Public Health Agency

Report 1: Preventing mental ill health among the general population

Mental Health Survey 2023/24

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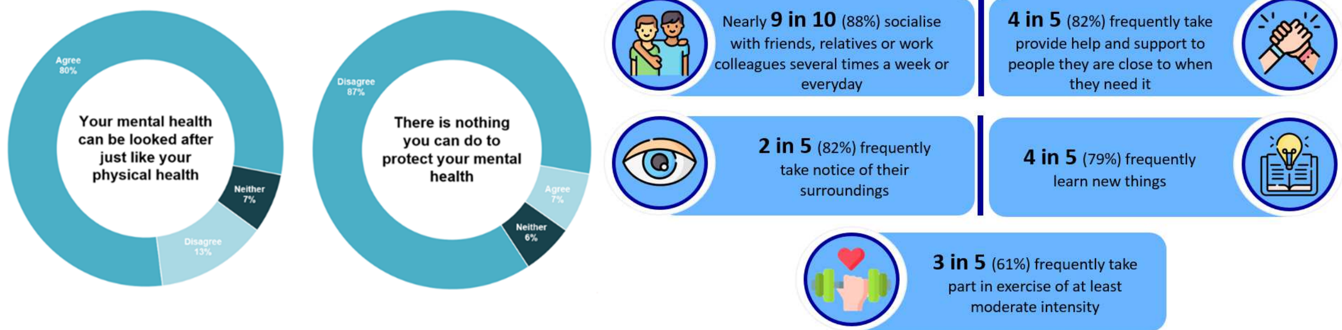
Improving your health and wellbeing

1. Executive summary

The Public Health Agency developed the Mental Health Survey 2023/24 to support work undertaken for the Mental Health Strategy [1] and the Protect Life 2 strategy [2]. The strategies aim to promote mental wellbeing and reduce suicide prevalence in Northern Ireland (NI), respectively. This paper presents findings relating to the prevention of mental ill health among the NI general population.

A telephone survey was conducted in Spring 2023 with a nationally representative sample of 1,009 adults aged 18 years and above in the Northern Ireland general population. Participants were surveyed about a range of issues relating to the topics of mental health and suicide prevention. Findings included in this paper focus on attitudes to mental wellbeing and ill health, experience of mental ill health, behaviours that promote wellbeing, and coping with challenges to mental wellbeing.

Findings indicated that overall, participants held attitudes and engaged in behaviours that positively impact their mental health.



Participants reported having access to a range of activities, groups and services that have the potential to promote social inclusion which may contribute to the prevention of mental ill health.

Common strategies used by participants to help them cope with challenges to mental wellbeing included engaging in self-distraction, gaining emotional support from others, and active coping. Instrumental social support was used as a coping mechanism but less frequently and using alcohol and/or drugs to help cope was the least frequently used coping strategy reported.

Associations between the topics examined and key demographic groups indicated some consistent patterns. Most notably, those with disabilities were disadvantaged across all measures and those aged 65+ years reported less access to services, groups and activities in their areas. Other significant associations are discussed.

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2. Background

The Mental Health Survey 2023/24 was undertaken to support the work conducted by the Public Health Agency to address Actions 1 and 2 of the Mental Health Strategy and the Protect Life 2 strategy. The survey aims to further understanding of the knowledge, attitudes and behaviours of the general population in Northern Ireland in relation to mental health and suicide. This paper presents findings on the prevention of mental ill health.

2.1. Mental health in Northern Ireland

Everyone has mental health and your mental health can be either good or poor, just like your physical health. Mental health influences how we think and feel about ourselves and others, and how we interpret and react to events. It affects our capacity to learn, communicate, manage interpersonal relationships, and influences our ability to cope with life events and transition periods.

Good mental health is referred to as mental wellbeing which the World Health Organization (WHO) define as ‘a state of wellbeing in which an individual can realise his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community” [3].

When mental health declines, mental ill health can occur. Mental ill health occurs when an individual feels they cannot cope with the challenges they face and this impacts their cognitive, emotional and/or social abilities. Mental ill health may resolve in time or as a person’s situation changes but mental ill health can also progress to mental illness. Mental illnesses refer to conditions that are clinically diagnosed by a medical professional and are defined by WHO [3] as:

> *“a broad range of problems with different symptoms. They are generally characterised by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia”.*

Mental ill health and illness affects our society as a whole and no individual or group is immune to experiencing mental ill health and/or illness. However, the risk of mental ill health and/or illness is increased with other factors such as inequality, poverty, chronic physical ill health, minority group status, exposure to war, conflict and violence etc. Individuals who experience mental ill health are also vulnerable to disability, mortality, stigma and discrimination, and social exclusion [4].

It is important to understand that recovery from mental ill health and/or illness is possible, as is emphasised by the WHO [3]. Furthermore, an individual can have a diagnosed mental illness and also have good mental wellbeing. For example, an individual can be diagnosed with schizophrenia which is successfully treated with medication which means they are able to continue with their normal routines and are able to cope with challenges they face.

Understanding among the general population has increased with regards to mental health ill health and illness. However, negative attitudes prevail based on embarrassment, fear and stigma. This can impact a person’s willingness to open up about their experience of mental ill health and/or illness and often prevents people from accessing help which ultimately can hinder recovery.

Whilst there is a scarcity of robust mental health statistics available in Northern Ireland [5], the Health Survey Northern Ireland [6] has consistently indicated that approximately 20%[a] of the general population have potential psychiatric morbidity based on symptoms reported in the

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[a] This trend has remained stable over time with the exception of an increase in 2020/21 to 27% of the population. However, caution is advised in interpreting this change as there were methodological changes implemented due to COVID-19 restrictions that may have impacted this.

preceding four weeks. Although, the trend increased in 2020/21 to 27%. Potential psychiatric morbidity is higher among females compared to males (22% vs 18%, respectively for 2023/24). Furthermore, Bunting et al (2012) estimated the lifetime prevalence of a mental disorder among the NI general population was 39.1% [7].

The Health Survey NI also provided an indication on the population's mental wellbeing with the latest survey data being available for 2018/19. As with potential psychiatric morbidity, a consistent trend was observed from 2020/11 to 2018/19 with mental wellbeing scores on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBs) [8] averaging approximately 51 out of a total score of 70. This indicates good mental wellbeing on average. Since the latest date of available data for the NI population, cut offs have since been established for WEMWBs which provide more detailed interpretation of findings. Therefore, in future population-based surveys, we may have a better understanding of mental wellbeing among the NI population and this will be re-established via the NI Heath Survey from 2024/25.

2.1.1. Suicide in Northern Ireland

Suicide results from a complex interplay between biological, psychological, social and environmental factors. Globally, suicide rates have increased over the last 45 years by 60% with approximately 10.6 suicide deaths per 100,000 population in 2016 [9]. Suicide represents 1.5% of the total global burden of disease. When someone takes their own life, their friends, families and communities are affected. This means that suicide has a wide impact with substantial human and financial cost. It is important to remember that suicide is not inevitable – it is preventable and this makes suicide prevention a key priority for public health. The Government's over-arching message continues to be that one death by suicide is one too many and there is a firm commitment to reduce death by suicide.

Crude suicide rates in Northern Ireland were 12.3 deaths per 100,000 population in 2022 with the rate of death three times higher for males than females (19.2 vs 5.7 deaths per 100,000 population, respectively) [10]. Why individuals take their own lives is unknown. However, there are a wide range of factors at the individual, community and societal level that are associated with increased risk of suicide. Risk factors include (but are not limited to) age, gender, history of suicidal behaviour, suicide bereavement, chronic illness, mental disorders, alcohol and substance misuse, hopelessness, financial instability, stressful life events, interpersonal conflict, war and conflict, violence, trauma, abuse, sexuality, personality traits, high risk occupations, discrimination, criminality, deprivation and inequality, access to means etc. However, there are also a wide range of protective factors which include (but are not limited to) effective coping strategies, resilience, self-esteem, financial stability, strong interpersonal connections, religiosity and cultural beliefs, conflict resolution skills, help-seeking, access to services, effective clinical care etc.

It is estimated that suicide impacts on at least six other individuals and for 2022, this would equate to approximately 1,218 individuals bereaved by suicide [11]. The impact of suicide on those bereaved is vast and can impact on individuals' physical, psychological and social lives. These impacts include confusion, loss of sleep/insomnia, lack of energy, numbness, nightmares, feelings of unreality, loss of control, fear, blame, anger, guilt, social isolation, stigma, unemployment, anxiety, depression, homelessness etc [12, 13, 14].

2.1.2. Policy context

There are a number of policies focussed on improving the mental health and wellbeing of people in Northern Ireland which also contribute to reductions in suicide and self-harm [15, 16, 17].

Protect Life 2 [2] is Northern Ireland's strategy for preventing suicide and self-harm. Launched in 2019, the Strategy aims to reduce deaths by suicide by 10% by 2024 and to ensure support and prevention services for suicide are delivered to communities most at risk. PL2 includes a ten-point action plan including objective 4 which aims to *"enhance community capacity to prevent and respond to suicidal behaviour within local communities"*.

The Mental Health Strategy [1] for Northern Ireland was launched in 2021 and has 35 actions that aim to improve mental wellbeing for the whole population. The PHA has been tasked with Actions 1 and 2 of the Strategy which centre around improving the publics' awareness and understanding of mental health, mental ill health, reducing stigma, and mental health promotion across the life course.

Suicide prevention also features in a range of other policies, including:

- Making Life Better – A Whole System Framework for Public Health 2013-2023;
- Health and Wellbeing 2026: Delivering Together;
- New Strategic Direction for Alcohol and Drugs (NSD) Phase 2 2011-2016;
- Health and Social Care Commissioning Plan and Indicators of Performance Direction 2019–20;
- PHA Corporate Plan 2017-2021;
- Bamford Action Plan 2012-2015; and the Interdepartmental Action Plan[b].

2.2. The Mental Health Survey 2023/24

The Mental Health Survey 2023/24 was undertaken to gain insight into the knowledge, attitudes and behaviours of the general population in Northern Ireland in relation to mental health and suicide. The objectives are:

1. To assess current mental health literacy and attitudes among the NI general population;
2. To provide an indication of mental wellbeing and ill health among the general population that does not duplicate measures collected via other means (eg Health Survey NI);
3. To determine the steps taken by the general population in Northern Ireland to prevention mental ill health;
4. To examine attitudes and behaviours regarding help-seeking for mental ill health and suicide and evaluate satisfaction with help received, where relevant;
5. To explore stigma relating to mental ill health among the general population;
6. To ascertain readiness to intervene with individuals experiencing mental health problems and/or suicidal crisis.

This paper focuses on the prevention of mental ill health among the general population and thereby focuses on objectives 1, 2 and 3.

[b] NB: these are the most up-to-date policies that are currently in place.

3. Evaluation approach

A telephone survey was conducted of the general population in Northern Ireland between May and June 2023, with 1,009 adults (aged 18+ years) participating. The sample was statistically representative of the general population based on Census 2011 data for gender, age, socioeconomic status, and local government district. Fifty-one percent of the sample were female (n=517). The survey took approximately 20 minutes to complete and topics were guided by the Mental Health and Protect Life 2 strategies which included the following:

- Attitudes to mental health, mental ill health and suicide
- Stigma against help-seeking
- Self-stigma
- General help-seeking behaviours
- Personal experience of mental ill health
- Looking after one's own mental health and coping
- Intervening when concerned about someone
- Awareness of mental health and suicide prevention training.

3.1. Measures

The Mental Health Survey 2023/24 incorporated a number of standardised scales to measure the topics identified. All scales have been psychometrically tested and are shown to be reliable and valid.

Attitudes Towards Suicide (ATTS) [18] is a 20-item 5-point Likert scale used to measure attitudes towards suicide and has been validated for use among the general population. The scale is widely used and has been used by the European Alliance Against Depression [19]. While the scale includes ten subscales, the psychometric properties of the scale do not replicate across studies [20]. The Public Health Agency included the scale in a survey conducted in 2022/23 examining attitudes towards suicide. The psychometric properties of the scale were tested for use among the general population in Northern Ireland. Subscales identified in this analysis were included in this survey which were *Suicide Prevention* (2-items) and *Suicidal behaviour as attention-seeking* (2-items).

The Brief COPE [21] is a 28-item 4-point Likert scale designed to measure the ways in which people respond to stress. The scale includes 14 subscales of which five were included in this survey: active coping (2-items), self-distraction (2-items), instrumental social support (2-items), substance use (2-items) and emotional support (2-items).

The Self-Stigma of Seeking Help Scale (SSOSH) [22] is a 10-item 5-point Likert scale designed to measure self-stigma of seeking psychological help. This is a potentially important barrier to seeking help. This is the first of two stigma-related scales that were used in this survey.

The Self-Stigma of Mental Illness Scale [23] is a 20-item Likert scale that measures internalised stigma and self-stigma against mental illness. It consists of four subscales: awareness, agreement, application and harm to self-esteem and is designed for use among people living with mental illness. However, the Awareness subscale measures awareness of public stigma and items are similar to public stigma scales. Items are phrased '*I think the public believes that most people with mental illness are…to blame for their problems/are unpredictable/will not recover or get better/are dangerous/are unable to take care of themselves*'. Given the brevity of the awareness subscale, the current survey tested the use of the subscale among the general population.

The Five Ways to Wellbeing scale was developed for inclusion in the European Social Survey 2012[3] and includes: connect, be active, take notice, keep learning and give. Responses to items on the scale can indicate participation in each of the measures and cumulative participation calculated.

The General Help-Seeking Questionnaire [24] was developed to measure help-seeking intentions. The original scale consisted of 20-items asking who you would seek help from if you and a personal or emotional problem (10-items) or if experiencing suicidal thoughts (10-items). Responses are rated on a 7-point Likert scale ranging 1 'extremely unlikely' to 7 'extremely likely'. As the scale measures help-seeking intentions, it was adapted for the current survey as a measure of help-seeking behaviour.

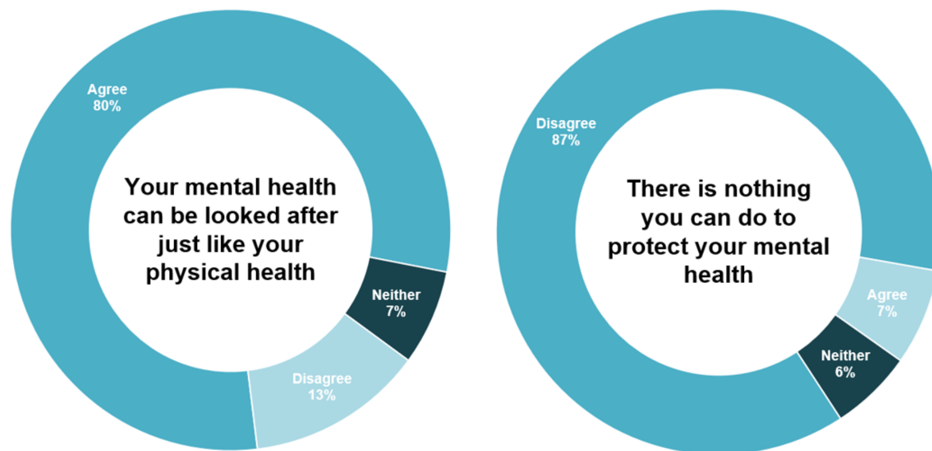
In addition to the standardised scales, the Mental Health Survey 2023/24 asked participants about their experience of mental ill health, intervening when concerned about someone, and awareness of mental health and/or suicide prevention training programmes.

NB: The findings from the survey will be addressed through a series of papers that focus on topics. As such, not all scales will be covered in all presentations of findings.

[3] See Home | European Social Survey

4. Findings

4.1. Attitudes towards preventing mental ill health



Participant's attitudes towards mental health were positive with four in five agreeing with the statement '*your mental health can be looked after just like your physical health*', and nearly nine in ten (87%) disagreed with the statement '*there is nothing you can do to protect your mental health*'.

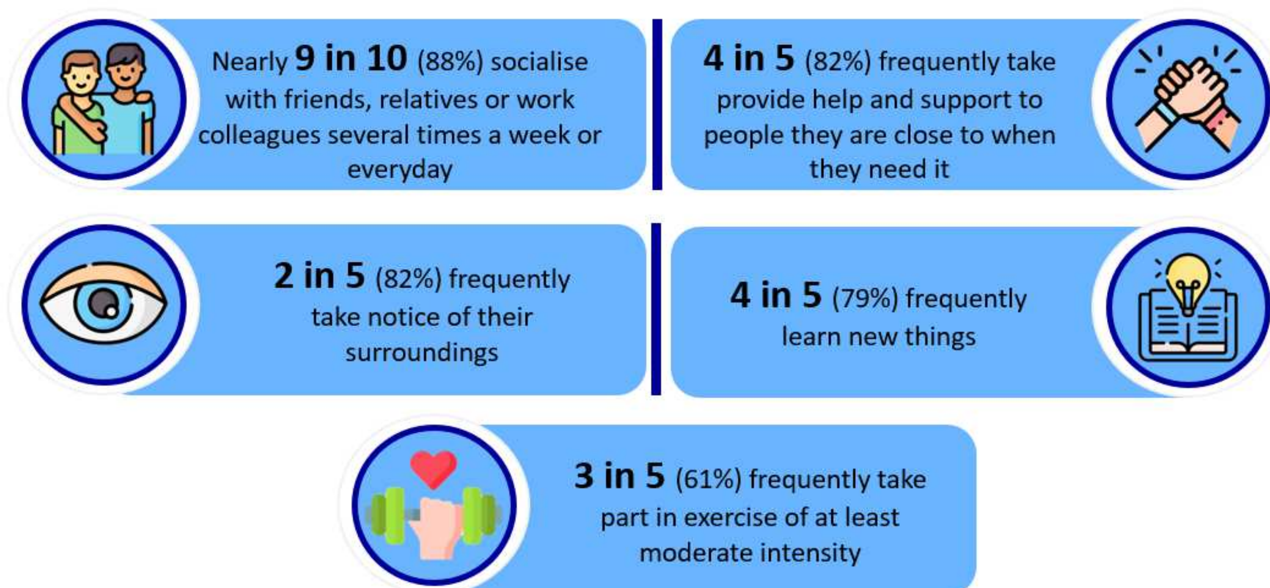
The proportion agreeing that your mental health can be looked after like your physical health was consistently high across key demographic variables (see Table 4 and

Table 5 for details). There were two exceptions with those living in the South Eastern Trust being less likely to agree (69% vs BHSCT, 80%; NHSCT, 83%; SHSCT, 87%; WHSCT, 80%; $p \leq .001$). Agreement with this statement was also significantly lower among those who had a disability (71% vs 82%; $p \leq .01$).

Similarly, disagreement with the statement 'there is nothing you can do to protect your mental health' was consistently high across key demographic groups with two exceptions. Disagreement with the statement was lower among those in the lower socioeconomic groups compared to those in higher socioeconomic groups (85% vs 89%; $p \leq .05$). Furthermore, those with a disability were more likely than those without a disability to agree with this statement (14% vs 5%; $p \leq .001$).

4.2. Preventing mental ill health

Frequently socialising, providing help/support to others, noticing surroundings, learning new things and exercising were used to measure the five steps to wellbeing. High proportions of participants reported frequently engaging in each of the measures: 88% socialised with friends; 82% provide help and support to others, 82% take notice of their surroundings, 79% learn new things, and 61% take part in exercise of at least moderate intensity. More than two thirds (69%) reported frequently engaging in at least four out of the five mea



Just over a third (36%) of those surveyed reported frequently taking part in all of the five measures. There were few significant associations between participating in all five measures and key demographic variables (Table 1 below and Table 6 in Appendix).

Frequent participation in **all five** measures was:

- lower among those living in the Southern HSCT compared to all other HSC Trust areas;
- lower among those living in Deprivation quintile 2 compared to other deprivation quintiles; and
- lower among those with a disability compared to those without a disability.

For each of the **individual measures**, those with a disability reported less frequently socialising, providing help/support to others, learning new things or exercising. There were no significant

differences between those with and those without a disability and taking notice of things around them.

For the individual measures, findings were more mixed for the following:

- Females were more likely to provide help/support to others compared to males but males were more likely to learn new things compared to females;
- Findings in relation to age were mixed: taking notice of things around us was lowest among those aged 30 to 44 years and those aged 18 to 29 years were more likely to take frequent exercise compared to other age groups;
- Those in higher socioeconomic groups were more likely to frequently socialise or exercise compared to those in lower socioeconomic groups;
- Those living in the most deprived deprivation quintile reported more frequently providing help/support to others than other deprivation quintiles, and those living in deprivation quintile 2 reported taking notice of things around them less than those living in other deprivation quintiles;
- Those who work within health and social care reported engaging in frequent exercise more than those who do not work for HSC;
- Those who had experience mental ill health themselves, at some point, reported being less likely to socialise frequently or taking notice of things around them.

Finally, there were no significant associations between participating in the individual measures and living in urban/rural areas or whether participants worked in the areas of mental health and/or suicide prevention.

Table 1: Significant associations between key demographic variables and participation in measures to look after mental wellbeing

	Participation in…					
	Socialising	Providing help	Taking notice	Learning new things	Exercise	All 5 measures
Gender		Higher among females (88% vs 76%)***		Higher among males (82% vs 76%)*		
Age			Lowest among those aged 30–44 years (76%, 18–29, 79%; 45–64, 86%; 65+, 89%)***		Highest among those aged 18–29 years (66%; 30–44, 64%; 45–64, 58%; 65+, 55%)*	
Socioeconomic group	Higher among ABC1s (91% vs 86%)**				Higher among ABC1s (65% vs 57%)*	
HSCT						Lowest among those living in the SHSCT (29%; BHSCT, 66%; NHSCT, 61%; SEHSCT, 66%; WHSCT, 37%)*
Area of deprivation		Highest among those living in the most deprived quintile (91% vs quintile 2, 74%; quintile 3, 85%; quintile 4, 83%; least deprived, 80%)***	Lowest among those living in Quintile 2 (75%; most deprived, 91%; Quintile 3, 85%; Quintile 4, 83%; Least deprived, 80%)*			Lowest among those living in Quintile 2 (27%; most deprived, 42%; Quintile 3, 35%; Quintile 4, 37%; Least deprived, 41%)*
Disability	Lower among those with a disability (83% vs 89%)*	Lower among those with a disability (77% vs 84%)*		Lower among those with a disability (70% vs 81%)***	Lower among those with a disability (38% vs 67%)***	Lower among those with a disability (18% vs 41%)***
Settlement						
Works in HSC					Higher among those working in HSC (72% vs 60%)**	
Works in areas of mental health and/or suicide prevention						
Experienced MH problem, self	Lower among those who had experienced mental ill health, self (85% vs 90%)*		Lower among those who had experienced mental ill health, self (79% vs 85%)*			
Significance level: ***p≤.001; **p≤.01; *p≤.05						

4.3. Access to activities, groups and services

Access to activities, groups and services in communities are one way to help ensure individuals protect their mental health. by accessing activities, groups and services, individuals connect with others, benefit from green spaces, exercise, learn new skills etc. All of these activities relate to the Take 5 approach to looking after your mental health (Figure 1). High proportions of participants said they could access green spaces (89%), community groups (72%), outdoor gyms (76%) and food banks (66%). While half said they could access self-help groups (50%) and counselling services (50%) if needed. Access was lower for cookery groups and befriending services with one third saying they could access either of these (34% for both).

Figure 1: Access to activities, groups and services (n=1,009)

There were some significant associations between key demographic variables and access to activities, groups and services, as follows (Table 2 below and Table 7 in Appendix):

- Those aged 65 years and above were significantly less likely than other age groups to say they had access to counselling, self-help groups, foodbanks or cookery groups;
- Those with a disability were significantly more likely than those without a disability to say they could access green spaces, community groups, self-help groups and outdoor gyms;
- Those living in rural areas were significantly less likely to have access to counselling services, outdoor gyms, food banks and cookery groups;
- Those employed by HSC were more likely to say they can access self-help groups, outdoor gyms and food banks; and
- Those who had experienced mental ill health themselves were significantly less likely to say they had access to green spaces and more likely to have access to food banks.

While there were some other significant associations between key demographic variables and whether participants felt they could access a range of activities, groups and services, the associations were few but are presented in Table 2.

Table 2: Significant associations between key demographic variables and access to activities, groups and services

	Activities, groups and services							
	Green spaces	Counselling services	Community groups	Self-help groups	Outdoor gyms	Food bank	Befriending services	Cookery groups
Gender						Lower among males		
Age		Lower among those aged 65+ years		Lower among those aged 65+ years		Lower among those aged 65+ years		Lower among those aged 65+ years
Socioeconomic group							Higher among C2DEs	
HSCT			Lower in SHSCT		Lower in SHSCT		Lower in SEHSCT	
Disability	Higher among those with a disability		Lower among those with a disability	Lower among those with a disability	Lower among those with a disability			
Settlement		Lower among those in rural areas			Lower among those in rural areas	Lower among those in rural areas		Lower among those in rural areas
Deprivation quintile								
Work in HSC				Higher among those who work in HSC	Higher among those who work in HSC	Higher among those who work in HSC		
Work in mental health area								Higher among those who work in mental health area
Experienced mental ill health, self	Less likely to have access					More likely to have access		

4.4. Coping with challenges to mental wellbeing

Participants were asked about different measures people take to help them cope with difficult times. The measures included active coping, self-distraction, substance use, emotional support and instrumental social support (Figure 2).

Self-distraction and emotional support were common strategies used by participants to help them cope with difficult times. For emotional support, 68% said they would get emotional support from friends/family at least a medium amount and 63% said they would get comfort and understanding

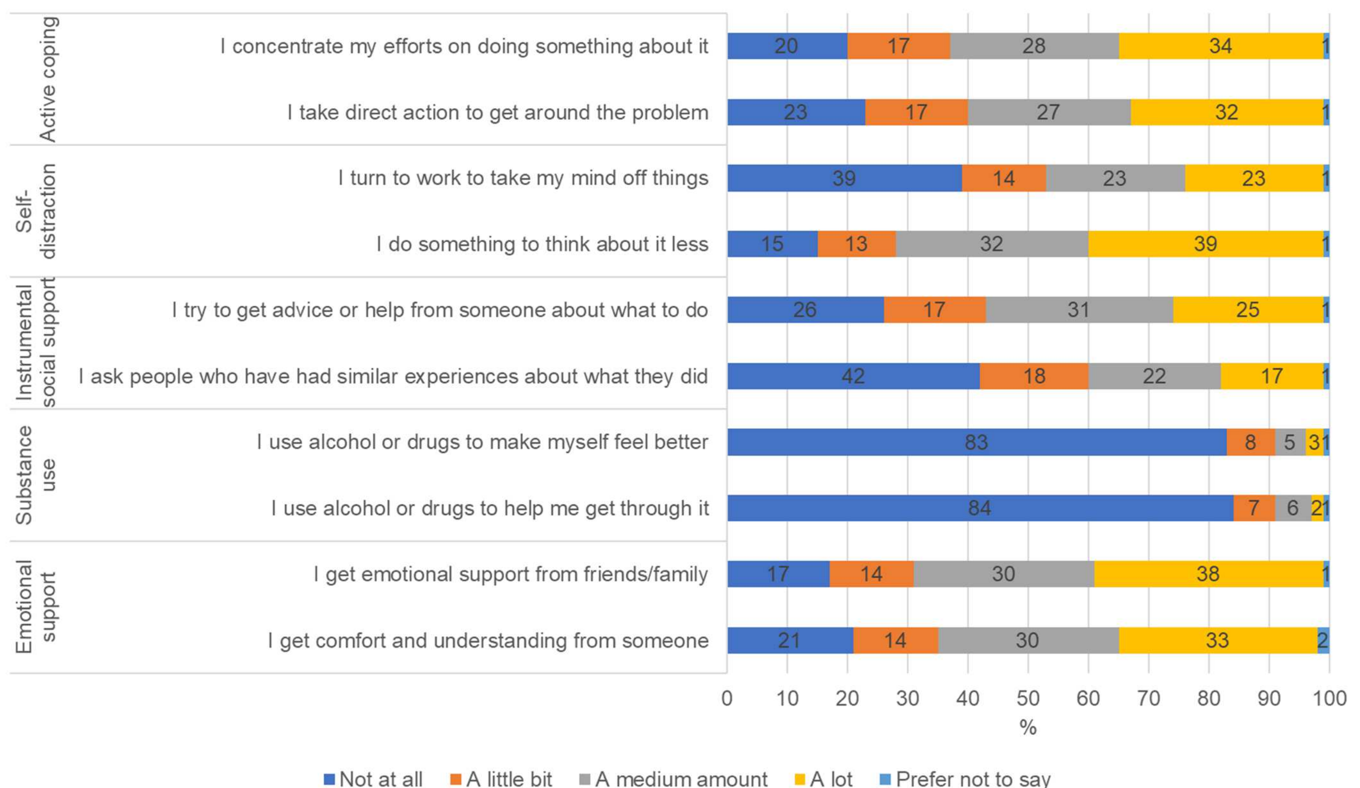
from someone. While 71% said they would do something to think about the issue less at least a medium amount of the time, less than half (46%) said they would turn to work to help take their mind of the issue.

Active coping was the next most common type of coping style that participants reported engaging in at least a medium amount of the time. Two in five (62%) said they would concentrate their efforts on doing something about the issue and/or they would take direct action to resolve the problem (59%).

Instrumental social support was less commonly reported with just over half (56%) saying they try to get advice or help about what to do at least a medium amount of the time, and one in four (39%) reported asking people who have had similar experiences about what they did to deal with the problem.

Using alcohol or drugs was the least commonly reported coping strategy. Eight percent said that used alcohol or drugs to help them get through the problem at least a medium amount of the time and eight percent said they use alcohol or drugs to make themselves feel better.

Figure 2: Measures taken to cope with difficult times (n=1,009)



Analyses were undertaken to examine significant differences between demographic groups in relation to coping styles. A summary of these differences are as follows (Table 3 below and Table 8 in Appendix):

While females were significantly more likely than males to engage in active coping (M=5.6 vs M=5.3; p≤.05), instrumental social support (M=4.9 vs M=4.4; p≤.001) and emotional support strategies (M=6.0 vs M=5.3; p≤.001), males were significantly more likely to engage in substance use (M=2.7 vs M=2.4; p≤.01).

Those who had a disability were significantly less likely than those without a disability to use self distraction (M=4.9 vs M=5.4; p≤.01) and instrument social support strategies (M=4.4 vs M=4.7; p≤.05), but were more likely to use substance use as coping strategies (M=2.8 vs M=2.5; p≤.001).

There were no differences between those with or without a disability and active coping or emotional support strategies.

Those who had experienced mental ill health themselves at some point were significantly more likely to engage in active coping, self distraction, instrumental social support, emotional support and substance use compared to those who had never experienced mental ill health.

Findings were more mixed for age groups:

- Those aged 18 to 29 years were more likely than all other age groups to engage in self-distraction.
- Those aged between 18 and 44 years were more likely to engage in instrumental social support compared to those aged 45 years and above.
- Those aged 65 years and over were significantly less likely to engage in substance abuse compared to all other age groups.
- Age was not associated with active coping or emotional support strategies.

Findings were also mixed for HSC Trust:

- Those living in the WHSCT and SHSCT were more likely to engage in active coping compared to those living in BHSCT;
- Those living in SHSCT were more likely to engage in self-distraction compared to those living in SEHSCT or BHSCT;
- Those living in WHSCT were more likely to engage in instrumental social support compared to those living in SEHSCT.

Socioeconomic group, settlement (ie whether participants lived in urban or rural areas), area of multiple deprivation and working for the Health and Social care sector were not significantly associated with coping styles.

Table 3: Summary of significant associations between demographic variables and coping styles

	Active coping	Self-distraction	Instrumental social support	Substance use	Emotional support
Gender	Females higher (M=5.6 vs M=5.3)*		Females higher (M=4.9 vs M=4.4)*	Males higher (M=2.7 vs M=2.4)**	Females higher (M=6.0 vs M=5.3)*
Age		Higher among 18–29 year olds (M=5.6; 30-44, 5.3; 45-64, 5.1; 65+, M=5.1)*	Highest among 18–44 year olds (M=4.4; 18-29, M=4.9; 30-44, M=4.9; 45-64, M=4.6; 65+, M=4.3)*	Lowest among 65+ (M=2.3; 18-29, M=2.7; 30-44, M=2.6; 45-64, M=2.6)**	
Socioeconomic group					
HSCT	Highest in WHSCT and SHSCT compared to BHSCT (M=5.8 and M=5.8 vs M=5.2, respectively)*	Highest in SHSCT compared to SEHSCT or BHSCT (M=5.7 vs M=5.0 and M=5.1, respectively)**	Higher in WHSCT compared to SEHSCT (M=5.0 vs M=4.4, respectively)*		Higher in SHSCT compared to BHSCT, NHSCT and SEHSCT (M=6.2 vs M=5.4, M=5.6, M=5.5, respectively)**
MDM					
Disability		Lower among those disabled (M=4.9 vs M=5.4)**	Lower among those disabled (M=4.4 vs M=4.7)*	Higher among those disabled (M=2.8 vs M=2.5)***	

Settlement					
Working in HSC					
Experienced mental ill health, self	Higher among those who had experienced mental ill health at some point (M=5.8 vs M=5.3)***	Higher among those who had experienced mental ill health at some point (M=5.5 vs M=5.1)***	Higher among those who had experienced mental ill health at some point (M=5.1 vs M=4.4)***	Higher among those who had experienced mental ill health at some point (M=2.8 vs M=2.4)***	Higher among those who had experienced mental ill health at some point (M=6.0 vs M=5.4)***

4.5. Experiencing mental ill health

Two in three of the general population surveyed said they had experienced mental ill health.

This was through personal experience or having cared for a friend, family member or in a professional capacity. Of these:

- 2 in 5 (40%) had experienced mental ill health themselves
- 36% had cared for a family member who had mental ill health at some point
- 11% had a work colleague who had experienced mental ill health

Experiencing mental ill health was significantly higher among:

- Females compared to males (45% vs 34%; p≤001);
- Those aged 18 to 44 years (18–29, 50%; 30–44 years, 50%; 45–64, 36%; 65+, 23%; p≤.001);
- Those with a disability (63% vs 34%; p≤.001);
- Those living in urban areas (43% vs 36%; p≤.05); and
- Those who work in the area of mental health and/or suicide prevention (58% vs 39%; p≤.05).

5. Conclusions

Overall, participants held attitudes and engaged in behaviours that positively impact their mental wellbeing. Four in five agreed that mental health can be looked after like physical health and nearly nine in ten disagreed with a statement there is nothing you can do to protect your mental health.

Participation in activities, attending groups and having access to services can contribute to mental wellbeing as it promotes social inclusion and prevents isolation which can detrimentally impact mental health. Access to activities, groups and services were relatively high with more than two thirds of participants reporting they have access to food bank (66%), community groups (72%), outdoor gyms (76%), and green spaces (89%). Half also reported access to self help groups (50%) and counselling services (50%). Access to cookery groups and befriending services were lower with just over a third of participants reporting access to these (34% and 34%, respectively).

More than two thirds (69%) regularly engaged in four out of five activities promoted as five steps to wellbeing. Participation was high for the individual activities:

- 9 in 10 frequently socialise with friends/family/work colleagues;
- 2 in 5 frequently provide help and support to others;
- 4 in 5 frequently take notice of things around them;
- 4 in 5 frequently learn new things;
- 3 in 5 frequently exercise.

Common strategies to help participants cope with challenges to mental wellbeing included self-distraction from the problem, gaining emotional support and active coping (tackling the problem directly). Instrumental social support was also used but reported less frequently. Using alcohol and/or drugs to cope with challenges was the least frequently reported strategy used.

There were some noteworthy findings when analysis examined associations between demographic groups and the measures discussed in this report:

- Those with a disability were consistently disadvantaged across all measures, with some exceptions. Those with a disability were significantly less likely than those without a disability to engage in all five indicators associated with the five steps to wellbeing. For the individual measures, frequently socialising, providing help/support to others, learning new things, and exercising were significantly lower among those with a disability compared to those without. Those with a disability also reported less access to green spaces, community groups, self-help groups and outdoor gyms compared to those without a disability. While there were no significant differences between those with and without a disability and active coping or emotional support strategies to deal with challenges to mental wellbeing, those with a disability scored lower for self-distraction and instrumental social support but higher on substance use. Those with a disability were also more likely to report having experienced mental ill health.

- There were consistent patterns associated with age and access to services, groups and activities and coping strategies. Those aged 65 years and above were significantly less likely to say they had access to counselling services, self-help groups, food banks or cookery groups compared to those in younger age groups. In terms of coping strategies, those aged 65+ years were less likely than other age groups to report using substances to help them cope when they were finding things difficult. Instrumental social support was highest among those aged 19–29 years and self-distraction was highest among those aged 18–44 years. There were no age-related differences between taking part in all five measures of wellbeing but for the individual measures, those aged 30–44 years were more

likely to take notice of things around them compared to other ages, and those aged 18–29 years were more likely to frequently exercise compared to other age groups.

- There were consistent findings associated between gender and coping strategies. Females were significantly more likely to engage in active coping, instrumental social support, and emotional support. Males were significantly more likely to engage in substance use. Significant associations between gender and the five measures of wellbeing were less consistent. However, for the five measures of wellbeing, females were more likely than males to provide help/support to others and males were more likely to learn new things. Finally, males were significantly less likely to say they had access to food banks compared to females but no other gender associations were found.

- Those who had experienced mental ill health at some point were significantly more likely to use active coping, self-distraction, instrumental social support, substance use and emotional support strategies to help them cope when faced with difficult times. This group were also significantly more likely to report having access to food banks but there were no other significant associations with access to groups, services and activities. With respect to the five measures of wellbeing, those who had experienced mental ill health at some point were significantly less likely than those who had never experienced mental ill health to frequently socialise or take notice of things around them.

- There were no significant associations between settlement and the five measures of wellbeing and coping strategies. However, those living in rural areas were significantly less likely to say they had access to counselling services, outdoor gyms, foodbanks and cookery groups compared to those living in urban areas.

While there were significant associations between other demographic variables and the measures discussed in this paper, the findings were mixed and difficult to interpret. There were few associations between the measures and socioeconomic group, area of deprivation, and whether participants worked in Health and Social Care or in the fields of mental health/suicide prevention.

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Appendix

Table 4: Associations between responses to "*Your mental health can be looked after just like your physical health*" and key demographic variables

		Base	Agree %	Neither %	Disagree %
Overall		1,007	80	7	13
Gender	Male	485	80	8	12
	Female	517	79	8	13
Age	18–29	152	82	7	11
	30–44	325	82	7	12
	45–64	296	80	5	15
	65+	207	75	12	13
Socioeconomic group	ABC1	478	80	9	11
	C2DE	476	79	7	15
HSCT* **	Belfast	200	80	8	12
	Northern	282	83	7	10
	South Eastern	196	69	14	17
	Southern	172	87	4	10
	Western	157	80	5	15
Disability**	Yes	202	71	11	18
	No	795	82	7	11
Settlement	Urban	604	79	8	12
	Rural	403	81	6	13
Deprivation	Most deprived	190	76	10	14
	Quintile 2	200	78	7	16
	Quintile 3	211	78	8	14
	Quintile 4	208	83	6	11
	Least deprived	198	84	7	9
Work in mental health area	Yes	45	84	4	11
	No	962	80	8	13
Work in HSC	Yes	124	81	4	15
	No	883	80	8	12
Experienced mental ill health, self	Yes	401	79	7	14
	No	606	80	8	12

*** p≤.001; ** p≤.01; * p≤.05

Table 5: Associations between responses to "*There is nothing you can do to protect your mental health*" and key demographic variables

		Base	Agree %	Neither %	Disagree %
Overall		1,009	7	6	87
Gender	Male	485	8	6	85
	Female	517	6	5	88
Age	18–29	152	5	5	90
	30–44	325	6	5	89
	45–64	296	9	4	87
	65+	208	8	8	84
Socioeconomic group*	ABC1	478	5	6	89
	C2DE	476	9	6	85
HSCT	Belfast	200	8	6	86
	Northern	282	7	5	88
	South Eastern	196	7	9	84
	Southern	172	6	3	91
	Western	157	9	5	86
Disability***	Yes	202	14	10	75
	No	795	5	5	90
Settlement	Urban	604	7	6	87
	Rural	403	7	6	87
Deprivation	Most deprived	190	9	10	82
	Quintile 2	200	5	6	89
	Quintile 3	211	10	5	86
	Quintile 4	208	5	4	91
	Least deprived	198	8	5	87
Work in mental health area	Yes	45	7	7	87
	No	962	7	6	87
Work in HSC	Yes	124	4	6	90
	No	883	8	6	87
Experienced mental ill health, self	Yes	401	8	6	87
	No	606	7	6	87
***** p≤.001; ** p≤.01; * p≤.05**					

Table 6: Associations between frequently five steps to wellbeing and key demographic variables

			Frequently…											
			Socialising		Providing help/support to others		Take notice		Learn something		Exercise		All 5 measures	
		n	% Yes	Sig.	% Yes	Sig.	% Yes	Sig.	% Yes	Sig.	% Yes	Sig.	% Yes	Sig.
ALL		1,009	88		82		82		79		61		36	
Gender	Males	481	88		76	***	81		82	*	64		34	
	Females	513	88		88		83		76		58		38	
Age group	18–29	152	92		83		79	***	80		69	*	38	
	30–44	324	88		83		76		81		64		36	
	45–64	294	85		84		86		78		58		36	
	65+	203	88		80		89		76		55		35	
Socioeconomic group	ABC1	475	91	**	83		80		80		65	*	40	
	C2DE	473	87		82		84		77		57		34	
HSCT	BHSCT	198	89		84		87		84		66		43	*
	NHSCT	282	87		80		81		78		61		34	
	SEHSCT	195	88		81		80		78		66		40	
	SHSCT	171	90		83		79		77		55		29	
	WHSCT	152	85		86		87		76		56		37	
Disability	Yes	200	83	*	77	*	79		70	***	38	***	18	***
	No	793	89		84		83		81		67		41	
Settlement	Urban	601	89		83		82		79		63		39	
	Rural	397	87		81		83		78		59		33	
Working in HSC	Yes	123	87		89		78		77		72	**	44	
	No	875	88		82		83		79		60		35	
Working in MH	Yes	45	82		86		84		89		67		47	
	No	953	88		82		82		78		61		36	
Deprivation	Most deprived	185	85		91	***	84	*	81		59		42	*
	Quintile 2	200	85		74		75		74		57		27	
	Quintile 3	210	89		85		82		76		65		35	
	Quintile 4	206	89		83		85		79		59		37	
	Least deprived	197	90		80		87		83		65		41	
MH problem self	Yes	398	85	*	81		79	*	77		59		33	
	No	600	90		83		85		80		62		39	

***** p≤.001; ** p≤.01; * p≤.05**

Table 7: Associations between access to services groups and services and key demographic variables

			Green spaces		Counselling services		Community groups		Self-help groups		Outdoor gyms		Food bank		Befriending services		Cookery groups	
		Base	%	Sig.	%	Sig.	%	Sig.	%	Sig.	%	Sig.	%	Sig.	%	Sig.	%	Sig.
Overall		1,009	89		50		72		50		76		66		34		34	
Gender	Male	487	91		65		74		50		77	***	61	***	34		27	
	Female	517	87		65		70		51		76		71		35		28	
Age	18–29	152	91		72	***	76		57	*	88		66	**	36		35	**
	30–44	325	88		68		75		53		82		66		35		31	
	45–64	297	88		67		69		49		72		73		31		26	
	65+	208	89		55		69		45		66		57		32		20	
Socioeconomic group	ABC1	478	90		63		73		48		78		68		32	*	28	
	C2DE	478	88		67		72		54		75		65		38		27	
HSCT	Belfast	200	89		62		67	**	50		81	**	61		40	*	29	
	Northern	283	88		65		75		49		76		68		36		27	
	South Eastern	197	91		68		75		45		81		69		26		25	
	Southern	172	90		62		62		52		65		65		31		29	
	Western	157	87		69		78		60		78		68		38		28	
Disability	Yes	202	84	*	63		65	*	43	*	70	*	65		30		25	
	No	797	72		66		73		52		78		67		36		28	
Settlement	Urban	606	88		68	*	72		50		80	**	72	***	36		30	*
	Rural	403	89		61		72		51		72		58		32		24	
Deprivation	Most deprived	190	88		66		75		55		80		67		34		31	
	Quintile 2	200	90		69		70		52		77		63		38		27	
	Quintile 3	212	84		67		68		51		72		69		34		26	
	Quintile 4	208	89		61		73		49		73		64		32		27	
	Least deprived	199	92		64		74		47		81		68		34		27	
Work in mental health area	Yes	45	87		76		78		56		82		78		33		42	*
	No	964	89		65		71		50		76		66		34		27	
Work in HSC	Yes	124	90		71		76		61	*	86	**	76	*	40		34	
	No	885	89		64		71		49		75		65		34		26	
Experienced mental ill health, self	Yes	401	86	*	68		69		49		76		70	*	33		26	
	No	608	90		63		74		52		76		64		35		28	
***** p≤.001; ** p≤.01; * p≤.05**																		

Table 8: Significant differences between demographic groups and coping measures

		Active coping			Self-distraction			Instrumental social support			Substance use			Emotional support		
		n	Mean score	Sig.	n	Mean score	Sig.	n	Mean score	Sig.	n	Mean score	Sig.	n	Mean score	Sig.
ALL		993	5.5		999	5.3		996	4.7		996	2.5		994	5.7	
Gender	Males	474	5.3	*	480	5.2		478	4.4	***	479	2.7	**	476	5.3	***
	Females	514	5.6		514	5.3		513	4.9		512	2.4		513	6.0	
Age group	18–29	151	5.3		151	5.6	*	150	4.9	**	151	2.7	**	150	6.0	
	30–44	322	5.4		322	5.3		322	4.9		322	2.6		322	5.7	
	45–64	290	5.6		293	5.1		292	4.6		292	2.6		292	5.6	
	65+	203	5.4		206	5.1		205	4.3		204	2.3		203	5.5	
Socioeconomic group	ABC1	473	5.5		475	5.3		474	4.8		475	2.5		473	5.8	
	C2DE	470	5.5		473	5.2		472	4.6		471	2.5		471	5.6	
HSCT	BHSCT	196	5.2	*	196	5.1	**	196	4.7	*	195	2.5		195	5.4	**
	NHSCT	277	5.4		281	5.3		280	4.6		281	2.6		279	5.6	
	SEHSCT	196	5.3		196	5.0		196	4.4		196	2.5		196	5.5	
	SHSCT	170	5.8		170	5.7		170	4.9		170	6.2		170	6.2	
	WHSCT	154	5.8		156	5.4		154	5.0		154	2.5		154	5.8	
Disability	Yes	198	5.3		198	4.9	**	198	4.4	*	198	2.8	***	198	5.5	
	No	785	5.5		791	5.4		788	4.7		788	2.5		786	5.7	
Settlement	Urban	595	5.4		599	5.2		596	4.7		596	2.5		594	5.6	
	Rural	398	5.6		400	5.4		400	4.6		400	2.5		400	5.7	
Working in HSC	Yes	121	5.6		121	5.4		121	4.8		121	2.5		121	5.7	
	No	872	5.4		878	5.3		875	4.7		875	2.5		873	5.7	
Deprivation	Most deprived	188	5.3		188	5.0		188	4.6		188	2.5		188	5.5	
	Quintile 2	197	5.6		199	5.1		198	4.6		198	2.5		198	5.6	
	Quintile 3	208	5.5		211	5.4		211	4.7		211	2.5		211	5.8	
	Quintile 4	204	5.4		205	5.3		204	4.5		205	2.6		204	5.6	
	Least deprived	196	5.6		196	5.5		195	5.0		194	2.5		193	5.8	
MH problem self	Yes	397	5.8	***	398	5.5	***	398	5.1	***	398	2.8	***	397	6.0	***
	No	596	5.3		601	5.1		598	4.4		598	2.4		597	5.4	

***** p≤.001; ** p≤.01; * p≤.05**