Public Health Agency

Report 3: Preparedness to intervene when concerned about someone's mental health

Mental Health Survey 2023/24

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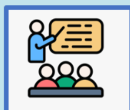
Improving your health and wellbeing

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.

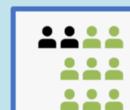
A telephone survey was conducted in Spring 2023 with a nationally representative sample of 1,009 adults aged 18 years and above in the Northern Ireland general population. Participants were surveyed about a range of issues relating to the topics of mental health and suicide prevention. Findings included in this paper focus on awareness of mental health and/or suicide prevention training, beliefs about suicide and willingness to intervene when concerned.

Key findings:



Over half of participants aware of at least one mental health and/or suicide prevention training course (61%)

High willingness to intervene with 95% of participants being willing to help someone in suicidal crisis

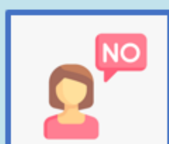


8 in 10 participants had previously intervened and asked someone if they were okay because they were concerned

82% had no worries that would put them off trying to help someone they thought was struggling with their mental health

Awareness of at least one mental health and/or suicide prevention training course:

More likely to see suicide as preventable



Less likely to dismiss suicidal behaviour

Higher willingness to intervene

More likely to have previously asked someone if they were okay

Contents

1. Executive summary 2
List of tables 4
List of figures 4
2. Background 5
2.1. Mental health in Northern Ireland 5
2.1.1. Suicide in Northern Ireland 6
2.1.2. Policy context 6
2.1.3. Mental Health and Suicide Prevention Training 7
2.2. The Mental Health Survey 2023/24 8
3. Evaluation approach 9
3.1. Measures 9
4. Findings 11
4.1. Awareness and attendance of mental health and/or suicide prevention Training 11
4.2. Attitudes towards suicide 13
4.2.1. Suicide as Preventable 13
4.2.2. Dismissing Suicidal Behaviour 14
4.2.3. Talking about Suicide 15
4.3. Willingness to Intervene 16
4.3.1. Having intervened when concerned 17
4.3.2. Worries about Intervening 18
5. Conclusions 19
References 21
Appendix ..... **Error! Bookmark not defined.**

List of tables

Table 1: Summary of significant associations between key demographic groups and the number of mental health and/or suicide prevention training courses (n=1,009) 12
Table 2: Summary of significant differences between demographic groups and the suicide is preventable subscale (n=1,009) 13
Table 3: Summary of significant differences between demographic groups and the 'Dismissing Suicidal Behaviour' subscale (n=1,009) 15
Table 4: Associations between awareness of training courses and key demographic variables (n=1,009) 23
Table 5: Associations between responses to "Talking about suicide or asking someone if they are suicidal will encourage suicide attempts" and key demographic variables (n=1,009) 24
Table 6: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they were struggling/had a mental health problem?'' and key demographic variables (n=1,009) 25
Table 7: Associations between responses to "Have you ever asked someone if they were okay because you thought they might be thinking of suicide?'' and key demographic variables (n=1,006) 26
Table 8: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they may be intentionally harming themselves?'' and key demographic variables (n=1,009) 27
Table 9: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they may be drinking more than usual?'' and key demographic variables (n=1,009) 28
Table 10: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they may be using drugs to help them escape?'' and key demographic variables (n=1,009) 29

List of figures

Figure 1: Proportion of participants who had heard of or attended each of the mental health and/or suicide prevention training courses (n=1,009) 11
Figure 2: Frequency of responses to items on the 'prevention' subscale (n=1,009) 13
Figure 3: Frequency of responses to the items on the 'Dismissing Suicidal Behaviour' subscale (n=1,009) 14
Figure 4: Frequency of responses to 'Willingness to Intervene' items (n=1,009) 16
Figure 5: 'Have you ever asked someone if they were okay because you thought they might be…' (n=1,009) 17

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].

2.1.3. Mental Health and Suicide Prevention Training

In Northern Ireland, mental health and suicide prevention training is one of the key objectives of the Protect Life 2 [2] strategy. This includes a focus on training not only those on the frontline in emergency departments, health and social care, and primary care, but across a range of sectors which interact with vulnerable people as it is known that many people who are suicidal do not have contact with healthcare professionals. Specific targets in relation to training include:

- The number of people working in the community who are trained in suicide awareness or prevention.
- Aiming for 50% of the frontline HSC staff trained in suicide awareness and prevention.

Another action was the development of the Mental and Emotional Health and Wellbeing and Suicide Prevention Training Framework by the Public Health Agency. This framework aligns with both Protect Life 2 [2] and the Mental Health Strategy [1], aiming to address both mental and emotional health and wellbeing and the prevention of suicide aiming to raise awareness, improve understanding, knowledge, confidence, resilience and skills. This framework takes a four-tiered approach to training:

- Tier 1: Information sharing for the whole population of Northern Ireland
- Tier 2: Developing awareness and understanding within the whole population of Northern Ireland
- Tier 3: Enhancing knowledge and skills training for gatekeepers, management and frontline services;
- Tier 4: Specialised skills training for gatekeepers, frontline services and those working directly with others experiencing mental health problems.

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

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 awareness of mental health and/or suicide prevention training, beliefs about suicide and willingness to intervene among the general population and thereby focuses on objective 6 and contributes to objective 4.

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 *Dismissing Suicidal Behaviour* (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

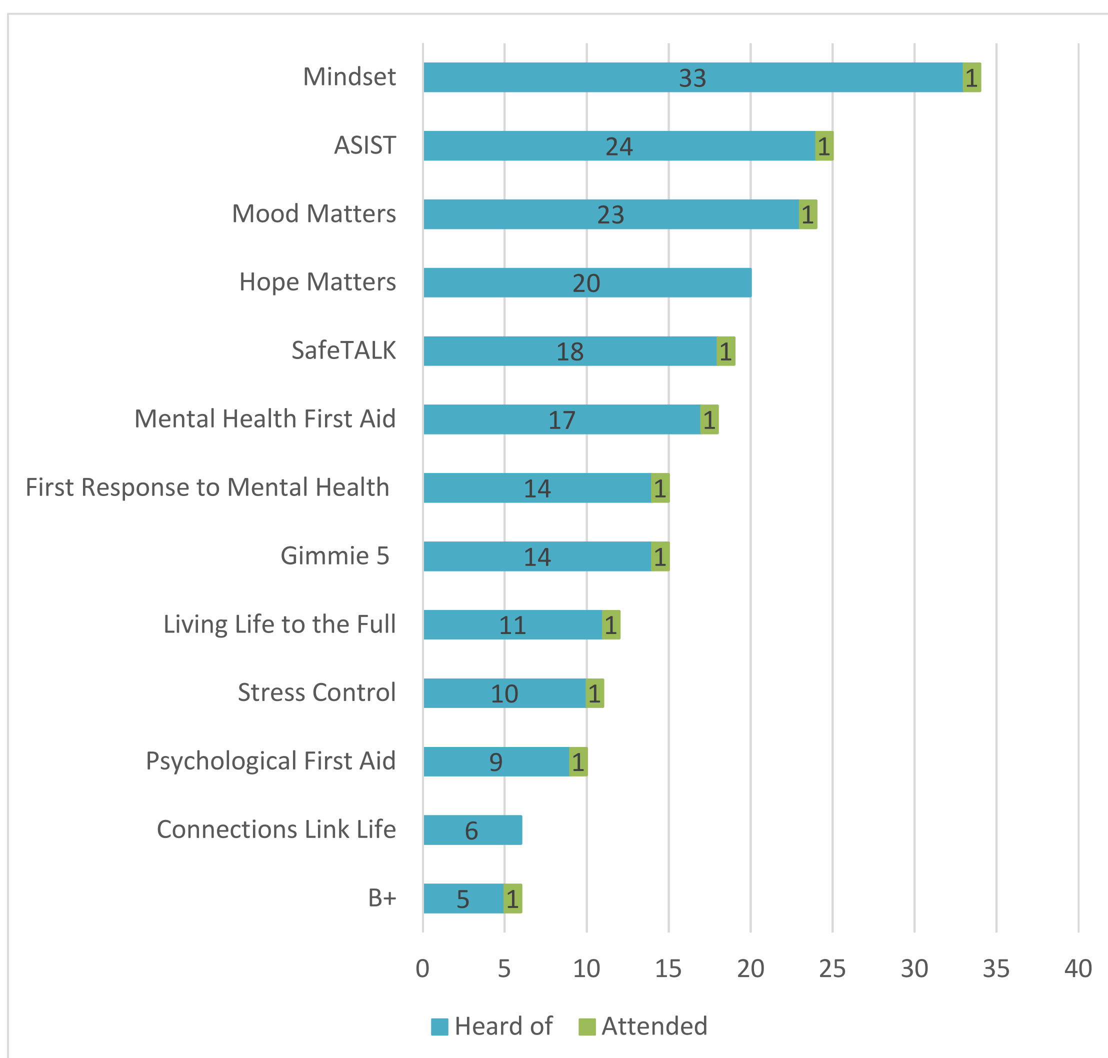
4. Findings

4.1. Awareness and attendance of mental health and/or suicide prevention Training

Participants were asked if they had ever heard of or attended a number of mental health awareness and/or suicide prevention training courses. Over half of participants, had heard of at least one of the thirteen training courses (61%). The mental health and/or training programmes that participants had most frequently heard of were Mindset (33%), followed by ASIST (24%) and Mood Matters (23%) (**Figure 1**).

Attendance at mental health and/or suicide prevention training courses was much lower than awareness, with only 4% of participants having attended one or more course. Only 1% of participants reported attending each of the training courses, with the exception of Hope Matters and Connections Link Life where none of the participants reported attending these training courses.

Figure 1: Proportion of participants who had heard of or attended each of the mental health and/or suicide prevention training courses (n=1,009)



Combining those who had either heard of or attended a mental health and/or suicide prevention training into a variable for 'awareness of at least one training course,' showed significant associations between awareness and the following demographic groups were found (see summary **Table 4** in **Error! Reference source not found.** for more detail):

- Females were more likely than males to be aware of training courses;

- Those aged between 30-44 were more likely to be aware of at least one course, whereas those aged 65+ were more likely to not be aware of any courses;
- Those in the higher socioeconomic group were more likely to be aware of at least one course;
- Compared to the other Health and Social Care Trusts (HSCTs), those living in the South Eastern HSCT were more likely to have not heard of one of the training courses;
- Those living in urban areas were more likely to be aware of at least one course compared to those living in rural areas;
- Those living in the most deprived areas had the highest awareness;
- Those who work in the mental health and/or suicide prevention field were more likely to be aware of at least of one the training courses;
- Those who were employed within the HSC in Northern Ireland were more likely to be aware of training courses;
- Those who had experienced mental ill-health were less likely to be unaware of training courses.

In those who had heard of at least one course, the average number heard of was three. Significant differences were found in the number of courses heard of and all of the key demographic groups, apart from disability (**Table 1**). The demographic characteristics significantly associated with having heard of a greater number of training courses were being; female, in a younger age group (19-29 and 30-44), in the highest socio-economic group, in the BHSCT, in the most deprived area, in urban areas, an employee of the HSC, working in mental health and those who had never experienced mental ill health themselves. Attendance at any mental health and/or suicide prevention training courses was too small to analyse any associations between key demographic groups and the number of courses attended.

Table 1: Summary of significant associations between key demographic groups and the number of mental health and/or suicide prevention training courses (n=1,009)

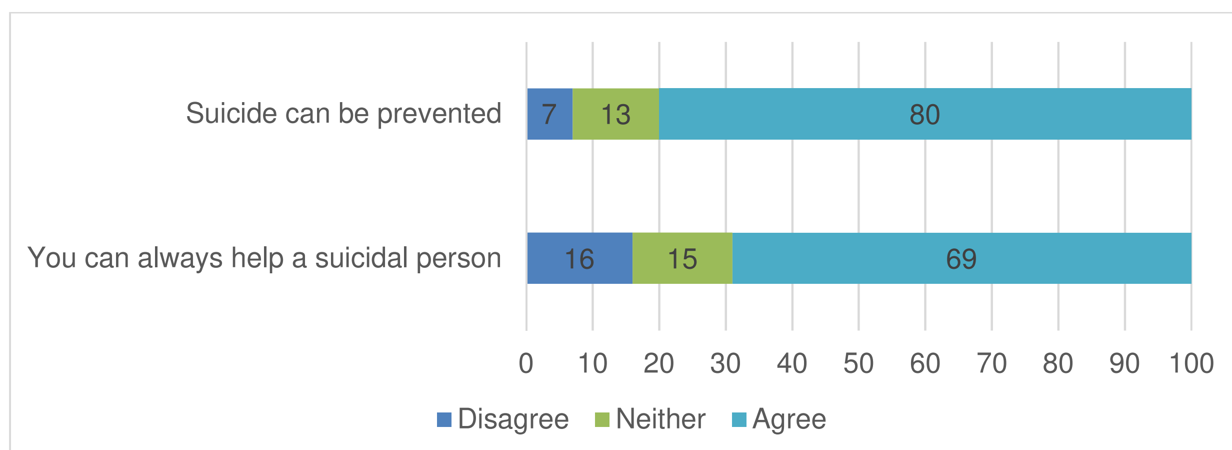
	Number of training courses heard of
Gender	Females higher (M=2.4 vs M=1.7)***
Age	Higher among 18–29 year olds and 30–44 year olds (M=2.4 and M=2.4, respectively vs. 45–64, M=2.0; 65+, M=1.4)***
Socioeconomic group	Highest in ABC1s (M=2.2 vs M=1.9) *
HSCT	Highest in BHSCT (M=2.5 vs NHSCT, M=1.9; SEHSCT, M=1.4; SHSCT, M=2.0; WHSCT, M=2.3) **
Deprivation quintile	Highest in the most deprived areas (M=2.5 vs quintile 2, M=2.1; quintile 3, M=2.1; quintile 4, M=1.7; least deprived, M=1.8) **
Disability	Ns.
Settlement	Highest in urban areas (M=2.3 vs M=1.6) ***
Working in HSC	Higher in those working in the HSC (M=3.4 vs M=1.8) ***
Working in Mental Health and Suicide Prevention	Higher in those working in the field of mental health and/or suicide prevention (M=4.0 vs M=1.9) ***
Experienced mental ill health, self	Higher among those who had not experienced mental ill health at some point (M=2.3 vs M=1.8) ***
*** p≤.001; ** p≤.01; * p≤.05	

4.2. Attitudes towards suicide

4.2.1. Suicide as Preventable

Participants were asked to respond to two statements from the Attitudes Towards Suicide Scale (ATTS) to assess to what extent they believe suicide is preventable (**Error! Reference source not found.**). Agreement was high for the statement '*Suicide can be prevented*' with four out of five participants agreeing (80%) and only 7% disagreeing. Agreement was slightly lower for the second statement, '*You can always help a suicidal person*' with more than two thirds (69%) agreeing and 16% disagreeing.

Figure 2: Frequency of responses to items on the 'prevention' subscale (n=1,009)



Participants' responses to these statements were totalled to calculate a prevention subscale score, with higher scores indicating a higher belief that suicide is preventable. Prevention scores ranged from two to ten and had a mean of eight. Differences were found in prevention scores between key the demographic groups, with males, the youngest age group (18–29-year olds) and the highest socioeconomic group all having significantly higher scores (**Table 2**). A significant strong correlation was found between the number of mental health and/or suicide prevention training courses heard of and high prevention scores: the more courses participants were aware of was associated with stronger views that suicide is preventable ($r=.07$, $p\leq.05$). However, those who were aware of at least one mental health and/or suicide prevention training course had significantly higher prevention scores.

Table 2: Summary of significant differences between demographic groups and the suicide is preventable subscale (n=1,009)

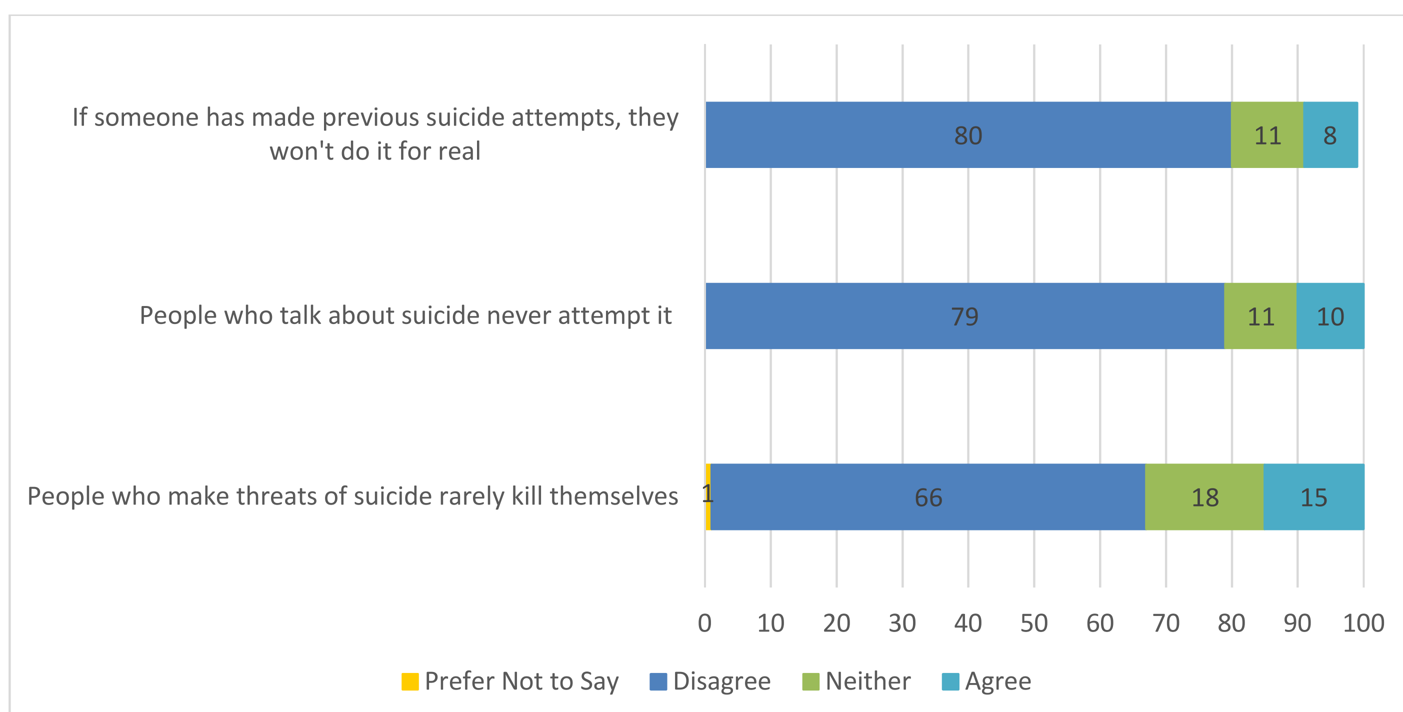
	Suicide seen as more preventable among…
Gender	Males (M=7.4 vs M=7.7). ***
Age	18–29-year olds (M=7.7 vs 30–44 M=7.6; 45–64, M=7.5; 65+, M=7.3) *
Socioeconomic group	Higher socio-economic groups (M=7.6 vs M=7.5). *
HSCT	Ns.
MDM	Ns.
Disability	Ns.
Settlement	Ns.

Working in HSC	Ns.
Working in Mental Health and Suicide Prevention	Ns.
Experienced mental ill health, self	Ns.
Aware of at least 1 training course	Those aware of at least 1 training course (M=7.6 vs M=7.4)*
*** p≤.001; ** p≤.01; * p≤.05	

4.2.2. Dismissing Suicidal Behaviour

Participants were also asked to respond to three statements from the ATTS designed to assess to what extent they dismiss suicidal behaviour (Error! Reference source not found.). Disagreement was highest (80%) for the statement '*If someone has made previous suicide attempts, they won't do it for real*.' There was a similar level of disagreement with the statement '*People who talk about suicide never attempt it*' (79% disagreed), however agreement with this statement was slightly higher at one in ten participants. The third statement, '*People who make threats about suicide rarely kill themselves*' was the most agreed with statement (15%). Almost one in five participants were also unsure and neither agreed or disagreed with this statement (18%).

Figure 3: Frequency of responses to the items on the 'Dismissing Suicidal Behaviour' subscale (n=1,009)



Responses to these statements were totalled to provide a score on '*dismissing suicidal behaviour*' for each participant, with a greater score indicating a higher level of dismissal. Scores ranged from three to fifteen, with a mean six. Significant differences were found between a number of the key demographic groups (**Table 3**). Dismissing suicidal behaviour scores were significantly higher in males compared to females, the oldest age group (65+), those living in the WHSCT, non-HSC employees, those who had not experienced mental ill health themselves and those who were not aware of at least one mental health and/or suicide prevention course Furthermore, a significant but small negative correlation was found between the number of courses heard of and dismissing suicidal behaviour (r=-.09; p≤.01).

Table 3: Summary of significant differences between demographic groups and the 'Dismissing Suicidal Behaviour' subscale (n=1,009)

	Dismissing Suicidal Behaviour
Gender	Males higher (M=6.7 vs M=6.4)*
Age	Higher among 65+ year olds (M=7.0, 18-29, M=6.4; 30-44, M=6.2; 45-64 M=6.6) ***
Socioeconomic group	Highest in lower socio-economic group (M=6.8 vs M=6.2). ***
HSCT	Highest in WHSCT (M=7.2 vs BHSCT, M=6.7; NHSCT, M=6.6; SEHSCT, M=5.9; SHSCT, M=6.6)***
MDM	Ns.
Disability	Ns.
Settlement	Ns.
Working in HSC	Highest in non-HSC employees (M=6.6 vs M=6.1). **
Working in Mental Health and Suicide Prevention	Ns.
Experienced mental ill health, self	Higher among those who had not experienced mental ill health at some point (M=6.7 vs M=6.3)**
Aware of at least 1 training course	Higher among those who were not aware of at least 1 course (M=6.8 vs M=6.4)**
***** p≤.001; ** p≤.01; * p≤.05**	

4.2.3. Talking about Suicide

Participants were asked to respond to the statement, '*Talking about suicide or asking someone if they are suicidal will encourage suicide attempts.*' In response to this statement, the majority of participants disagreed (71%). However, 11% still felt that talking about suicide or asking someone if they are suicidal will encourage suicide attempts and around one in five neither agreed nor disagree with this statement. Analyses found a number of significant associations between demographic variables and responses to this statement (**Table 5,** in the appendix), as follows:

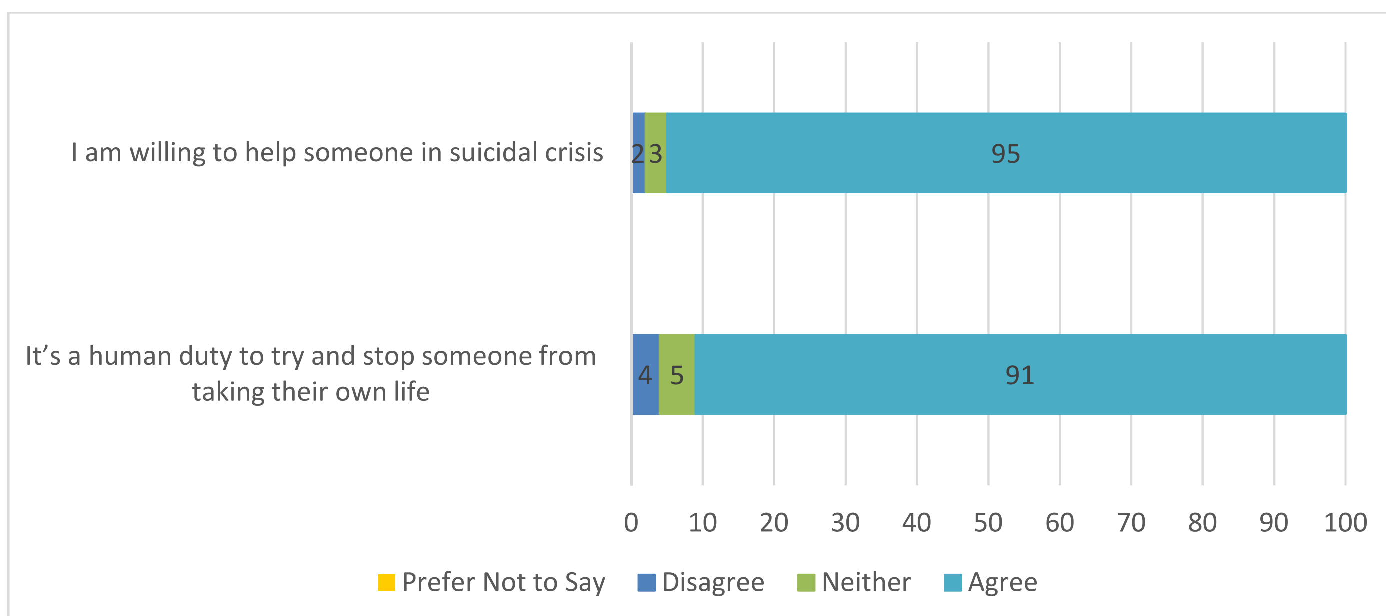
- Males more likely to agree with this statement compared to females;
- Those aged 65 years and over were significantly more likely than other age groups to neither agree or disagree with this statement;
- Those in a lower socioeconomic group were more likely to agree;
- Residents of the WHSCT were more likely than other HSC Trust area to say they neither agreed or disagreed with this statement;
- Those working in the HSC were more likely to disagree;
- Those working in the field of mental health and/or suicide prevention were more likely to disagree with this statement.

There were no significant associations between this statement and awareness of any mental health and/or suicide prevention courses.

4.3. Willingness to Intervene

Participants were asked to respond to two statements which would measure their willingness to intervene with an individual who is suicidal (Error! Reference source not found.). Overall, 95% of participants agreed that they are willing to help someone in a suicidal crisis and only 2% disagreed indicating that they would not be willing to help. Agreement was slightly lower for the statement 'it's a human duty to try and stop someone from taking their own life' (91%).

Figure 4: Frequency of responses to 'Willingness to Intervene' items (n=1,009)



Responses to the two statements were totalled to produce a *willingness to intervene* score, where a greater score would indicate a greater willingness to intervene if concerned that someone is experiencing suicidal crisis. In a possible range of two to ten, there was a mean score of nine for participants, again highlighting the high willingness to intervene. Analyses were undertaken to examine whether there were significant differences between demographic groups and the willingness to intervene score. The groups with a higher score and were therefore more willing to intervene included:

- Males compared to females (M=9.0 vs M=8.8; p≤.05);
- Those in a higher socio-economic group (M=9.0 vs M=8.7; p≤.001); and
- Those living in the SEHSCT (M=9.1; p≤.01, BHSCT=8.9, NHSCT=8.8, SHSCT=8.9, WHSCT=8.9).

Those who were aware of at least one mental health and/or suicide prevention training course had a higher willingness to intervene score (M=8.9 vs M=8.7; p≤.01) and a significant positive correlation was found between willingness to intervene scores and the number of courses attended (r=.10; p≤.01).

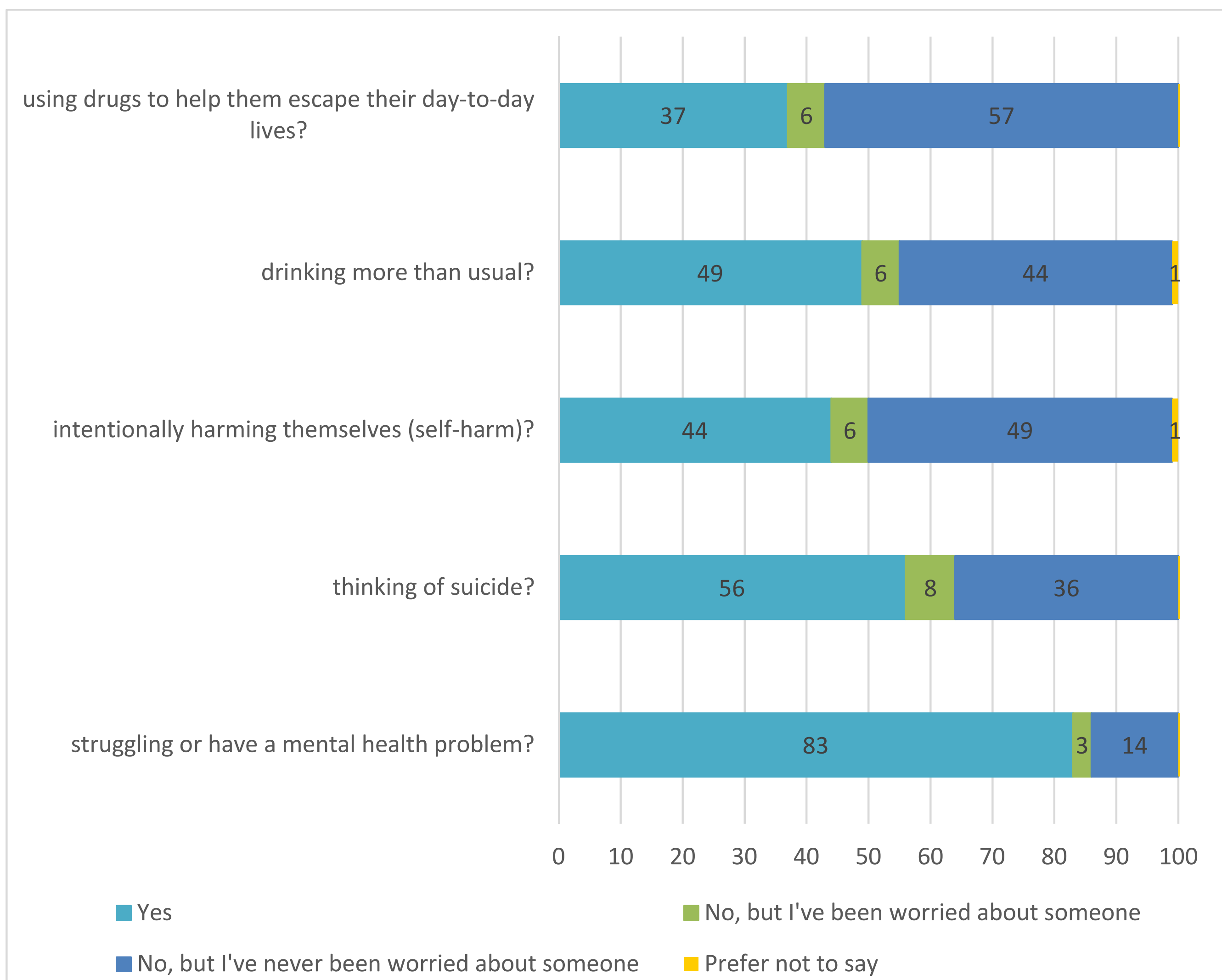
Significant correlations between overall scores on prevention, dismissing suicidal behaviour and willingness to intervene were also found:

- There was a significant small negative correlation between dismissing the suicidal behaviour score and willingness to intervene ($r=-.22$; $p\leq.001$), meaning that as dismissal of suicidal behaviour increases, willingness to intervene decreases.
- There was a significant small positive correlation between prevention score and willingness to intervene ($r=.15$; $p\leq.001$), meaning that as the prevention score increases so too does the willingness to intervene when concerned.

4.3.1. Having intervened when concerned

Participants were asked if they had ever asked someone if they were okay because they were concerned (
). Overall, over eight in ten participants (85%) had intervened for any reason. The most common reason for intervening was if they thought someone was struggling or might have a mental health condition (83%), followed by concerns that someone was thinking of suicide (56%). Less than half of participants had intervened when concerned about someone drinking more than usual (49%) and self-harming (44%), with the lowest proportion intervening when concerned about someone using drugs (37%). Throughout only a small proportion had not intervened when concerned about someone, this was smallest for when worried about someone having a mental health problem (3%) but largest for those worried about suicide (8%), suggesting being unsure of how to intervene.

Figure 5: 'Have you ever asked someone if they were okay because you thought they might be…' (n=1,009)



There were no significant associations found between intervening when worried about someone struggling or having a mental health condition and key demographic variables. However, comparable findings were found for the other four concerns:

- Those working in the HSC were significantly more likely to have intervened;
- Those with personal experience of mental health were significantly more likely to have intervened whereas those without were more likely to say no because they had not been worried about someone;
- Those aware of at least one course were significantly more likely to say they had intervened, whereas those not aware of any courses were more likely to say no because they had never been worried about someone.

Additional findings included that females compared to males, and those living in urban compared to rural areas were more likely to have intervened when concerned about self-harming. In addition, those living in urban compared to rural areas were more likely to have intervened when concerned about someone using drugs to escape their day to day lives. The full details of these findings can be found in **Tables 6-10** in the appendix.

4.3.2. Worries about Intervening

Participants were also asked if they had any worries that would put them off trying to help someone they thought were struggling with mental health or were suicidal. The majority of participants indicated that they had no worries about this situation (82%). In those who did have worries about intervening, the top concerns included being afraid of making the situation worse (5%), being afraid of their own safety (5%), not having the skills or knowing how to approach the situation (4%), it not being their business (2%), lacking confidence in dealing with the situation (1%) and accessing professional help (1%).

There were no significant associations found between having concerns about intervening and any of the key demographic variables.

5. Conclusions

There was reasonably high awareness of mental health and/or suicide prevention training courses, with almost two thirds of participants having heard of at least one course (61%). Attendance however, was extremely low amongst participants, with only 4% having attended one or more training course. This was lower than previously found in the Protect Life 2 Survey (2022), where 14% of participants had indicated that they had attended one or more mental health and/or suicide prevention training course [25]. Previous findings from the PL2 2022 survey suggested there is a high level of interest in attending mental health training (56%), and good awareness that training is available to everyone in Northern Ireland. Given the disconnect between the awareness of training courses and attendance, further exploration is needed into the barriers to attending.

The level of awareness of mental health and/or suicide prevention training in HSC staff is of particular importance as this links to some of the objectives outlined in the Protect Life 2 strategy. One such aim is for 50% of HSC staff to be trained in suicide awareness and intervention by 2022. In the results of this survey we found that 85% of participants who reported working for the HSC were aware of one or more training course with HSC workers being significantly more likely to have heard of more courses than non-HSC workers. Another indicator of the Protect Life 2 strategy is the number of people working in the community who are trained in suicide awareness/prevention. Of the participants in this survey, 57% of non-HSC workers reported being aware of at least one mental health and/or suicide prevention training course.

Responses to each of the individual attitude items were largely positive, with the majority of participants agreeing with the preventable items and disagreeing with dismissing suicidal behaviour items. However, there remains a persistent proportion of the population who answered negatively to each of the items (7-16% for prevention and 8-15% for dismissing suicidal behaviour) and a slightly larger proportion who neither agreed or disagreed (13-15% for prevention and 11-18% for dismissing suicidal behaviour). Moreover, when considering any agreement with dismissing suicidal behaviour items and disagreement on the preventability items, 42% of participants had indicated at least one negative belief about suicide. Awareness of mental health and/or suicide prevention training showed some association with the attitude towards suicide statements, with the knowledge of more courses correlating with higher prevention scores and lower dismissing suicidal behaviour scores.

The statement '*Talking about suicide or asking someone if they are suicidal will encourage suicide attempts'* was included from the ATTS, as talking about suicide is one of the key messages conveyed by many of the mental health and/or suicide prevention training programmes. As with the other statements, the majority reacted in a positive manage disagreeing with this statement. Again, there was a high proportion who neither agreed or disagreed (one in five).

Correspondingly, participants showed extremely high willingness to intervene, with 95% stating that they would be willing to help someone in suicidal crisis, 85% having previous experience in asking someone they were concerned about if they were okay and the majority having no concerns about intervening (82%). In the previous PL2 Survey, there were concerns that responses were affected by socially desirable reporting given that the majority of participants indicated that they were willing to help but yet a quarter of participants had been worried about something feeling suicidal but did not ask them if they were okay [25]. This was less of a concern in this sample, as at most only 8% said they had been worried about someone and not intervened.

There were strong associations between awareness of mental health and/or suicide prevention training courses and willingness to intervene, with greater awareness of training linked to higher willingness to intervene scores. Moreover, those who were aware of at least one training course were more likely to have previously intervened when concerned about someone being suicidal, self-harming, drinking too much or taking drugs, whereas those who had not heard of and/or

attended a training course were more likely to have never intervened because they had not been worried about someone. Attitudes towards suicide also showed some association with willingness to intervene. Higher dismissing suicidal behaviour scores showed a negative correlation with willingness to intervene, and high prevention scores showed a positive correlation with willingness to intervene.

There were also a number of significant and consistent associations found between demographic subgroups and mental health and/or suicide prevention training, attitudes and willingness to intervene, including:

- There were significant age-related differences which were consistent throughout the results. The middle age group (30 to 44 years old), showed the greatest awareness of mental health and/or suicide prevention training courses, being both significantly more likely to have heard of at least one course and having heard of a greater number of courses compared to other age groups. On the other hand, the oldest age group (65+), were the most likely to have not heard of any courses. This age group also consistently were more likely to respond '*neither agree or disagree'* to the attitude towards suicide and willingness to intervene statements, perhaps indicating a lack of knowledge.

- There were consistent patterns based upon socio-economic group. Those in the higher socio-economic group were more aware of mental health and/or suicide prevention training courses, had greater preventability scores and a higher willingness to intervene score. The lower socio-economic group on the other hand had higher dismissing suicidal scores.

- Employment, both in the field of mental health and in the wider HSC, was found to be a key factor. Those who had worked in the HSC were more aware of training courses and were more likely to have previously intervened, whereas those who had never worked for the HSC showed high dismissing suicidal behaviour scores. Working in the field of mental health and suicide prevention was linked to having have heard of and attended more mental health and/or suicide prevention training courses.

- Participants who indicated that they had previously experienced mental ill health themselves, were more likely to have asked someone if they were okay and intervened. Conversely, those who stated that they did not have previous experience of mental ill health were more likely to have heard of and attended mental health and/or suicide prevention training courses yet also have a higher dismissing suicidal behaviour score.

There were some associations between other demographic variables and mental health and/or suicide prevention training, attitudes and willingness to intervene, however these findings were inconsistent and difficult to interpret. This included gender, disability and the area-level variables of region, deprivation and HSC Trust.

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All images used in infographics in this report were taken from www.flaticon.com

Appendix

Table 4: Associations between awareness of training courses and key demographic variables (n=1,009)

			Aware of at least 1 training course		
		Base	Sig.	% Yes	% No
Overall		1,009		61	39
Gender	Male	487	***	54	46
	Female	517		67	33
Age	18–29	152	***	68	32
	30–44	325		71	30
	45–64	296		58	42
	65+	234		46	54
Socioeconomic group	ABC1	478	**	66	34
	C2DE	478		57	43
HSCT	Belfast	200	*	65	35
	Northern	283		61	39
	South Eastern	197		50	50
	Southern	172		62	38
	Western	157		66	34
Disability	Yes	202		60	40
	No	797		61	39
Settlement	Urban	606	**	64	36
	Rural	403		56	44
Deprivation	Most deprived	190	**	68	32
	Quintile 2	200		66	34
	Quintile 3	212		61	39
	Quintile 4	208		55	45
	Least deprived	199		53	47
Work in mental health area	Yes	45	***	87	13
	No	964		59	41
Work in HSC	Yes	124	***	85	15
	No	885		57	43
Experienced mental ill health, self	Yes	401	***	65	35
	No	606		56	44
*** p≤.001; ** p≤.01; * p≤.05					

Table 5: Associations between responses to "Talking about suicide or asking someone if they are suicidal will encourage suicide attempts" and key demographic variables (n=1,009)

		Sig.	Base	Agree %	Neither %	Disagree %
Overall			1,009	11	19	71
Gender	Male	**	487	13	17	69
	Female		517	8	20	72
Age	18–29	**	152	13	12	76
	30–44		325	12	14	75
	45–64		296	11	17	72
	65+		234	8	27	65
Socioeconomic group	ABC1	*	478	8	17	75
	C2DE		478	13	19	68
HSCT	Belfast	**	200	10	19	72
	Northern		283	8	20	71
	South Eastern		197	10	14	76
	Southern		172	13	13	73
	Western		157	14	28	59
Disability	Yes		202	15	18	68
	No		797	10	19	72
Settlement	Urban		606	11	19	70
	Rural		403	10	19	71
Deprivation	Most deprived		190	10	28	62
	Quintile 2		200	12	17	72
	Quintile 3		212	12	17	72
	Quintile 4		208	10	18	72
	Least deprived		199	9	15	76
Work in mental health area	Yes	**	45	4	2	93
	No		964	11	19	70
Work in HSC	Yes	***	124	5	8	87
	No		885	11	20	69
Experienced mental ill health, self	Yes		401	11	16	74
	No		606	11	21	69
Aware of at least 1 training course	Yes		612	11	17	72
	No		397	11	21	69
***** p≤.001; ** p≤.01; * p≤.05**						

Table 6: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they were struggling/had a mental health problem?" and key demographic variables (n=1,009)

		Base	Sig.	Yes %	No, but have been worried %	No, but haven't been worried %	Prefer Not to Say %
Overall		1,009		83	3	14	1
Gender	Male	487		81	4	15	1
	Female	517		85	2	12	<1
Age	18–29	152		95	1	4	<1
	30–44	325		91	4	6	<1
	45–64	296		85	2	13	<1
	65+	234		60	4	34	2
Socioeconomic group	ABC1	478		86	3	11	<1
	C2DE	478		80	3	17	<1
HSCT	Belfast	200		87	3	10	1
	Northern	283		82	2	16	<1
	South Eastern	197		81	6	12	1
	Southern	172		84	2	14	<1
	Western	157		82	2	16	1
Disability	Yes	202		85	2	13	<1
	No	797		83	3	13	1
Settlement	Urban	606		84	3	12	<1
	Rural	403		81	2	16	<1
Deprivation	Most deprived	190		86	1	14	<1
	Quintile 2	200		84	3	13	1
	Quintile 3	212		81	2	17	1
	Quintile 4	208		79	4	16	1
	Least deprived	199		86	4	9	1
Work in mental health area	Yes	45		96	2	2	<1
	No	964		83	3	14	1
Work in HSC	Yes	124		94	3	2	<1
	No	885		82	3	15	1
Experienced mental ill health, self	Yes	401		93	2	6	<1
	No	606		77	3	19	1
Aware of at least 1 training course	Yes	612		87	3	10	<1
	No	397		77	3	19	1

*** p≤.001; ** p≤.01; * p≤.05

Table 7: Associations between responses to "Have you ever asked someone if they were okay because you thought they might be thinking of suicide?" and key demographic variables (n=1,006)

		Base	Sig.	Yes %	No, but have been worried %	No, but haven't been worried %	Prefer Not to Say %
Overall		1,009		56	8	36	1
Gender	Male	487		52	8	39	1
	Female	517		59	8	33	1
Age	18–29	152		70	7	21	1
	30–44	325		65	9	26	<1%
	45–64	296		60	6	34	<1%
	65+	234		26	10	60	4
Socioeconomic group	ABC1	478		56	10	33	1
	C2DE	478		54	7	38	1
HSCT	Belfast	200		63	5	32	1
	Northern	283		53	9	36	2
	South Eastern	197		52	10	37	1
	Southern	172		54	6	40	1
	Western	157		56	10	34	1
Disability	Yes	202		62	6	30	2
	No	797		54	8	37	1
Settlement	Urban	606		58	7	34	1
	Rural	403		52	9	38	1
Deprivation	Most deprived	190		58	5	36	1
	Quintile 2	200		61	5	34	1
	Quintile 3	212		54	9	36	1
	Quintile 4	208		50	10	39	1
	Least deprived	199		55	10	34	2
Work in mental health area	Yes	45		78	9	13	<1%
	No	964		55	8	37	1
Work in HSC	Yes	124	***	73	10	18	<1%
	No	885		53	8	38	1
Experienced mental ill health, self	Yes	401	***	72	7	20	1
	No	606		45	8	46	2
Aware of at least 1 training course	Yes	612	***	63	9	27	1
	No	397		44	6	48	2
***** p≤.001; ** p≤.01; * p≤.05**							

Table 8: Associations between responses to "Have you ever asked someone if they were okay because you were concerned they may be intentionally harming themselves?'' and key demographic variables (n=1,009)

		Base	Sig.	Yes %	No, but have been worried %	No, but haven't been worried %	Prefer Not to Say %
Overall		1,009		44	6	49	1
Gender	Male	487	***	37	7	54	2
	Female	517		51	5	44	1
Age	18–29	152		58	5	36	1
	30–44	325		55	7	38	1
	45–64	296		45	6	48	<1
	65+	234		17	6	73	4
Socioeconomic group	ABC1	478		42	7	49	2
	C2DE	478		46	5	49	1
HSCT	Belfast	200		52	6	42	1
	Northern	283		42	5	51	2
	South Eastern	197		42	7	51	1
	Southern	172		41	6	52	1
	Western	157		45	5	48	3
Disability	Yes	202		50	5	45	2
	No	797		43	6	50	1
Settlement	Urban	606	*	48	5	46	1
	Rural	403		39	7	52	2
Deprivation	Most deprived	190		51	3	46	1
	Quintile 2	200		47	5	47	2
	Quintile 3	212		43	7	49	1
	Quintile 4	208		37	6	55	2
	Least deprived	199		44	8	47	2
Work in mental health area	Yes	45		80	4	13	2
	No	964		42	6	50	1
Work in HSC	Yes	124	***	65	7	27	1
	No	885		41	6	52	2
Experienced mental ill health, self	Yes	401	***	60	6	34	1
	No	606		34	6	59	2
Aware of at least 1 training course	Yes	612	***	54	6	39	1
	No	397		29	6	63	2

***** p≤.001; ** p≤.01; * p≤.05**

Table 9: Associations between responses to “Have you ever asked someone if they were okay because you were concerned they may be drinking more than usual?” and key demographic variables (n=1,009)

				Yes	No, but have been worried	No, but haven't been worried	Prefer Not to Say
		Base	Sig.	%	%	%	%
Overall		1,009		49	6	44	1
Gender	Male	487		47	6	46	1
	Female	517		50	7	42	1
Age	18–29	152		59	7	34	1
	30–44	325		58	7	35	1
	45–64	296		51	6	43	<1
	65+	234		27	5	64	4
Socioeconomic group	ABC1	478		50	7	41	2
	C2DE	478		47	6	46	1
HSCT	Belfast	200		53	8	39	1
	Northern	283		50	4	45	1
	South Eastern	197		43	9	48	1
	Southern	172		53	5	41	1
	Western	157		44	6	48	3
Disability	Yes	202		53	6	40	2
	No	797		48	6	45	1
Settlement	Urban	606		52	6	42	1
	Rural	403		44	7	47	2
Deprivation	Most deprived	190		50	3	46	1
	Quintile 2	200		53	8	38	2
	Quintile 3	212		46	8	46	1
	Quintile 4	208		48	6	45	1
	Least deprived	199		47	5	46	2
Work in mental health area	Yes	45		73	2	22	2
	No	964		47	6	45	1
Work in HSC	Yes	124	***	70	8	21	1
	No	885		46	6	47	1
Experienced mental ill health, self	Yes	401	***	61	6	33	1
	No	606		41	6	52	2
Aware of at least 1 training course	Yes	612	***	56	7	37	1
	No	397		38	5	56	2

***** p≤.001; ** p≤.01; * p≤.05**

Table 10: Associations between responses to “Have you ever asked someone if they were okay because you were concerned they may be using drugs to help them escape?” and key demographic variables (n=1,009)

		Base	Sig.	Yes %	No, but have been worried %	No, but haven’t been worried %	Prefer Not to Say %
Overall		1,009		37	6	57	1
Gender	Male	487		34	6	59	2
	Female	517		39	5	55	1
Age	18–29	152		53	4	43	1
	30–44	325		45	5	49	1
	45–64	296		37	6	56	1
	65+	234		13	6	76	4
Socioeconomic group	ABC1	478		36	7	55	2
	C2DE	478		37	4	58	1
HSCT	Belfast	200		41	6	52	1
	Northern	283		38	4	57	2
	South Eastern	197		26	9	65	1
	Southern	172		38	6	55	1
	Western	157		38	4	55	3
Disability	Yes	202		39	5	54	2
	No	797		36	5	57	1
Settlement	Urban	606	*	39	5	55	1
	Rural	403		32	7	59	2
Deprivation	Most deprived	190		40	2	57	1
	Quintile 2	200		39	5	55	2
	Quintile 3	212		35	9	55	1
	Quintile 4	208		36	5	57	1
	Least deprived	199		33	6	60	2
Work in mental health area	Yes	45		64	2	31	2
	No	964		35	6	58	1
Work in HSC	Yes	124	***	57	7	35	1
	No	885		34	5	60	2
Experienced mental ill health, self	Yes	401	***	50	5	44	1
	No	606		27	6	65	2
Aware of at least 1 training course	Yes	612	***	45	6	48	1
	No	397		24	4	70	2

***** p≤.001; ** p≤.01; * p≤.05**