The Níamh Louise Foundation

suicide awareness, prevention and support

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Breaking the Silence in Rural Areas

'Rural mental health, stigma, services and supports within the SWARD Region'

Research Report

By

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Executive summary

Introduction and overview

The aim of this research piece initiated by the Níamh Louise Foundation and funded by SWARD under the Rural Development Programme for Northern Ireland was to examine the issues of rural mental health, stigma and services within the four constituent district council areas of the SWARD region i.e., Fermanagh, Dungannon and South Tyrone, Cookstown and Magherafelt. The research used a multi-method consultation process which engaged paid professionals from the mental health, rural development and community development sectors and the general public online, as well as facilitating 4 rural community focus groups and conducting semi-structured interviews in person and by telephone with a number of key informants.

This research has sought to establish the prevalence and cost of poor mental health within the SWARD region and to listen and really hear the experiences of as many people as possible who have insight, experience and understanding in relation to the issues of rural mental health, stigma and services. The analysis and findings from the research ultimately lead to the setting out of a serious of conclusions and recommendations which are intended to encourage dialogue and development within and across all sectors who have a role and investment in the promotion of mental health and well-being and ensuring the very best possible provision is in place to address the needs and issues facing the SWARD rural community generally and more specifically those groups who are identified as 'at risk' with in it.

Conclusions

- ▶ Mental health as a term is most generally associated with mental illness within the rural reaches of the SWARD region; seen as something from which an individual will not recover and will have for life; and is generally referred to in negative and stereotyping terms such as 'psycho', 'schizo', 'mad', 'the big house', 'avoid like the plaque' and 'nutter', etc.
- ▶ Poor mental health is a major issue within the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt.
- ▶ The potential economic and social cost of poor mental health within the SWARD region per annum is estimated to be in the region of £319,424,000).
- ▶ There were 187 deaths by suicide registered within the SWARD region over the period 2004/05 to 2009/10(p).
- ▶ 385 registered deliberate self-harm admissions to hospital were recorded for the SWARD region in 2010. Additionally, it is estimated that there were approximately 2,210 'hidden' deliberate self-harm episodes in 2010.
- ▶ It is estimated that 40,259 (1 in 5; 20%) of the total SWARD population of 202,259 are potentially experiencing a poor mental health problem right now.
- ▶ There is real concern at the apparent growth in the nature and extent of poor mental health within the rural community of the SWARD region.

- There is considerable concern at the long waiting lists from six to nine months for help through the NHS for talking therapies.
- The regional media campaigns, LifeLine, ASIST, SafeTalk and Mental Health First Aid, Farmers Health Fairs within the local markets and small grants schemes were all seen as having affected significant change in terms of knowledge, skills and confidence across the sectors, as well as having facilitated a number of positive interventions in crisis situations.
- The rural culture of self-reliance and stoicism, combined with a heightened awareness of neighbours business and movements works against the propensity to admit to needing help to self and others and thereafter seeking help. This is highly exacerbated by stigma and discrimination within the rural community.
- Mental health stigma and discrimination for a potential individual experiencing a mental health issue is seen to permeate all aspects of their rural life, especially within the context of employment and the social setting.
- There is a high need for a range of mental health services and supports within the SWARD rural community; that availability of rural mental health services and supports are on the whole viewed as being low to moderately available; accessibility to the services and supports is by and large seen as low; and effectiveness of the services and supports which address the mental health needs of the rural SWARD constituents are viewed low to moderate.
- Cross-sectoral working is good within the context of crisis response planning, but poor in relation to positive mental health and well-being promotion. Considerable opportunity for improvement in cross-sectoral working is identified.
- The situation in relation to mental health related stigma and discrimination has improved generally, whilst being viewed as having declined for disadvantaged communities, farmers, young men, boys and the Traveller community. The situation in relation to the LGBT community remains unclear.
- There is a call for greater tolerance and acceptance of those individuals within the rural SWARD context who experience a mental health issue.
- Mental health provision for the LGBT, minority ethnic, farmer and young male groups is far from adequate, as is provision across the array of rural stakeholders generally.
- There is a call for a substantial move toward positive mental health and well-being promotion, whilst retaining a focus on those services and supports for individuals with mild, moderate and severe mental health issues, and for those who are impacted and bereaved by suicide.
- There is a strong call for an increased provision of support and service for those who self-harm.
- Regional media campaigns are seen to be rurally insensitive.
- Lack of available and accessible information on services and supports available to the rural community.
- Services and supports are fragmented and not necessarily coming at the issues from the perspectives of the rural communities and the 'at risk' groups therein.
- Minority ethnic supports and services are particularly weak.

- Individuals would not be comfortable sharing that they had a mental health issue or problem personally within their rural community. Further, they would be least likely to seek support or help from their employer and most likely to seek support and help through their GP, someone who has experienced the problem they are experiencing, and or through the internet, books or a magazine, etc.
- Churches within the SWARD region are seen to have a potentially positive and negative impact on the help-seeking behaviour and coping mechanisms of individuals.
- There is real concern at the upward trends in terms of young peoples suicide and deliberate self-harm within the SWARD rural area despite the many regional and local efforts which have been applied to the issues. In particular, there is a fear that there is a normalisation of the acts through conversations and the work which is taking place rather than a normalisation of the help-seeking behaviour and the protective coping mechanisms required.
- Other issues linked to young peoples mental health include the use and abuse of alcohol, unrealistic and destructive images through the media; emphasis and pressure for academic success; the impact and consequences of the Troubles (the passing of symptoms and problems between generations within families); reluctance of young people to talk to their parents, as well as parents having lost their parenting skills.
- Competition between community and voluntary organisations is seen as damaging and counter-productive to the needs and interests of those individuals in need within the SWARD region, as is the growth in unregulated services and supports and this inhibits referrals.
- A lack of recognised standards within the community and voluntary sector, as well as evaluation of services and supports.
- Short-term funding is damaging to effective long-term planning.
- There is considerable concern at the role, attitude and involvement of rural GP's and a lack of social prescribing.

Recommendations

- Regional media initiatives focusing on mental health and well-being should give greater attention and due regard to the rural community and the 'at risk' groups.
- Regional media initiatives should be supported by more localised and targeted communication activities.
- Consideration should be given to the piloting of a young persons smart phone app that specifically addresses the issue of mental health and emotional well-being.
- 'Skype™' should be considered as a potential part of the solution in addressing the mental health and emotional well-being needs of rural constituents in general and the indicated at risk groups more specifically.
- There is a tremendous opportunity and need to press ahead with a positive mental health and well-being promotion approach within the SWARD region. The author accepts that this will require the recalibration of focus by the various Protect Life

implementation groups in the Western, Southern and Northern Trust areas that have a role within the SWARD region.

▶ The Department of Health, Social Services and Public Safety should be encouraged to strengthen the recognition of the unique circumstances and needs regarding rural mental health and the necessary approaches required to affect lasting positive change. It would be appropriate to press for specific actions within both the next suicide prevention strategy and the new mental health promotion strategy which recognise specifically the unique challenges of engaging individuals in mental health related services given the nature and fabric of the rural community.

▶ Greater emphasis should be given to rural mental health research and the rural at risk groups by the DHSSPS, Public Health Agency and other agencies and organisations. Current research is far from adequate and should be addressed as a matter of urgency.

▶ There is considerable merit in more localised and strategic collaboration, needs assessment and joint planning to address the full spectrum of mental health needs. It is recommended that local social prescribing networks are created around a GP practice[s] to facilitate and encourage more localised and intelligent planning and provision of supports. Much remains to be done in terms of information on available social interventions and clear standards for the voluntary and community sector.

▶ More effort and resources need to be directed at the issue of self-harm, both for those directly engaging in this behaviour and those who care for and support them. It would be appropriate to consider the development of a ZEST NI initiative across the SWARD region, given the increasing prevalence of deliberate self-harm episodes.

▶ ASIST, SafeTalk and Mental Health First Aid should continue to be rolled out across the SWARD region, especially within those areas and toward the 'at risk' groups. It is important that these programmes are complimented with a portfolio of positive mental health and resilience type programmes.

▶ ASIST, SafeTalk and Mental Health First Aid should be made available to the minority ethnic communities in their own languages, as should the necessary materials online and offline.

▶ Opportunity exists to develop a mental health church initiative which seeks to enable and support the churches and the clergy within the SWARD area to encourage and support their congregations to acknowledge they need help and support for a mental health issue and seek support accordingly.

▶ Serious consideration should be given to the piloting of a Jigsaw type initiative within the SWARD region in order to address the current high concern and prevalence of issues amongst the youth populations. There is a definite need to address the needs of young people in a holistic and systemic manner reconfiguring youth mental health services and supports to incorporate the entire sub-systems/ domains within which the young people exist. This approach recognises and supports the belief that positive mental health and especially young peoples positive mental health is everyone's business, not just the traditional Community and Adolescent Mental Health Teams. Capacity and capability needs to be built across the entire youth ecosystem.

▶ Effort should be invested in the development of a Coach for Coaches Programme[1], Rural Adolescent Programme type initiative[2], and a Whole School Approach to positive mental health and well-being. All of the initiatives need to start from the premise that young males in particular do not come to services and or engage in formal settings. All of the initiatives will require proactive and assertive outreach at population and targeted levels.

▶ Develop greater detailed intelligence led needs assessment and planning within the various Protect Life implementation groups which attempts to establish a shared and joint understanding of the detailed picture and presentation of mental health need and promotion within a Trust area. At present, the fragmented nature of provision and the unregulated growth of services and supports need to be addressed.

▶ A mechanism needs to be found within the Protect Life implementation groups which build a greater degree of independence between an objective assessment of need and the allocation of funding appropriately and proportionately. Further, any such mechanism needs to address the current competition between community and voluntary organisations.

▶ Clear, comprehensive and accessible information must be made available which outs what is available depending on an individuals need whether as the individual experiencing the issue and or as someone who is caring for an individual and or is concerned.

Background to the Níamh Louise Foundation

Níamh Louise Foundation Charitable Trust

The Níamh Louise Foundation was founded in February 2006 following the death of Níamh Louise McKee, who died by suicide aged 15. The Níamh Louise Foundation aims to implement the 'Protect Life Strategy for Northern Ireland' at ground level in local communities to reduce the numbers of people taking their own lives in Northern Ireland.

The main activities of this locally based charity is to provide suicide awareness, prevention, intervention and postvention services across the areas of Armagh, Tyrone and further afield, particularly to rural areas which can be very hard to reach and highly stigmatised and very reluctant to seek help.

The mission statement of The Níamh Louise Foundation is:

 "...to provide a safe environment where anyone can drop in to chat about worrying thoughts, thoughts of suicide and/ or self- harm. The Charity will provide love, understanding and respect with a non-judgemental listening ear to everyone regardless of age, sex, religion, or ethnicity."

Currently, the foundation which is presently headquartered in Coalisland has three outreach resource centres in Dungannon, Armagh and Cookstown. The NLFCT employs 5 staff and has more than 30 active volunteers working alongside.

The organisation is a contracted organisation working under the LifeLine tender, and offers one to one mentoring, befriending and alternative therapies to those referred to it from the emergency number and other stakeholders working under the Protect Life Strategy and Action Plan   banner. In this way, a lot of outreach support occurs in rural areas where the charity works in the heart of isolated communities.

For more information on the Níamh Louise Foundation, please visit www.Níamhlouisefoundation.com.

Introduction and Background to the Breaking the Silence in Rural Areas Research Project

Research Proposal

The primary purpose for this research project within the rural communities of the four district council areas which comprise the SWARD region was to build increased awareness and understanding around the needs of rural residents and those groups and individuals who are especially vulnerable and in need of the nature and type of resources and support provided by a community based organization such as the Níamh Louise Foundation Charitable Trust. This research by its' nature acknowledged that much remains to be done in developing deep awareness and understanding in relation to rural communities, mental health, suicide and self-harm. It was intended that this project would develop a substantial knowledge base that would not only allow the Níamh Louise Foundation to better meet the presenting needs and issues evident and emerging within the four communities, but also to inform the policy and practice of all the stakeholders who have an investment and role in addressing issues related to suicide, self-harm and emotional and mental well-being within the SWARD region.

There has been no substantive research to date that has sought to identify the real needs of rural communities in relation to mental health and well-being, as well as views on suicide and self-harm, etc.

Research Aim

The overall research aim at the outset of the project was to establish as accurately as possible on the basis of up to date primary and secondary information, what services and supports currently exist within the four communities in regard to suicide, self-harm and emotional well-being, what the gaps are and what improvements need to be made by the Níamh Louise Foundation and others individually and collaboratively in addressing these gaps in order to ensure that a strong and robust support and service framework is available, accessible and non-stigmatizing within the four district council areas which comprise the SWARD area.

Research Objectives

It was intended that the research would be undertaken in close collaboration and liaison with the Níamh Louise Foundation Charitable Trust and other relevant key stakeholders from across the various sectors within the target areas. The Foundation recognizes that suicide and self-harm prevention, intervention and postvention takes a multi-disciplinary and integrated response in order to ensure that appropriate, relevant and timely supports are in place. It was

essential that the overall approach to this project reflected and honoured the insights, knowledge and experience of all those involved and impacted by the issues concerned.

Key Objectives

1. Examine and baseline the current status and availability of help available to rural areas as regards mental health, suicide and self-harm within the four designated rural areas from across the statutory, community and voluntary sectors.

2. Through a sensitive and comprehensive consultation process, explore current perceptions, attitudes and experiences by communities, families and individuals in relation to service provision and stigma, etc., as well as identifying gaps and short-falls.

3. Seek to explore how real an issue stigma is and how best this might be overcome within the rural context, especially for those communities, groups and individuals presenting the greatest level of 'risk factors'.

4. Consider international good practice in terms of suicide, self-harm and emotional well-being service and support delivery with rural contexts and especially models that demonstrate efficacy in addressing the issue of stigma.

5. Advise and make recommendations on the basis of the research in its' totality how the Níamh Louise Foundation and others can deliver improved community services within the four rural catchment areas individually and or collaboratively, and set out a series of recommendations for how services across the sectors might be improved in order to provide a greater seamless and integrated service which is centred on the genuine needs of those experiencing issues related to suicide, self-harm and emotional well-being.

Refinement of research objectives at the outset

Following appointment of the consultant and detailed dialogue there-after in regard to the initial research aims and objectives, the objectives themselves were further refined in order to leverage greater awareness and understanding of the issues surrounding mental health, stigma and services within the rural communities of the SWARD region. It was felt that the research project should facilitate as wide an engagement as possible around the issue of mental health and not confine itself largely to the issues of suicide and self-harm. This decision was influenced by an acknowledgement of a changing understanding of what constitutes mental health, as well as the huge pressures that a number of the research objectives would have placed on the Niamh Louise Foundation itself at the time in facilitating access to individuals. Given the heavy work pressures on the organisation as well as significant personnel changes, that aspect of the research which originally sought to engage directly with individuals with experience of mental health issues and or their carers was revised to maximise the widest possible involvement. To have attempted to have pursued this avenue with the individuals and or their carers as originally envisaged would have inappropriately detracted the Niamh Louise Foundation from

the delivery of its frontline services and supports. The reduced staff complement would have been required to have undertaken substantial pre-liaison, briefing and meeting set-up, as well as facilitating the provision of their facilities for this purpose.

The Foundation was also aware of the strategic point in the journey of the current Protect Life and Mental Health strategies and the unique opportunity which this research presented to feed into and support the development of these important strategic policy documents and their related action plans. The research was seen as an opportunity to raise awareness and understanding in relation to mental health and the rural community within the SWARD region.

Project methodology

In order to fulfil the revised objectives of the Breaking the Silence in Rural Areas community research project, it was decided that the following approach should be taken. An assessment of the nature and extent of mental health issues within the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt. An estimation of the cost burden of mental illness on the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt. A review of existing mental health services and supports within the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt.

An online confidential and anonymous survey targeted at paid professionals within the SWARD region who were engaged in and or concerned with the issues of mental health and well-being, stigma and rural services and supports. The survey which was developed and deployed using the Survey Monkey consultation tool was widely advertised and distributed throughout the professional networks within the SWARD region. Every effort was made to ensure that the maximum participation of professionals could be facilitated. To this end, an explanatory letter setting out the aims and objectives of the survey and containing a unique link to the online survey was distributed through the email distribution list held by the Niamh Louise Foundation itself. Each of the organisations on the internal email distribution list were asked to circulate the explanatory letter and the related survey link to their professional colleagues and contacts who they felt might also be interested. Further, the Rural Community Network (NI), the Community Development and Health Network (NI), Cookstown and Western Shores Rural Support Network, COSTA and the Fermanagh Trust kindly facilitated the distribution of the survey letter and link through their email distribution lists and e-zines. 29 professionals completed the online survey.

An online confidential and anonymous survey targeted at individual members of the public within the rural community within the SWARD region in order to garner their opinion, insights and experiences in regard to mental health and well-being, stigma and rural services and supports. The process used to engage members of the public from within the rural communities of the SWARD region was identical to that used for the professional online survey. Individuals who received the email containing the information letter and a unique link to the public survey, were asked to forward on the link to other friends and acquaintances whom they felt might also

be interested in being involved in the research project. 55 individuals completed the public online survey.

The running of four community based focus groups across the rural reaches of the SWARD region. The rural focus groups were conducted in Coalisland, Pomeroy, Draperstown and Augher. In total, 80 individuals attended the workshops.

A comprehensive consultation process with a range of cross-sectoral key informants who work directly within the arena of mental health and or who have experience of working with the rural community and or with those groups and communities identified as being at a greater risk of developing mental ill health within the rural areas of the SWARD region and who could speak to the issues of mental health needs, stigma and services, etc.

A series of semi-structured interviews were held in person with 9 key informants and an additional 3 semi-structured interviews with key informants were undertaken by telephone.

Finally, a brief review of literature on approaches to mental health in rural settings was undertaken. It was felt that the greater emphasis through the research should be on listening to and reflecting the experiences and thoughts of the professionals and public with direct experience of the rural communities and the issues pertaining to mental health therein. The resources of the project did not permit a comprehensive review of rural mental health literature, which in comparison to mental health literature generally, there is a distinct dearth of.

Literature review

"Mental health is as important as physical health. Mental health means feeling positive about yourself, being able to cope with everyday pressures and being able to realise your own abilities."
[3]

"Mental health should be a priority for everyone. Mental health problems affect society as a whole, and not just a small, isolated segment. While certain groups are more vulnerable, no-one is immune to poor mental health."[4]

"The economic and social costs of mental illness in Northern Ireland amounted to nearly £3 billion in 2002/03 – more than the total spend on all health and social care for all health conditions."[5]

"Our rural communities, who account for 4 out of 10 people here, make a significant contribution to the economic, social, cultural and environmental well-being of our society".[6]

"One in six people in Northern Ireland will suffer from a medically identified *mental* illness at any one time and research indicates that the history of sectarian violence in Northern Ireland continues to have a serious impact on the *mental health* of individuals" [7]

"People diagnosed with *mental health* problems face a high level of stigma and discrimination. Public assumptions about *mental health* need to be challenged in a process of re-education."[8]

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[3] http://www.mindingyourhead.info/home/what-mental-health

[4] ibid

[5] http://www.niamhwellbeing.org/Site/26/Documents/niamh_counting_cost.pdf - 'Counting the Cost: The Economic and Social Costs of Mental Illness in Northern Ireland', Northern Ireland Association of Mental Health in collaboration with the Sainsbury Centre for Mental Health.

[6] Gildernew, Michelle, 'Thinking Rural: The Essential Guide to Rural Proofing'. Department of Agriculture and Rural Development: Belfast, 2011, p.3.

[7] http://www.lawcentreni.org/mental-health-policy.html?q=mental+health – Mental Health Policy: Law Centre (NI) Briefing December 2006.

[8] ibid

Introduction

This short literature review seeks to define mental health, as well as set out the key policy frameworks and developments within Northern Ireland in regard to mental health and suicide. It further seeks to establish what are seen to be the key issues relating to mental health within Northern Ireland and the rural context in particular.

Defining Mental Health

In reviewing the literature in relation to mental health and well-being and mental health generally, it is evident that there is no one universally agreed and official definition of what constitutes mental health.[9]   What this literature review seeks to do is to give a brief overview and introduction to the dominant definitions and their key components.

"Many ingredients of mental health may be identifiable, but mental health is not easy to define...what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgements that may vary across cultures..."[10]

 Mental Health Europe on their website state:

"Cultural differences and competing professional theories all affect how 'mental health' is defined. In general, however, most experts agree that mental health and the absence of mental illness are not the same thing. In other words, the absence of a recognised mental disorder is not necessarily an indicator of mental health."

The Mental Health Europe definition reflects the World Health Organisations definition of mental health which is:

"...a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[11] [12] [13]

The National Office for Suicide Prevention in the Republic of Ireland defines good mental health as:[14]

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[9] Janmohamed, K (?), 'Know It Works! WEMWBS: A Scale for Measuring Mental Well-being', The University of Warwick, Powerpoint Presentation

[10] http://www.surgeongeneral.gov/library/mentalhealth/home.html –' Mental Health: A Report of the Surgeon General,' US Department of Health and Human Sciences, 1999, p.ix.

[11] WHO. (2001) *Mental health: New understanding, new hope. The World Health Report*. Geneva: World Health Organization, p.1.

[12] WHO (2005) Atlas of Child and Adolescent Mental Health Resources – Global Concerns: Implications for the Future, p.2.

[13] IMHC (2010) Irish Mental Health Coalition, What Is Mental Health? - http://imhc.ie/public-information/what-is-mental-health/

[14] NOSP (2010) National Office for Suicide Prevention Annual Report 2010.

"Good mental health means you can cope with the normal stresses of life, you realise your abilities, you can work productively and are able to make a contribution to your community. Your mental health is an important part of you; it's an important part of everyone. It's about how we see and feel about ourselves and those around us – our family, our friends, classmates and colleagues – people we see every day. When our mental health is good we can enjoy day to day life and we can get the best out of things. Good mental health also helps us deal with problems and tough times in our lives."

SpunOut.ie which is an independent Irish youth centred national charity working to empower young people to create personal and social change describes mental health on their website as follows:

"Mental health is a way to describe the state of your mind, feelings, emotions and nerves... Mental health is the balance between all aspects of life - social, physical, spiritual and emotional. It impacts on how we manage our surroundings and make choices in our lives - clearly it is an integral part of our overall health. Mental health is far more than the absence of mental illness and has to do with many aspects of our lives including how we feel about ourselves; how we feel about others; how we are able to meet the demands of life".[15]

The Government Office for Science in the United Kingdom in their Foresight report entitled 'Mental Capital and Well-being: Making the Most of Ourselves in the 21st Century' introduce the concepts of mental capital and mental well-being.[16] The report which explores the challenges facing mental health in the United Kingdom in the 21st Century and how best these might be addressed, argues that mental health is an asset - or a source of "capital" which contributes to mental well-being which in turn contributes to an individual's capacity and capability to function and achieve in all life's spheres. Mental capital is defined as:

"... a person's cognitive and emotional resources. It includes their cognitive ability, how flexible and efficient they are at learning, and their "emotional intelligence", such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high quality of life."

Mental well-being is defined as:

"...a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community."

"It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society".

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[15] Http://www.SpunOut.ie
[16] Foresight Mental Capital and Well-being Project (2008) 'Final Project Report - Executive Summary', The Government Office for Science, London.

A highly apparent observation in the literature is the development of the concept over recent time of 'positive mental health'. The WHO/HBSC Forum 2007 defines positive mental health and well-being as: [17]

"…assets for growth and development at individual and Member State levels."

This "assets" based definition reinforces the importance of positive family, social, community, school and environmental relationships on positive mental health, as well as maximising the exposure and experience to protective factors that outweigh exposure to risk factors.

The World Health Organisation in its paper 'Promoting Mental Health: Concepts, Emerging Evidence and Practice' notes that mental health promotion has reconceptualised "mental health in positive rather than in negative terms." [18]

This definition acknowledges the shift within the arena of mental health from one predominantly predicated on intervention and poor mental health and illness to one which is marked by a focus on prevention, and building an individual's capacity and capability to achieve and maintain positive mental health, which is much more than the mere absence of mental illness as has been emphasised earlier. It is about a positive outlook on life, a belief in oneself and one's self-efficacy, the ability to deal with the ups and downs of life, to contribute productively to and have successful and positive relationships with family, community, work and society, to feel valued and at the same time to value others, to have goals, to be able to deal with the knocks and challenges life throws at you and bounce back.

Resilience

Inherit within all of the definitions that specifically speak to mental well-being and positive mental health is the idea of 'resilience' as it relates to an individual, family, community, work-place and society. All of the definitions thus far to a greater or lesser degree have spoken to the increased interest in and pursuit of resilience, which in its simplest form of expression means that a person, family, community, workplace or society has the ability to overcome stressful and testing life events, learn from them and move on. [19]

Mental Health Policy in Northern Ireland

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[17] WHO/HBSC (2007) Social Cohesion For Mental Well-being Among Adolescents, World Health Organisation.

[18] WHO (2005) Promoting mental health: concepts, emerging evidence, practice : report of the World Health Organization,Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne / [editors: Helen Herrman, Shekhar Saxena, Rob Moodie], p.28.

[19] HMG (2010) Confident Communities, Brighter Futures: A Framework for Developing Well-being, A Good Practice Guide, Department of Health: Mental Health Division, p.40-47.

The primary mental health strategy for Northern Ireland is 'Promoting Mental Health: Strategy and Action Plan 2003 to 2008'.[20]

This Strategy's aims are to improve people's mental and emotional wellbeing, in particular that of people at risk or vulnerable, and people with identified mental health problems, their carers and families; prevent, or reduce the incidence and impact of, mental and emotional distress, anxiety, mental illness and suicide; raise awareness of the determinants of mental and emotional health at public, professional and policy making levels and reduce discrimination against people with mental health problems; ensure that all those with a contribution to make are knowledgeable, skilled and aware of effective practice in mental and emotional health promotion.

The target for the strategy was set as follows:

"To reduce the proportion of people with a potential psychiatric disorder (as measured by the GHQ-12 score) to 19.5% by 2008."

Rural is mentioned within the strategy report within the context of Annex 1, where the DHSSPS sets out the risk factors which precipitate poor mental health and emotional well-being.

The Department of Health, Social Services and Public Safety in 2002 set-up an independent review of mental health and learning disability law, policy and service provision which affected people with mental health needs or a learning disability in Northern Ireland. The review completed its task on 16th August 2007 with the publication of its report on legislative reform. This has now become known as the Bamford Review.[21] One of the outputs of the overall Bamford Review process was a report entitled 'Mental Health Improvement and Well-being – A Personal, Public and Political Issue'.[22] This report set out to strengthen the original mental health strategy of 2003 to 2008. Consequently, the DHSSPS developed a response to the Bamford review report process entitled 'Delivering The Bamford Vision – The Response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability: Action Plan 2009 to 2011'[23] This document builds on the 2003 to 2008 strategy and sets out the commitment of the Government to the development of a new mental health and well-being strategy and addressing the issues and concerns raised by the Bamford Review in regard to mental health improvement and well-being. This document strengthens the Governments focus and intention toward a strategy focused on mental well-being. The DHSSPS does not explicitly mention rural within the response document. However, the Bamford Review of Mental Health and Learning Disability noted in relation to rural areas and specifically in relation to progress with regard to the actions outlined within Promoting Mental Health - Strategy and Action Plan

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[20] http://www.dhsspsni.gov.uk/menhealth.pdf - – Promoting Mental Health: Strategy and Action Plan 2003 to 2008, DHSSPS, January 2003.

[21] http://www.patientclientcouncil.hscni.net/bamford-monitoring-group

[22] http://www.dhsspsni.gov.uk/mentalhealth-promotion-report.pdf.

[23] http://www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf, October 2009.

2003-08 (DHSSPS 2003) that rural areas had been "identified as being particularly prone to risk factors such as isolation and specific problems related to the farming community, and are particularly at risk of suicide…". It further identified the major impediment which stigma plays in the rural context in inhibiting people from seeking help. This was seen to be especially the case with regard to young men.[24]

In December of 2008, the Northern Ireland Association of Mental Health (NIAMH) was commissioned by the DHSSPS to conduct a review of the current mental health promotion and suicide prevention strategies in Northern Ireland. The document produced by NIAMH entitled 'A Flourishing Society: Aspirations for Emotional Health and Well-being in Northern Ireland' sets out a series of recommendations for the development of a new mental health promotion strategy, ensuring the most efficient use of available resources in Northern Ireland.[25]

'Protect Life: A Shared Vision', the first dedicated strategy and action plan document for suicide and self-harm reduction and prevention in Northern Ireland was developed by the Department of Health Social Services and Public Safety and officially launched in October 2006.[26] The document has been further refreshed in 2011 following an extensive review of the evidence base in support or otherwise of the actions set-out within the original strategy by the National Suicide Research Foundation in Ireland on behalf of the DHSSPS.[27] The refreshed strategy is entitled 'Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006 – 2013 (Refreshed December 2010)'. The period of the original strategy has been extended from 2011 to 2013.

The original aim of the strategy was to:

"To reduce the suicide rate in Northern Ireland".

This has been replaced within the refreshed document:

"To maximise the number of years of life saved"

Linked to the overarching aim are a series of objectives. They are to raise awareness of mental health and well-being issues; to ensure early recognition of mental ill-health, and to provide appropriate follow-up action by support services; to develop co-ordinated, effective, accessible and timely response mechanisms for those seeking help; to provide appropriate training for people dealing with suicide and mental health issues; to enhance the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts; to support the media in the development and implementation guidelines for a suitable response to suicide related matters; to provide support for research

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[24] http://www.dhsspsni.gov.uk/mentalhealth-promotion-report.pdf – 'Mental Health Improvement and Well-being: A Personal, Public and Political Issue', DHSSPS, May 2006
[25] http://www.niamhwellbeing.org/Site/26/Documents/compass_flourishing.pdf, May 2009.
[26] http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf
[27] http://www.dhsspsni.gov.uk/review-evidence-base-protect-life.pdf - Review of the Evidence Base for Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy (January 2010)

and evaluation of relevant suicide and self-harm issues; and to restrict access, where possible, to the means of carrying out suicide.

Rural is specifically and briefly mentioned within the document in relation to the action concerned with marginalised and disadvantaged groups. The document reads:

"To ensure that appropriate support services reach out to all marginalised and disadvantaged groups, in particular lesbian, gay, bi-sexual, and transgender groups, rural communities, ethnic minorities, and those people who are economically deprived."

Whilst not being more specific in regard to rural, it is clear that the broader population based approaches, targeted approaches and cross cutting measures are intended to address the suicide and self-harm issues experienced within the rural community. It is accepted that those groupings specifically identified within the strategy and action plan and indicated within the same action are to be found within the rural areas of Northern Ireland and therefore, specific actions addressed at this would have a Northern Ireland wide reach. In the refreshed strategy greater emphasis is placed on rural dwellers and farm families as key risk groups within the rural community.

The refreshed strategy aims to reduce suicide from a baseline of 12.6 per 100,000 by 2013, the period to which the refreshed version of the strategy has been extended.

NI Facts and Figures

The Public Health Agency in their publication 'Health Intelligence Briefing' on suicide and self-harm in Northern Ireland indicates that "Suicide rates in rural areas are lower than for the Northern Ireland average but have increased by almost 50%, from 7.8 in 2001 to 11.6 deaths per 100,000 in 2008(p)." In also establishes that "Between 2003/04 and 2008/09(p), the admission rate for self-harm in rural areas was consistently almost half the regional rate. This was also true for both males and females." [28]

Looking at Northern Ireland as whole, 2009 recorded 260 deaths by suicide, of which 205 were male and 55 female. The suicide rate for males is 3.5 times higher compared to females for the period 2007 to 2009 at 22.9 and 6.9 respectively. Deliberate self-harm hospital admission figures for 2009 to 2010 were 4,637, of which 2,383 were female and 2,254 were male. The briefing paper acknowledges "...the difference between female and male admissions is lower than seen is previous years." Also of interest in terms of deliberate self-harm hospital admissions over the period of 2005/06 to 2009/10 (5 year average) is the fact that the highest rate of admissions per 100,000 of the population is amongst females in the 15 to 19 age range at 630 per 100,000. Rates amongst males are highest in the 20 to 24 age range with a rate of 492 per 100,000. The briefing notes that "Between 2005/06 and 2009/10, young males aged 15-19

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[28] Public Health Agency, 'Health Intelligence Briefing: Suicide and Self-harm in Northern Ireland', 2011.

years show the highest rate of increase (79%) in self-harm admissions from 265 per 100,000 in 2005/06 to 473 per 100,000 in 2009/10."[29]

19% of the Northern Ireland population in a health and well-being survey over the period 2005 to 2006 indicated through their responses that they might possibly have a psychiatric mental health problem.[30]

Northern Ireland is estimated to have a 20 to 25% higher rate of mental problems that the rest of the United Kingdom. The cost of poor mental health to Northern Ireland in 2006 to 2007 was predicated to be in the region of £3.5 billion.[31]

The Nature of Rural Mental Health Needs and Issues

"At least one in five people in Northern Ireland will experience problems that affect their mental health, yet very few of us are willing to talk about the subject openly. Those with mental health problems often face stigma and discrimination, and fear of these can prevent them from getting help and hinder their recovery."[32]

The Patient and Client Council through their work on the 'Rural Voices Matter' initiative identified what 1,500 rural residents in Northern Ireland see as the main strengths and weaknesses in relation to rural health and social care generally and set out a series of recommendations for the Health and Social Care Board and the Trusts across Northern Ireland.[33] Whilst the research does not address mental health, suicide and or self-harm directly, it does draw attention to a number of issues pertinent to the delivery of mental health services within the rural context. It refers to a number of particular issues. It highlights issues regarding hidden deprivation, access and transport, the importance of primary care, difficulties with domiciliary care, associated health and social care outcomes, culture, and staffing and the impact of service reductions.

The report establishes that there has been very little research done on health and social care needs and experiences from the perspective of rural dwellers and that the tendency has been to transfer urban thinking to the rural context. Within the body of the literature review within the report and quoting Heenan 2010 and 2006 it is stated that "Policy makers and politicians do not have an understanding of rural communities and rural life; they tend to focus on urban areas (Heenan 2010:4). Policies must acknowledge the specific characteristics of rural populations if they are to be effective; simply transferring policies from the urban setting to the rural is not effective (Heenan 2006: 373).

[29] ibid
[30] Mental Health First Aid Northern Ireland Manual, Public Health Agency, 2010, p.13.
[31] Ibid, p.14.
[32] http://www.mindingyourhead.info/home/what-mental-health
[33] http://www.patientclientcouncil.hscni.net/uploads/research/Rural_Voices_Matter_-_June_2011.pdf

Other points of interest that emerge from the report are the general satisfaction reported by the rural dwellers with their GP service and their local community pharmacy. However, concerns are expressed in relation to A&E departments, Out of Hours GP services, waiting times and transport and accessibility.

In a briefing paper to the Assembly entitled 'Key Health Issues Affecting Rural Communities' in 2010 the following were highlighted in relation to mental health in rural Northern Ireland:[34]

"People in rural areas tend to come from a culture of self-sufficiency and there is a reluctance to seek outside help, particularly in relation to mental health issues. Social factors such as fear about confidentiality in small communities can also prevent individuals from making use of services. Concomitantly, associated stigma can be intense and off-set by under-reporting, under-diagnosis and a lack of timely treatment."

"There has been an increasing incidence of depression, stress and suicide across Northern Ireland over the last ten years. Suicide affects more males than females, and farmers are consistently considered to be a high risk group. Stresses are magnified by isolation, single-worker situations, a lack of knowledge about services and difficulties in accessing them. It is also thought that the financial pressures resulting from the current economic climate have had wide ranging effects on the agricultural industry and have led to increased stress and pressure on family relationships. The economic situation is further compounded by an increase in living costs, a lack of employment opportunities, low rates of pay and the often seasonal nature of farming and tourism work. These factors have implications on rural dwellers quality of life."

Identified Risk factors

Kessler[35] identified risk factors for mental illness along three key criteria (1) gender, (2) social class and (3) adversity in childhood. DHSSPS identified the following risk factors which might contribute to poor mental health and emotional wellbeing.[36] Firstly, it identified internal factors such as quality of relationships, feelings of isolation, experience of disharmony, conflict or alienation, physical illness, infirmity or disability, a lack of self-esteem. Secondly, it identified the following external factors. They are poverty and unemployment, social exclusion or discrimination, poor physical environment, negative peer pressures, experience of abuse or violence, family or community conflict or tension. Others identified by the DHSSPS include family breakdown, sexual or emotional abuse, social exclusion or discrimination, domestic violence and bullying. It identifies other specific risk factors facing certain groups and

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[34] http://www.niassembly.gov.uk/researchandlibrary/2010/12510.pdf – 'Key Health Issues affecting Rural Communities', Research and Library Service Briefing Paper 125/10, Northern Ireland Assembly, 4th September 2010.
[35] http://www.hcp.med.harvard.edu/research/projects/kessler_WMH – 'Risk Factors: World Health Organisation World Mental Health Survey', Kessler, R.C.
[36] http://www.dhsspsni.gov.uk/menhealth.pdf – Promoting Mental Health: Strategy and Action Plan 2003 to 2008, DHSSPS, January 2003.

communities. One of those was the rural community. It states "People living in rural areas may experience particular problems including social isolation, unemployment, poor housing, lack of public transport and public amenities. In addition, recent years have brought a succession of crises affecting farming which have increased financial stress and led to further job losses."

At Risk Rural Groups

A factsheet produced by MIND in March 2006 gives a very clear and comprehensible overview of the mental health issues in rural areas in England and Wales.[37] The factsheet echoes the issues mentioned within the previous paragraphs, whilst at the same time going further in articulating the issues in relation to stigma, accessibility and the (lack) of provision of services within rural communities. As well as exploring the importance of the latter issues, it gives a useful and detailed insight into what Mind sees as the "high risk groups" i.e., Farmers and farm workers, Black and Minority Ethnic communities, Lesbian, Gay, Bisexual and Transgendered communities, Women and Children (especially those who are without transport), Older people without extended family present in close proximity to them, The Traveller community and Migrant Workers. The fact sheet emphasises that most if not all of these communities have little power in effecting change in regard to provision of appropriate mental health services and supports within rural communities, given their smaller numbers and the dispersed nature of the communities themselves, not to mention the stigma and discrimination which many of them face given their identity and difference. The paper emphasises how much of the need and difficulties of these groups goes unseen, given the communities are effectively "hidden" and "remote".

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[37] 'Rural Issues in Mental Health' Factsheet authored by Rachel Twomey, Mind Information Unit, March 2006.

Prevalence and Potential Cost of Mental Illness within the SWARD Region

Introduction

In this section of the report, the most recent statistics relating to key indicators of the prevalence of mental ill health are presented as they relate to the constituent council areas of Fermanagh, Dungannon, Cookstown and Magherafelt. Proceeding these statistics, the author attempts to place a cost on the impact of mental illness in the council areas and the SWARD region overall.

The key indicators used in this section are:

- Number and Cost of Items Dispensed for Antidepressant Drugs (BNF 4.3) by Local Government District, 2010
- Admissions to Hospital as a Result of Mood or Anxiety Disorder 2009/2010
- Equality Monitoring System Mood and Anxiety Disorders - April 2008 Percentage on Prescribed Drugs for Mood and Anxiety Disorders Perc_Drugs_d08
- All Persons Standardised Admission Rate for Self Harm for the Years 2004/05 to 2008/09
- Female Standardised Admission Rate for Self Harm for the Years 2004/05 to 2008/09
- Male Standardised Admission Rate for Self Harm for the Years 2004/05 to 2008/09
- Deaths by Cause 2010
- All Persons Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by Year Per Local Government District and LCG/Trust area
- Male Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by year per Local Government District and LCG/Trust area
- Female Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by year per Local Government District and LCG/Trust area

Prevalence of Poor Mental Health within the SWARD Region

Graph 1 below illustrates the number and cost of items dispensed for antidepressant drugs by local government district in 2010 and compares these to the Northern Ireland average.[38]

Graph 1: Number and Cost of Items Dispensed for Antidepressant Drugs (BNF 4.3) by Local Government District, 2010
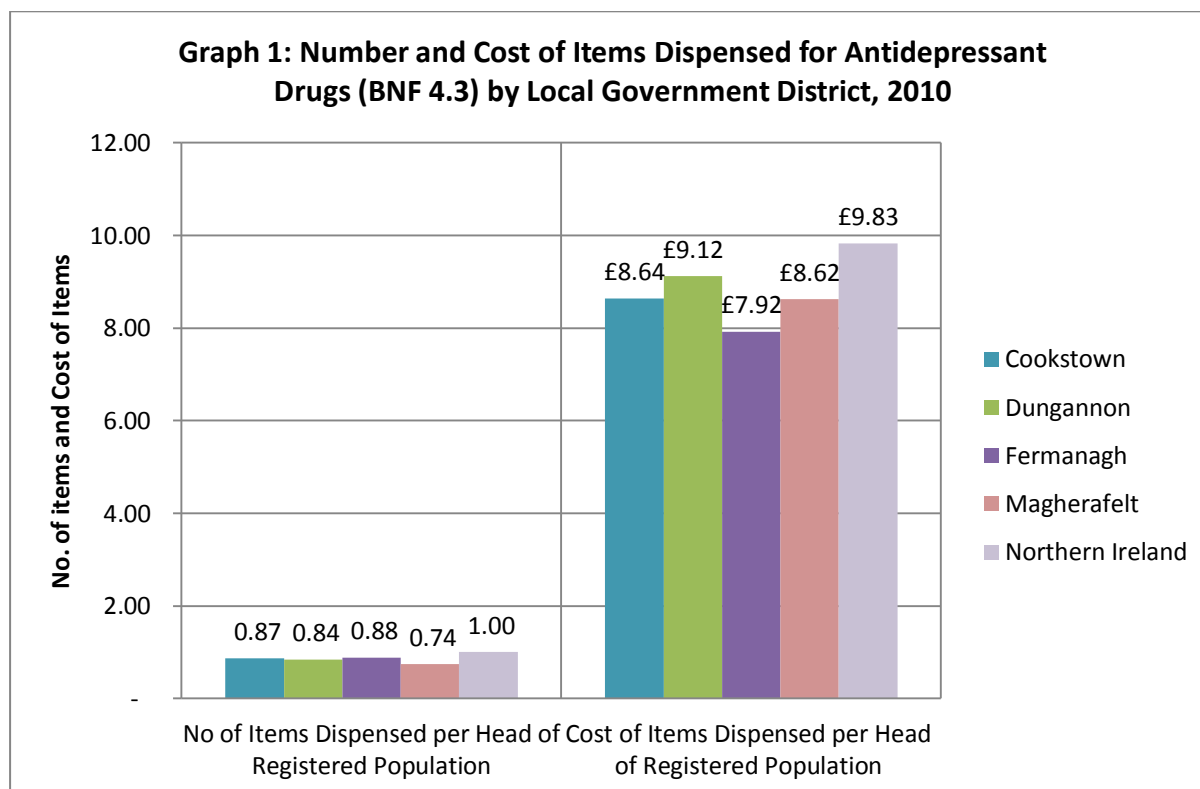
Firstly, if the left hand side of the graph is examined, it is found that Northern Ireland has an average number of items dispensed per head of registered population of 1.00. All of the district councils which comprise the SWARD region are lower than the Northern Ireland average. The district council area with the highest number of items dispensed per head of the registered population is Fermanagh at 0.88. This is 12.0% lower than the Northern Ireland average. Behind Fermanagh by 1.0% is Cookstown at 0.87, followed by Dungannon at 0.84. Magherafelt District Council area has the lowest number of items dispensed per head of the registered population within the SWARD region at 0.74. This is 26.0% lower than the Northern Ireland average. Overall, there is a 0.14 range between the highest and lowest number of items dispensed per head of registered population within the SWARD region.

As would reasonably be expected, as Northern Ireland has the highest number of items dispensed per head of the registered population, so to it has the highest cost at £9.83. What is found in relation to the district council areas is a change of ordering relative to the Northern Ireland average. Whereas Fermanagh was first in terms of the number of items dispensed, Dungannon is rated first within the SWARD area in terms of cost of items dispensed per head of

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[38] ibid

the registered population with a cost of £9.12. This places Dungannon at 7.2% or 71p behind the Northern Ireland average cost. Cookstown is located second at £8.64 and Magherafelt third at £8.62. In fourth position is Fermanagh at £7.92. Overall, there is a £1.20 (13.2%) difference between the highest and lowest district council area cost of items dispensed per head of the registered population.

From these statistics it might inferred that Dungannon has a tendency toward higher cost anti-depressants. Whether this is on the basis of GP prescribing preferences, or that those individuals presenting require a more expensive prescription would require further research in this regard.
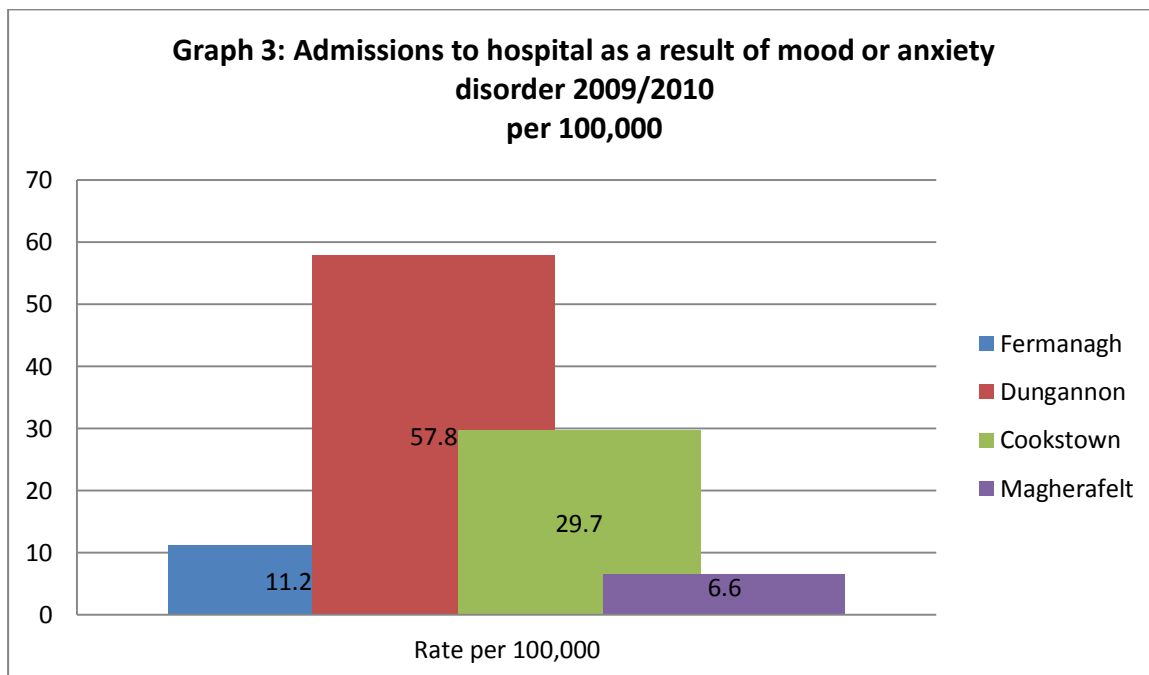
On the whole, the district council areas located within the SWARD region are lower than the Northern Ireland rates for the number and cost of items dispensed per head of the registered population. However, there is considerable consistency internally within the region across the four district council areas.

Graph 2 below illustrates the number of admissions to hospital as a result of a mood or anxiety disorder for the period 2009 to 2010[39]. Over the period of the year for which the statistics are presented, Dungannon has by far the highest level of absolute admissions with 34 persons being recorded as admitted to hospital as a result of a mood or anxiety disorder in 2009 to 2010. Dungannon's figure of 34 accounted for 4.8% of the total admissions to hospital in Northern Ireland as a result of a mood or anxiety disorder in 2009 to 2010. Cookstown is second with 11 admissions, followed by Fermanagh with 7 admissions and Magherafelt with 3 admissions.
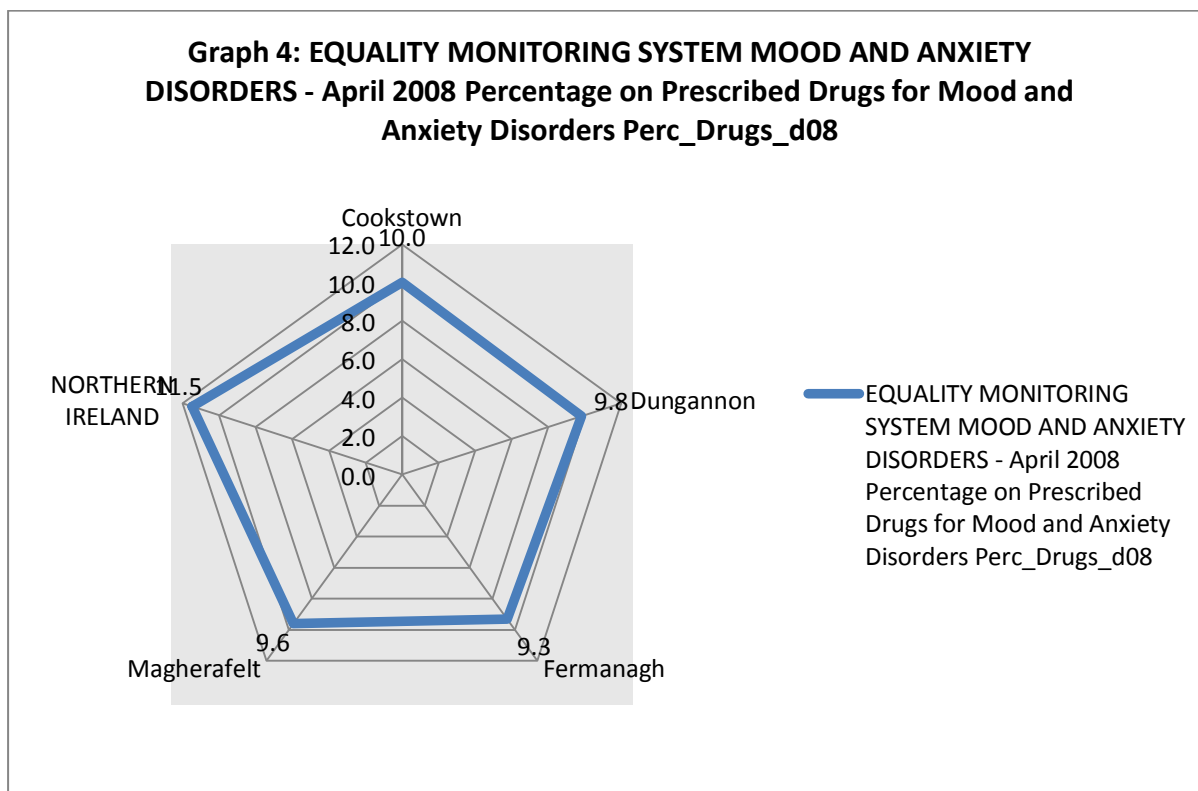
[39]ibid

Graph 2: Admissions to hospital as a result of mood or anxiety disorder 2009/2010
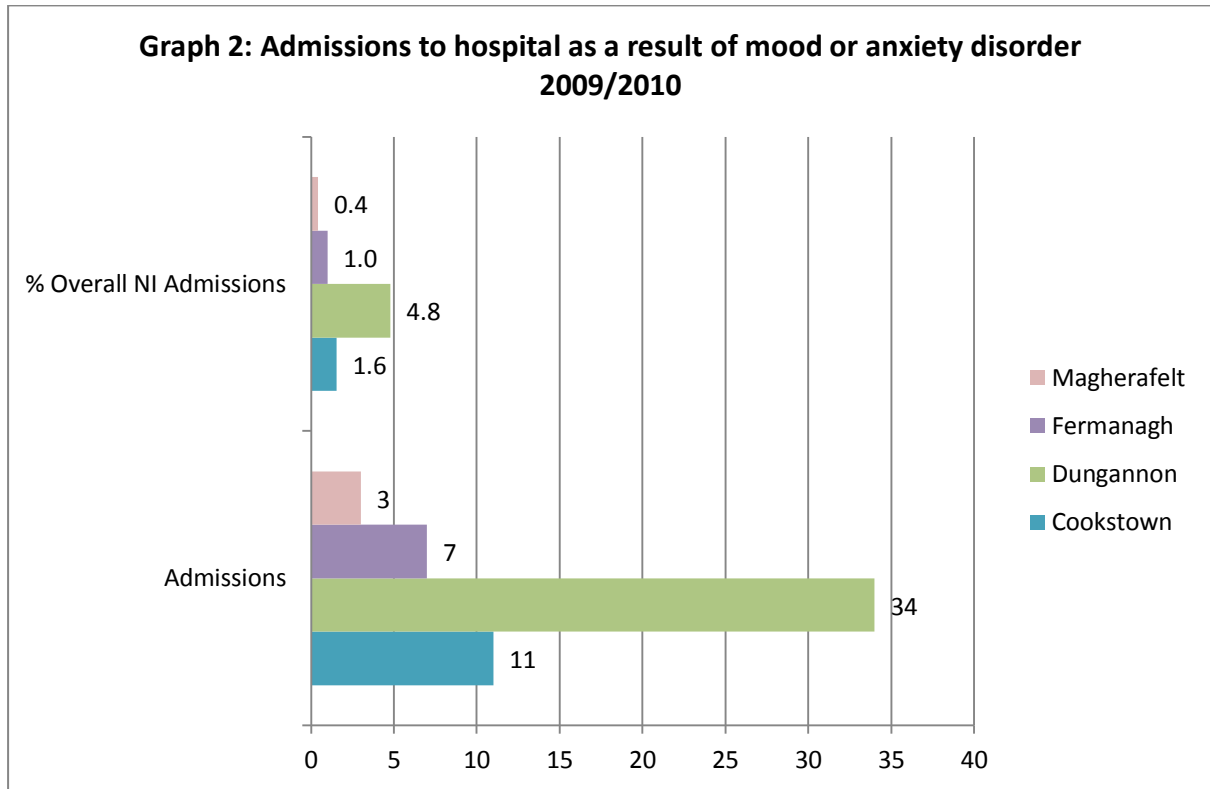
When considered in respect to the 2010 populations for each of the district council areas within the SWARD region and having been converted by the author into the standardised per 100,000 ratio , Graph 3 shows that Dungannon experiences by far the highest admissions to hospital at 57.8 per 100,000 equivalent population. This locates Dungannon at 48.6% ahead of Cookstown which returns a rate of 29.7 per 100,000 equivalent population. Fermanagh has a standardised rate of 11.2 per 100,000 followed by Magherafelt at 6.6 per 100,000.

Graph 3: Admissions to hospital as a result of mood or anxiety disorder 2009/2010 per 100,000

- Fermanagh
- Dungannon
- Cookstown
- Magherafelt

11.2 57.8 29.7 6.6

Rate per 100,000

Graph 4 below illustrates the percentage of the population of each of the SWARD district council areas who are recorded as of April 2008 as being on prescribed drugs for mood and anxiety disorders. The graph illustrates the respective district council percentages in relation to the Northern Ireland percentage.

Graph 4: EQUALITY MONITORING SYSTEM MOOD AND ANXIETY DISORDERS - April 2008 Percentage on Prescribed Drugs for Mood and Anxiety Disorders Perc_Drugs_d08

Cookstown 10.0
Dungannon 9.8
Fermanagh 9.3
Magherafelt 9.6
NORTHERN IRELAND 11.5

EQUALITY MONITORING SYSTEM MOOD AND ANXIETY DISORDERS - April 2008 Percentage on Prescribed Drugs for Mood and Anxiety Disorders Perc_Drugs_d08

Graph 4 shows that between 9.3% and 10.0% of the district council areas populations within the SWARD region were on prescribed drugs for mood and anxiety disorders in April 2008. The Northern Ireland rate was 11.5%.[40]

Admission rate for self-harm

In this sub-section of the report the incidence of recorded self-harm admission rates at accident and emergency departments are explored. The data is based on the number of admissions due to self-harm for the financial years 2004/05 to 2008/09.[41]

Graph 5: All Persons Standardised Admission Rate for Self Harm
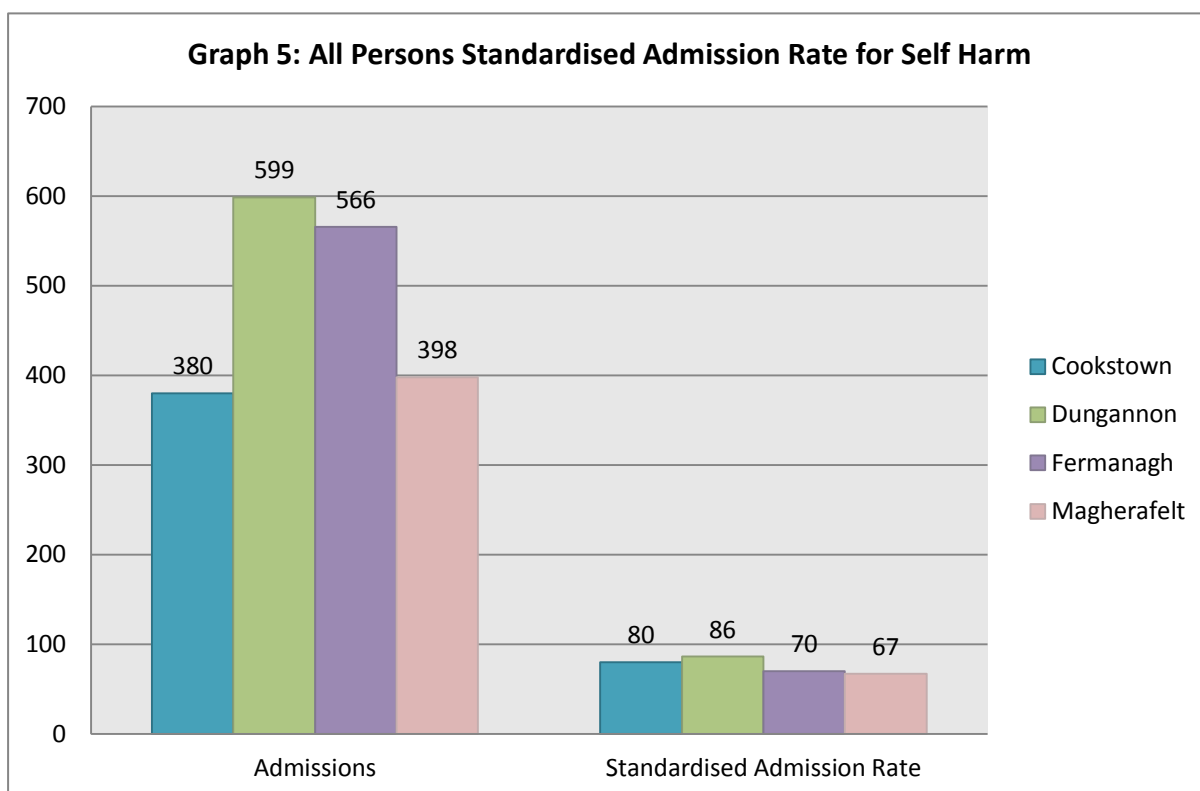
What is found by looking at Graph 5, is that Dungannon had a total of 599 persons recorded as attending A&E for self-harm in the period 2004/05 to 2008/09. The standardised admission rate for Dungannon is 86 per 100,000. Fermanagh is located in second position in regard to absolute rates at 566 per 100,000 or 70 per 100,000. Magherafelt records 398 persons admitted for self-harm for the period 2004/05 to 2008/09 and a rate of 67 per 100,000. Cookstown records the lowest absolute number at 380 persons or 80 per 100,000.

Graph's 6[42] and 7[43] look in more detail at the admission rate for self-harm by gender for the period 2004/05 to 2008/09 across the four district council areas. It is realised in each regard

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[40] ibid
[41] ibid
[42] ibid

with the exception of Magherafelt that more females were admitted across the district council areas within the SWARD region. Magherafelt shows a remarkable similarity between males and females at 200 and 198 respectively.

Graph 6: Female Standardised Admission Rate for Self Harm

Graph 7: Male Standardised Admission Rate for Self Harm
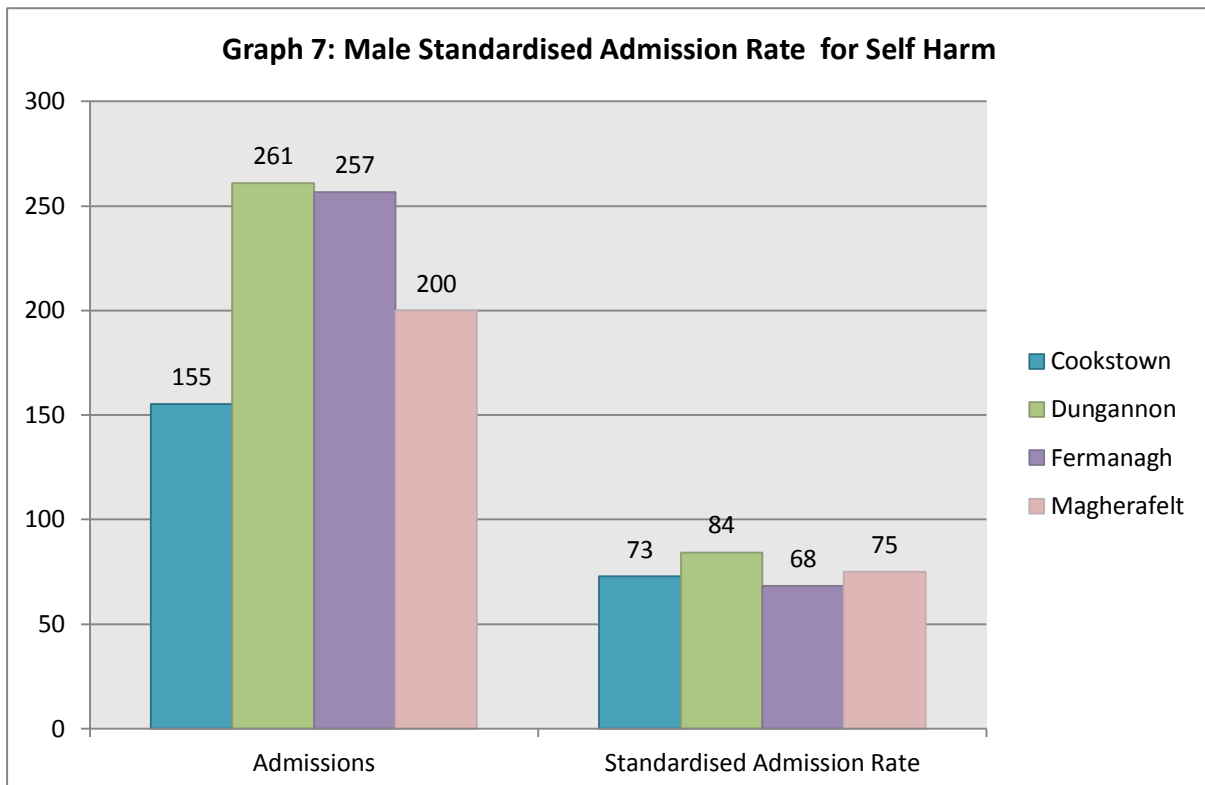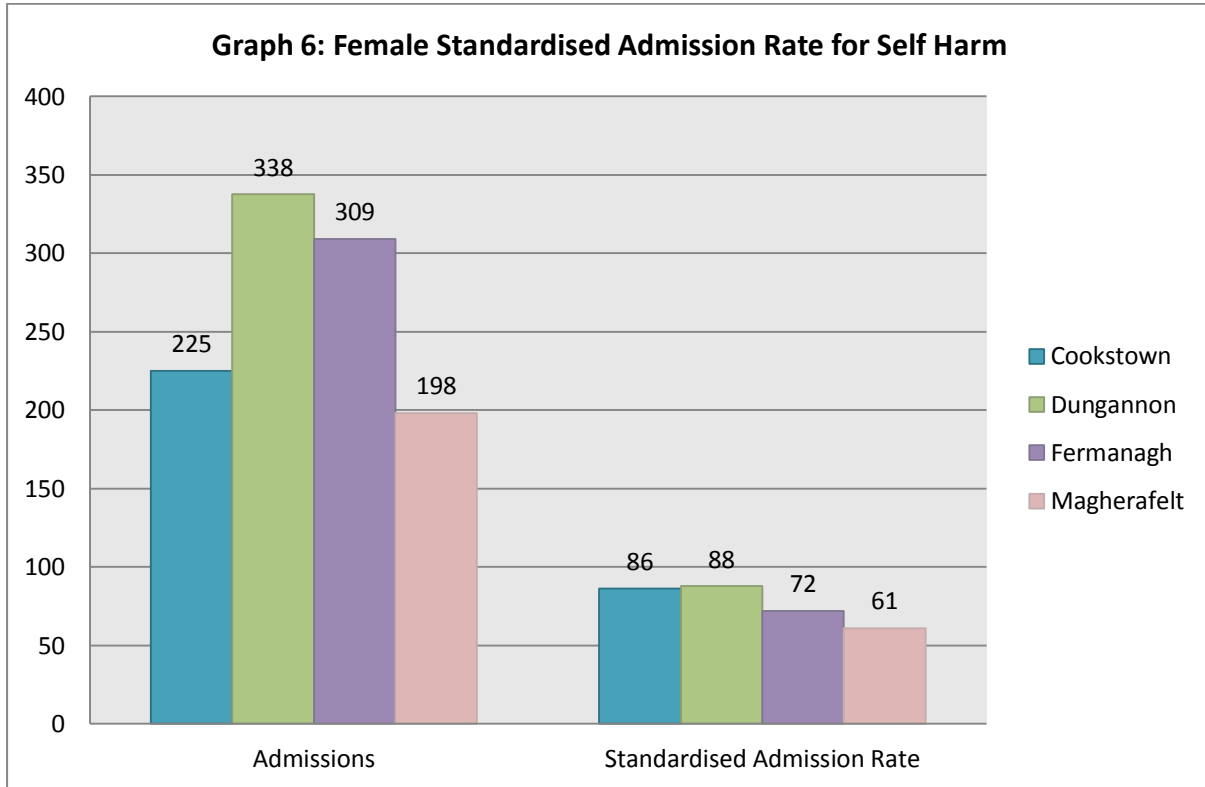
When considered in terms of the standardised rate, males show a total of 14 more admissions per 100,000 when compared to females. This represents a difference of 18.7% in regard to standardised rates, compared to 1.0% in absolute admission rates.

Dungannon records the highest absolute and standardised rate of self-harm admissions for females for the period 2004/05 to 2008/09 at 338 and 88 respectively. Its respective male figures are 261 and 84, again placing it in first position across the SWARD region. Second in terms of female absolute rates and males rates is Fermanagh. When considered in standardised terms, Fermanagh is located third at 72 and 68 respectively for females and males. Cookstown is third in regard to females with 225 admission to A&E departments for deliberate self-harm for the period 2004/05 to 2008/09. Its male figure is the lowest absolute figure at 155, although it is rated third in terms of the standardised rate at 73.

Deaths by cause

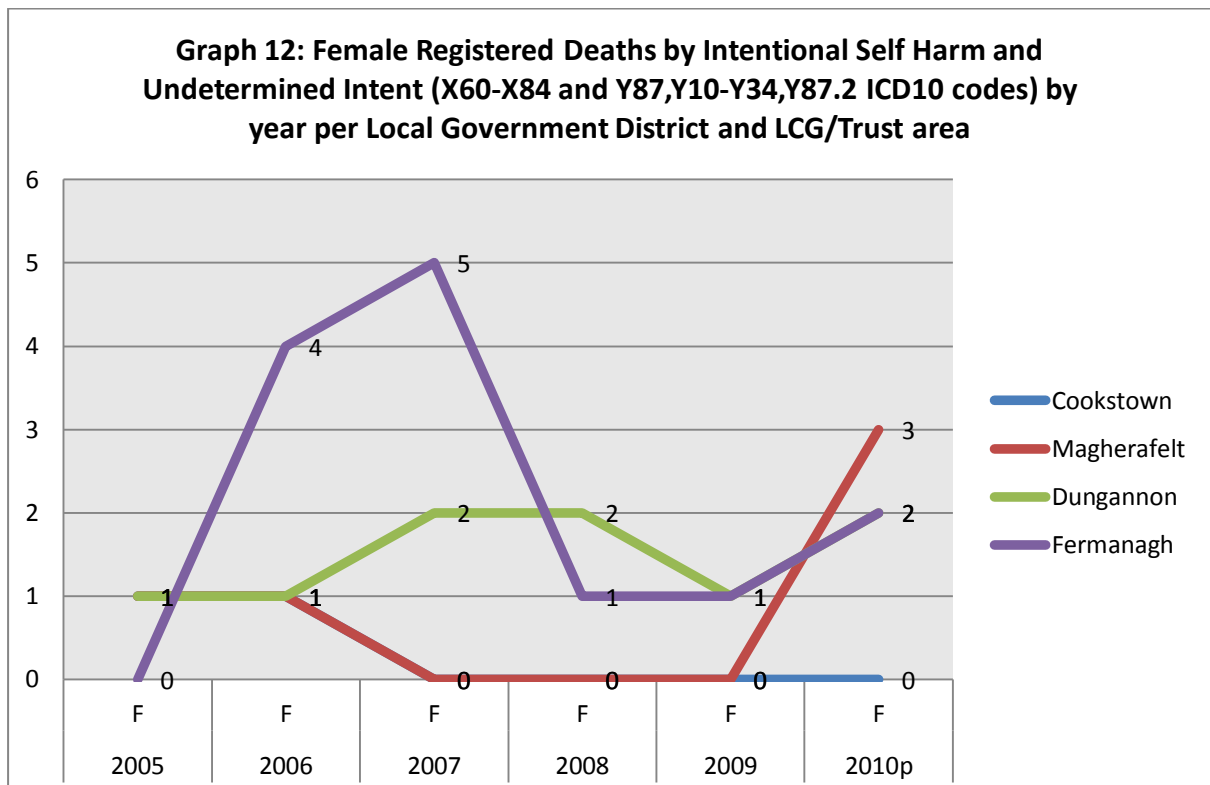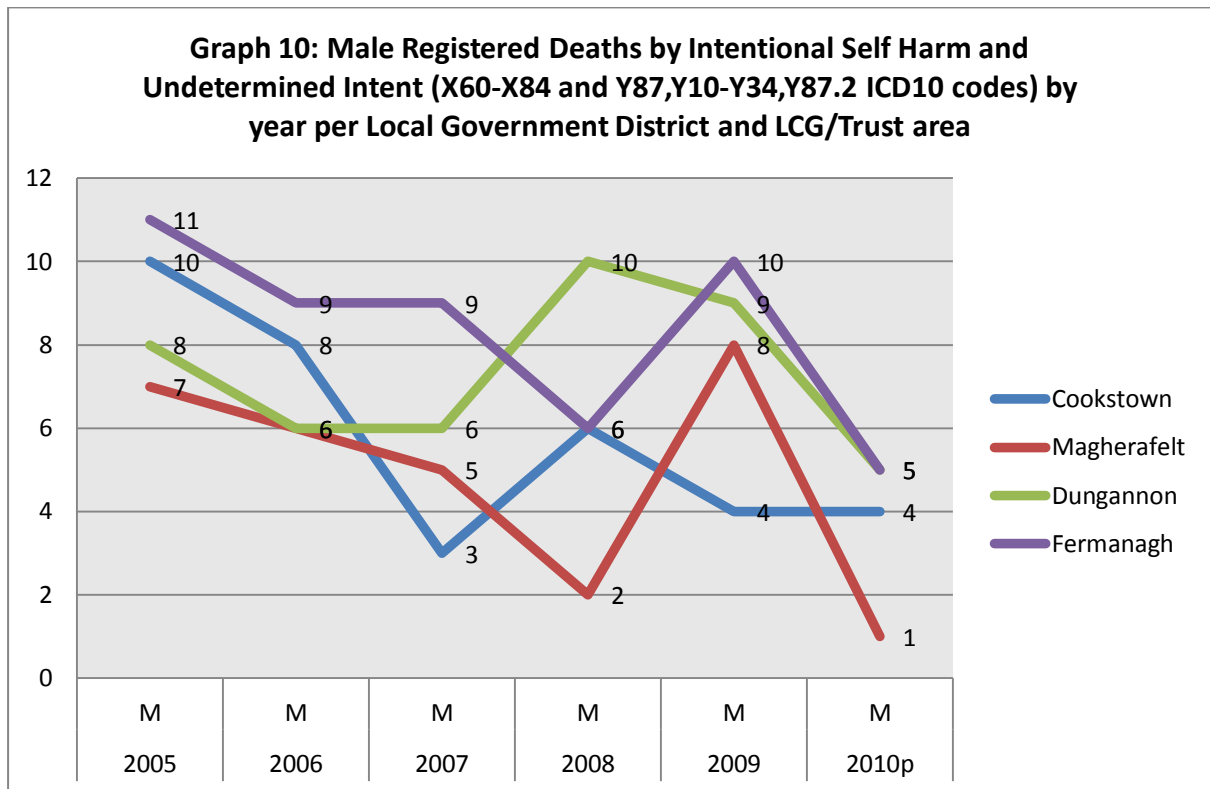**Graph 8: Deaths By Cause 2010**
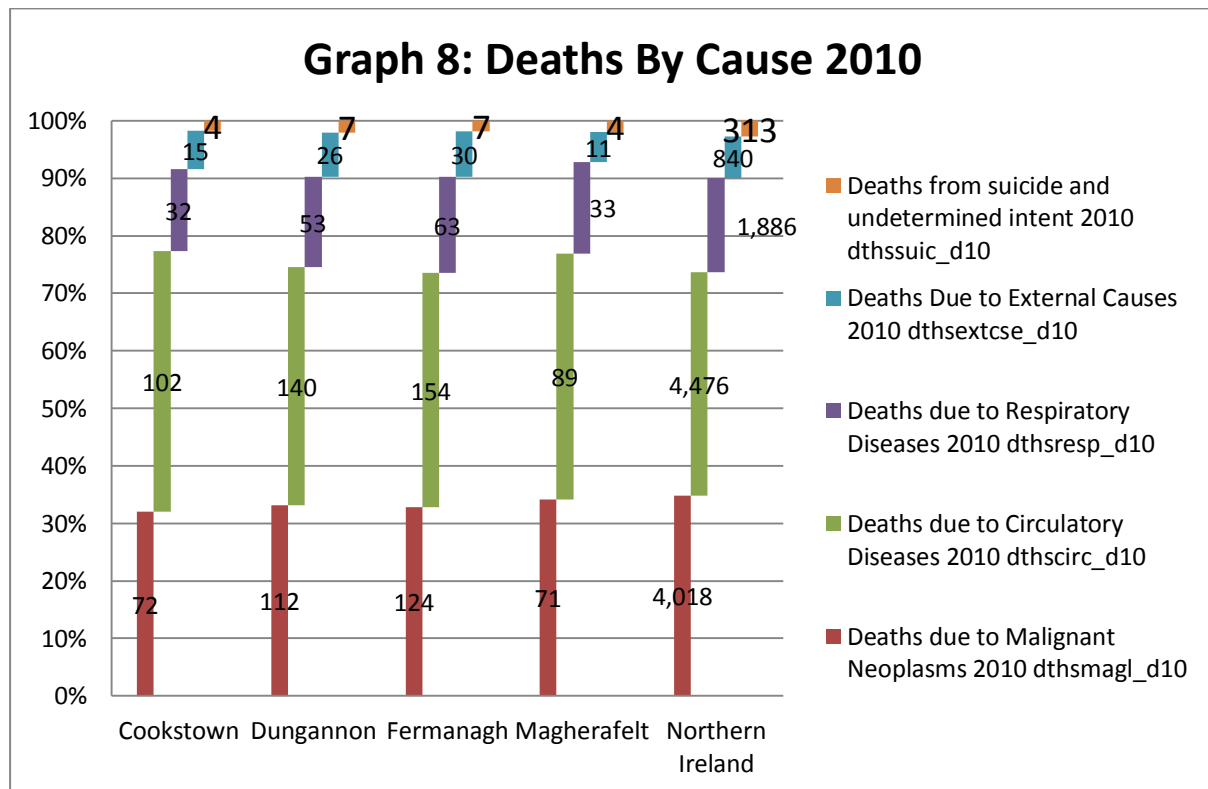
Graph 8 above demonstrates the causes of death across the four district council areas within the SWARD region and compares these to Northern Ireland for 2010. Across the four council districts the average percentage of deaths relative to the other causes shown on the right hand side of Graph 8 was 1.9%. The respective percentage rates from left to right were Cookstown 1.8%, Dungannon 2.1%, Fermanagh 1.8% and Magherafelt 1.9%. At a Northern Ireland level, the relative rate attributed to deaths from suicide and undetermined intent in 2010 was 2.7%.

Graph 9 presents the trend in all persons registered deaths by intentional self-harm and undetermined intent by year per Local Government District and LCG/Trust area.

Graph 9: All Persons Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by year per Local Government District and LCG/Trust area
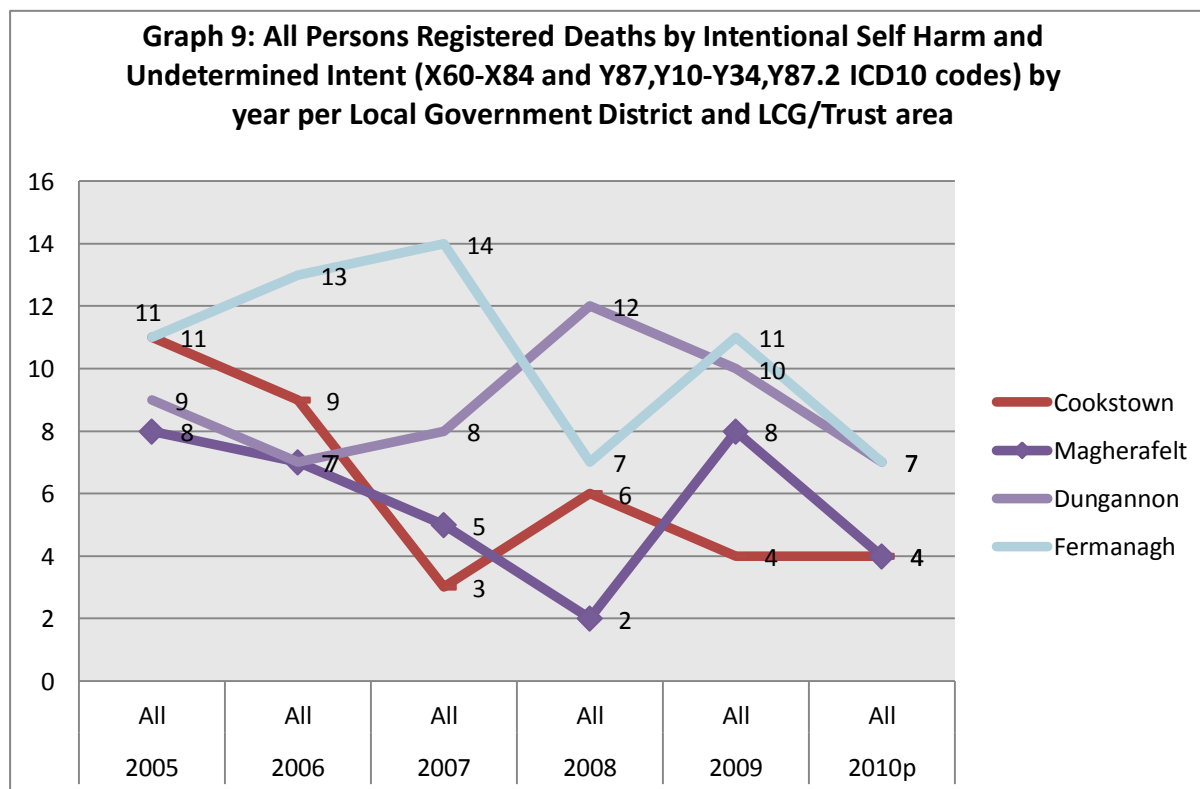
Graph 9 illustrates that the registered deaths by intentional self-harm and undetermined intent per year by local government district within the SWARD region has fluctuated quite substantially year on year across the four district council areas. The figures appear to show a decline in 2010, but it is important to emphasise that the figures are provisional as provided through NINIS and are subject to change. If the figures for the period 2005 through to 2010 are aggregated, it is shown that Fermanagh had a total of 63 registered deaths by intentional self-harm and undetermined intent. Dungannon was second with a total of 53 deaths by intentional self-harm and undetermined intent for the period 2005 to 2010. Cookstown recorded 37 registered deaths and Magherafelt 34 registered deaths by intentional self-harm and undetermined intent for the period 2005 through to 2010.

Graph 10 looks specifically at male registered deaths by intentional self-harm and undetermined intent by year per local government district within the SWARD region for the period 2005 to 2010. As with Graph 9, Graph 10 shows a mixed picture. Graph 11 shows the situation in regard to female registered deaths.

Graph 10: Male Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by year per Local Government District and LCG/Trust area

Cookstown · Magherafelt · Dungannon · Fermanagh

Graph 12: Female Registered Deaths by Intentional Self Harm and Undetermined Intent (X60-X84 and Y87,Y10-Y34,Y87.2 ICD10 codes) by year per Local Government District and LCG/Trust area

Cookstown · Magherafelt · Dungannon · Fermanagh

What is immediately evident from Graph's 11 and 12, is that registered deaths by intentional self-harm and undetermined intent by local government district over the period 2005 to 2010 is a much more prevalent phenomena among males compared to females.

In order to gain a perspective on the overall scale of the male and female registered deaths by intentional self-harm and undetermined intent by local government district over the period 2005 to 2010, each of the district council areas statistics for males and females have been added up to give a (1) a total for the period 2005 to 2010, and (2) to establish the annual mean for each of the district council areas by male and female for the period 2005 to 2010. The figures are shown in Table 1 below.

Table 1: Male and female registered deaths by intentional self-harm and undetermined intent by local government district over the period 2005 to 2010 and average per annum for the period

Male			
District Council area	Absolute number of registered deaths 2005 to 2010	Average	Rank
Cookstown	35	5.8	3
Magherafelt	29	4.8	4
Dungannon	43	7.2	2
Fermanagh	50	8.3	1
Female			
District Council area	Absolute number of registered deaths 2005 to 2010	Average	Rank
Cookstown	2	0.3	4
Magherafelt	5	0.8	3
Dungannon	9	1.5	2
Fermanagh	13	6.5	1

In terms of both male and female registered deaths, Fermanagh District Council area is ranked first in terms of the four SWARD district council areas. It had 50 male deaths and 13 female deaths by intentional self-harm and undetermined intent by local government district over the period 2005 to 2010. In terms of the annual average over the period 2005 to 2010, the male and female figures were 8.3 and 6.5 respectively. Perhaps the most notable anomaly within Table 1 is the high comparative rate of females within Fermanagh at 6.5 average per annum compared to 1.5 in Dungannon average per annum. Dungannon is second to Fermanagh in terms of male registered deaths at an annual average rate for 2005 to 2010 of 7.2.

Suicide, self-harm and poor mental health pyramids for each district council

The following pyramids have been constructed in order to help give a sense of the burden of poor mental health within each of the district council areas.

Firstly, the figures which comprise the apex of the triangles are the 2010 figures presented in Graph 9 which relate to all persons registered deaths by intentional self-harm and undetermined intent by Local Government District. Secondly, the annual mean of the five year period for the registered deliberate self-harm figures for the period 2004/05 to 2008/09 for each district council area are included in the next tier down. Thirdly, estimated episodes of hidden deliberate self-harm are contained within the next tier down. These figures have been calculated by multiplying the mean of the registered deliberate self-harm presentations at A&E departments by 5.45. This method reflects that used by the National Suicide Research Foundation Cork in a presentation made to members of the community and voluntary sector in Belfast. As this suggests, for every registered deliberate self-harm episode admitted to an A&E department, it is estimated that there is another 5.45 hidden and unregistered episodes. Below this again is an estimation of the number of people within each district council area who could realistically be experiencing poor mental health at any one time. Finally, on the very bottom tier of the pyramid, the total population of the district council area is shown for 2010.
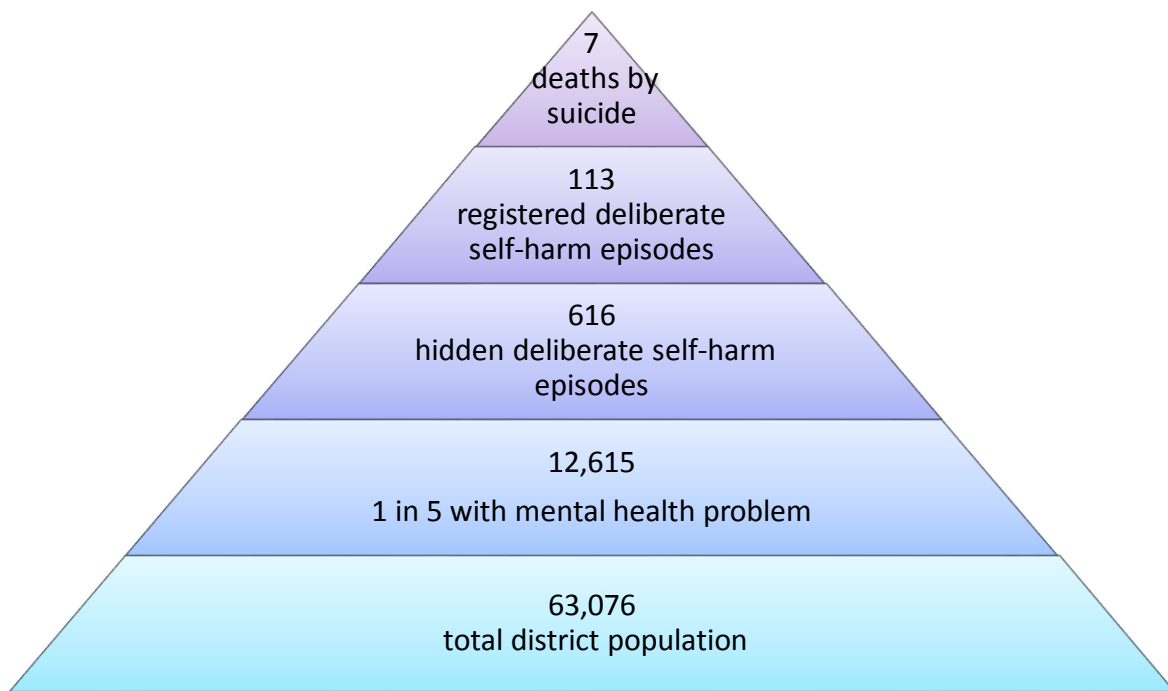
Diagram 1: Fermanagh

7
deaths by suicide
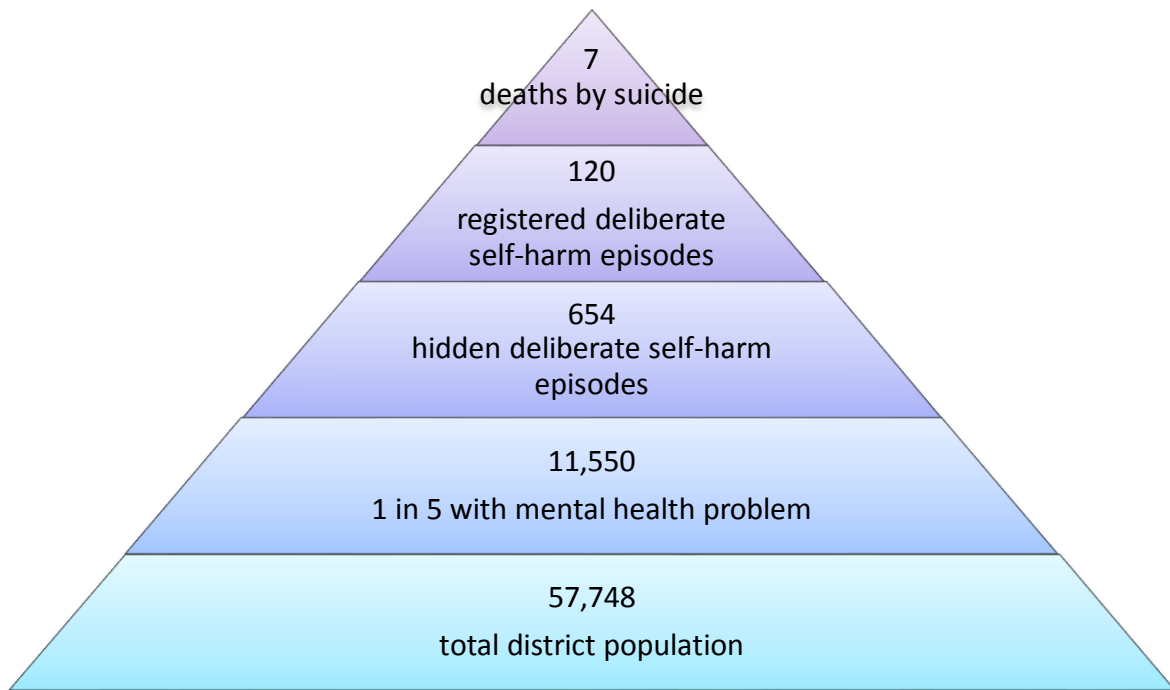
113
registered deliberate self-harm episodes

616
hidden deliberate self-harm episodes

12,615
1 in 5 with mental health problem

63,076
total district population

Diagram 2: Dungannon

7
deaths by suicide

120
registered deliberate
self-harm episodes

654
hidden deliberate self-harm
episodes

11,550
1 in 5 with mental health problem

57,748
total district population

Diagram 3: Cookstown

4
deaths by suicide

76
registered deliberate
self-harm episodes

414
hiiden deliberate self-harm
episodes

7,331
1 in 5 with mental health problem
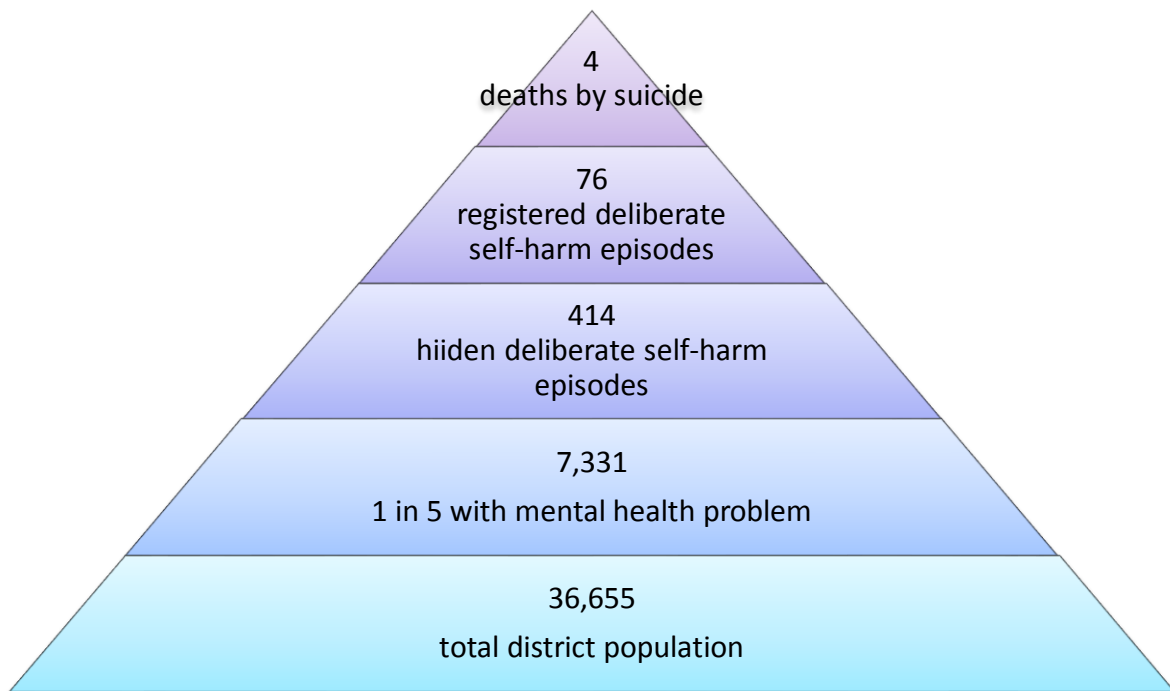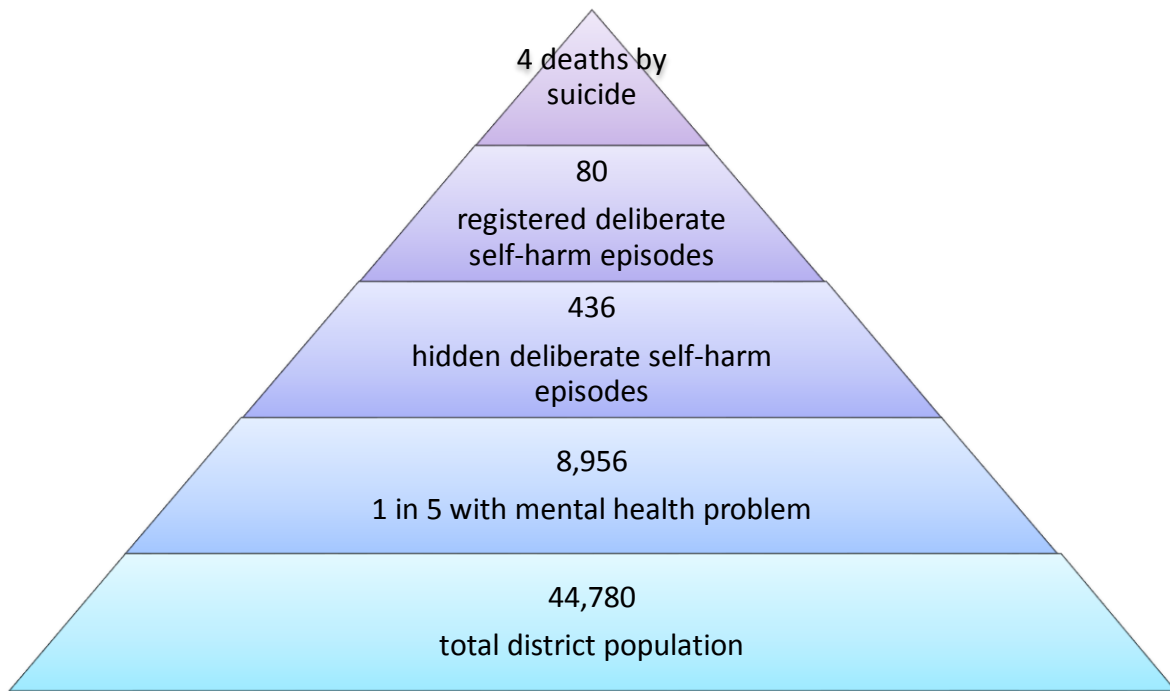
36,655
total district population
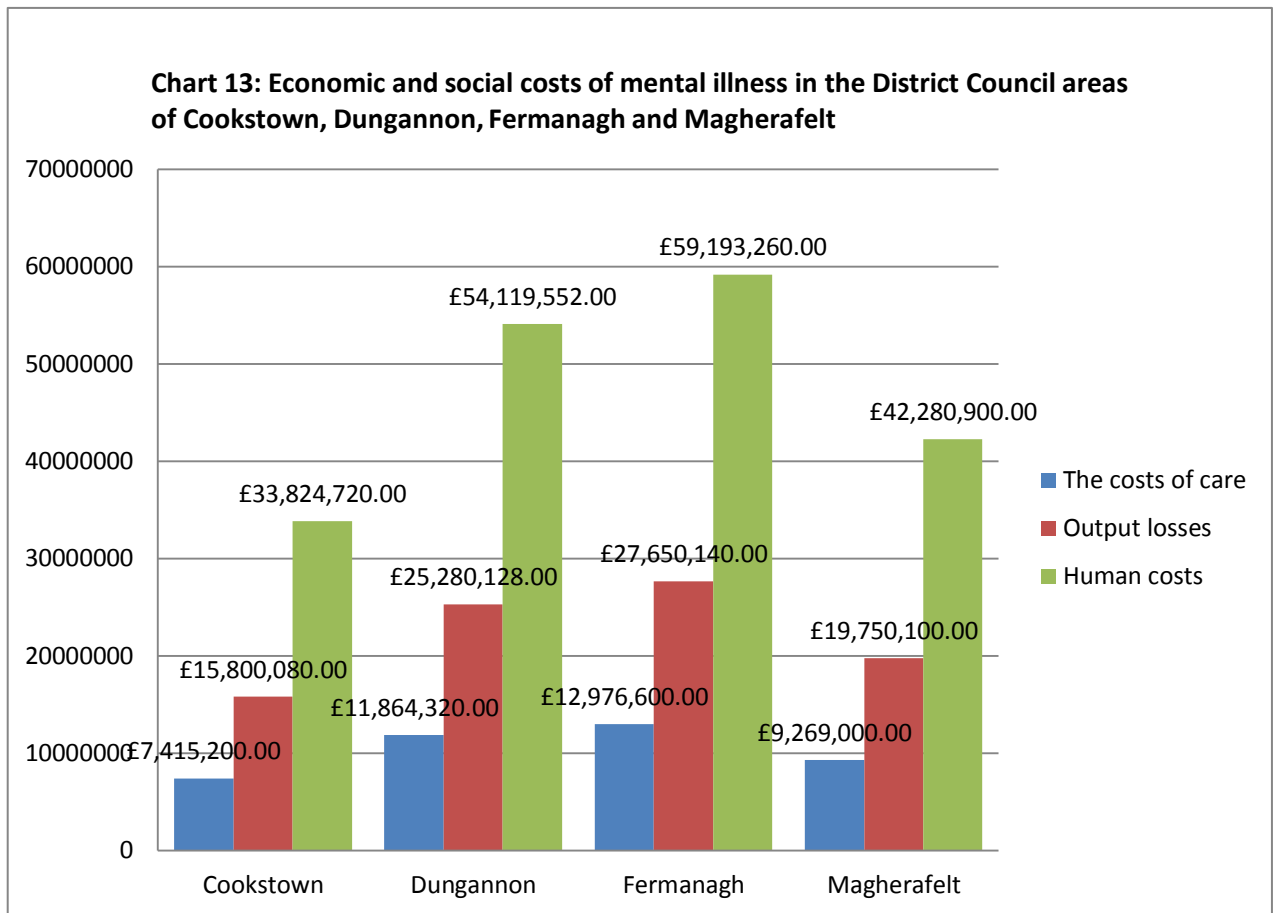
Diagram 4: Magherafelt

Estimated Economic and Social Cost of Mental Ill Health in the SWARD Region

Chart 13 below has been constructed using research commissioned by the Northern Ireland Association of Mental Health (NIAMH) for Northern Ireland. What the chart attempts to achieve is a representation of the costs associated with the economic and social aspects of mental illness within the district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt. The costs generated within the report by NIAMH have been apportioned pro rata to each of the district council areas relative to their population.[44] The three different categories of cost are described briefly below.

The SWARD region accounts for 11.2% (£319,424,000) of the total estimated social and economic cost of mental illness in Northern Ireland at £2,852,000,000.

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[44] http://www.niamhwellbeing.org/Site/26/Documents/niamh_counting_cost.pdf - 'Counting the cost: the economic and social costs of mental illness in Northern Ireland', Northern Ireland Association of Mental Health in collaboration with the Sainsbury Centre for Mental Health.

Chart 13: Economic and social costs of mental illness in the District Council areas of Cookstown, Dungannon, Fermanagh and Magherafelt

	Cookstown	Dungannon	Fermanagh	Magherafelt
The costs of care	£7,415,200.00	£11,864,320.00	£12,976,600.00	£9,269,000.00
Output losses	£15,800,080.00	£25,280,128.00	£27,650,140.00	£19,750,100.00
Human costs	£33,824,720.00	£54,119,552.00	£59,193,260.00	£42,280,900.00

The costs of health and social care covering such costs as the services provided by the NHS for people experiencing mental health problems and also the costs of informal care given by family and friends.

The costs of output losses in the economy which result from the negative impact of mental illness on an individual's ability to work.

The human costs of mental illness corresponding to the adverse effects of mental illness on the health related quality of life.

Professionals Survey on Mental Health, Stigma and Services and Supports in the SWARD Rural Communities

Introduction

This aspect of the research project was conducted online with paid professionals who were identified as having a significant role and or interest in the provision of rural mental health services within the Fermanagh, Dungannon, Coosktown and Magherafelt District Council areas. In order to ensure as wide an involvement of professionals from across the four districts, the researcher disseminated information and a link to the survey through the Rural Community Network NI and the Community Development and Health Network NI. Further, those individuals who did click through to the survey were asked to forward (snowball) the survey to other professionals whom they felt might have an interest and investment in the issues of rural mental health, stigma and services across the four district council areas that comprise the SWARD region.

Analysis and findings

Number of professional responses

Chart 14: Please indicate the sector within which your organisation is located?
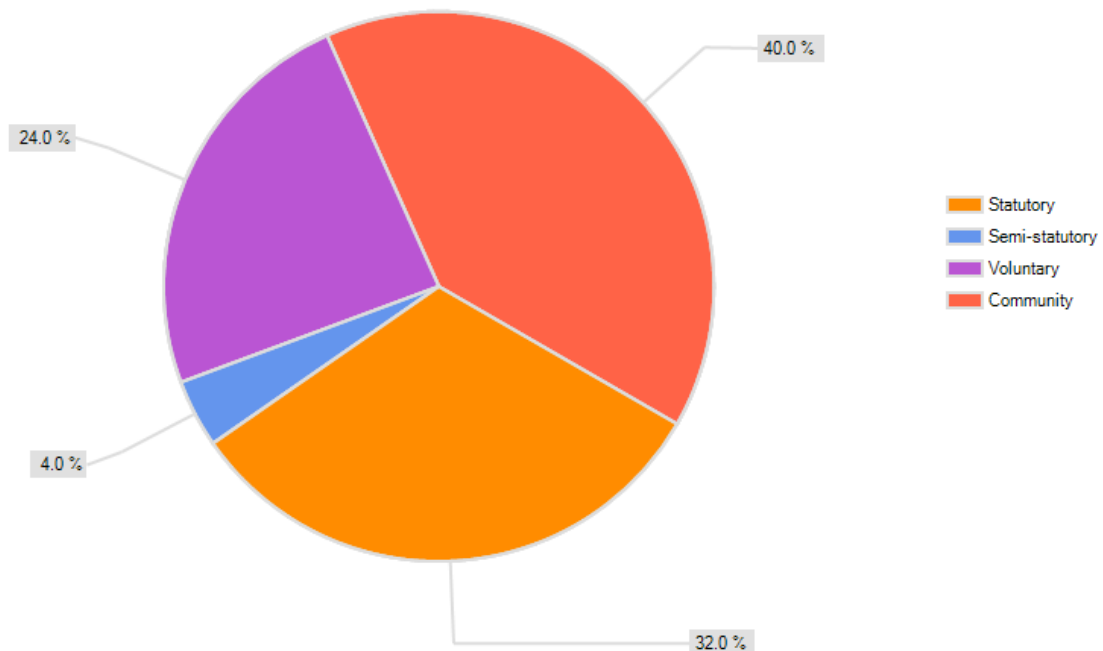
A total of 29 professional responses were returned via the comprehensive online survey. Of the 29 responses, 4 skipped this question with a further 3 indicating 'other'. 32.0% (8) responses were received from individuals describing their organisational background as statutory, 4.0% (1) as semi-statutory, 24.0% (6) were from a voluntary sector background, whilst the remaining 40.0% (10) of responses were from the community sector.

District council area served

In terms of the distribution of the total number of responses from across the district council areas, 60.7% (17) of the respondents indicated that they worked within the Dungannon and South Tyrone Borough Council area. 62.5% (5) of the professional respondents from within the statutory sector to the online survey were drawn from within the Dungannon and South Tyrone Borough Council area. 100.0% (1) of the total semi-statutory response was located within the Dungannon and South Tyrone Borough Council area. Dungannon and South Tyrone Borough Council area accounted for 50.0% (3) of the entire voluntary sector response to the survey, whilst the community sector accounted for 50.0% of the entire community response to the survey.

Chart 15: Please indicate which of the following District Council areas you work in?
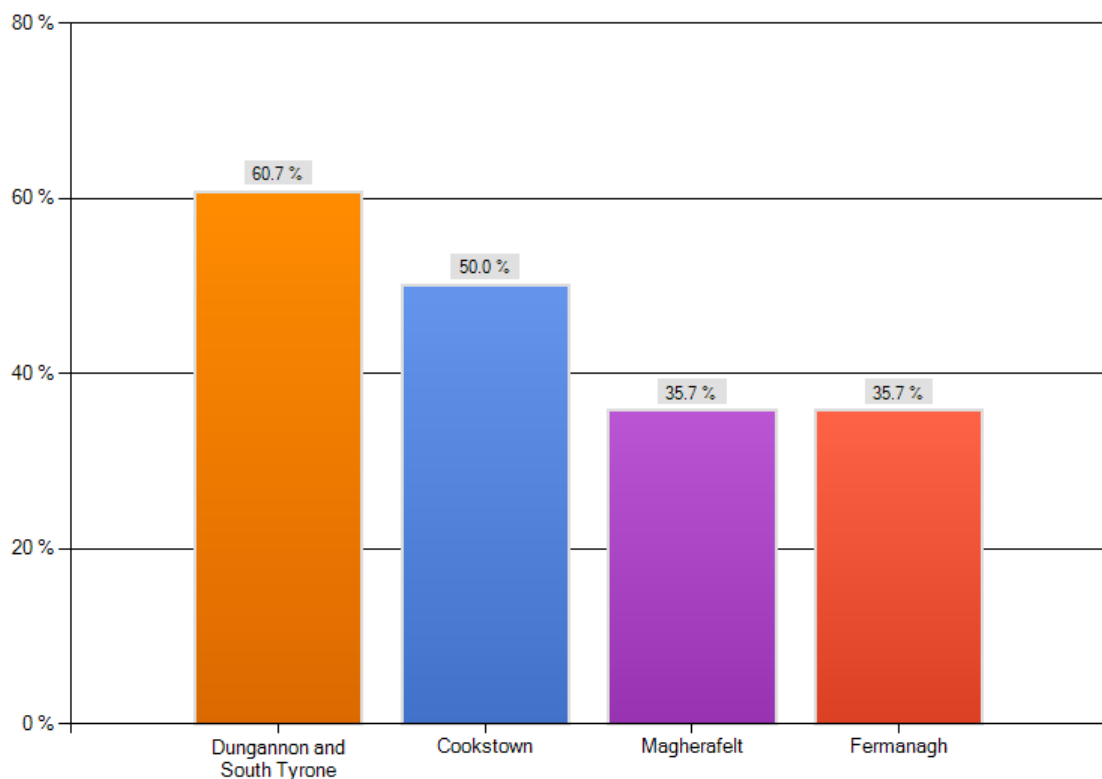
50% (14) of the respondents to the overall survey indicated that they worked within Cookstown District Council area. Within Cookstown District Council area, 50.0% (4), 50.0% (3)

and 60.0% (6) of the respondents where from within the overall respective categories of statutory, voluntary and community.

35.7% (10) indicated that they worked within Fermanagh District Council area. When looked at in respect of the response categories across organisational sector, Fermanagh District Council area accounted for 12.5% (1) of the total statutory response, 66.7% (4) of the total voluntary sector response and 40.0% (4) of the total community sector response.
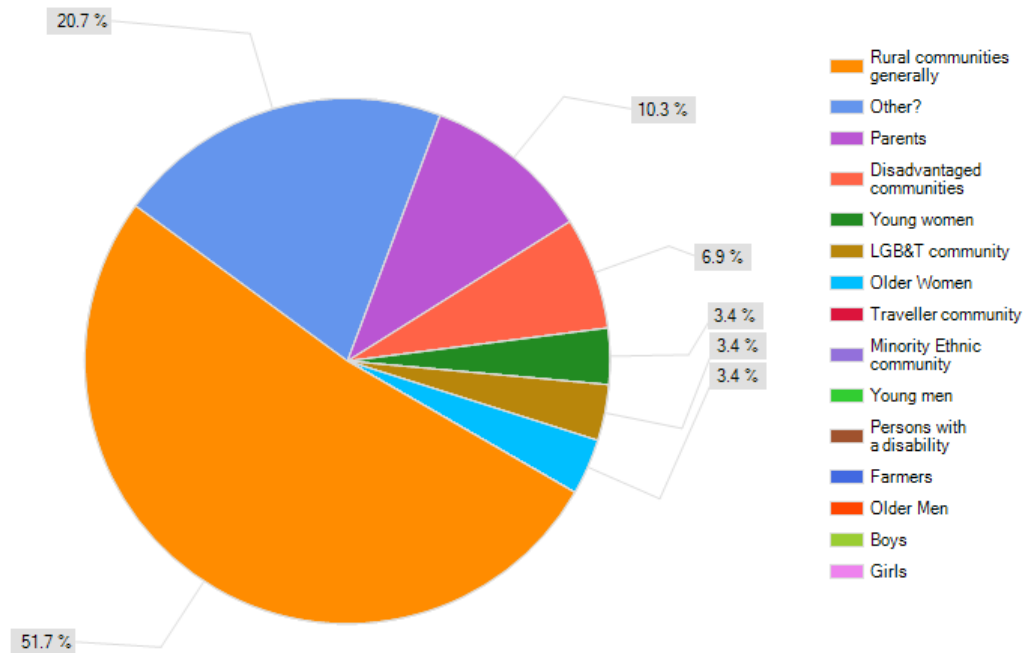
35.7% (10) of the professional respondents indicated that they worked within the Magherafelt District Council area. Of the total statutory response to the online survey, 37.5% worked within the Magherafelt area. 50.0% (3) of the total voluntary sector response and 30.0% (3) of the total community sector total were located within the Magherafelt District Council area.

It is important to acknowledge and recognise that the figures as presented indicate that a great many of the professional respondents work across and within more than one of the district council areas.

Community focus

When asked to describe the community or communities they worked with in their professional capacity within the rural context of the four district council areas, 51.7% (15) professional respondents described their community focus as being 'rural communities generally'. Those working with parents accounted for 10.3% (3) of the professional responses. 3.4% (1) professional respondent described their community as being young women, LGBT community and older women respectively. 20.7% (6) described their community of focus as other.

Chart 16: How would you describe the community or communities you work with?


Focus of supports and services

Of the 16 professionals who completed this question, 81.3% (13) of the professional respondents established that the focus of their service and supports was mental health and well-being, compared to 37.5% (6) who indicated that their focus was self-harm prevention, intervention and postvention. 50.0% (8) of the respondents indicated that the focus of their service and supports was suicide prevention, intervention and postvention. 37.9% (11) of the professional respondents described their service and support focus as other.   13 (44.8%) of the 29 potential respondents to this question did not choose to complete it.

Graph 17: Please indicate the focus of your supports and services?
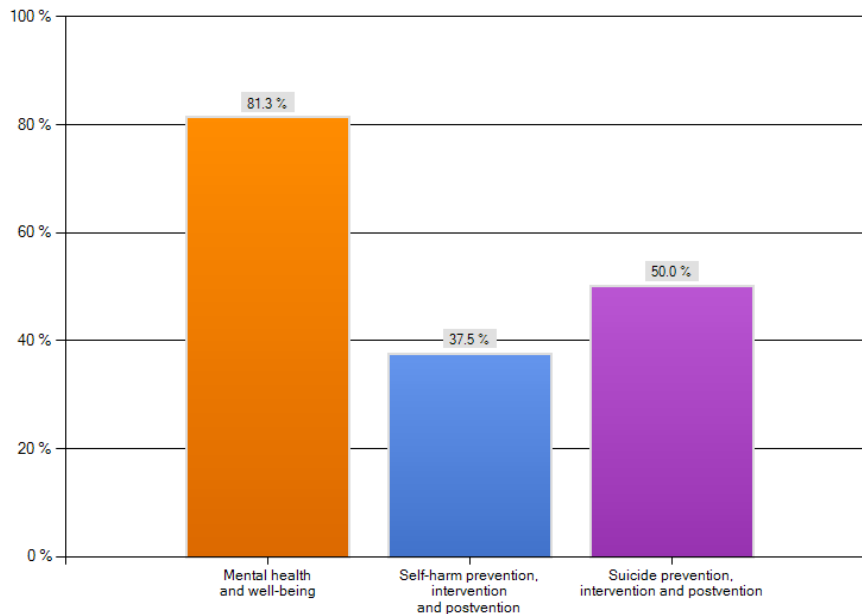
Need for services within your rural community

Graph 18: Please indicate the extent to which you feel there is a need for the following services within your rural community?
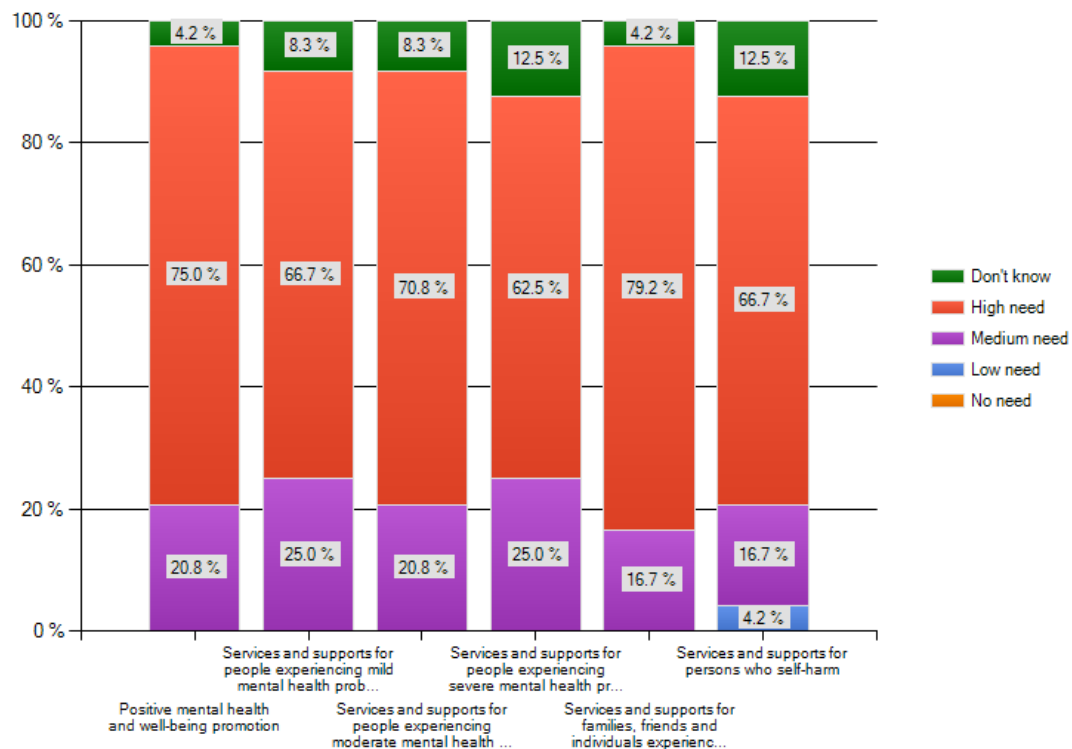
Positive mental health and well-being promotion

The vast majority at 75% (18) of the respondents to the professional online survey indicated that they felt there was a 'high need' for positive mental health and well-being promotion within their rural community. 20.8% (5) of the respondents felt there to be a 'medium need'. None of the respondents expressed their perception of the level of need as being 'no need' or of 'low need'. 4.2% (1) of the respondents did not know.

Services and supports for people experiencing mild mental health problems

In respect of services for people experiencing mild mental health problems, a lower majority compared to that garnered for the previous question at 66.7% (16) felt there was a 'high need' for such services. 25.0% (6) felt there was a 'medium need'.   8.3% (2) did not know.

Services and supports for people experiencing moderate mental health problems

70.8% (17) of the professional respondents to the online survey felt there was a 'high need' for services and supports for people experiencing moderate mental health problems. 20.8% (5) felt there to be a 'medium need', whilst 8.3% did not know.

Services and supports for people experiencing severe mental health problems

Across the questions in relation to section 5 in the online survey, the question relating to services and supports for people experiencing severe mental health problems returned a majority, albeit the lowest majority of the six questions at 62.5% (15). 25.0% (6) rated the level of need as medium and 12.5% (3) did not know.

Services and supports for families, friends and individuals experiencing bereavement through suicide
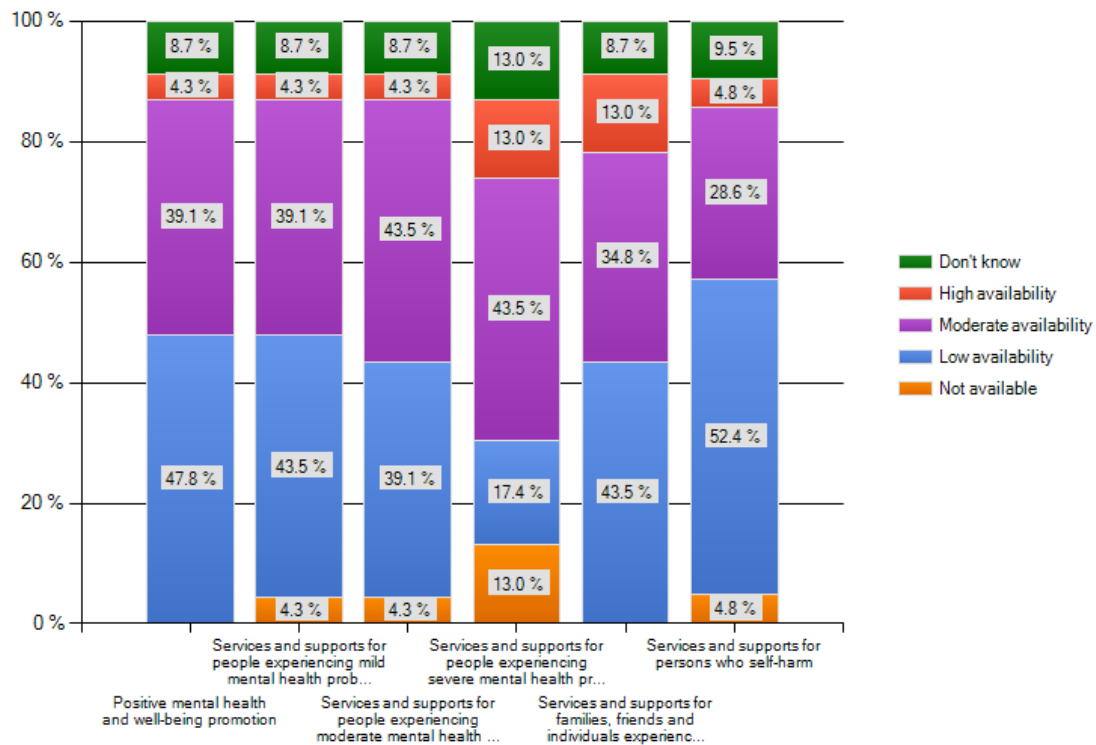
79.2% (19) of the professional respondents felt the need for services and supports for families, friends and individuals experiencing bereavement by suicide was high. Across the 6 questions, this returned the highest majority. 16.7% (4) rated the need as medium and 4.2% (1) did not know.

Services and supports for persons who self-harm

When considering the need for services and supports for persons who self-harm 66.7% (16) of the respondents felt there is a 'high need'. 16.7% (4) of respondents felt there is a 'medium need', whilst 4.2% (1) felt there is a 'low need'. 12.5% (3) were di not know.

Perceived availability of mental health supports and services within the rural community

Graph 19: How available do you feel current mental health supports and services are within your rural community to address the following community mental health needs?

When the professional respondents were asked in Section 6 to consider the availability of current mental health supports and services within their rural community to address the mental health needs as per the previous questions in Section 5, what is discovered is that the overall appraisal is one of mental health services and supports which are viewed to be lie predominantly between low and moderate availability.

Services and supports for persons who self-ham were perceived to be the weakest in terms of availability. 52.4% (11) of the professional respondents felt there is a 'low availability', 28.6% (6) 'moderate availability' and only 4.8% (1) 'high availability'. 9.5% (2) respondents were unsure. 4.8% (1) felt services and supports in respect of self-harm are not available.

Availability of services and supports within the rural community in relation to positive mental health and well-being promotion returned the second lowest rating in terms of availability. 47.8% (11) of the respondents felt that there is 'low availability'. 39.1% (9) of the respondents felt there is 'moderate availability', whilst only 4.3% feel there is 'high availability'. 8.7% (2) did not know.

Services and supports for people with mild mental health problems returned an almost identical response set to that for positive mental health and well-being. The only difference between the
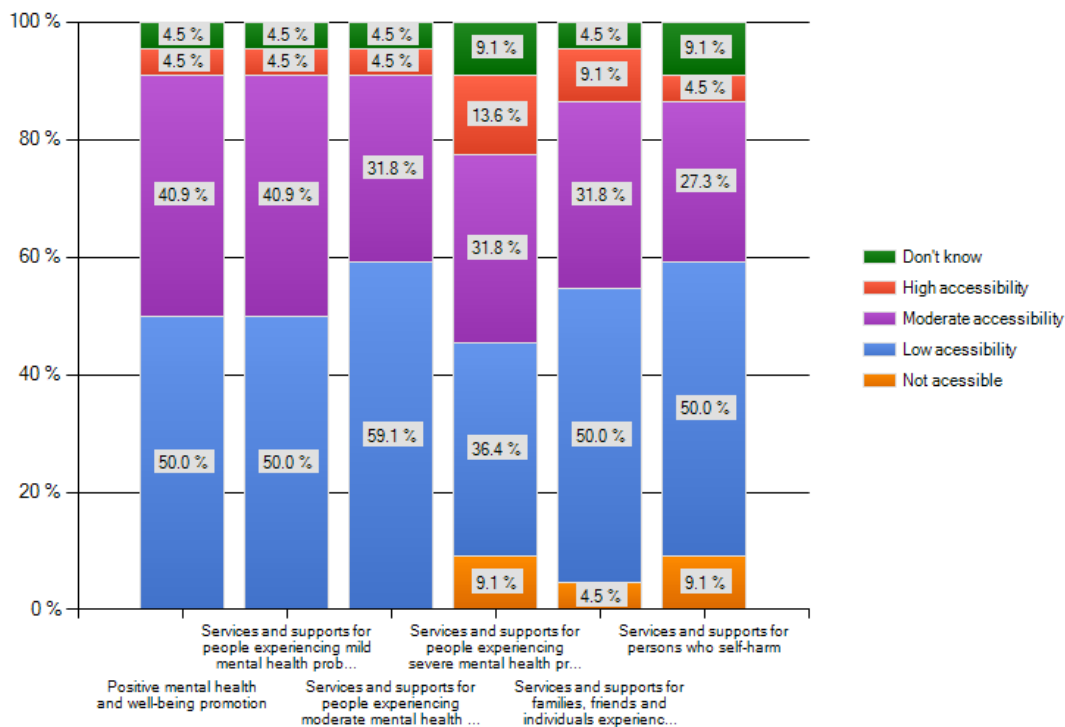
response distribution was that 4.3% (1) of responses felt that the services and supports are 'not available'.

Services and supports for people experiencing severe mental health problems return the highest availability rating. 43.5% (10) of the responses indicate 'moderate availability' and a further 13.0% (3) indicate 'high availability'. However, despite the highest rating in terms of availability, responses also indicate 13.0% (3) 'don't know'. An equivalent 13.0% (3) feel the services and supports for people experiencing severe mental health problems are 'not available'.

Services and supports for people with moderate mental health problems, and for families, friends and individuals experiencing bereavement through suicide return the second highest availability rating at 47.8% (11) respectively, with the latter recording 13.0% (3) rating availability as 'high'. Availability for moderate mental health problems lean more toward 'moderate availability compared to suicide bereavement support services.

Accessibility

Graph 20: How accessible do you feel current mental health supports and services are within your rural community to address the following community mental health needs?


In regard to consideration to the extent of perceived accessibility of current mental health supports and services within their rural community in relation to the mental health issues set-

out, overall the respondents feel that accessibility is by and large low. Accessibility for services and supports for people experiencing severe mental health problems, and services and supports for persons who self-harm return the highest rate in terms of 'not accessible' at 9.1% (2) respectively. Services and supports for families, friends and individuals experiencing bereavement through suicide records the second highest 'not available' rating at 4.5% (1).

Effectiveness of current mental health supports and services within the rural community

Graph 21: How effective do you feel current mental health supports and services are within your rural community to address the following community mental health needs?
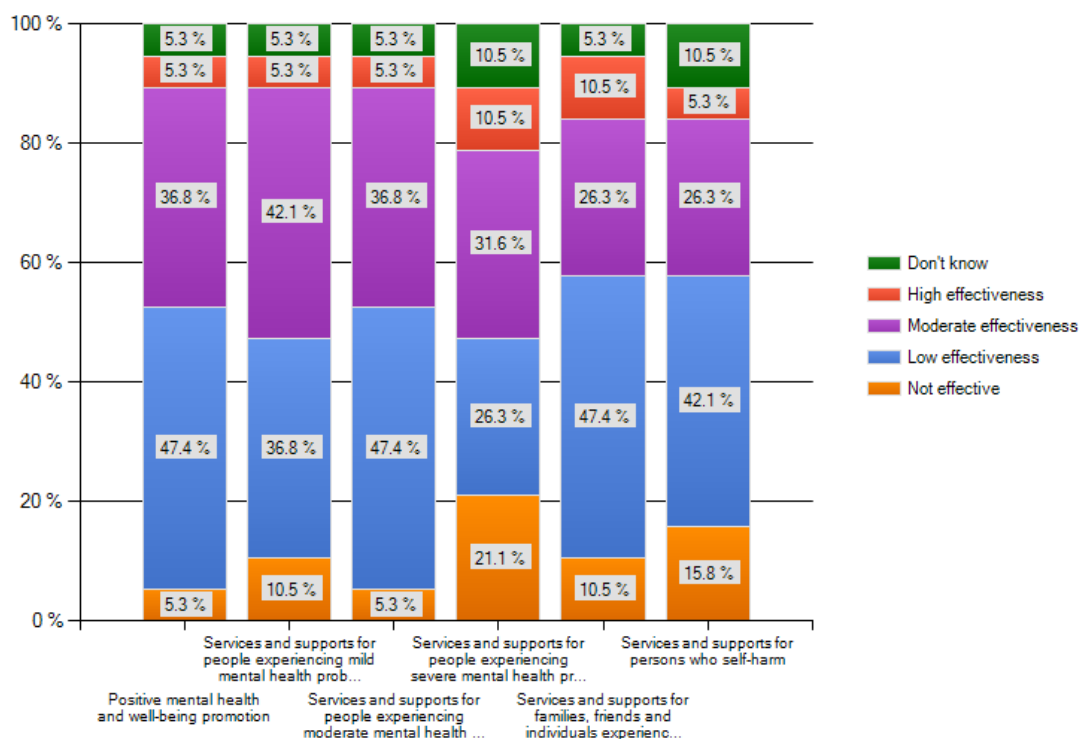

The overall impression returned in terms of effectiveness of current mental health services and supports within the rural community by the professional respondents is one of 'low effectiveness' to 'moderate effectiveness'. In terms of 'not effective', services and supports for people experiencing severe mental health problems returns a response of 21.1% (4) and, 15.8% (3) in relation to services for those who self-harm yields a response of 15.8% (3).

Performance of the statutory, voluntary and community sector

The professional online respondents were asked to indicate how effective they felt the statutory, voluntary and community sectors performed in relation to nine statements. On the

whole, the nine statements return an assessment of 'poor' to 'average'. They indicate from the perspective of the respondents, considerable room for improvement in terms of performance.

Graph 22: How would you rate the performance of the statutory, voluntary and community sector in regard to the following areas within your rural community?
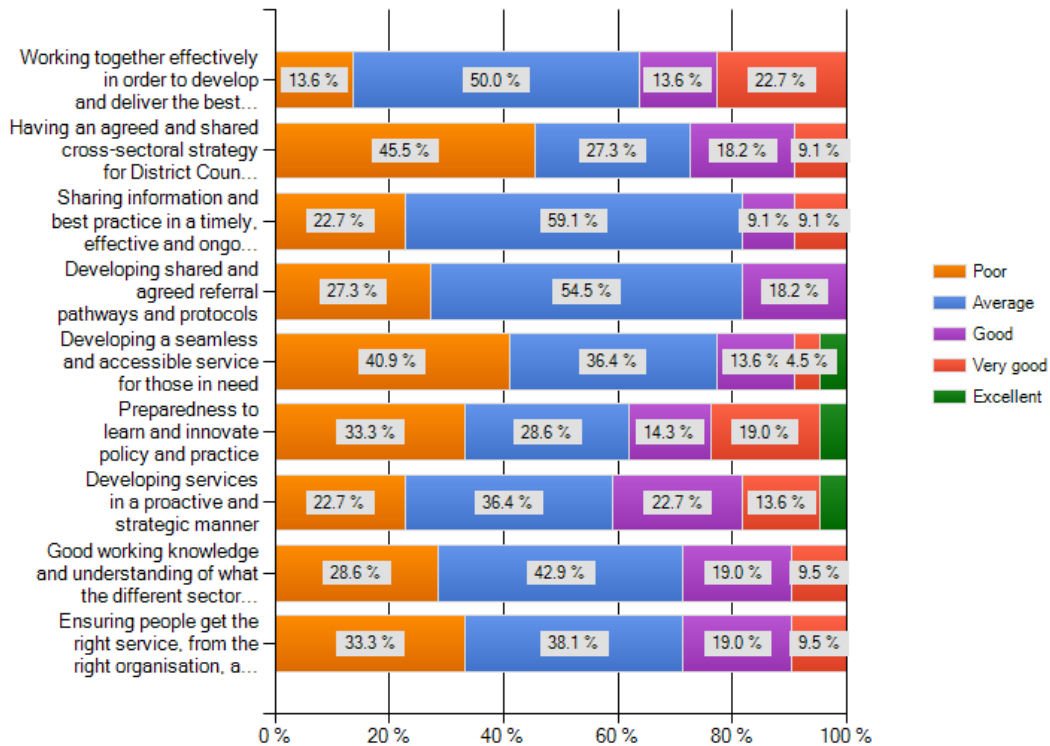
That statement which shows the worst performance rating in terms of being 'poor' is "Having an agreed and shared cross-sectoral strategy for district council areas. 45.5% (10) of the respondents rate performance as poor in this respect. A further 27.3% (6) rate the performance as 'average'.

Developing a seamless and accessible service for those in need returns the second highest 'poor' rating by the respondents at 40.9% (9) and a further 36.4% (8) rate this statement performance as 'average'.

In considering 'average' performance ratings, "sharing information and best practice in a timely, effective and on-going basis" shows the worst performance at 59.1% (13) responses. This is closely followed by "developing shared and agreed referral pathways and protocols" at 54.5% (12) responses. In third position in terms of 'average' performance rating is "working together effectively in order to develop and deliver the best possible range of services and supports" at 50.0% (11). In fourth place in terms of 'average' rating is "good working knowledge and understanding of what the different sectors provide" at 42.9% (9).

Performance across the nine statements in terms of being good, very good or excellent is weak.

Mental health related stigma and discrimination, rural communities and change

The professional respondents were asked to consider whether or not they felt mental health related stigma and discrimination has changed for people with mental health needs and problems from across a range of rural constituents over the past 3 years.

Graph 23: Do you think mental health related stigma and discrimination has changed for people with mental health needs and problems from within the following groups within your rural community in the past 3 years?
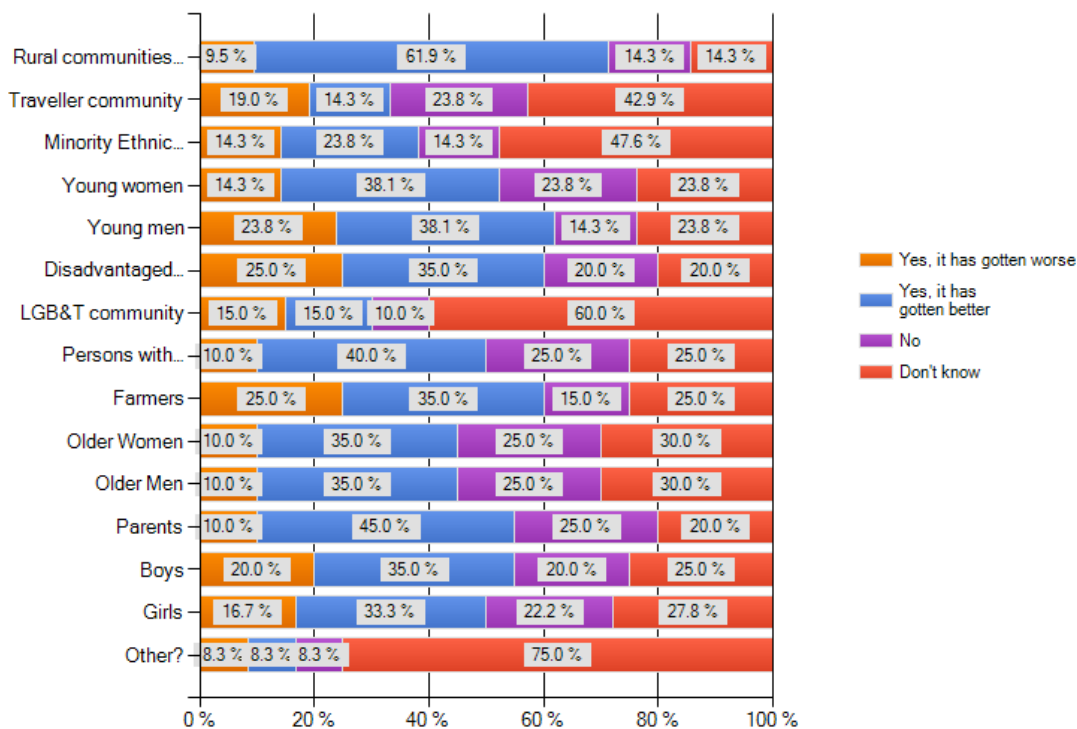
By and large, there is a wide spread of opinion across the constituent groups. In relation to three of the constituent groups there are out right majorities returned from the professional respondents. 61.9% (13) of the responses feel that the situation has gotten better over the last three years for rural communities generally. 60.0% (12) of the responses 'don't know' in regard to the situation pertaining to the Lesbian, Gay Bisexual and Transgendered community. 75.0% (9) 'don't know' in terms of 'other'

In respect of the Traveller, Minority Ethnic, Older Women, Older Men and Others the largest single category of response is 'don't know' or 'no' (the situation has remained the same).

Those constituents which in the opinion of the professional respondents show the greatest deterioration in terms of the mental health related stigma and discrimination shown toward

them are Disadvantaged communities, Farmers, Young Men, Boys and the Traveller communities. In

Adequacy of provision of mental health services within rural communities

The results from the professional respondents show very clearly and immediately that the overall impression by them is of a provision which is far from adequate across a whole array of rural people. The three worst areas for provision in terms of adequacy were found to be Lesbian, Gay, Bisexual and Transgendered community, Farmers, and Boys. The remainder of the categories of rural community follow closely behind.

Graph 24: To what extent do you feel there is adequate provision of mental health and well-being services within your rural communities for the following groups of people?
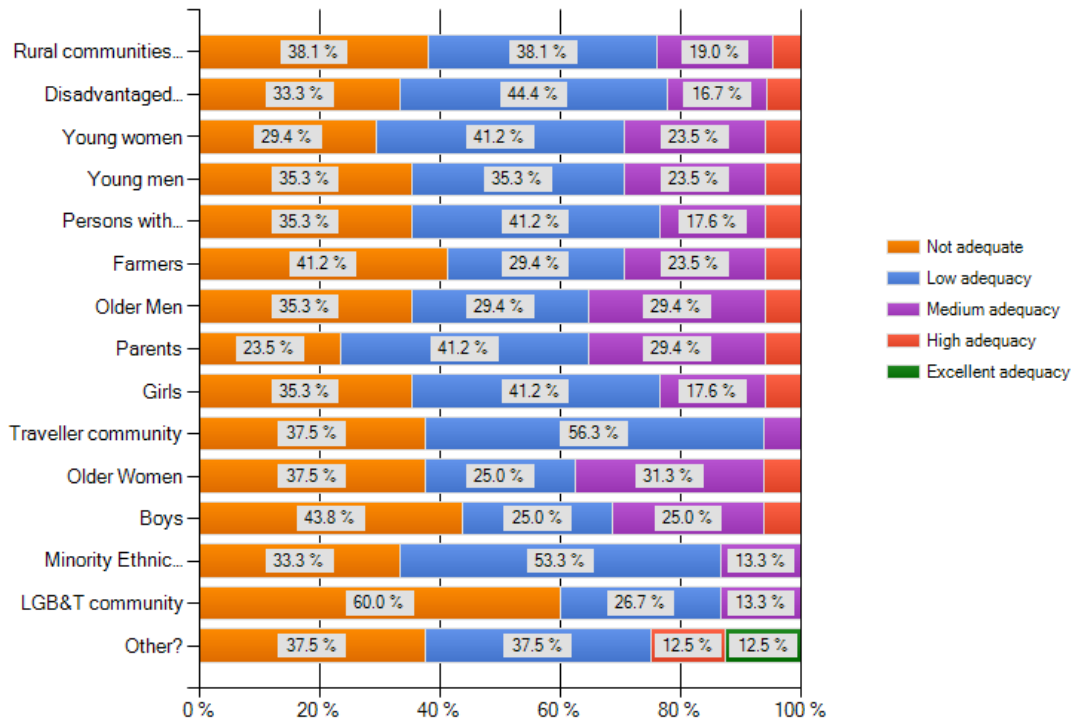
Current and preferred focus of support and services for mental health within the rural community

Graph 25: Please indicate how you would like to see the focus of support and services within your rural community develop?
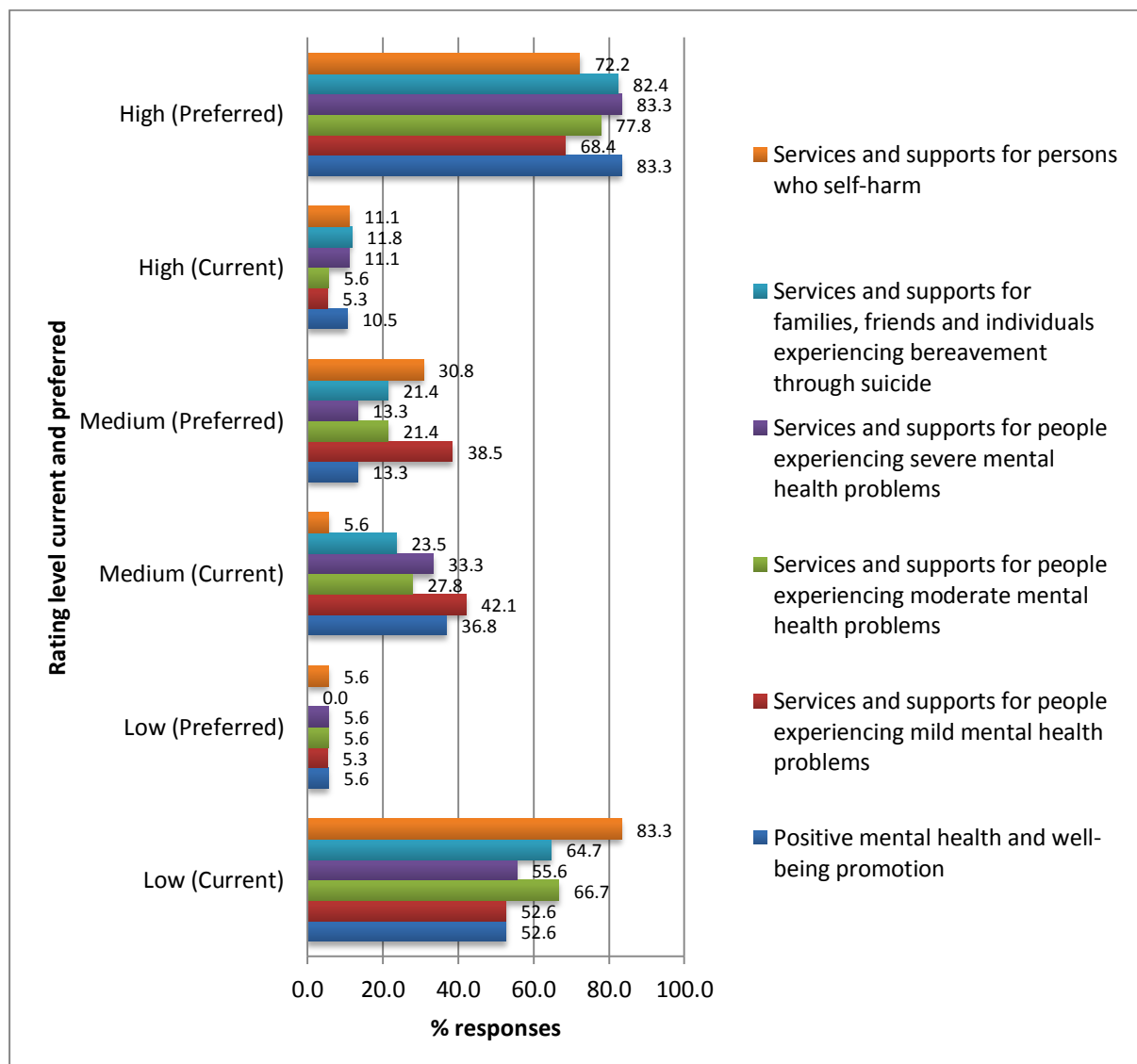
What the graph above illustrates is the current rating by the professional respondents of the different rural mental health services and supports and where they feel they should be at (developed) in light of their experience and understanding of the mental health needs within their rural community.

Straight away, it is evident that there is a huge swing from the lower end of the graph to the upper most end of the graph. Across all of the areas indicated for rating within the online survey, all of the services and supports were rated by the majority as 'low'. Services and supports for persons who self-harm is by far the most notable service dimension within Low (Current). Looking at the 'High (Preferred)' category, it is established by the majority of the respondents that greater development needs to happen across the board in relation to rural mental health services and supports. The professional respondents wish to see positive mental health and well-being promotion and services and supports for people experiencing severe mental health problems as the two key priorities, having realised the backing of 83.3% (15) of the responses respectively. In a very close second place are services and supports for families, friends and individuals experiencing bereavement through suicide at 82.4% (14%) of the responses. Services and supports for people experiencing moderate mental health problems are in third position with 77.8% (14) of the responses. In fourth place are services and supports for persons who self-harm with 72.2% (13) of the responses. Services and supports for people experiencing mild mental health problems whilst located in fifth place still achieves 68.4% (13) of the responses.

Overcoming stigma and supporting improved help-seeking behaviour amongst those individuals, groups and communities most at risk within rural communities

"I don't really know about the services available but I feel that the farming community have started the conversation about mental ill health and I am aware of several young men who have sought but not received any help in rural areas."

In response to the question "What in your opinion needs to be done in order to overcome the stigma, and support improved help-seeking behaviour especially for those communities, groups and individuals at the greatest risk in terms of poor mental health, self-harm and or suicide within our rural community?" the following points predominated.

Firstly, the professional respondents call for a greater rural focus in terms of the current regional media campaigns aimed at promoting improved mental health and suicide prevention. There is a strong sense the campaigns need to reflect the people and places of rural communities in order to help reduce the stigma and enable and support rural residents to seek help when they need it. It was also emphasised that more localised media work should be undertaken to complement the work at the regional level and that local papers would be a good instrument in this regard in terms of the farming community and social networking in terms of the younger generation.

In general, it is felt that it is not clear what is available to support individuals who reside within the SWARD area in terms of their potential mental health and well-being needs. Respondents call for the provision of comprehensive, easy to access and practical guidance and advice on what is available, how to seek help and how to promote and maintain positive mental health.

Stigma is seen to be alive and well in rural areas and a force which needs to be challenged and replaced with attitudes and understanding which create a supportive, understanding and

enabling environment for those who wish to address their mental health needs. In this respect, as well as more rural orientated campaigning and messaging, respondents call for greater awareness and understanding amongst the business community, schools, general practitioners and other health related professionals. Respondents call for greater training amongst parents, schools, churches and GP's in terms of recognising and addressing stigma and spotting early signs of mental health distress and how to respond appropriately, as well as how to promote positive mental health and resilience.

"…GP's and schools and parents need more training on spotting the signs, young people need to experience resilience training – making suicide the last option rather than the default position."

It is suggested that encouraging more local well known rural people to talk about and share their mental health experiences would go a long way to removing the "taboo" and stigma which surrounds rural mental health.

In advocating for a greater focus on positive mental health promotion, the respondents call for greater links with sporting organisations, parent support groups and help for those who have become recently unemployed as a result of the recession.

Finally, the respondents call for more resources to be made available and that these resources need to be professionally co-ordinated.

What do you see as the key strengths in regard to mental health, self-harm and suicide support services and provision in your rural communities right now?

The professional respondents outlined a number of strengths which they feel exist currently with respect to mental health, self-harm and suicide support services and provision in their rural communities. The respondents feel that the fact it is being recognised that there is a "problem" is a strength, as is the work of organisations such as the Niamh Louise Foundation and PIPS in addressing suicide and self-harm prevention, intervention and postvention, as well as the provision of ASIST and other training opportunities.

It is felt that good partnership working does exist across sectors, especially within the context of "crisis response" within the rural communities of the SWARD region. Further, respondents feel that there is a strong rural network of voluntary organisations which is an asset when it comes to the potential for the greater use of community development approaches to mental health promotion.

Lifeline and the Wraparound services in the community and the regional media campaigns are seen as strengths, as is the preparedness of some people to talk more openly about mental health (albeit not in terms of their own mental health needs and challenges).

The provision of small grants through organisations such as Cookstown and Western Shores Rural Support Network which specifically focus on mental health was seen as encouraging.

What do you see as the weaknesses in regard to mental health, self-harm and suicide support services and provision in your rural communities right now?

"The fact that it remains largely 'underground' and families don't realise that they aren't 'the only ones' having to deal with something that although it has improved is still largely seen as 'shameful'.

"Rural areas are devoid of conversations about youth mental health in particular."

The two quotes above speak to two of the key weaknesses proposed by the respondents with respect to rural mental health services. Other issues related to the cutbacks within the statutory sector and the voluntary and community sectors, A& E closures, lack of understanding, awareness of, and services and supports for those who experience self-harm and the parents/carers and friends.

Generally, there is a strong feeling among respondents that there is an overall lack of knowledge and understanding in relation to the nature and extent of rural mental health issues and needs and how these differ from those experienced by urban communities. In particular, whilst the idea of the rural community is often seen as a strength and something which can be called upon in times of stress, it is equally seen as a prohibitive factor in acknowledging and seeking help within a rural community. This is felt to be further compounded for those who are "transport poor" and who depend on other people to bring them to population centres for essential services and supports.

Other observations in terms of weaknesses relate to the apparent competition between organisations for funding, which in the opinion of the respondents results in the rural communities who should be at the centre of the decision-making in regard to funding and service development and delivery being confused and put off seeking help. As well the competition within and between the voluntary and community sector, the entire mental health system is seen as confusing, with rural communities and individuals unsure what exists for what and where? Long waiting lists for services are viewed as a real problem and disincentive for rural people seeking help, as well as provision of services generally being piecemeal.

There is a strong perception of a lack of services and supports for mild to moderate mental health issues which suffer as a consequence of agencies and organisations having to prioritise their efforts and resources toward those persons experiencing severe mental health issues.

What do you see as the key opportunities in regard to mental health, self-harm and suicide support services and provision in your rural communities?

One of the key opportunities felt to exist in relation to mental health, self-harm and suicide support services and provision in rural communities is the need for an increased emphasis on and funding for promoting positive mental health and well-being, prevention and early intervention, working with and within rural communities, rural networks, schools and early years settings within the context of the Protect Life Strategy and the soon to be revised Mental Health Promotion Strategy. Respondents identify opportunity for greater working together within and across sectors at the local and regional level in order to establish a shared and

Page 56

agreed understanding of need and joint planning. It is felt that collaboration must go far beyond the "crisis planning and intervention."

There is a strong belief that services and supports must be embedded within and through existing community and voluntary organisations and structures that work with and support the needs of all rural residents and especially those who are at a higher risk of developing a mental health issue. Respondents call for "assertive outreach" to rural constituents and a greater focus on "rural community gatekeepers". Further, respondents call for the provision of self-help/ self-healing directories and resources for use by rural residents and those who work with and support others.

What do you see as the key threats in regard to mental health, self-harm and suicide support and services and provision in your rural communities?

"Lack of resources and constraints of budget is putting everyone under pressure. Therefore, we tend to deal with the most urgent which leaves the 'mild and moderate' to fend for themselves. I see very few opportunities at present!"

The quote above resonates with the vast majority of opinion from the professional respondents i.e., their predominant concerns regarding the cuts within the health service and cuts to funding within the community and voluntary sector and the consequences this will have for their rural communities whom already experience highly centralised health services, and whom it appears will increasingly continue to experience this trend in light of the economic pressures linked to the recessionary context.

The respondents feel there is a danger that mental health services will be one of the sectors which will face extreme budgetary cuts, as it is often seen as the "poor relation" within the health and social care realm.

One of the respondents exclaims that the greatest threat they see at the present time in terms of mental health within their rural community is "That people grow to accept [poor mental health and its consequences] as something that just happens."

Improving the availability, accessibility and effectiveness of rural mental health services and supports within the SWARD region

Considering availability (a service is available) and accessibility (the rural resident can access it), the professional respondents recommend that more supports and services be developed for young people, schools and young carers and the farming community in particular. It is strongly pressed for that new services and supports should be outreach in nature, building the capacity and capability of all organisations who make up the fabric of the rural community in order that they can spot early signs and symptoms, be effective sign-posting agents, as well as being in a position to be positive mental health and resilience promoting organisations. A strong rural community development approach is seen as critical to this. The respondents urge for existing

rural infrastructure to be used and leveraged in building more psychologically and emotionally resilient communities.

Looking from the perspective of increasing effectiveness, the respondents suggest greater effort toward more collaborative working and networking, as well as taking a more strategic approach to the identification of need and the planning of services, supports and resources needed within the rural community. There is a call for a greater emphasis on evaluation which demonstrates effectiveness of services and for those services and supports which prove themselves to be given continued and or increased support.

Other suggestions relate to utilising to the fullest potential the existing social networking platforms and facilities used by rural young people, as well as proactive campaigning which promotes the benefits of positive mental health and how it can be realised, as well as retaining the focus on raising awareness of supports and interventions for those experiencing poor mental health.

Finally, isolation within the rural context of the SWARD region is emphasised and for all service design and innovation to take this into account. Public transport is seen as less than adequate and expensive, thus reinforcing the case for outreach and satellite provision.

The general conclusion and perception is that the demand will continue to increase for rural mental health and well-being services, particularly given the current difficult financial and economic circumstances facing the rural communities within Dungannon, Coosktown, Magherafelt and Fermanagh.

Public attitudes to mental health, stigma and services in rural communities

Introduction

This section of the report presents the analysis and findings from the public online survey which was administered as part of the overall community research. As was the case with the professional respondents online survey, the link to this survey was distributed through the Rural Community Network (NI), the Rural Support Networks and other local development agencies. Those who visited and or completed the survey were asked to forward (snowball) the link for the survey onto people they thought might have an interest and or opinion on the subject matter. The survey was entirely confidential and anonymous. Potential respondents were sought who perceived themselves to live within the rural environments of the constitute district council areas.

Analysis and Findings

Overall, 55 individuals accessed the survey. Of the 55 respondents, 80% were female and 20% male.
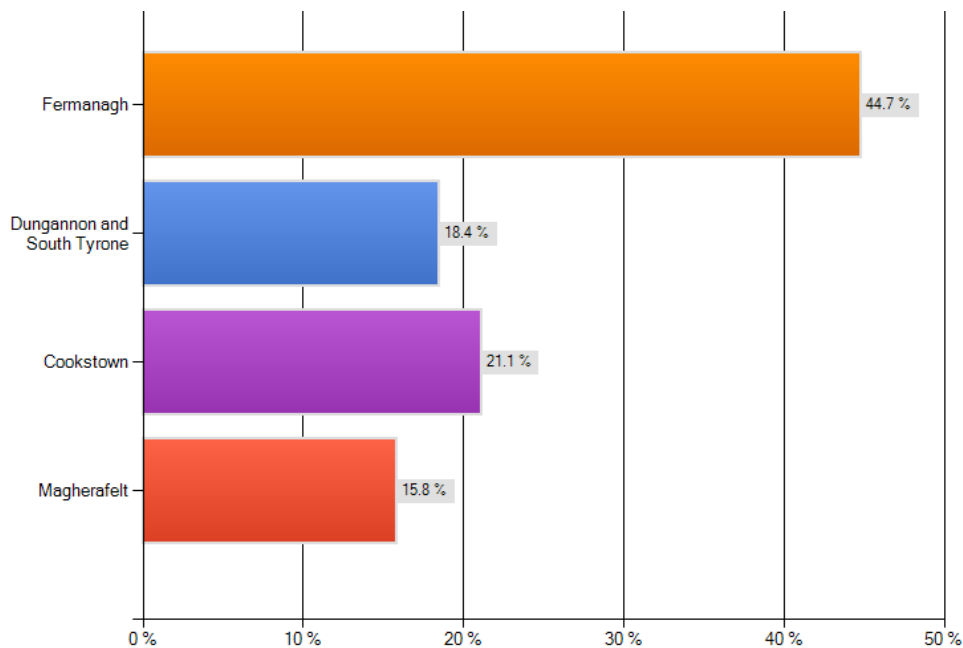
Graph 26: Are you male or female?
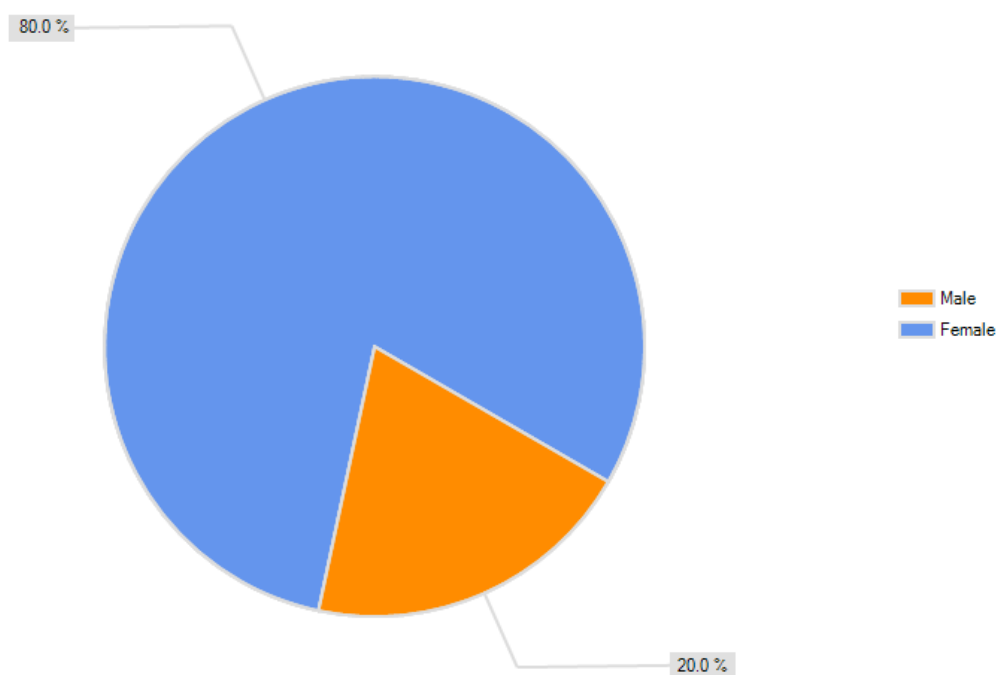
Graph 27: Please indicate to which age group you belong?
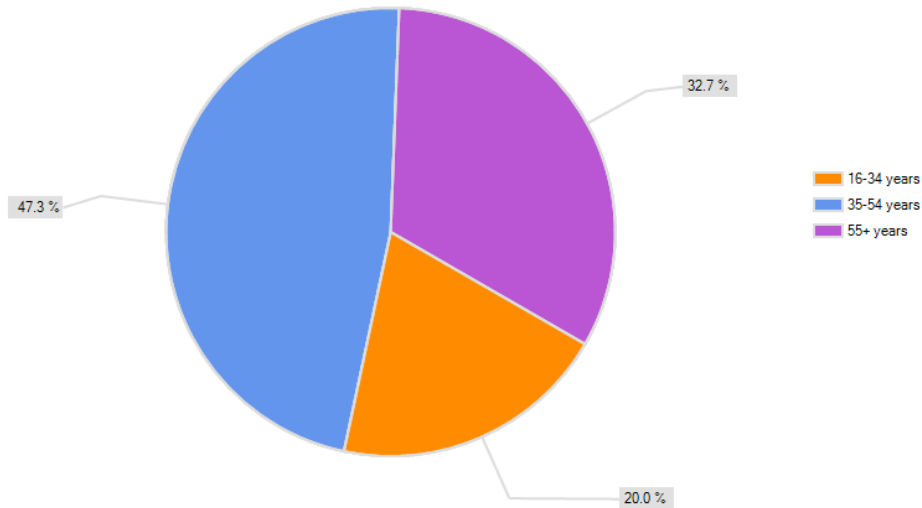
Of the 55 individual respondents, 47.3% were in the 35 to 54 age range, whilst 32.7% were 55 plus, and the remaining 20% were in the 16 to 34 age range.

**Graph 28: Please indicate which District Council area you live in?**

17 individual respondents skipped this question in relation to indicating which district council area they lived within, giving a total of 38 individual responses. The percentages in the following paragraph are based on the 38 valid responses.

Respondents to the online survey were drawn from across the four district council areas which comprise the SWARD region. Fermanagh District Council area returned the highest response rate at 44.7%. Cookstown District Council was second with 21.2% of the response rate. In third place was Dungannon and South Tyrone Borough Council. Finally, Magherafelt District Council was in fourth position accounting for 15.8% of the individual online respondents.

81.8% of the respondents indicated that they lived within a rural environment. 18.2% indicated that they perceived themselves living within an urban environment.

Graph 29: How would you describe the community you live in?
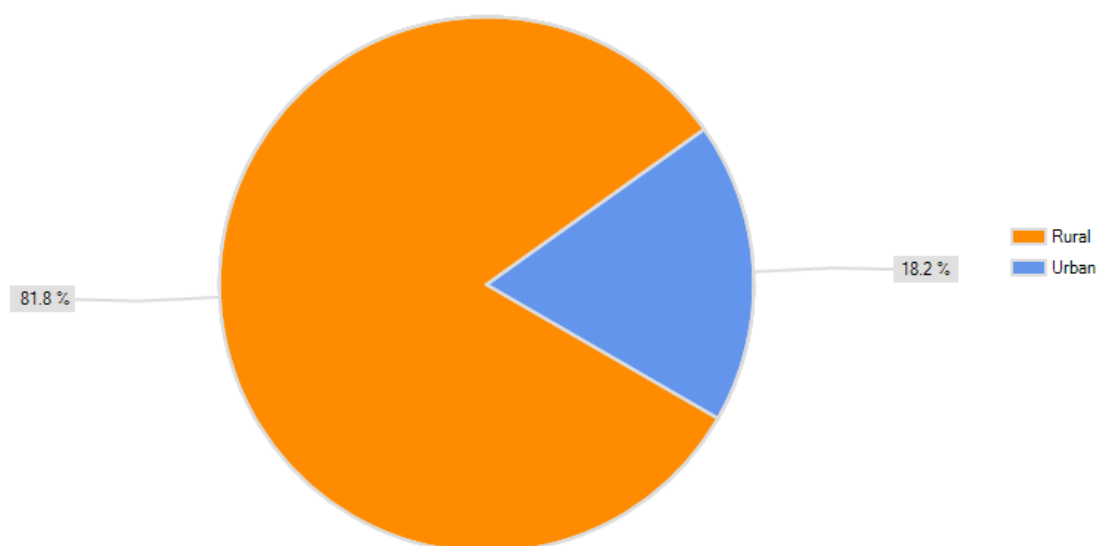
The following section of the individual online survey asked the members of the public to consider the following 21 statements and illustrate their level of agreement with each one. The distribution of the responses across the 21 statements are shown in the table below.

Table 2: Please indicate the extent to which you agree with each of the following statements:

Statements	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Don't know
1. There is something about people with mental illness that makes it easy to tell them from apart from "normal" people	4.8% (2)	16.7% (7)	9.5% (4)	7.1% (3)	**61.9% (26)**	0.0% (0)
2. Mental illness is an illness like any other	**57.1% (24)**	21.4% (9)	4.8% (2)	4.8% (2)	11.9% (5)	0.0% (0)
3. Secure psychiatric units are an outdated means of treating people with mental illness	**63.4% (26)**	12.2% (5)	9.8% (4)	9.8% (4)	4.9% (2)	0.0% (0)
4. Virtually anyone can become mentally ill	**92.7% (38)**	7.3% (3)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
5. People with mental illness have for too long been the subject of ridicule	**73.2% (30)**	17.1% (7)	2.4% (1)	4.9% (2)	2.4% (1)	0.0% (0)
6. We need to adopt a far more tolerant attitude toward people with mental illness in our society	**87.8% (36)**	12.2% (5)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
7. We have a responsibility to provide the best possible care for people with mental illness	**95.0% (38)**	5.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
8. People with mental illness don't deserve our sympathy	4.9% (2)	0.0% (0)	0.0% (0)	2.4% (1)	**92.7% (38)**	0.0% (0)
9. People with mental illness are a burden on society	2.4% (1)	0.0% (0)	4.9% (2)	4.9% (2)	**85.4% (35)**	2.4% (1)
10. Increased spending on mental health services is a waste of money	4.9% (2)	0.0% (0)	2.4% (1)	7.3% (3)	**82.9% (34)**	2.4% (1)
11. There are sufficient existing services for people with mental illness	12.2% (5)	0.0% (0)	4.9% (2)	26.8% (11)	**48.8% (20)**	7.3% (3)

12.	People with mental illness should not be given any responsibility	5.1% (2)	7.7% (3)	2.6% (1)	12.8% (5)	**66.7% (26)**	5.1% (2)
13.	A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	10.0% (4)	2.5% (1)	2.5% (1)	10.0% (4)	**70.0% (28)**	5.0% (2)
14.	I would not want to live next door to someone who has been mentally ill	7.7% (3)	0.0% (0)	5.1% (2)	5.1% (2)	**76.9% (30)**	5.1% (2)
15.	Anyone with a history of mental problems should be excluded from taking public office	7.5% (3)	2.5% (1)	5.0% (2)	7.5% (3)	**70.0% (28)**	7.5% (3)
16.	No-one has the right to exclude people with mental illness from their neighbourhood	**75.0% (30)**	7.5% (3)	2.5% (1)	2.5% (1)	10.0% (4)	2.5% (1)
17.	People with mental illness are far less of a danger than most people suppose	**60.0% (24)**	15.0% (6)	10.0% (4)	0.0% (0)	10.0% (4)	5.0% (2)
18.	Most women who were once patients in a mental hospital can be trusted as babysitters	**31.7% (13)**	17.1% (7)	24.4% (10)	12.2% (5)	7.3% (3)	7.3% (3)
19.	The best therapy for many people with mental illness is to be part of a normal community	**68.3% (28)**	22.0% (9)	2.4% (1)	2.4% (1)	0.0% (0)	4.9% (2)
20.	As far as possible, mental health services should be provided through community based facilities	**63.4% (26)**	22.0% (9)	9.8% (4)	2.4% (1)	0.0% (0)	2.4% (1)
21.	People with mental health problems should have the same rights to a job as anyone else	**82.9% (34)**	7.3% (3)	4.9% (2)	2.4% (1)	0.0% (0)	2.4% (1)

What the analysis presented within the table above demonstrates is that the individuals agree strongly by a majority with 11 of the individual statements (No's 2,3,4,5,6,7,16,17,19,20 and 21) and strongly disagree by a majority with 8 of the individual statements (No's 1,8,9,10,12,13,14 and 15). Two of the statements do not achieve an outright majority (No's 11 and 18).

Looking in more detail at the responses to the individual statements the following impressions are realised:

Whilst the majority at 61.9% of the 42 respondents to this statement disagree strongly that 'There is something about people with mental illness that makes it easy to tell them apart from "normal" people', 32% account for the agree strongly and slightly and neither agree or disagree categories.

The statement 'Mental illness is an illness like any other' returned a majority agree strongly at 57.1% and 21.4% agree slightly. 11.9% disagree strongly, 4.8% disagree slightly and the remaining 4.8% neither agree or disagree.

63.4% of the 41 total respondents to statement 3 'Secure psychiatric units are an outdated means of treating people with mental illness' agree strongly with this statement. 12.2% agree slightly. 9.8% of the respondents neither agree or disagree. 9.8% disagree slightly and 4.9% disagree strongly.

The joint second highest outright majority at 92.7% of the total 41 respondents was returned in regard to statement 4, 'Virtually anyone can become mentally ill'. There was no uncertainty or disagreement with this statement.

Statement 5, 'People with mental illness have for two long been the subject of ridicule' returned at majority at 73.2% who agree strongly with the statement. 17.1% agree slightly.

In considering the statement 'We need to adopt a far more tolerant attitude toward people with mental illness in our society', 87.8% of the total 41 respondents agree strongly. There was no disagreement or uncertainty in regard to this statement expressed by the respondents.

40 individuals responded to statement 7, 'We have a responsibility to provide the best possible care for people with mental illness'. 95.0% of the respondents strongly agree with this statement. This represented the highest majority in terms of agreeing strongly across all of the 21 individual statements.

'People with mental illness don't deserve our sympathy' returned in a 92.7% response rate in regard disagreeing strongly. 4.9% agree strongly with the statement.

Statement 9 relates to the extent which the respondents feel persons with a mental illness are a burden on society. 85.4% disagree strongly with the statement. 2.4% agree strongly and 4.9% neither agree or disagree.

The vast majority of the respondents at 82.9% disagree strongly that increased spending on mental health services is a waste of money.

The majority of respondents disagree slightly or strongly with statement 11, 'There are sufficient existing services for people with mental illness'. 12.2% agree strongly that there are sufficient existing services.

Looking at statement 12, 66.7% of the total 39 respondent disagree strongly with the statement that 'People with mental illness should not be given any responsibility'. 15.4% agree strongly or slightly or neither agree or disagree. 5.1% do not know.

Statement 13 (which was completed by 40 respondents), 'A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered' returns a majority at 70.0% who disagree strongly with this statement. 10.4% agree strongly and 2.5% agree slightly. 5% don't know.

76.9% of the 39 respondents to statement 14 'I would not want to live next door to someone who has been mentally ill' disagree strongly with this statement. 7.7% agree strongly, 5.1% neither agree or disagree, 5.1% disagree slightly and a further 5.1% don't know.

Statement 15 states 'Anyone with a history of mental problems should be excluded from taking public office'. A majority at 70.0% disagree strongly with this statement which 40 people completed. 7.5% were unsure and 7.5% agree strongly.

In regard to statement 16, 75.0% of the individuals agree strongly that 'No one has the right to exclude people with mental illness from their neighbourhood'. 12.5% disagree.

In statement 17, 'People with a mental illness are far less of a danger than most people suppose' 60.0% strongly agree. 10.0% neither agree or disagree and a 10.0% disagree strongly.

In respect of statement 18, 31.7% of the 41 respondents to the statement 'Most women who were once patients in a mental hospital can be trusted as babysitters' indicated that they agree strongly. 17.1% agree slightly. 24.4% neither agree or disagree. 12.2% disagree slightly and 7.3% disagree strongly. 7.3% don't know.

68.3% agree strongly and 22.0% agree slightly with statement 19 that 'The best therapy for many people with mental illness is to be part of a normal community'.

In response to statement 20, 'As far as possible, mental health services should be provided through community based facilities', 63.4% of the 41 respondents to this statement agree strongly and 22.0% agree slightly. 9.8% neither agree nor disagree.

82.9% of the 41 respondents to statement 21 agree strongly that 'People with mental health problems should have the same rights to a job as anyone else'.

50% of the 40 respondents to the question 'Are you currently living with, or have you ever lived with, someone with a mental health problem?' indicated yes. 60% of the respondents indicate that they have or are currently working with someone with a mental health problem. 42.1% stated that they have or have had a neighbour with a mental health problem. 31.6% state that they don't know if they have currently and or in the past had a neighbour with a mental health problem. When asked if they have or ever have had a close friend with a mental health problem, 69.2% say yes.

Graph 30: The following statements ask about any future relationships you may experience with people with people with mental health problems. Please tell me how much you agree or disagree with each one:
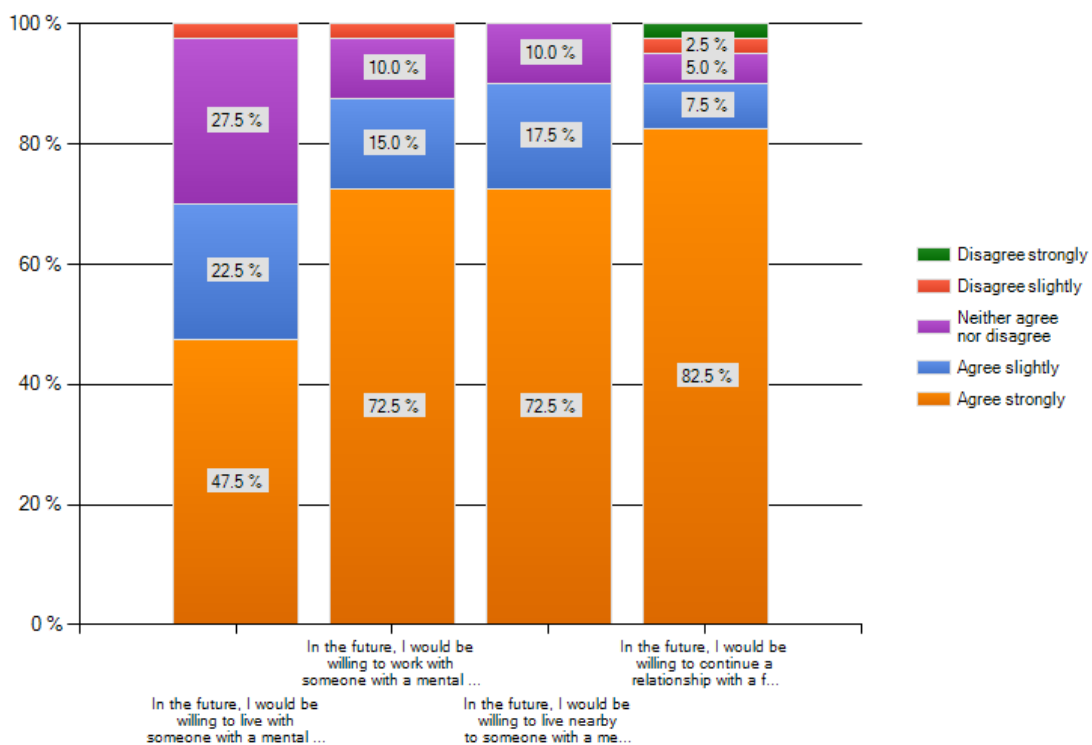
From the chart above it is seen that of the four statements, 3 return a majority in terms of agree strongly.   The statement relating to the respondents preparedness to live with someone with a mental health problem in the future shows the weakest response overall. The respondents would be most likely to continue a relationship with a friend who developed a mental health problem in the future, followed by being willing to work and or live near to someone with a mental health problem.

Graph 31: Below are a number of statements about mental health problems, again that is conditions for which an individual would be seen by healthcare staff. Please tell me how much you
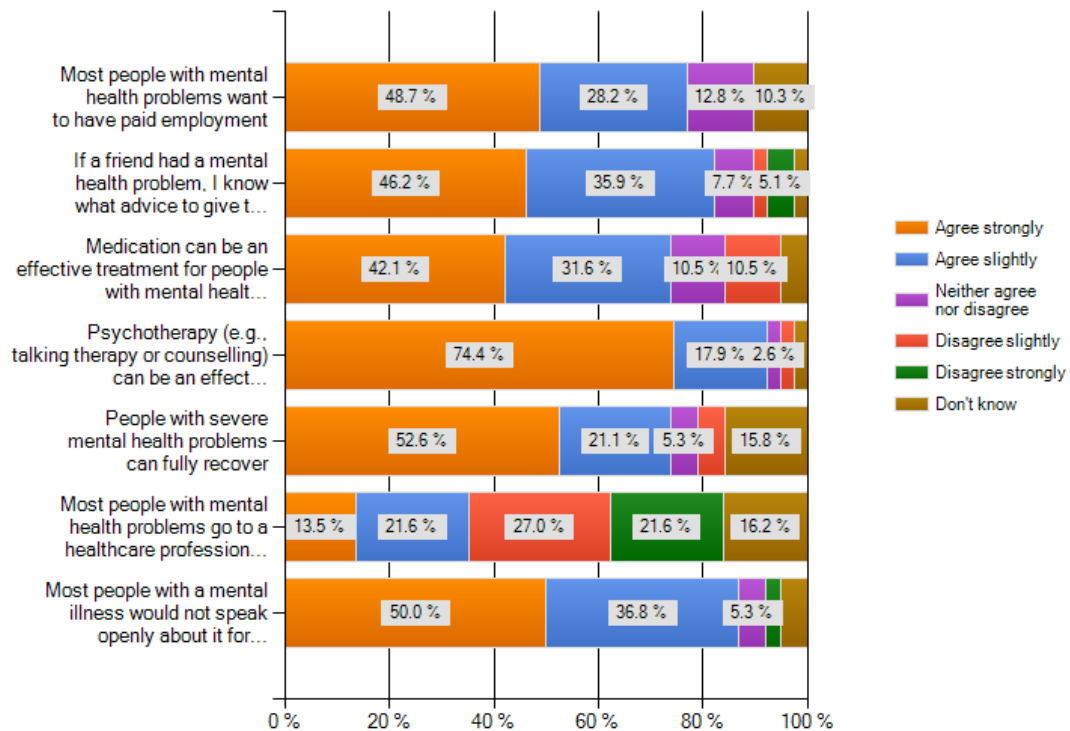
agree or disagree with each one?

In regards to the statements contained within the graph above, two return a majority in relation to a response. 74.4% of the 39 respondents to the question agree strongly that psychotherapy can be an effective treatment for people with mental health problems. The second statement 'People with severe mental health problems can fully recover' returns a much more modest majority of agree strongly at 52.6%. Just under 50.0% agree strongly that people with mental problems want to have paid employment. 28.2% agree slightly. In terms of knowing what to do if a friend had a mental health problem and was in need of professional help 46.2% agree strongly that they would know what to do. 31.6% agree slightly. 42.1% and 31.6% respectively agree strongly and slightly that medication can be an effective treatment for people with mental health problems. The statement with the greatest degree of distribution of responses is in relation to whether people with a mental health problem go to a healthcare professional for help. 27.0% disagree slightly and 21.6% disagree strongly. A further 16.2% don't know. When presented with the statement 'Most people with a mental illness would not speak openly about it for fear of losing their job', 50.0% agree strongly and a further 36.8% agree slightly.

Graph 32: What proportion of people in your rural community do you think might have a mental health problem at some point in their lives?
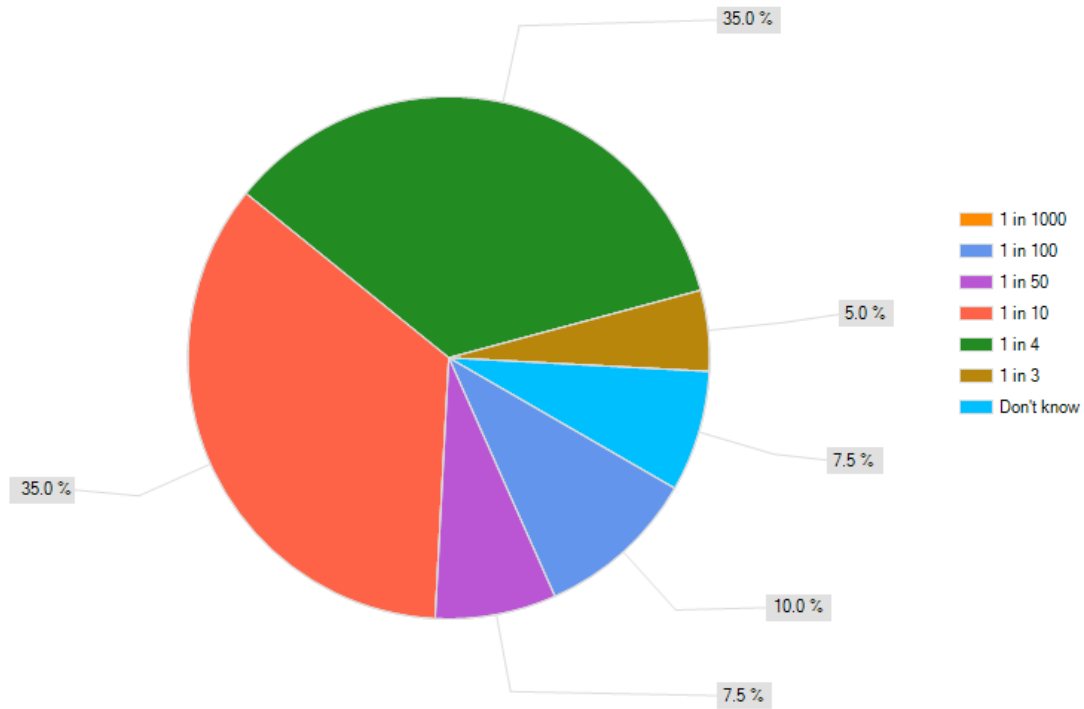
35.0% respectively of the 40 respondents to the question 'What proportion of people in your rural community do you think might have a mental health problem at some time in their lives?' stated 1 in 10 and 1 in 4.

Help-seeking behaviour and attitudes

The following graph presents the results to the question 'If you felt that you had a mental health problem, how likely would you be to seek help?'

Graph 33: If you felt you had a mental health problem, how likely would you be to seek help?
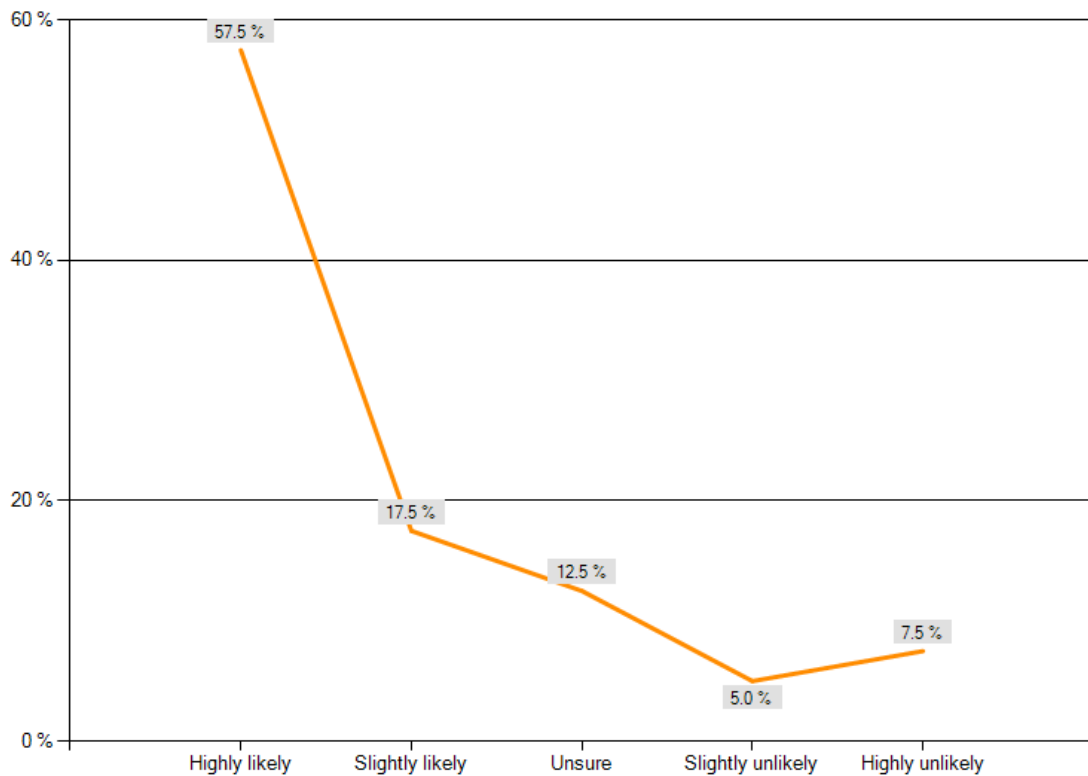
Of the 40 respondents who completed this question, the majority at 57.5% say they would be highly likely to seek help. 12.5% are unlikely to do so to a greater or lesser extent, and a further 12.5% are unsure. 17.5% felt they are only slightly likely to seek help.

The respondents were asked to consider if they were (hypothetically) to experience a mental health issue such as stress, anxiety or depression, how comfortable would they be in seeking help and support from a list of potential supports.

Table 3: If you were to experience a mental health issue such as stress, anxiety or depression, how comfortable would you be in seeking help and support from the following sources?

	Very uncomfortable	Moderately uncomfortable	Slightly uncomfortable	Neither comfortable nor uncomfortable	Fairly comfortable	Moderately comfortable	Very comfortable
Someone in your family	19.4% (7)	16.7% (6)	13.9% (5)	0.0% (0)	19.4% (7)	2.8% (1)	**27.8% (10)**
Friend	11.1% (4)	11.1% (4)	13.9% (5)	8.3% (3)	16.7% (6)	**25.0% (9)**	13.9% (5)
Work colleague	16.7% (6)	16.7% (6)	**33.3% (12)**	0.0% (0)	13.9% (5)	19.4% (7)	0.0% (0)
GP	11.1% (4)	5.6% (2)	2.8% (1)	5.6% (2)	25.0% (9)	16.7% (6)	**33.3% (12)**
Your employer	**37.1% (13)**	11.4% (4)	28.6% (10)	5.7% (2)	8.6% (3)	5.7% (2)	2.9% (1)
Clergy	**41.7% (15)**	8.3% (3)	8.3% (3)	5.6% (2)	16.7% (6)	8.3% (3)	11.1% (4)
Social Worker	**31.4% (11)**	11.4% (4)	17.1% (6)	0.0% (0)	17.1% (6)	17.1% (6)	5.7% (2)
Psychologist/ psychiatrist	20.0% (7)	5.7% (2)	8.6% (3)	5.7% (2)	14.3% (5)	17.1% (6)	**28.6% (10)**
Someone who has experienced the issue which you are experiencing	11.1% (4)	5.6% (2)	8.3% (3)	2.8% (1)	22.2% (8)	22.2% (8)	**27.8% (10)**
Community/ voluntary support organisation	14.3% (5)	11.4% (4)	8.6% (3)	2.9% (1)	**28.6% (10)**	25.7% (9)	8.6% (3)
Telephone Helpline	13.9% (5)	8.3% (3)	5.6% (2)	5.6% (2)	**27.8% (10)**	**27.8% (10)**	11.1% (4)
Advice centre	19.4% (7)	5.6% (2)	5.6% (2)	11.1% (4)	**30.6% (11)**	22.2% (8)	5.6% (2)
Other sources (e.g.,internet, book, magazine, another person, etc?)	19.4% (7)	0.0% (0)	5.6% (2)	2.8% (1)	13.9% (5)	27.8% (10)	**30.6% (11)**

The table above demonstrates the spread of opinion across the different potential sources of help.

50% of the respondents would be comfortable to talk with a family member. However, of this 50%, just over half would be completely happy to talk with a family member. 55.6% of the respondents would be comfortable talking with a friend, although the level of comfort is more located with respect to the slightly and moderately comfortable categories.

66.7% of the respondents would be uncomfortable to a greater or lesser degree in speaking with a work colleague about a mental health problem they might be experiencing. In regard to the gp, the majority of the respondents would be comfortable to a greater or lesser degree, with the biggest category being very comfortable at 33.3%. 25% are fairly comfortable with the idea of talking about a mental health problem with their gp. 16.7% of the respondents are at the level of moderately comfortable. Similar results are returned in respect of psychologist and psychiatrist. Uncomfortable levels are high, especially in relation to an employer, with 77.1% of the respondents to a greater or lesser degree being uncomfortable with the idea of talking to an employer about a mental issue they might be experiencing. Clergy and social workers return similar results. Interestingly, Clergy returns the highest level of respondents being very uncomfortable at 41.7%.

72.2% of the respondents would be comfortable talking to someone who had experienced the same issue as them. 22.2% respectively indicated that they would be fairly and moderately comfortable talking to someone who has experienced a similar issue, whilst 27.8% are very comfortable.

62.9% of the respondents are comfortable with the idea of talking to a voluntary/ community support organisation. A similar distribution is discovered for telephone helplines, although it has a slightly overall higher level of comfort than the community/voluntary support organisations.

The majority of the respondents would feel comfortable speaking with an advice centre, albeit that the level of comfort overall is lower than for that expressed for community and voluntary support organisations and someone else who has experienced a similar issue to yourself.

Other sources such as the internet, books, magazine and or another person return the second highest overall level of comfort across the different help sources at 72.3%, just behind GP at 75.0%. 30.6% are very comfortable with the idea of seeking help through the other sources.

The graph below presents the aggregated comfortable percentages. This graph illustrates very clearly the relative popularity of the alternative possible support types for the respondents were they to experience a mental health issue for which they might need to seek help.

Graph 34: Level of comfort by type of support?
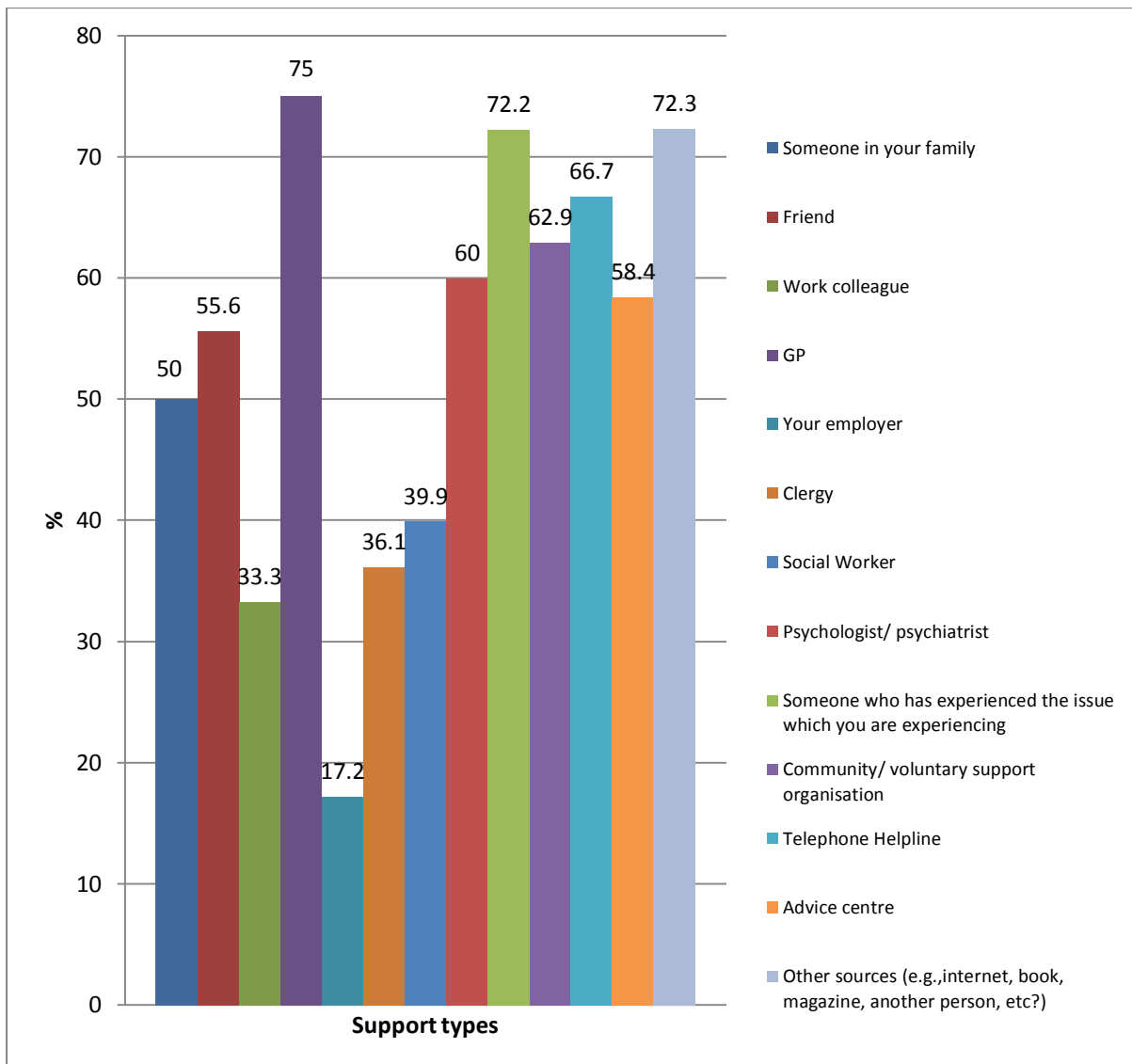
In considering the need for the differing types of services within their rural communities, the vast majority of the respondents in each case indicate a high need. The highest scoring service need is that for people experiencing severe mental health problems at 76.5%. In second place is need for positive mental health and wellbeing services and supports at 75.0%. In joint third place are services and supports for people experiencing mild mental health problems, services and supports for those bereaved by suicide, and for people who self-harm.

Graph 35: Please indicate the extent to which you feel there is a need for the following services within your rural community?
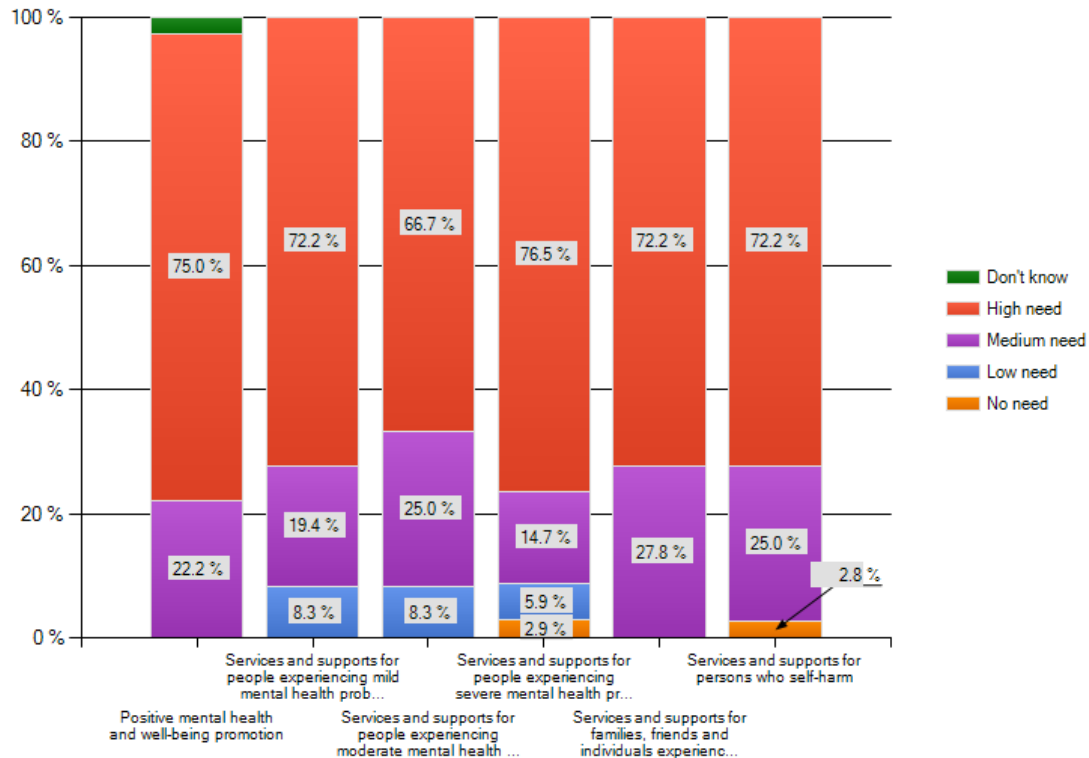
The respondents assessment of the availability of the mental health supports and services within their rural community in regard to the needs they identified are illustrated in the graph below. On the whole, respondents assessments suggest that the services and supports are generally of low to moderate availability.

Graph 36: How available do you feel current mental health supports and services are within your rural community to address the following community mental health needs?
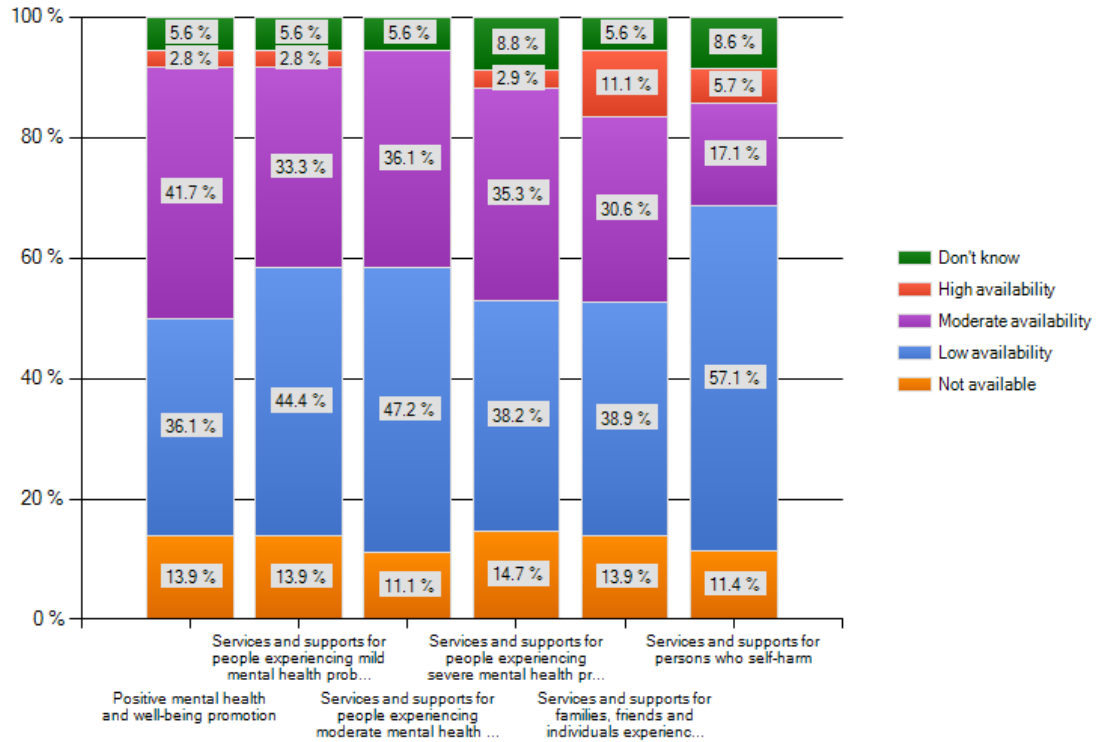
When asked how familiar they are with the range of community, voluntary, private and statutory mental health support and services available within their rural community, 33.3% said they were moderately familiar. 30.6% said they were highly familiar. 19.4% and 13.9% were slightly familiar and not familiar respectively.

Graph 37: How familiar are you with the range of community, voluntary, private and statutory mental health support and services available within your rural community?
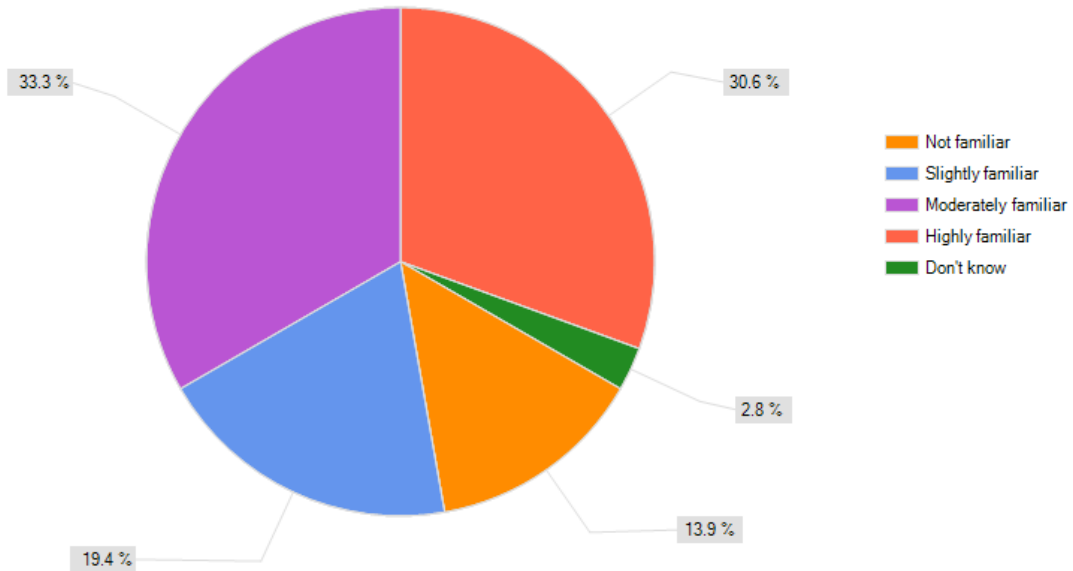
When it comes to knowing whether or not they would know what to do if a friend came to them seeking help for a mental health problem, 72.2% felt they would know how to help them get the right support. 11.1% said they would not know.

Graph 38: In the event of a person you might know experiencing a mental health problem, would you feel you would know how to help them to get the right support?
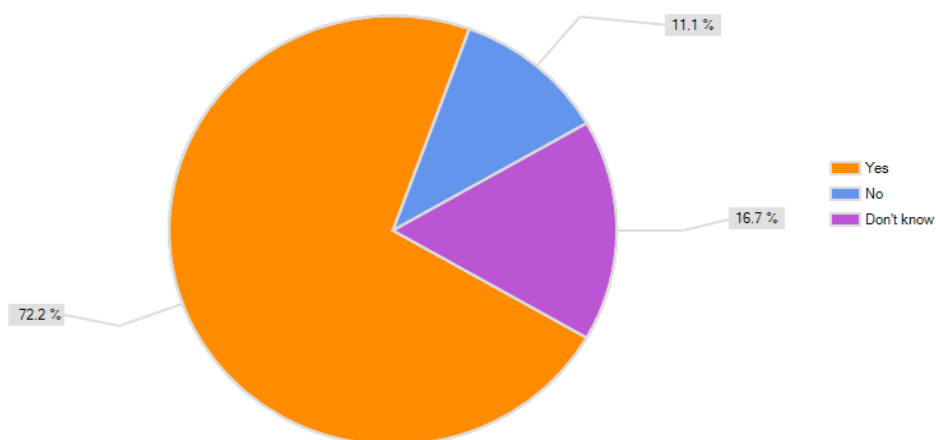
The respondents indicate that in all dimensions of life as presented within the next graph, people with a mental health need or problem experience stigma and discrimination. It was felt that those experiencing mental health problems will experience the greatest stigma and discrimination within their employment and social spheres, each returning 83.3%. Second is community at 80.6%, followed by public life at 77.8%. Further, 66.7% believe that persons with a mental health need or problem within a rural community will experience stigma and discrimination within their sporting/ recreational life domain. Whilst the majority still felt that the church was an area of life within which a person would experience stigma and discrimination at 58.3%, it was marginally higher that in respect of an individuals family context. Clearly, 30.6% of the respondents felt that the family context was the area of life within which the person with a mental health problem or need would not experience stigma and or discrimination.

Graph 39: Do you think people with mental health needs and problems in your rural community experience stigma and discrimination nowadays because of their mental health problems in the following areas of their life?
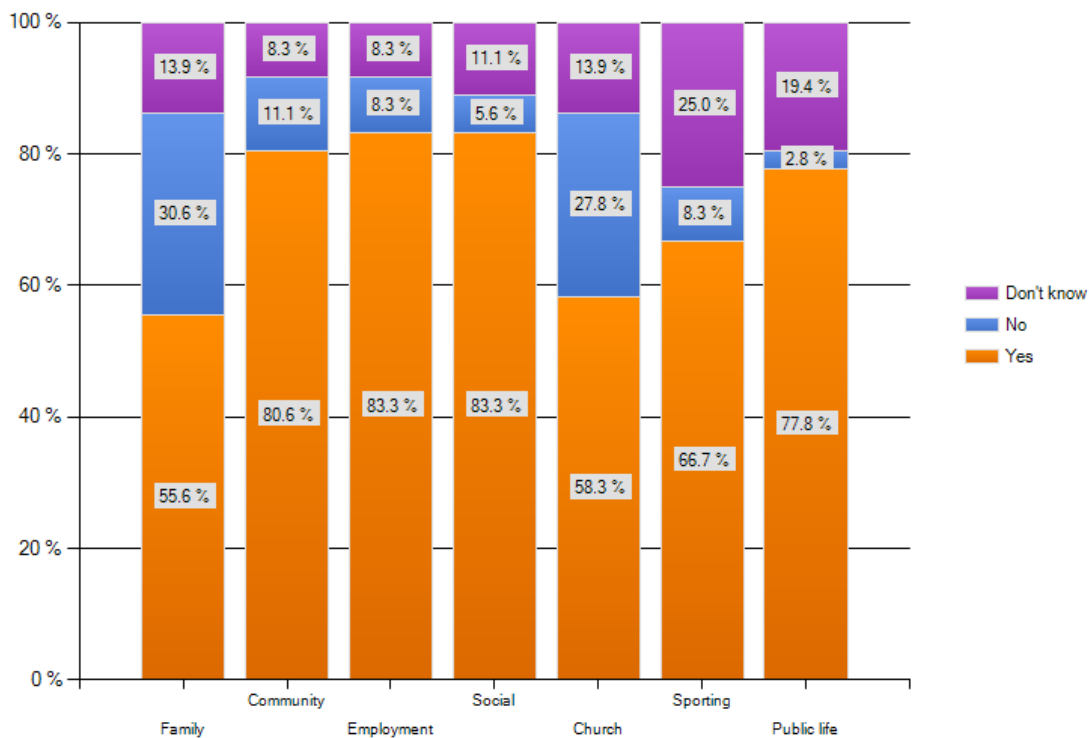
The opinion of the respondents whether stigma and discrimination facing people with mental health needs and problems in rural communities has changed over the past three years is shown below in the pie chart. 27.8% indicate that in their opinion it has remained the same.

11.1% indicate that in their opinion it has become worse. 36.1% feel that it has improved. Finally, 25.0% don't know.

Graph 40: Do you think mental health related stigma and discrimination has changed for people with mental health needs and problems within your rural community in the past 3 years?
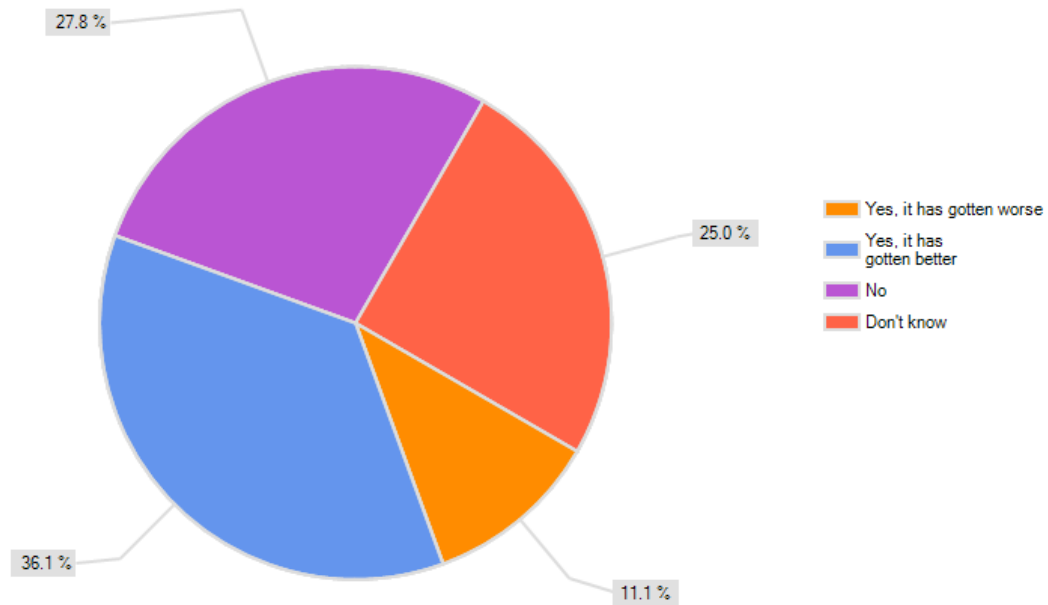
When asked if they were to experience a mental health issue or problem personally (i.e., you were the person to experience it) would you feel comfortable talking about it openly within your rural community, the vast majority at 71.4% said they would not feel comfortable. 14.3% said yes they would. 14.3% are unsure.

Graph 41: If you were to experience a mental health issue or problem personally (i.e., you were the person to experience it) would you feel comfortable talking about it openly within your rural community?
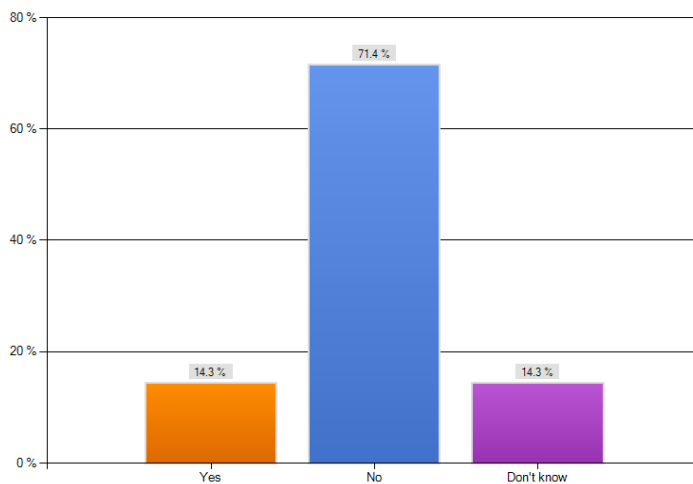
40.0% of the respondents indicated that the person closest to them who has experienced a mental illness has been an immediate family member such as a spouse, child, sister, brother and or parent, etc. The joint second highest categories are self and friend.

Graph 42: Who is the person closest to you who has or has had some kind of mental illness?
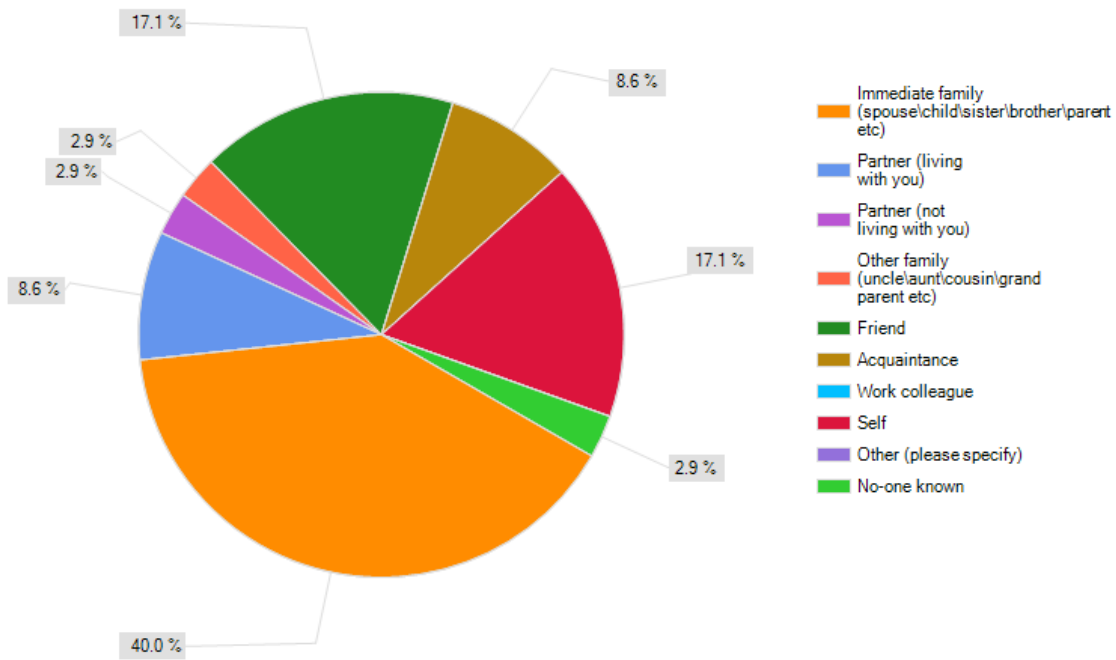
44.4% of the respondents indicated that they have experienced a mental health issue which personally affected their ability to function normally on a day to day basis.

Graph 43: Have you ever experienced a mental health issue personally which affected your ability to function normally on day to day basis?
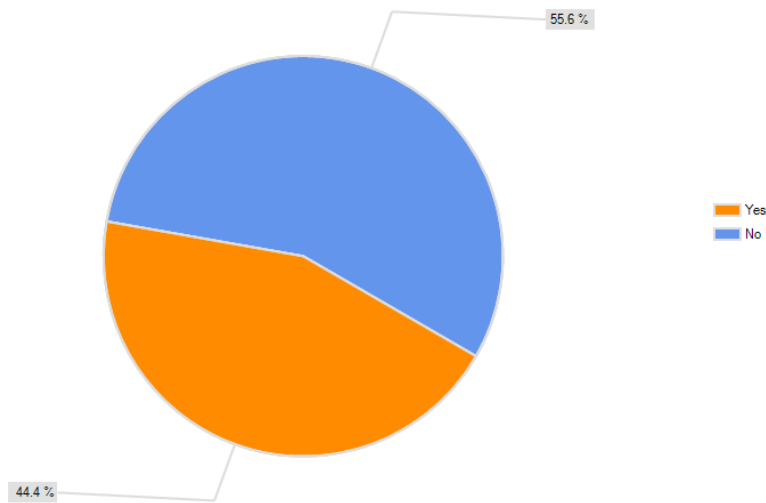
41.7% of the respondents described themselves as belonging to the rural community. 22.2% said they belong to the employed community. It is evident from the pie chart below that none of the respondents identified themselves as belonging to the LGB&T, Traveller, Parents and Persons with a Disability communities.

Graph 44: How would you describe the community you belong to?
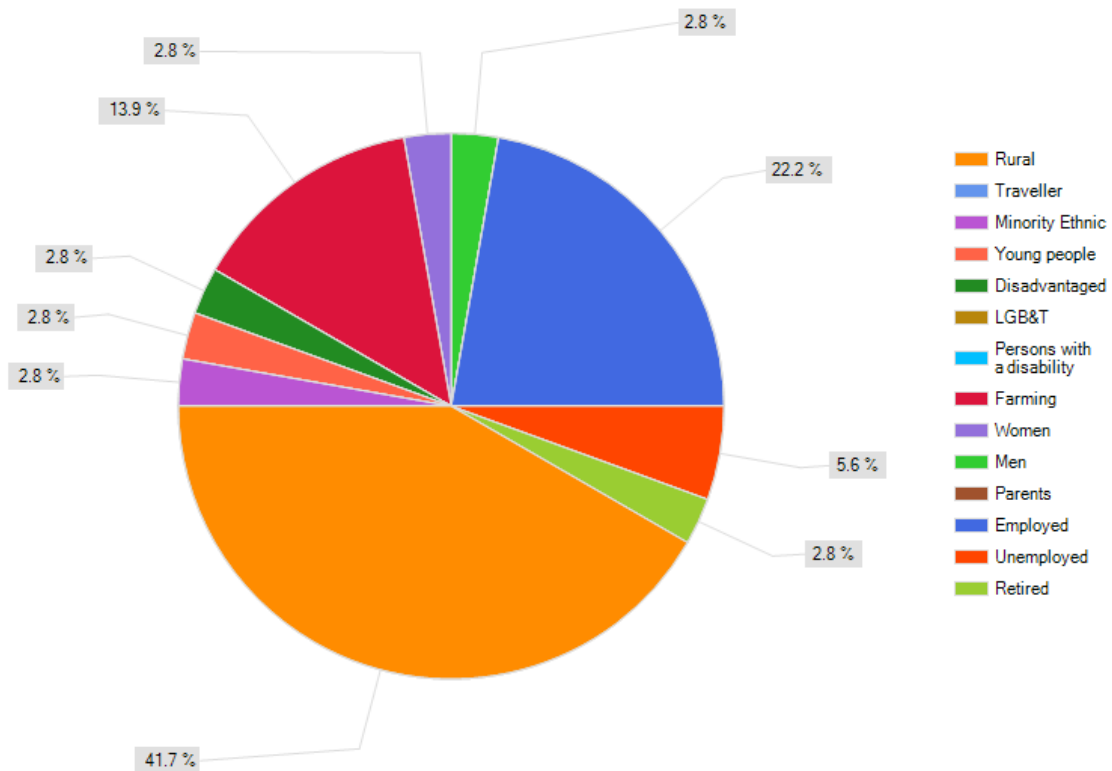
It is appropriate at this point to establish that considerable effort went into attempting to engage those groups who were not indicated within the pie chart above. Despite concerted efforts on the part of the researcher, it proved challenging to make contact with the LGBT and Traveller communities in particular within the SWARD area. Numerous correspondence attempts were made with these groups by both the Niamh Louise Foundation and the researcher. Regrettably, requests for the opportunity to meet with these communities did not materialise. In regard to parents and young people, several opportunities presented themselves throughout the course of the extensive focus groups and interviews with the key informants from throughout the SWARD area.

Encourage help seeking behaviour

The respondents indicated that it is important for the taboo and stigma which still exists in regard to mental health in rural areas to be reduced and removed all together. They want to see rural areas become more tolerant of mental health issues and those who experience it. They call for greater advertising and awareness raising of the issues within their rural communities. They also want to see those services that are available more widely communicated and promoted in an accessible manner which encourages people to make contact with them. Additionally, it is felt that if mental health can be seen on a par with "traditional medical" experience, that this would go a long way to encouraging greater help-seeking, as is the importance of someone who can listen and is non-judgemental. Respondents feel that it is important that supports and services work with the entire family who will continue to be the immediate network of the individual with the immediate mental health issue.

The GP is seen as an important role. The respondents would wish to see GP's really listening to patients presenting with mental health issues and directing them to a wider range of potential services and supports, rather than defaulting to prescribing of pills.

The respondents also suggest that knowing the extent of their responsibilities such as being a single parent and or being responsible for other family members would encourage them to seek help in order that they can retain their ability to fulfil their caring duties and responsibilities. Also knowing that people can recover from mental illness is important and that they will not be pushed from pillar to post within the health service and come out the other end worse off.

Prevent help-seeking behaviour

In presenting the feedback from the respondents in regard to what would prevent them from seeking help in the future for a mental health issue or problem, the researcher felt that the direct responses are powerful and speak for themselves. They are thus presented below as they were received by the researcher anonymously and in confidence:

Probably the fact that I would be talking to a stranger about my private problems that might be

passed on to others.

The lack of confidentiality within health centres and community groups.

Fear of losing a job.
Fear of losing friends.
Fear of being discriminated against.

If it were to affect my job role/ employment.

Lack of service; so many different people to tell story to. Get the help you ask for. Do not put persons off. Listen to family.

Afraid it would affect my job and others opinions of me.

Nothing will prevent me from seeking help. My family may not approve of me making it public.

Other peoples opinion.

Patronising attitudes.

Stigma, lack of understanding and lack of confidentiality around services.

I would worry about being judged, particularly in work. Also, there is still a perception that mental illness is a sign of weakness, much more so than a physical illness.

Peoples attitude towards me in the future.

Stigma and fear for my children.

People would connect you with that problem forever.   You would always be tainted.

Worrying about impact on family. Keeping it together.

Free time and availability of help. How far do I need to travel and how flexible is it?
The councillors attitude, knowledge and rapport would also be important.

Don't know.

My independent living.

Stigma.

Stigma.

Nothing.

I still think it can be very difficult for people to talk to employers, friends etc.   It's not completely that there is a stigma around mental health illness, more that it is an inconvenience for employers and friends unless the person is a very, very close friend.   What I'm trying to say is that a lot of employers could not be bothered, and casual friends/acquaintances may just be fair weather friends.

Only close friends and family members are really interested.

Health service.

Cuts to medical care, waiting lists for counselling (or having to pay for private), not wanting to take anti-depressants, fear that people would think differently of me.

In summarising the above points which have been presented verbatim, it is evident that the big issues for people are fear of discrimination and stigma, not just for themselves but for their children. The respondents fear the possibility of the stigma staying with you and the potential leakage of the information that has been shared in confidence with the support provider into the community within which one lives and the consequence this would have for one's potential employment and social relationships.

Additional thoughts and comments

A certain amount of people in the rural community will play shy to admitting a problem maybe through pride or ignorance to seek help until it's too late. I like to encourage all of my family to speak openly about all problems at school and work.

I strongly believe that GP's should be more aware of other mental health services. Time and time again I see gp's handing out tablets but no other signposting to holistic therapies or organisations, i.e. counselling. No follow up appointments are ever made. In relation to my father, he is in and out of Gransha all the time and no follow up when he gets out. In turn this leads to him being admitted again. It's a joke!!!

Resilience should be developed in children and young people to lessen the risk of future mental health problems, i.e. it should be part of the school curriculum.
The health service should focus more on preventing (rather than managing) mental health problems, e.g. providing a programme on positive psychology.

A comprehensive survey. There has been no mention of the terrible mental health legacy as a result of the Troubles.

More public awareness meetings.

I think there is less access to services in the rural community, i.e. barriers for women who are at home, to transport, childcare and who may be in relationships where they are not allowed to do what their husbands don't approve off.

The downturn in farming, employment and no work.

There is an obvious need.   One only has to talk about the suicide rate.

The comments above speak to the very real nature of experiencing poor mental health within a rural community. People may be less likely to try and seek help because of a certain self-sufficiency mind-set and or for the fear of being seen as weak. The whole notion of inaccessibility and the transport poor is alluded to, as is the potential influence of a partner/family in enabling or disabling an individual from seeking help. Further, the respondents express concern at the lack of availability of services and the necessary follow-up to establish if a person is improving or otherwise.

There appears to be a recognition that the rural communities need to take a look up-stream before "it becomes too late", to work on addressing the causal factors which give rise to poor mental health in the first place. The respondents call for a greater focus on prevention and positive psychology, especially in regard to our young people. The need to build resilience in light of the current recessionary context and the pressures this is placing on individuals, families and communities, as well as the need to address what often seems like an overwhelming issue of inevitable suicide are pressed for.

"I would worry about being judged, particularly in work. Also, there is still a perception that mental illness is a sign of weakness, much more so than a physical illness."

"Stigma and fear for my children"

Community Focus Group and Professional Key Informants Feedback

Introduction

The following pages reflect the dominant key themes which emerged from the extensive consultation process across the SWARD region with members of the public consulted through the focus groups held in Augher, Pomeroy, Draperstown, and Coalisland, as well as the semi-structured interviews held in person with 9 key informants and an additional 3 semi-structured interviews with key informants undertaken by telephone who were drawn from across the entire SWARD region.

The feedback from both the public and the key informants has been drawn together for the purposes of presentation within this document given the relatively high degree of correlation of both sets of feedback.

Key Themes

Stigma

"Stigma is absolutely massive."

"Mental health is something to be ashamed of and hidden away."

"I'm a paid professional… and I would be uncomfortable sharing with others that I have a mental health problem."

The majority of opinion is that stigma surrounding mental health is still a very real and powerful issue within and across the SWARD region.   There is a wide recognition that much good work is taking place at both the local, sub-regional and Northern Ireland levels aimed at challenging the stigma and encouraging people to seek help, especially through the campaigns run by the Public Health Agency such as 'Under the Covers', 'Mind Your Head' and the 'Lifeline' television adverts, etc.

When discussing the issue of stigma, it was felt that people from across the rural community are more prepared to talk about mental health in so far as it relates to someone else, but much less likely to talk about an issue regarding themselves. "They'll talk about it in the third person." There remains a very pervasive and deep sense of shame, anxiety and fear around being known as someone who is or has experienced a mental health issue.

One individual within one of the public focus groups spoke of the sheer fear if it were to become known in this individual's place of employment that they experienced on-going episodes of depression. The individual worried about the consequences of public disclosure in regard to their job and how they would be seen. A further very real concern on the part of this individual

was what was felt to be a real possibility that parents would not want this individual to work with their children.

The nature of the rural community

The very nature of the rural community itself within the SWARD region was seen to contribute heavily to and exacerbate the sense of potential and real stigma felt by an individual who might be in need of support and services for a mental health issue. Many consultees referred to the close-knit nature of the rural communities and the case that everybody tends to know everybody else and their business (whether you want them to or not). Whilst this was seen as a tremendous strength and asset in one regard, it was seen to create an immense barrier for those who might wish to seek help in another. Given the tendency toward heightened awareness amongst the rural community of the movements and business of neighbours and friends, it was felt that this places a considerable pressure on rural dwellers to "...keep the issue bottled up..." If people were seen to be attending a mental health related service or support within their rural community, it is felt that it would tend to get out very quickly into the wider public domain. The possibility of this wider public disclosure inhibits the individual from seeking help for fear of the stigma that may be visited on them and or their families, the gossip and "curtain twitching" which might take place, the fear of been seen as "mad" or having "to go to the big house" and "Having their life chances" severely curtailed because of the prejudice which is present toward those perceived to have a mental health issue within the rural community. Individuals fear that they will be ostracised from their previous social networks, that they might lose their jobs and all future prospects.

The role and influence of the church in the rural community

A number of the consultees spoke about the influence and role of the church within the rural community. There was a split in opinion in regard to the role and influence of the church in relation to mental health within the SWARD region. On the one hand, it was acknowledged that whilst the role and influence of the church might be in decline overall, that it still holds a great deal of sway within the rural communities of the SWARD region. A number of instances were shared were it was alleged that some members of the clergy (in recent times) asserted that suicide would result in the person being condemned to Hell, as well as other instances of families being advised that it might be better for them to leave an area to avoid the stigma and shame of their loved one having taken their life through suicide. This in the opinion of a key informant was seen to be adding tremendously to the stigma for other individual's and their families seeking help who might also have strong ties with the same church. On the other hand, a number of consultees noted that whilst the view amongst churches that suicide was a sin created/ creates a stigma, they also acknowledged that in their opinion it probably prevented a great many individuals from taking their own lifes. Whilst they were not condoning the perpetuation of the stigma, they felt that it would have had the effect of regulating the behaviour.

The issue of the role and influence of the church emerged as a significant theme within the Draperstown focus group in particular. When considering to whom an individual and or family could turn within the local community for help and support in a time of mental and emotional crisis and or following a suicide episode, the individuals present within the group were adamant that they would not turn to the local clergy or church. One of the individuals present was vehement in their opinion that "they would be the last place I'd turn to."

One of the key informants talked about the powerful role of the churches within the SWARD region in giving permission to their congregations to seek help for mental health and stress related issues. One example was shared with the researcher where a church posted materials in the foyer of the church which set-out details on help and support organisations for rural individuals and their families. This approach was found to have generated quite a considerable response and demonstrated this to be an effective means of encouraging and enabling people to acknowledge and seek help. However, there is felt to be considerable opportunity for churches and clergy within the region to talk about the issues of mental health and stress from the pulpit. This is seen as important in terms of normalising the nature of the subject and help seeking.

Associations with mental health within the rural communities of the SWARD region

All of those engaged through the consultation process were asked to indicate what terms they heard associated with mental health within their community as they go about their work and social life, etc. The predominant terms were psycho, schizo, mad, depression, suicide or suicidal. Other expressions which were presented included the T&F (Tyrone and Fermanagh), St. Luke's Hospital in Armagh and the "The consci house". These terms were felt to be used pejoratively.

The majority of opinion felt that the rural community was very unaware of what mental health is and what it means. From within one of the public focus groups it was asserted that mental health was pretty much "...equated with suicide within the rural community."

At risk groups

When asked to consider those groups at greatest risk, the professional respondents tended to focus on many of those groups already mentioned, especially farmers, young people, middle aged men and women who may be experiencing marital or relationship breakdown, younger couples with young families who now find that one or the other or both are out of work or that one of the partners has to work away from home, the lesbian, gay, bisexual and transgendered community and the minority ethnic community.

The groups seen as most at risk within the community focus groups were, young people, especially those self-harming, young couples under pressure because of the current economic crisis, women experiencing post-natal depression, and those who are suicidal.

Young people

Young people are another group which evoked considerable interest throughout the consultations. There is a strong feeling that the youth of the SWARD region are experiencing increasing mental health issues, most strongly evidenced by the perception of a rapid rise in the prevalence of young female self-harm and young male suicide episodes. A number of professional workers questioned the link and the underpinning assumptions between the current publicity and practice aimed at promoting awareness and prevention around these growing rural community phenomena and the fact that the issues in terms of recorded instances are continuing to rise. One professional noted "Stigma generally exists to moderate maladaptive behaviour. Whilst we should be removing the stigma, there appears to be the possibility that somehow the normalisation of the act of self-harm and suicide is taking place, rather than the intended normalisation of help-seeking behaviour and the development of coping mechanisms. Let's face it, self-harm and suicide are maladaptive behaviours." This sentiment was echoed by another professional informant who felt that much of the work being done does not emphasis the consequences of the act of self-harm and suicide for the individual, their family and the wider community. It is felt that young people whilst more prepared to talk about mental health generally, don't appear to be grasping the real consequences of self-harming and or the finality of suicide, as well as in the first instance being able to recognise they need help and seek that help. Another professional respondent asked "Are we as a society failing our young people?" Another key informant expressed concern that self-harm and suicide is almost been seen as a "rite of passage".

Huge concern at the prevalent and widespread drinking culture amongst young people within the rural community emerged throughout the consultation. The issue of alcohol, its use and abuse came up time and time again across all of the regions. Parents present at the focus groups and indeed many of the key informants expressed their concern at the culture of heavy drinking and the growing concern within the rural community of the availability and selling within licenced premises of branded and "bootleg" liquor.

Another area of major concern was the growth in the phenomena of school formal's after parties, often held in remote venues into the early hours of the morning proceeding the formal itself. Parents were concerned at the apparent acceptance of this practice, how alcohol was being accessed so readily, easily and illegally by the young people, and transport services which they feel are complicit in the transference of the young people to these inappropriate and illegal events, not to mention those who are making the venues available. They questioned what more could be done by schools within the region to counter the growth and normalisation of these parties.

Further, the whole area of peer pressure was seen to be massive. It was felt by and large that it is hard for a young person not to go along with their friends and peers, for the fear of being seen to be outside the mainstream or excluded. It was felt that pressures from all angles are piling up on the young people of the SWARD region. Those pressures which note mention are academic success and the need to be successful felt to emanate predominantly from parents and schools; relationships and sexuality; image; drugs and alcohol. It is felt that young peoples senses are being bombarded with messages through the TV and online social networks pushing messages

of what it is to be a young person. These messages were viewed to be wholly unrealistic and unhealthy.

There is a strong perception that young people from across the SWARD region do not want to upset or annoy their parents if they are experiencing a problem or issue. There is a real sense that the young people are increasingly seeing their parents under pressure in terms of financial pressures and worries and that they don't wish to add to this. "Young people don't want to annoy their parents. We need to reassure them that they're not."

Following on from the latter point, it was generally felt that young people have been "wrapped up in cotton wool by their parents" to the detriment of their (the young peoples) help-seeking and coping behaviours and mechanisms in regard to the stress and pressures of life.

All of the preceding discussions led to a consideration of the role and importance of parents in the occurrence of poor mental health in their young people and in its remedying. One individual said "Do we not encourage our children to talk openly about how they are feeling? We'll tell them to eat their veg and take exercise. But, why don't we tell them in the same breath to take 30 seconds to focus on their breathing and relax?"

Another issue which arose on a number of occasions was the impact and consequences of the "Troubles" and "The Conflict" on young people within the SWARD region. Many public participants at the focus groups and a number of key informants emphasised the psychological consequences and scars for many of having lived through and witnessed the Troubles. One parent and qualified counsellor noted "Everyone was living on their nerves. Our children were brought up in this atmosphere of anxiety and fear...There is the intergenerational consequences of this experience. Not only are our young people carrying on that anxiety, but the parents in many instances are showing the signs and symptoms of "survivors guilt from conflict"".

In reflecting on instances when a young person from within the SWARD region may be receiving help and support within school or from a therapist etc., many of the professional key informants and parents within the public focus groups felt that it is important that the messages and support at home build on and reinforce that which is being received by the young person. That said, it was felt that supports for the parent simply aren't there to help them create and nurture a supportive home environment which builds the mental health and well-being of their young person. A consequence of the economic growth and prosperity which preceded the downturn was felt to be the loss of parenting skills and communication and connection between the young person and the parent. Many noted the tendency to "Throw money at the young people and let them fire on."

Lesbian, Gay, Bi-sexual and Transgendered Community

It was acknowledged by numerous professionals that they have tried to engage with the LGBT community. However, there is a strong feeling that the stigma is such that it is very difficult to openly engage this community in a public forum to discuss their particular rural mental health needs. Anecdotal evidence from the consultees would suggest that the LGBT community

gravitate toward Belfast and Derry and the specific LGBT supports and services available within these population centres. In acknowledgement of this, there was considerable concern for the potential needs of those young members of the rural community who might be struggling to come to terms with their sexuality, combined with the limited/ non-existent rural support services for the LGBT community and the lack of transport and an apparently all too familiar presence of homophobic bullying and intimidation, especially within the school setting throughout the SWARD region. Further, as was noted in regard to young people generally, if they require the assistance of a support or service for a mental health need, they would most likely be dependent on a parent, carer or someone familiar to them and that this would probably mitigate against help-seeking behaviour.

The researcher was informed during the process of the research by an organization in County Fermanagh that it had tried to establish and facilitate a young peoples LGBT group. However, this was proving challenging as the young people feared being identified and verbally and physically abused. Indeed, such was the fear that the group could not advertise openly its venue and time for meeting.

A number of key respondents shared anecdotal evidence of young men having taken their lifes by suicide as a result of the fear and stigma they experienced. Numerous other examples of violence toward the LGBT community were cited.

Minority Ethnic community

There was considerable consternation expressed at the lack of progress in making available the many supports and services to the minority ethnic communities across the SWARD region that are taken for granted by the indigenous communities. In particular, through the consultations it was emphasised that help and support leaflets have not been sufficiently translated into the necessary languages. Also, there is no ASIST, SafeTalk and Mental Health First Aid training available in the languages of the minority ethnic communities. The issue of suicide support services for the minority ethnic community was seen as a critical one. One of the professional respondents indicated that it was a case of learning as you go along when such an incident happens within the minority ethnic community, and that as your experience of the issue grows, you pick up an understanding of how to handle the protocol surrounding the coroner, the repatriation of the deceased, breaking the news to a family who are often at home, addressing the mental and emotional needs of the friends and colleagues who become the de facto surrogate family for the deceased, etc.

The farming community

The farming community was mentioned frequently when discussing the issue of need and stigma surrounding rural mental health. By and large the agricultural community is seen to be characterised as a "hardy" community within which a "macho" culture and mindset is predominant. One of the professional respondents noted "No farmer wants to be the generation

that lost the farm. You think to yourself, your father could cope and those before him." This attitude is seen to work against the propensity to seek help for an issue that is causing mental distress. This issue is seen as all the more important as agriculture faces increasing economic pressures and the trend for farms to get bigger and more self-reliant. "The bigger farms get, they are becoming more isolated and self-sufficient. There is no going to this one or that one to borrow a piece of machinery or look for a helping hand."

One of the key informants spoke of a number of instances known to them personally where two suicides had taken place from within one family. However, this fact was never publicly acknowledged and or indeed discussed within the family. In considering the reasons for the family's response, it was suggested that a considerable issue within the farming community in regard to a lack of willingness toward disclosure of a suicide episode is in relation to life insurance and the protection and retention of the family home, farm and business.

"One individual who took their life was said to have died as a result of an accident with a shot-gun; another who had taken his own life was said to have fallen into a slurry tank. There are many examples of this across our rural community."

Other identified at risk groups

Given the current economic climate within the rural SWARD region, there is a very real sense that many individuals and couples are under real pressure to pay bills and the mortgage, etc. It was a point of discussion in many instances how many of the young and older men from the area are having to travel further afield to find work, often staying away from home for long periods whilst the partner will remain at home, holding down a job, looking after the children and the home. The pressure and stress that this is giving rise to was something that the vast majority of the consultees felt was very real and pressing. There is seen to be a direct link between these pressures and the onset of poor mental and emotional health for the individuals and families concerned.

Many members of the public and the key informants spoke of the changing role for young men who through the strong economic times were doing very well and quite able to provide for their often new family in a new home which they will have purchased. However, with the sudden collapse in the construction industry as the "credit crunch" kicked in, many of the young men have found themselves having to adopt to the role of a stay at home husband and or father. Instances were shared with the researcher where young men are struggling to accept this new role they find themselves in, guilty and angry that they cannot provide for their family as they have done previously, combined with the traditional and deep rooted view of the man within the rural reaches of the SWARD region as the "main bread winner."

Domestic violence is seen as a major issue with the rural areas contributing to poor mental health and illness, especially amongst a considerable section of the female community, but also within the male community. As economic and financial pressures mount on couples, there is a

strong sense that the experience of domestic violence is on the increase and the consequent toll on mental health and well-being. For those who work with individuals who are experiencing and or coming out of such a situation, there is a lack of opportunity for early mental health and well-being promotion, empowering and showing those persons who might be at risk of or experiencing domestic violence that it not a normal or acceptable situation to get into or remain in, and that they can with appropriate help regain their emotional and mental well-being, self-esteem and confidence.

Perceived needs and rural services and supports

ASIST, SafeTalk and Mental Health First Aid

Current programmes such as ASIST, SafeTalk and Mental Health First Aid were highly commended for the impact they have had on professionals ability to recognise and respond professionally to persons whom they have come into contact with who have been in mental and emotional distress, self-harming and or suicidal. Several examples were shared with the researcher by various professionals in regard to how they felt they have been able to make an effective intervention which prior to the training they would not have been able to do. All were of the opinion that the programmes gave them the skills, knowledge, experience and confidence to ask, listen and support. At least three occasions were shared with the researcher that the training provided by the Niamh Louise Foundation directly contributed to the saving of lifes of people who were actively suicidal.

Other provision such as the Bounce programme and The Chill Initiative were also praised for their focus on young people and their mental health and resilience, as were the health fairs which have been held in local farmers markets.

Suicide awareness, prevention, intervention and post-vention supports

The suicide awareness, prevention, intervention and post-vention supports across the SWARD area were also mentioned as strengths in regard to current mental health provision. The work being done by the respective health trusts, the PHA (NI), through the rural support networks and the Niamh Louise Foundation were all seen as contributing significantly to bring the issue of suicide onto the agenda and consciousness of local communities, and providing a critical support service for those who are suicidal and or for those bereaved by suicide within the SWARD area

Perception of increasing self-harm

Across the board there is a strong call for more services and supports to address the worrying trend of self-harming within the SWARD region. There is currently felt to be a wholly inadequate service response in respect of this issue.   Time and time again, this issue was recounted. It would seem that the only recourse for a small number of potential self-harmers is engagement with the ZEST Project, a project originally set-up to serve the needs of the Western Health and Social Care Trust area. It is the researchers understanding that the service is co-ordinated and delivered by one person who effectively acts as a triage for the young person who is self-harming, directing them toward a local counselling service located more locally to the young person which is acceptable to them.

Imbalance along the rural mental health and well-being continuum

In considering the nature and extent of rural services and supports in respect to the mental health needs and issues being presented by rural residents, there is a resounding level of agreement that change needs to happen sooner rather than later. There is a real feeling of imbalance in the support and services available.

There is a strong recognition of the need for suicide prevention, intervention and post-vention services across the SWARD region. However, many of the professional respondents questioned the resource allocation and focus toward this issue relative to the rest of the mental health continuum. It was noted on a number of occasions that suicide is a painful and horrific experience which evokes a powerful and widespread emotional response from the community. It was stated by one of the professionals that "suicide is the exception rather than the norm." Many of the respondents emphasised that suicide is relatively rare compared to other causes of death. They question the appropriateness of the current focus and priority given to the issue and the degree to which this emphasis may be sending out a message of acceptance and fatalism to the wider community. They ask, might there be the potential that the idea and perception may be reinforced that you have to be very ill and or regrettably, bereaved by suicide, before you can effectively engage with a service?

Across the board, regardless the particular constituents of the SWARD rural community, the public and the professional consultees whilst wishing to see an appropriate focus maintained on suicide and self-harm awareness, prevention, intervention and post-vention, want to see a greater resource and priority brought to mental health and well-being promotion. They wish to see a greater focus on resilience and well-being, equipping people with the skills and knowledge to be able to read their mental and emotional well-being and affect the necessary help-seeking behaviour and coping mechanisms at the earliest opportunity. There is a strong desire to see a strong development around the area of prevention, rather than people having to escalate in severity of their mental health issue to a point where it becomes acute and difficult to manage and address.

"There isn't the importance put on prevention and early intervention. You have to be seen to be in crisis."

The general feeling is that much more effort must be given to the "upstream" aspect of rural mental health and well-being, exploring and addressing it's underlying causes and seeking to minimise and or ameliorate these by way of a choice of proactive promotion initiatives which seek to place mental and emotional health and well-being on the same par as physical health and well-being.

"Rural communities should be given a menu of mental health options."

Initiatives should promote positive mental health and emotional well-being as a positive asset to the individual and as something which each and every person is entitled to. Further, it was emphasised that these mental health and well-being initiatives must be accompanied by measures and activities that promote the understanding and awareness of the prevalence of mental health issues within the rural context. Also, all of these activities were felt to require a stronger focus on the message that "recovery" is a natural and normal possibility.

"Mental health in the rural community is a bit like the issue of incest. If you have been impacted by it, you are likely to feel like and be treated like a victim, rather than a survivor. Mental health needs to shift to the idea of a survivor, rather than a victim."

Within one of the community workshops, it was stressed that when someone within the community is known to have a mental health issue, there is an automatic assumption by the wider community that the person "won't be right for the rest of their life." Mental health in terms of mental illness is seen as something which is life-long and not "fixable".

In devising and delivering these positive mental health, resilience and promotion activities, it was urged that these are not about developing or opening new "positive mental health and well-being centres" throughout the rural community. The public and the professionals feel that positive mental health, resilience and promotion activities, attitudes and mind-set need to be part of the entire infrastructure of rural communities. Agencies, organisations, groups and businesses across the spectrum which come into contact regularly with the public and especially the high risk groups within the rural community need to be up-skilled in the promotion of positive mental health and resilience, in identifying potentially vulnerable individuals at an early stage, and when necessary being able to sign or refer individuals onto an appropriate service or support in a timely fashion.

"Mental health should be viewed like dental health. People should be encouraged in our rural communities that they should look after and develop their positive mental health (clean their teeth) thereby reducing their likelihood of having to visit mental health services and supports in the more traditional sense (the dentist and have a tooth removed because of preventable decay)."

General Practitioners

When the members of the public within the focus groups were asked what they would do if they knew a friend or acquaintance had a mental health issue, the majority said that they would direct the person toward their GP. However, a great majority were sceptical to the value and appropriateness of this avenue. The predominant opinion was that the GP will have 7 to 10 minutes to listen to the person who is presenting and then will most likely prescribe anti-depressants. It must be emphasised, that whilst the respondents felt this to be the default situation, they recognised that GP's are under severe pressures and that individuals and families often demand a quick fix. The general opinion across the range of consultees is that they would like to see a greater awareness and understanding amongst GP's of the wider system of supports and services available across the sectors within their local areas that can assist and facilitate patients on the road to recovery and resilience. There was notable evidence within the Magherafelt region of work being undertaken in close collaboration with GP Practice Managers, who were keen to develop their practices understanding of mental health.

A number of consultees expressed a strong desire to see a tab on GP's computer screens which sits alongside the screen for setting up and prescribing medication. This tab would provide a drop-down menu of locally available supports and services. There is concern that the powerful pharmaceutical industry and its interests drive the default prescribing intervention. Consultees wish to see a more social orientated model of prescribing which looks to the underlying causes of the presenting symptoms and to direct the patient appropriately and in a timely fashion.

An individual in the Coalisland focus group reported how having felt anxiety for a prolonged period of time (i.e., in excess of weeks) attended the GP in order to seek help. This individual spoke highly of the intervention provided by the GP. The GP listened to the individual and recommended that they attend a stress management class which was taking place within a local hospital. This was far from what was expected. However, as a consequence of this intervention, the individual now reports being able to effectively manage anxiety and no longer feels that it limits or confines their life. The individual in reflecting on the experience, acknowledges that their experience would appear to be the exception rather than the norm.

Another point of discussion which emerged when GP provision was being discussed, was the potential and legitimate barrier to GP's referring individuals on to services based locally because GP's could not assure their quality and efficacy. Many professional respondents noted that GP's in making a referral are showing a trust and confidence in a service. To this end, it is much more likely that they will refer to LifeLine or the Samaritans and or indeed place an individual on a long waiting list for health service talking therapies, the recognised brands if you like. It is felt that GP's will be mindful of the potential litigation which could be visited upon them if they refer an individual to a local organisation for services and support and that individual through the process ends up in a worse position than before they started. It was felt that the lack of an agreed standards framework which gives recognition to required standards and professional capacity is very much needed and would probably go a long way to encouraging and supporting GP's to become more aware of and link in with local community and voluntary services.

Out of Hours GP Services

A number of instances were relayed to the researcher where individuals when having made contact with their out of hours services when experiencing severe mental and emotional issues, were treated most unsympathetically. In one instance, it was alleged that once the individual contacting the out of hours service had informed the GP on the other end of the phone that they were unable to carry on, the response they received from the GP was, "What the f**k have I done to deserve this call tonight?" This particular instance has apparently spread around the local area and the key informants who shared this extreme example with the researcher was concerned about the message it sent out to other individuals who might themselves in mental and emotional crisis require the out of hours service. It was felt that this will strongly disincentivise others from seeking help.

Mental Health Service Counselling Services

Across the focus groups and the key informants, a major area of concern was in respect of the long waiting times for NHS counselling. The vast majority of the key informants reported waiting times in excess of six months, proceeding the initial consultation and referral from a GP.

There is grave concern for those individuals who are placed on the waiting list for this length of time. Given the potential nature and severity of their mental health issues, many professionals feel fearful for the individuals. This was seen to be a major concern in Fermanagh, Dungannon, Cookstown and Magherafelt, and a point at which the traditional system of mental health support and services is under tremendous pressure and unable to keep pace with demand, which it was emphasised by many professionals is growing at a high rate.

All of the professional key informants report increasing presentation of individuals with anxiety and stress, precipitated by a wide array of issues. The key issue at the present time is very much the strain and worry being placed on individuals, families and communities around job insecurity and financial pressures.

One voluntary sector key informant who is involved in the delivery of Trust funded counselling services reported "There are 106 people on our waiting list at the present time. We saw 15 added to that list in October alone."

Community and voluntary sector

From all of the consultees there is a strong recognition of the need for the involvement and delivery of services by the community and voluntary sector in addressing rural mental health and well-being needs. The reasons given for this were many. Firstly, the community and voluntary organisations offer alternatives which reside outside of the statutory mental health service. This was seen as important because many people in the experience of those who attended the focus groups fear attending a GP or other statutory provision in case they "become

part of the system." One individual spoke of one mothers fear that social services would come and take her children away again, when she had a further episode of depression. Indeed, when members of a voluntary group which exists to support each other around post-natal depression went to make contact with the woman concerned, her teenage daughters ran to the door worried that the women who approached their house were social services who would separate them from their mother again. The notion of mental health and the "big house" or "sectioning" still play large in the minds of many within the rural community.

The community and voluntary sector are generally perceived to be more approachable and friendly and easier to access. It was also reinforced that quite often within these organisations, an individual would encounter professionals or volunteers who have or continue to experience the same and or similar issues to themselves.

On the other hand, one key informant directly involved in the provision of psychotherapies within the voluntary sector cautioned that "passion without awareness is lethal." This comment spoke to a certain perception that anyone could set up a support group or service and secure funding. It was also emphasised that because an individual or individuals go through a traumatic experience, this does not of itself mean that those individuals are necessarily best placed to provide a service or support nor may they be ready in terms of their own personal journey of healing.

Other concerns expressed in relation to the community and voluntary sector within the SWARD area is the perceived unregulated growth of organisations offering supports and services under the umbrella of suicide prevention and self-harm prevention and mental health, etc. Key in this apparent growth is a strong need to understand the motivation of the organisations concerned. An incident was referred to by a number of key informants and members of the public regarding a public event held in response to a number of suicides in the Ardboe area. Those who were present on the night were concerned at the apparent friction between organisations, especially between the statutory and the voluntary and community sectors, and the often conflicting advise been given. More concerning was the apparent use by one organisation of the event as a "soap box" to "lambast" the statutory sector and putting out the message "that no one is doing anything about suicide!" Rather than bringing hope and a belief that help and change was possible, it was felt that this event would have brought more anxiety and stress on those who were attendance, especially the immediate family of those who had lost their loved ones through suicide.

Other concerns related to the competitive environment within which the community and voluntary sector operate. It was felt that how the operating context is currently geared, effective collaboration is not encouraged or facilitated. There is a fear that the interests of those in need are being lost in the search for organisational sustainability and that effective interagency collaboration and mutual referral are not taking place as they should in pursuit of the best response to the needs of the individual. One key informant urged that everyone "keeps the individual at the centre of all decisions and actions."

Schools

All consultees acknowledge and accept the need to promote and prevent the onset of mental ill health from the earliest opportunity and to promote the proactive development of resilience and coping skills amongst young people whilst they are at school. It is recognised that this is a key setting to engage with a large body of young people. Once the young people leave school, it is harder to engage with them as their interests, associations and destinations post-school become more disparate. None of the consultees are sure as to the status of the promotion of positive mental health within the local schools, especially the second level schools. They hope that it is something which is on the school agenda, yet fear that it might become seen as yet another class or exam to be passed academically. There is a strong sense that it is critical to learning in itself and enabling the young people to thrive and regain their personal resilience and coping mechanisms.

Workplaces

Those key informants who have been involved with working with minority ethnic communities and issues in relation to their physical and personal needs have found workplaces from throughout the SWARD area reluctant to facilitate access to external bodies who could be of assistance to their personnel. There is a strong sense that organisations requesting to come in are viewed to be interfering or spying on the conditions within which the employees work.   One of the key informants shared a story that several businesses were interested in engaging with the minority ethnic project to the extent to which it might have facilitated their establishing the extent to which a member of a minority ethnic community was "taking unnecessary advantage of sick leave or otherwise."

The workplace is generally seen as an important context within which mental health promotion should be encouraged and supported and that employers should recognise the benefits in terms of better productivity and employee satisfaction. Many of those in the public focus groups noted the prevailing atmosphere and culture within their places of work and the apparent lack of appreciation for and attention to the mental and emotional wellbeing of staff by their employers.

Young men and men generally

There is a pressing call from the consultees for greater proactive outreach work within the community to access young men and older men. Many key informants noted the need to shift thinking in terms of accessing young men and men generally. One of the key informants pressed for organisations to outreach to where the young men and older men tend to gather and feel comfortable. The success of the Farmers Health Checks was continually cited as an example from which much could be learned, especially in terms of coming at mental health in an indirect manner, seeing it as part of a much wider service offering.

Awareness and information relating to local services and supports

Whilst many of the key informants had a good grasp of other organisations within their catchment area, it was apparent that the public are very unaware of the various supports and services. This was seen to offer a paradoxical situation in that people tend not to look for help and support until they are at breaking point or they just can't cope any more. The sense is that you only find out at the point of crisis. However, there is a strong feeling and support for a greater availability of information relating to all services and supports and awareness raising which promotes positive mental health and resilience and the fact that a person should be encouraged to build their mental and emotional wellbeing, as much if not greater than their physical well-being. One professional respondent noted "If someone fell and broke an ankle in front of me, I'd know what to do. I'd ring 999 and get an ambulance. They'd be taken to A&E and so on. However, if someone were to experience a mental health issue or need I'm not so sure what I'd do, being mindful that I probably know a fair bit more than a member of the general public."

It was also felt in relation to the regional media campaigns, that they lack rural representation and appeal. They tend to give the impression of an urban focus of poor mental health.

A major concern amongst the key informants was the short-term nature of the funding which is presently available for mental health and suicide prevention work. There is a strong feeling that there is a danger that organisations rush out into the rural community and "promise the moon and the stars. No sooner are they established, than they are struggling to secure continuation funding, as well as turning people away." It was emphasised that peoples expectations must not be raised unrealistically, because this can cause so much damage and hurt.

Other needs in relation to young men which were raised in the consultations were as follows:

"A lot of twenty somethings seeking anger management...It's not about going through a one day course or going through some hoops. It's about going back and reprocessing thoughts, feelings and emotions."

"There is huge anxiety across the board. There is a lot of people on medication who do don't want to be on it. We especially see a lot of young people who don't want to repeat or become what they might have experienced in their parents i.e., alcohol in childhood. They want to step outside of this."

Improving rural mental health and well-being within the SWARD region

Some of the suggestions which were presented in terms of promoting positive mental health and well-being by both the key informants and the wider public were:

- Provision and promotion of wellness classes such as mindfulness, managing your emotions, anger management, positive mental health and well-being, managing and

handling stress, etc. In this respect, many of the professionals feel that much opportunity exists to promote these activities through a small grants scheme of £500 to £1,000 for individuals or groups within rural communities. It was brought to the researchers attention on a number of instances by the professional consultees, that there appears to be a declining opportunity for rural residents to come together through small localised groups to engage in such activities.

- Groups and associations in receipt of grants to develop and incorporate a positive mental health and well-being policy and practice, giving the same merit to this as child protection, vulnerable adults and or safeguarding policy and practice, etc. It was stressed that many of the organisations in receipt of funding are directly engaged with those most vulnerable groups, especially the young. It was further asserted that these groups should be required to have a positive mental health and well-being nominated lead, who would ensure that the organisation fulfilled its responsibilities, as well as ensuring that paid staff and volunteers underwent training in SafeTalk, Mental Health First Aid and ASIST as appropriate.

- Coaches coach in positive mental health, well-being and resilience to work with and support rural coaches across all of the sporting and youth domains, as well as empowering and equipping youth and community workers.

- Equipping staff from across organisations who come into daily contact with rural residents. One interesting example which is being explored by Dungannon and South Tyrone Borough Council is the potential role of its building control and environmental health departments etc., in identifying and sign-posting individuals who they might recognise as being in distress due to the current economic climate, etc. Another opportunity is seen as the potential to offer guidance and sign-posting at the point of registering a death.

- Dedicated young mens project that would be culturally and gender appropriate. This initiative would need to recognise that men "don't go into formal settings." An initiative within cancer prevention and screening which was highlighted by one of the professional consultees was the 'Man Van' which is being deployed in the Southern Trust area by the Ulster Cancer Foundation. This initiative was seen to offer potential transferable learning to work with young men around their mental health needs in a confidential way. It was pointed out that the terminology used in the context of the UCF initiative has been particularly important. A further advantage of such an initiative is that it might pick up the individual young person, the majority of whom exist outside of any formal youth organisation or group.

- Schools and young peoples programme that is seen as more than another subject delivered in the conventional way and something to be assessed for academic performance. The programme would work within and outside of schools giving young people experiential learning opportunities in regard to positive mental health, well-being and resilience. The programme would seek to promote opportunity and potential and the fact that stress and challenge is a part of everyday life. The young people would be

encouraged to understand mental and emotional well-being, lifes stressors, and how to develop and nurture positive well-being coping mechanisms and help-seeking that builds their resilience and capacity to learn and grow.

- A Whole Setting Approach – The idea of the whole setting approach is seen as particularly critical to schools, youth organisations and workplace settings. This approach acknowledges that real change takes time and that it must be embedded within the ethos and fabric of an organisation in order to leverage long term sustainable change. There is a feeling that much of what is currently taking place with respect to the various domains mentioned above is piecemeal and disjointed.

- An online and social networking initiative that makes information and supports available to the rural young person consistent with the way they now tend to look for help and information, etc. It was acknowledged that whilst many people and communities feel the internet and social networking is damaging to our young people, it also has a great deal of potential to counter the negative influences and forces contained within it if alternatives are provided.

- Come at mental health promotion side-ways. What is being suggested here is that rural residents tend to seek help around practical everyday issues, which if left unchecked can effectively trigger poor mental health or depression.   Supports and sign-posting capability and capacity should be built into those organisations who provide practical support in terms of benefits, form-filling, agricultural returns, debt advice and job-seeking, etc. It was emphasised that the mental health issue is unlikely to be effectively resolved unless the underlying practical issues were sorted and or the individual empowered to manage and cope with them more positively.

- Programme aimed at bar staff, taxi drivers, hair and beauty, late night economy workers

- ASIST, SafeTalk and Mental Health First Aid to be developed in the languages of the minority ethnic communities.

- On several occasions the importance of language was emphasised and the degree to which a particular term would engage or disengage a rural resident.

- Guidance for minority ethnic community members in their own language on dealing with a suicide.

- Protocol developed for funeral undertakers in serving the needs of minority ethnic community members deceased through suicide.

Conclusions

Having considered the nature, prevalence and potential cost of poor mental health on the people and communities of the SWARD region, as well as having consulted widely with professionals and the wider public both online and face to face, this section of the report seeks to draw a number of key conclusions which emerge as a result of the preceding analysis and findings.

Mental health as a term is most generally associated with mental illness within the rural reaches of the SWARD region; seen as something from which an individual will not recover and will have for life; and is generally referred to in negative and stereotyping terms such as 'psycho', 'schizo', 'mad', 'the big house', 'avoid like the plaque' and 'nutter', etc.

Poor mental health is a major issue within the four district council areas of Fermanagh, Dungannon, Cookstown and Magherafelt, whether measured in terms of percentage of population on prescribed drugs, hospital admissions due to mood and anxiety, registered deliberate self-harm admissions to hospital and or deaths by suicide.

The SWARD region accounts for 11.2% (£319,424,000) of the total estimated social and economic cost of mental illness in Northern Ireland at £2,852,000,000. Over the period 2004/05 to 2009/10p there were 187 deaths by suicide within the SWARD region; 385 registered deliberate self-harm admissions to hospital in 2010; an estimated 2,210 hidden deliberate self-harm episodes which did not result in presentation and admission to an A&E department in 2010; 40,259 (1 in 5; 20%) of the total SWARD population of 202,259 potentially experiencing poor mental health in 2010.

There is real concern at the apparent growth in the nature and extent of poor mental health within the rural community of the SWARD region.

There is considerable concern at the long waiting lists from six to nine months for help through the NHS for talking therapies and the consequences for those individuals who find themselves having to wait this long and a lack of alternative social prescribing and or social prescribing in combination with pharmacological inteventions.

All of those individuals and organisations consulted across the platforms recognised the considerable work and effort which has gone into addressing the needs of rural residents mental health over recent years. The regional media campaigns, LifeLine, ASIST, SafeTalk and Mental Health First Aid, Farmers Health Fairs within the local markets and small grants schemes were all seen as having affected significant change in terms of knowledge, skills and confidence across the sectors, as well as having facilitated a number of positive interventions in crisis situations.

The rural culture of self-reliance and stoicism, combined with a heightened awareness of neighbours business and movements works against the propensity to admit to needing help to self and others and thereafter seeking help. This is highly exacerbated by a highly prevalent stigma and discrimination within the rural community of the SWARD region in regard to those who experience a rural mental health issue. Individuals fear the consequences of their

experiencing a mental health issue getting out into the wider public domain in terms of how people will view them and talk about them, they fear losing their job and future prospects, as well as the impacts disclosure might have on their families and children.

Mental health stigma and discrimination is seen to permeate all aspects of an individuals rural life, especially within the context of employment and the social setting.

There is perceived to be a high need for a range of mental health services and supports within the SWARD rural community; that availability of rural mental health services and supports are on the whole viewed as being low to moderately available; accessibility to the services and supports is by and large seen as low; and effectiveness of the services and supports which address the mental health needs of the rural SWARD constituents are viewed low to moderate.

The performance of cross-sectoral working across the SWARD region within the context of rural mental health is judged to be effective within the context of crisis response planning, but poor in relation to positive mental health and well-being promotion. Sharing of information and best practice in a timely and effective manner; developing shared and agreed referral pathways and protocols; working together effectively in order to develop and deliver the best possible range of services and supports; good working knowledge and understanding of what the different sectors provide; and the development and implementation of a shared and agreed strategy for mental health are on the whole seen as weak and showing considerable opportunity for improvement.

The situation in regard to mental health related stigma and discrimination is felt to have gotten better for rural communities generally. However, the situation in relation to the LGBT community remains unclear. Stigma and discrimination is felt to have deteriorated in terms of disadvantaged communities, farmers, young men, boys and the Traveller community within the SWARD region.

There is a call for greater tolerance and acceptance of those individuals within the rural SWARD context who experience a mental health issue. Respondents to the public online survey indicate that people with a mental illness have for too long been the subject of ridicule.

Provision for the LGBT, minority ethnic, farmer and young male groups is far from adequate, as is provision across the array of rural stakeholders generally. There is a call for a substantial move toward positive mental health and well-being promotion, whilst retaining a focus on those services and supports for individuals with mild, moderate and severe mental health issues, and for those who are impacted and bereaved by suicide. There is a strong call for an increased provision of support and service for those who self-harm.

In terms of overcoming stigma and improving help-seeking behaviour, it is felt that more 'rurally sensitive' regional mental health campaigning; greater use of local papers for the farming community and the use of social networking and online technologies to engage and inform young people; better and more accessible information on services and supports available to the rural community; the provision of localised anti-stigma and pro-positive mental health promotion campaigns; and better equipped and knowledgeable parents, teachers,

employers, churches, GP's and other health related professionals and those involved within the community and voluntary sector are needed vis-à-vis mental health literacy and capability.

Services and supports are viewed as fragmented and not necessarily coming at the issues from the perspectives of the rural communities and the 'at risk' groups therein. This is especially felt to be the case for rural males and farmers in particular, whom it is widely accepted do not engage with organisations and or services containing mental health and or suicide within their title.

Minority ethnic supports and services are particularly weak, with issues in regard to training programmes such as ASIST and materials in new communities languages not been available.

The vast majority of the members of the public through both the online survey and the community focus groups would not be comfortable sharing that they had a mental health issue or problem personally within their community. Further, they would be least likely to seek support or help from their employer and most likely to seek support and help through their GP, someone who has experienced the problem they are experiencing, and or through the internet, books or a magazine, etc.

Churches within the SWARD region are seen to have a potentially positive and negative impact on the help-seeking behaviour and coping mechanisms of individuals and the stigma and discrimination which surround the area of rural mental health.

There is real concern at the upward trends in terms of young peoples suicide and deliberate self-harm within the SWARD rural area despite the many regional and local efforts which have been applied to the issues. In particular, there is a fear that there is a normalisation of the acts through conversations and the work which is taking place rather than a normalisation of the help-seeking behaviour and the protective coping mechanisms required.

Other issues relating to young people which are seen as highly implicated in young peoples apparently increasing poor mental health is the growth in the use and abuse of alcohol, unrealistic and destructive images of what it is to be a young person being pumped into the senses of the young people from the vast array of media they experience day in and day out; the emphasis and pressure for academic success whilst young people remain highly uncertain as to their future given the current economic climate; and the impact and consequences of the Troubles (the passing of symptoms and problems between generations within families). Other issues raised included young peoples reluctance to cause their parents any concern in sharing if they have a mental health issue at a time when many see their parents under unprecedented pressures, as well as parents having lost their parenting skills.

Competition between community and voluntary organisations is seen as damaging and counter-productive to the needs and interests of those individuals in need within the SWARD region, as is the growth in unregulated services and supports and this inhibits referrals.

It is felt that there is a lack of recognised standards within the community and voluntary sector, as well as evaluation of services and supports.

Short-term funding is seen as damaging in that it does not permit the necessary long-term planning and provision of services and supports in addressing the very serious issues which require long-term commitment.

On the whole, there is a strong perception that considerable opportunity exists to work with GP's in improving their response capability to individuals in mental health crisis and in terms of looking at alternatives to prescribing medications.

Recommendations

As the previous section setting out the conclusions clearly demonstrates, there is a great deal of potential for a vast array of recommendations arising from this research project. However, the focus here is on those recommendations which honour and reflect those themes and issues which demonstrated the greatest level of interest throughout the extensive multi-method consultation process across the SWARD region with the public, paid professionals and key informants.

Regional media initiatives focusing on mental health and well-being should give greater attention and due regard to the rural community and the 'at risk' groups within it which have been indicated through the research consultation and through the literature review. From the consultations undertaken, it is clear that it is felt that the current adverts do not sufficiently address and or speak to rural constituents.

Regional media initiatives should be supported by more localised and targeted communication activities which build understanding and appreciation of what mental health really is and that it is something which everyone has. They should seek to illustrate the extent of mental health issues within the rural context and promote that recovery and resilience is possible. Local papers should be used to get the message[s] across to local farmers, and social media and online resources for young people within the SWARD region.

Consideration should be given to the piloting of a young persons smart phone app that specifically addresses the issue of mental health and emotional well-being. Please see the Surgeon General's website in the United States for detail on the 'healthy apps challenge.' [45] Currently, many of the materials aimed at young people are disconnected and in various sizes and formats, which do not necessarily facilitate everyday carriage on their person and use through media which is second nature to the young people themselves. See Rural Mental Health Australia, a social media initiative aimed at young rural Australians delivered through the 'twitter™' platform.[46] This project is particularly interested in engaging young males from agricultural backgrounds.

"In the same way that dietary salts, mosquito nets and condoms can be the highest-return investments in developing countries, investment in the mental wealth of young people through the use of technology may well be the highest-return investment available in the developed world. We must view young people as part of the solution – they are not simply a problem that must be fixed, externally and at arm's length."[47]

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[45] http://sghealthyapps.challenge.gov/
[46] http://ruralmh.com/
[47] http://blogs.crikey.com.au/croakey/2011/08/22/how-can-technology-be-harnessed-to-help-young-people-mental-wealth/ - 'How can technology be harnessed to help young people and "mental wealth"?'

There was a promising approach used within the context of a migrant working project which used 'Skype™' to link minority ethnic communities with a psychologist who could speak their native tongue in Belfast. The initial Skype contact was an initial chat by either text or voice and or if the individual felt able, by full video call. This approach and the others mentioned above could go a long way to addressing the needs of those most at risk. However, the approach would have to be tailored to each specific grouping and preferably facilitated by a regional group who has a mandate and expertise in regard to a particular rural constituent group e.g, the LGBT community, etc.

There is a tremendous opportunity and need to press ahead with a positive mental health and well-being promotion approach within the SWARD region. The author accepts that this will require the recalibration of focus by the various Protect Life implementation groups in the Western, Southern and Northern Trust areas that have a role within the SWARD region. The integration of positive mental health/ mental wealth/ resilience along the mental health continuum will send out a message of hope and possibility to the population generally within the SWARD region as well as toward those rural 'at risk' groups in particular. A failure to look up-stream and build positive mental health and resilience will result in the real potential and continuing growth in the number of persons presenting with mental health issues, and in the most extreme instances deliberate self-harm and suicide. The author recognises that in order for this approach to be fully realised that it will require the production of the new and long overdue mental health strategy by the Department of Health, Social Services and Public Safety. SWARD should in this regard lobby the DHSSPS specifically and DARD to move in this respect.

The Department of Health, Social Services and Public Safety should be encouraged to strengthen the recognition of the unique circumstances and needs regarding rural mental health and the necessary approaches required to affect lasting positive change. It would be appropriate to press for specific actions within both the next suicide prevention strategy and the new mental health promotion strategy which recognise specifically the unique challenges of engaging individuals in mental health related services given the nature and fabric of the rural community. Whilst many sources assert that mental health is better amongst rural populations compared to urban, many contest this given the self-sufficiency mentality within the rural community, the heightened awareness of one another's business, the stigma and discrimination related to mental health issues and problems, the fear of being seen to seeking help, the lack of rural mental health services, the centralisation of health and social care into urban population centres and the lack of available and accessible transport, etc.

Greater emphasis should be given to rural mental health research and the rural at risk groups by the DHSSPS, Public Health Agency and other agencies and organisations. There is clearly a great need to develop more detailed understanding of the experiences and needs of the rural community and mental health generally, as well as more specifically the LGBT, Minority Ethnic, Traveller and Young Peoples communities. Current research is far from adequate and should be addressed as a matter of urgency. The recent commencement of the 'Understanding Suicide'

Project is to be welcomed, which will investigate suicide related help seeking in urban and rural areas across NI.[48] [49]

Whilst organisations and agencies come together through local Protect Life Implementation Steering Groups, there is considerable merit in more localised and strategic collaboration, needs assessment and joint planning to address the full spectrum of mental health needs. As was recognised through the research, collaboration and co-ordination is currently perceived to be good in regard to cluster response planning. It is recommended that local social prescribing networks are created around a GP practice[s] to facilitate and encourage more localised and intelligent planning and provision of supports. It is evident through the research that much remains to be done in terms of information on available social interventions that can support individuals and their families and friends through a social prescribing framework, as well as the requirement for the development of clear standards for the voluntary and community sector which build confidence and assurance of professionalism. The SWARD region could effectively pilot a number of rural social prescribing initiatives in collaboration with GP's. The social prescribing pilot[s] would look to establish the role and importance of community and voluntary run activities/ resources and alternative and complimentary therapies in addressing mental health and well-being needs, and particularly those issues relating to bereavement support following a suicide.

More effort and resources need to be directed at the issue of self-harm, both for those directly engaging in this and those who care for and support them. It would be appropriate to consider the development of a ZEST NI initiative within and across the SWARD region, given the increasing prevalence of deliberate self-harm episodes.

ASIST, SafeTalk and Mental Health First Aid should continue to be rolled out across the SWARD region, especially within those areas and toward the 'at risk' groups. It is important that these programmes are complimented with a portfolio of positive mental health and resilience type programmes. Presently, the vast majority of the programmes have an underpinning premise that the person is experiencing poor mental health and or is in crisis. The additional new programmes and supports should speak to mental well-being.

ASIST, SafeTalk and Mental Health First Aid should be made available to the minority ethnic communities in their own languages. It is therefore important that individuals who speak the various languages are trained up as a matter of urgency. Further, mental health related materials should also be made available in the language of the minority ethnic communities.

It is evident that considerable opportunity exists to develop a mental health church initiative which seeks to enable and support the churches and the clergy within the SWARD area to encourage and support their congregations to acknowledge they need help and support for a mental health issue and seek support accordingly. This would include amongst other things,

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[48] http://www.compasswellbeing.org/Research-Projects-4952.html
[49] http://www.niamhwellbeing.org/News/Press-Release-from-DARDNI-5006-59407.html

encouraging and equipping clergy to speak from the pulpit about mental health and its importance to their congregation

Serious consideration should be given to the piloting of a Jigsaw type initiative within the SWARD region in order to address the current high concern and prevalence of issues amongst the youth populations. This initiative which originated in Australia has been replicated in numerous national settings, including the Republic of Ireland where it has been implemented in counties such Kerry, Cork and Roscommon. The initiative is led in the Republic of Ireland by Headstrong.ie. This approach could go a long way in addressing the clearly growing youth mental health needs within the SWARD region. There is a definite need to address the needs of young people in a holistic and systemic manner reconfiguring youth mental health services and supports to incorporate the entire sub-systems/ domains within which the young people exist. This approach is one of the clearest models to date internationally which is consistent with the definition of positive mental health. It recognises and supports the belief that positive mental health and especially young peoples positive mental health is everyone's business, not just the traditional Community and Adolescent Mental Health Teams. Capacity and capability needs to be built across the entire youth ecosystem.[50] [51] [52] [53] [54] [55] [56] This approach facilitates the help seeking behaviour and coping mechanisms of young people at the most critical stage in their life when they are most vulnerable to the onset of mental ill health. It does this by bringing together and engaging all the stakeholders, and most critically young people themselves within an area in building a shared understanding and picture of need and in designing and implementing a young persons mental health system which is fit for purpose and which speaks directly to the young people across the range of settings.

Independent of but preferably within the context of a wider Jigsaw type initiative, effort should be invested in the development of a Coach for Coaches Programme[57], Rural Adolescent Programme type initiative[58], and a Whole School Approach to positive mental health and well-being. Whilst an initiative is currently being developed and sponsored by the Public Health Agency in regard to a post-primary schools mental health initiative, it is important that this

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[50] Bates, T., Illback, R.J., Scanlan, F. & Carroll, L. (2009) Somewhere To Turn To, Someone To Talk To. Headstrong – The National Centre for Youth Mental Health. Dublin: Headstrong.

[51] Headstrong 2009 Annual Report

[52] Headstrong 2008 Annual Report

[53] Illback,R. (2010) 'Cumulative Evaluation Data for Jigsaw Galway: 1 Jan 2009 through 18 Feb 2010', Headstrong – The National Centre for Youth Mental Health, Powerpoint Presentation.

[54] Illback, R.J., Bates, T.,Hodges, C., Galligan, K., Smith, P., Sanders III, D. & Dooley, B. (2010) 'Jigsaw: Engaging Communities in the Development and Implementation of Youth Mental Health Services and Supports in the Republic of Ireland', Journal of Mental Health, October 2010; 10(5), pp.422-435.

[55] Illback,R. & Bates, T. (2011) 'Transforming Youth Mental Health Services and Supports in Ireland', Early Intervention in Psychiatry 2011; 5 (Suppl. 1): pp.2-27.

[56] www.**headspace**.org.au/core/Handlers/MediaHandler.ashx?mediaId..., ' Independent Evaluation of headspace: the National Youth Mental Health Foundation', Social Policy Research Centre, University of New South Wales, November 2009.

[57] http://www.ijmhs.com/content/4/1/10 - 'Australian rural football club leaders as mental health advocates: an investigation of the impact of the Coach the Coach project'.

[58] http://www.rap.qut.edu.au/ - Rural Adolescent Project

initiative is a comprehensive one which takes positive mental health and emotional wellbeing to the core of the ethos of the school. This approach needs to be set within the wider community context and how the school and the community can create synergies in terms of positive and emotional well-being. These approaches combined aim to identify early presentation of mental health issues, especially amongst the younger population, as well as building resilience in the first instance. This is important because 75% of mental illnesses have their onset in adolescence. If they are not dedicated at this early stage, the conditions tend to perpetuate into early and later stages of adult-hood at which point the issues become acute and much harder to resolve for the individual.

All of the initiatives need to start from the premise that young males in particular do not come to services and or engage in formal settings. All of the initiatives will require proactive and assertive outreach at population and targeted levels. In this regard, initiatives should be informed by the recently launched 'Providing Meaningful Care: Using the Experiences of Young Suicidal Men to Inform Mental Health Care Services' Report.[59]

The author would press for greater detailed intelligence led needs assessment and planning within the various Protect Life implementation groups which attempts to establish a shared and joint understanding of the detailed picture and presentation of mental health need and promotion within a Trust area. At present, the fragmented nature of provision and the unregulated growth of services and supports needs to be addressed, in order to ensure that available resources are being used in a manner which will maximise the return on investment in terms of the number of years saved and quality of life experienced.

A mechanism needs to be found within the Protect Life implementation groups which builds a greater degree of independence between an objective assessment of need and the allocation of funding appropriately and proportionately. Further, any such mechanism needs to address the current competition between between community and voluntary organisations.

The provision of information to the rural community is disparate and not that easy to access. Clear, comprehensive and accessible information must be made available which outs what is available depending on an individuals need whether as the individual experiencing the issue and or as someone who is caring for an individual and or is concerned. Dungannon District Council and the Anti-Poverty Network show promising progress in this regard. This work should be built on and replicated across the district council areas of the SWARD region.

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[59] http://www.publichealthagency.org/publications/providing-meaningful-care-using-experiences-young-suicidal-men-inform-mental-health-car

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