach to interventions addressing mental health, conflict resolution and social development.
3. Mental illness is a product of social factors, as well as individual vulnerabilities, broader policies promoting education, employability and economic stability should be assessed for their impact on mental health.

The implementation of these recommendations involves viewing individuals as potential parents and acknowledging the central role of population mental health as crucial to economic growth and prosperity.

**Roles of authors**

**Siobhan O’Neill prepared the initial draft of this article. Finola Ferry and Deirdre Heenan made revisions and prepared subsequent drafts prior to publication.**

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