New Bridge

Findings from a Community Survey

In Banbridge

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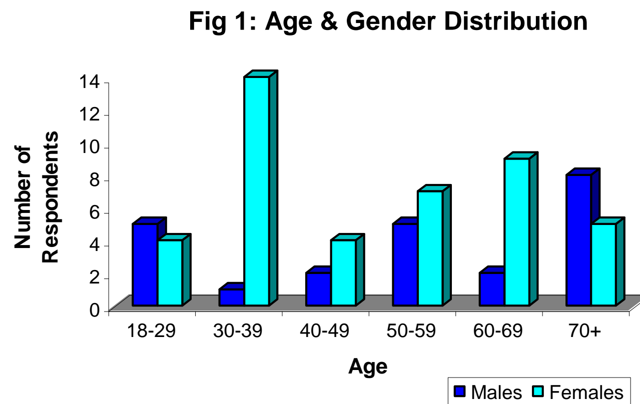
DEMOGRAPHICS[1]

66 individuals from the Banbridge area completed the survey questionnaire. 65% were female (n=43). 35% (n=23) were male. Their ages ranged from 18 to 86, with an average age of 51 years.

There was no significant age difference between male (average age 55 years) and female (average age 48 years) respondents. However, as indicated in Fig 1, more females than males fell within the 30-39 age category.

Fig 1: Age & Gender Distribution



Data on marital status was available for 62 individuals. 44% (n=27) were married/living with a partner; 24% (n=15) were separated/divorced; 23% (n=14) were single, never married; and 10% (n=6) were widowed.

The majority of respondents identified their religion as 'Protestant' (56%; n=37). 35% (n=23) reported their religion as 'Roman Catholic'. 2 individuals indicated their religion as 'other' and 1 person stated that s/he did not practise any religion. 3 individuals were unwilling to provide this information.

AREA & HEALTH

Respondents were asked a number of questions about the area they lived in. This included how individuals viewed the area in which they lived and what they considered to be the main social and/or economic issues affecting their community.

Resident Stability

The majority of respondents had lived in the Banbridge area for more than 10 years (55%; n=36). 27% (n=18) had lived in the area between 1 and 5 years and a further 11% (n=7) had lived in the area between 6 and 10 years. 8% (n=5) had lived in the Banbridge area for less than 1 year. Various reasons were given for living in the area, the most common being allocated a house in the area (38%; n=25) and having been born in the area (32%; n=21). Other common reasons included moving to be close to family or friends (23%; n=15) and because they liked the area (21%; n=14).

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[1] Due to rounding up or down, some percentages may be less than or exceed 100 when totalled.

Views on the Area

54% (n=35) of respondents indicated that the area they lived in was *‘ a good area, it is a good place to live’*. 37% (n=24) reported that they *‘don’t mind the area, it’s as good a place as any other’*. 9% (n=6) indicated that the area was *‘not a good area, I would like to be out of here’*. 1 individual did not respond to this question.

A variety of statements were presented to respondents. Respondents were asked to indicate how much they agree or disagree with each statement when thinking about the area that they live in. As indicated in Table 1, Banbridge respondents were generally positive about the area they lived in. The majority of respondents described the area as safe, with good community spirit and friendly people who were willing to help each other. Many respondents also felt the area was a good place to bring up children.

Views on noise levels at night were divided, as were views on whether too many people were moving in and out of the area. Many respondents identified lack of jobs as a problem and many also felt that there were not enough facilities for teenagers in the area. Almost three quarters of respondents agreed with the statement that alcohol abuse was rising in the area. Furthermore, drug abuse was viewed as a problem by 4 in every 10 respondents. Although over half of respondents disagreed with the statement *‘this area is changing for the better’*, two thirds described the area as having a lot of potential.

Table 1: Views on the Area

	Strongly Agree	Agree	Disagree	Strongly Disagree	D/K or No Answer
People here are friendly	36% (n=23)	58% (n=37)	6% (n=4)		N=2
Alcohol abuse is rising in this area	22% (n=13)	50% (n=30)	28% (n=17)		N=6
I feel safe here	27% (n=17)	67% n=43)	6% (n=4)		N=2
There are not enough facilities for teenagers around here	48% (n=27)	32% (n=18)	18% (n=10)	2% (n=1)	N=10
This area is changing for the better	6% (n=3)	37% (n=19)	47% (n=24)	10% (n=5)	N=15
There is conflict between old and young	2% (n=1)	37% (n=22)	58% (n=34)	3% (n=2)	N=7
This is a good place to bring up children	5% (n=3)	77% (n=44)	11% (n=6)	7% (n=4)	N=9
Drug abuse is a problem here	12% (n=5)	30% (n=13)	49% (n=21)	9% (n=4)	N=23
There are too many people moving in and out of the area	16% (n=9)	33% (n=19)	52% (n=30)		N=8
There is a good community spirit here	12% (n=7)	65% (n=39)	23% (n=14)		N=6
Lack of jobs is a big problem here	32% (n=18)	37% (n=21)	30% (n=17)	2% (n=1)	N=9
This area has a lot of potential	9% (n=6)	57% (n=35)	28% (n=17)	5% (n=3)	N=5
There is a lot of noise at night here	15% (n=10)	36% (n=24)	36% (n=24)	12% (n=8)	
People around here are willing to help each other	15% (n=9)	71% (n=43)	13% (n=8)	2% (n=1)	N=5

Social Problems

Respondents were asked to indicate whether various social issues were problems in their area by rating them as either *'a serious problem', 'a problem but not serious'* or *'not at all problem'*. Responses are summarised in Table 2.

Litter and rubbish in the street was viewed to be the most serious problem by respondents. Many also described vandalism and hooliganism as problems, although these were generally not deemed to be serious problems. Joy riding and threat of sectarian violence were least likely to be viewed as problems by Banbridge respondents.

Table 2: Social Issues

	A Serious Problem	A Problem but not Serious	Not a Problem	D/K or No answer
Vandalism and hooliganism	13% (n=8)	44% (n=28)	43% (n=27)	N=3
Graffiti	5% (n=3)	29% (n=19)	66% (n=43)	N=1
Theft or burglary	5% (n=3)	28% (n=18)	68% (n=44)	N=1
Litter and rubbish in the street	21% (n=14)	50% (n=33)	29% (n=19)	
Threat of sectarian violence	3% (n=2)	12% (n=8)	85% (n=55)	N=1
Joy riding	2% (n=1)	2% (n=1)	97% (n=62)	N=2

23% (n=12) of respondents stated that these problems affected their health, with females (29%; n=10) more likely to indicate that these problems affected their health than males (11%; n=2). This difference, however, failed to reach statistical significance.

LOCAL SERVICES & FACILITIES

Respondents were asked to rate on a 4-point scale, ranging from *'very easy'* to '*very difficult'*, the accessibility of a range of services/facilities. This included access to medical facilities, leisure/social facilities and general community facilities.

As indicated in Table 3, the majority of respondents could access the chemist and the Doctor's surgery either *'very'* or *'fairly easily'*. However, 3 in every 4 respondents reported difficulty in accessing a hospital casualty, with almost one fifth stating that this service was not available.

Most respondents could easily access the post office, supermarket, job centre and bus stop from their house. Many leisure-type facilities were also easily accessible, including the community centre, leisure centre, pensioners' drop-in and children's playground. Around half of respondents reported that a youth club was easy to access, although one third indicated that this service was not available in their area.

Table 3: Local Services & Facilities

	Very Easy	Fairly Easy	Fairly Difficult	Very Difficult	Service not Available	D/K or No Answer
Bus Stop	59% (n=38)	33% (n=21)	6% (n=4)	2% (n=1)		N=2
Chemist	33% (n=22)	42% (n=28)	21% (n=14)	3% (n=2)		
Community Centre	46% (n=25)	31% (n=17)	16% (n=9)	4% (n=2)	4% (n=2)	N=11
Doctor's Surgery	34% (n=22)	45% (n=29)	20% (n=13)	2% (n=1)		N=1
Hospital Casualty	2% (n=1)	8% (n=5)	20% (n=13)	55% (n=36)	17% (n=11)	
Job Centre	27% (n=16)	57% (n=34)	15% (n=9)	2% (n=1)		N=6
Leisure Centre	31% (n=20)	45% (n=29)	22% (n=14)	2% (n=1)		N=2
Children's Playground	35% (n=20)	30% (n=17)	11% (n=6)	9% (n=5)	16% (n=9)	N=9
Pensioners' Drop-in	16% (n=6)	50% (n=19)	8% (n=3)	8% (n=3)	18% (n=7)	N=28
Post Office	38% (n=25)	49% (n=32)	14% (n=9)			
Supermarket	36% (n=24)	52% (n=34)	12% (n=8)			
Youth Club	33% (n=12)	19% (n=7)	3% (n=1)	11% (n=4)	33% (n=12)	N=30

Transport

50% (n=33) of respondents indicated that they had regular use of their own transport - 56% (n=13) of males and 47% (n=20) of females. 41% (n=27) used public transport at least once a week, with 15% (n=10) using it almost daily. 11% (n=7) used public transport 2-3 times per month.

Of the 52% (n=34) of respondents who used public transport, 97% (n=33) used the bus service, with 1 respondent indicating that s/he used 'another type' of public transport. No respondents used the train service.

Almost half of respondents reported that they either never or rarely used public transport (49%; n=32). The most common reason given by respondents for using their own transport was that they preferred to use their own transport (72%; n=23).

HOUSING

The relationship between housing and health has been well documented. Indeed, the government white paper 'Saving Lives: Our Healthier Nation' (1999) recognises housing as a key health determinant. Much research has examined the complex relationship between poor housing and risk to health. For example, Evans and Bennett (1998)[2] summarised studies linking poor housing to increased levels of limiting long-term illness, respiratory and infectious diseases, accidents, psychological problems, perceived poor health and even increased mortality. It was therefore considered important to examine housing issues within the New Bridge study. Individuals were asked about their current housing situation, the number of household occupants, household overcrowding, household complaints and the impact of such housing conditions on their physical and mental health.

Housing Type

Over half (53%; n=34) of respondents lived in terraced housing. 25% (n=16) lived in semi-detached housing, with a further 8% (n=5) living in detached housing. 13% (n=8) of respondents lived in a flat/apartment and 1 cited 'other' housing. 2 respondents did not provide this information.

Housing Tenure

53% (n=35) of respondents rented their property from the Housing Executive while a further 6% (n=4) rented privately. 38% (n=25) of respondents had bought or were buying their home. 2 respondents indicated 'other' in terms of housing tenure.

Household Occupancy

A total of 156 individuals lived in 66 households, an average of 2.4 individuals per household. 36% (n=24) of respondents lived alone, with a further 30% (n=20) living with one other person. 30% (n=20) of households had between 3 and 5 people living within. 1 household accommodated 6 people and 1 accommodated 8 people. Only 3 individuals did not live full time in the home.

Housing and Health

Respondents were asked to rate, on a 4-point scale, the extent to which they experienced a number of housing problems. Respondents were generally satisfied with their housing and very few problems were identified (Table 4). However, outside noise was viewed as either a *'very'* or *'quite'* serious problem by over one third of respondents (36%; n=24). Other serious problems identified were draughty windows (20%; n=13) and poor heating (7%; n=4).

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[2] Evans, M, & Bennett, A. Healthy Environments. Health Evidence Bulletins. Wales. http://hebw.cf.ac.uk/healthyenvirnments/chpater10.html

Individuals who indicated that they experienced housing problems (n=34) were asked whether these problems affected their general health. Of the 24 individuals who responded to this question, 17% (n=4) indicated that their physical health was affected; 8% (n=2) reported that their mental health was affected; and 21% (n=5) stated that their housing problems affected both their physical and mental health.

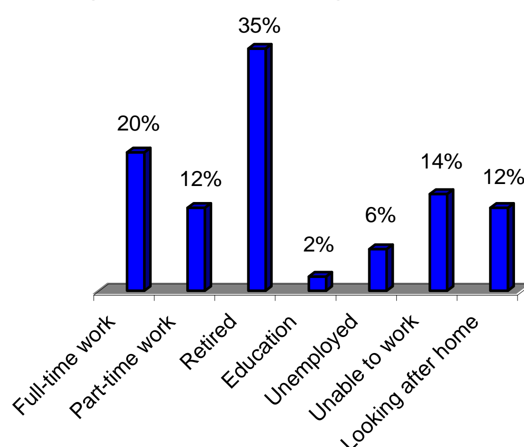
Table 4: Housing Problems

	Very serious problem	Quite serious problem	Minor problem	Not a problem	D/K or no answer
Damp/condensation		2% (n=1)	20% (n=13)	79% (n=52)	
Outside noise	9% (n=6)	27% (n=18)	15% (n=10)	49% (n=32)	
Leaking roof		2% (n=1)	99% (n=65)		
Draughty windows/doors	5% (n=3)	15% (n=10)	18% (n=12)	62% (n=41)	
Faulty electrical wiring			2% (n=1)	99% (n=64)	N=1
Inadequate hot water				100% (n=65)	N=1
Poor heating	2% (n=1)	5% (n=3)	9% (n=6)	85% (n=55)	N=1
General disrepair		5% (n=3)	2% (n=1)	94% (n=61)	N=1
Steps into the house	3% (n=2)	5% (n=3)	8% (n=5)	85% (n=55)	N=1
Lack of space	2% (n=1)	3% (n=2)	22% (n=14)	73% (n=47)	N=2

EMPLOYMENT

The relationship between employment and health has been well-documented. For example, Faragher, Cass and Cooper (2005)[3] reported job satisfaction to be associated with a number of psychological problems such as burnout, self esteem, depression and anxiety. Therefore individuals were asked about their current employment situation and the impact of this on their physical and mental well-being.

Fig 2: Employment Categories



As indicated in Fig 2, 32% (n=21) of respondents were in employment. 20% (n=13) were in full-time employment (30 or

[3] Faragher, E.B., Cass, M. & Cooper, C.L. (2005). The relationship between job satisfaction and health: a meta-analysis. *Occupational & Environmental Medicine, 62, pp105-112.*

more hours per week) and 12% (n=8) were in part-time employment (less than 30 hours per week). 6% (n=4) of respondents were registered unemployed and 14% (n=9) were unable to work due to long-term sickness or disability. 12% (n=8) indicated that they were looking after the home/family. 1 individual was in education.

35% (n=23) of respondents were retired. 50% (n=11) had been retired for more than 10 years; 27% (n=6) had been retired between 6 and 10 years; and 23% (n=5) had been retired for 5 years or less. 1 individual did not provide this information.

Economically Active

As indicated above, 32% (n=21) of respondents were employed. More males were in employment than females, with 39% (n=9) of males in either full (35%; n=8) or part-time work (4%; n=1). 28% (n=12) of females were in employment (12% or n=5 full-time; 16% or n=7 part time).

Respondents cited a variety of jobs, including shop assistants, domestics and the civil servants. 52% (n=11) of respondents worked within the local area and 29% (n=6) worked in the local town. 1 individual worked from home and 3 indicated that they worked either elsewhere in Northern Ireland or 'other'.

The majority of respondents had been in their job between 1 and 5 years (57%; n=12). 19% (n=4) had been employed between 6 and 10 years and 14% (n=3) less than 1 year. 2 respondents had been in their current job for more than 10 years. 19% of (n=4) employed respondents had been out of work during the last five years.

All respondents were either *'very'* (62%; n=13)) or *'quite'* (38%; n=8) satisfied in their current job. All also indicated that they thought their job was either *'very'* (62%; n=13) or *'fairly'* (38%; n=8) secure.

Economically Inactive

32% (n=21) of respondents were economically inactive[4] - 17% of males (n=4) and 39% of females (n=17). 38% (n=8) had not been in a paid job for 6 years or more (7 females; 1 male). Reasons for leaving their last paid job included:

- Leaving to look after children/home (43%; n=9 – 8 of these respondents were female)
- Medical/personal health reasons (43%; n=9 – 8 of these respondents were female)
- Being dismissed/ made redundant (10%; n=2 – 1 male and 1 female)

[4] 'Economically inactive' incorporates individuals who were either registered unemployed, looking after the home/family or long-term sick. The 23 retired respondents are not included.

60% (n=12) of economically inactive respondents indicated that they would like a job at present (3 or 75% of economically inactive males; 9 or 56% of economically inactive females). These respondents were asked to indicate what would improve their chances of finding employment. As indicated in Table 5, improved health (58%; n=7) and more jobs in the area (50%; n=6) were viewed by many respondents to improve their chances of finding employment *'a lot'*.

Of those 12 respondents who would like to be in a paid job, 92% (n=11) were either *'not very'* or *'not at all'* confident of getting a paid job in the next year. Only one person was *'very confident'* of securing employment.

55% (n=11) of respondents indicated that being unemployed had no noticeable effect on their health. However 30% (n=6) reported that unemployment affected their mental health; 1 felt it affected his/her physical health; and 2 indicated that unemployment affected both their physical and mental health. Only 14% (n=3) of respondents reported that being unemployed caused some arguments/tension with family, with the remaining 87% (n=18) indicating that family relationships were not affected.

Table 5: Improve Employability

	Improve chances a lot	Improve chances a little	Would not improve chances	Not relevant	D/K
More training	42% (n=5)	8% (n=1)		50% (n=6)	
More experience	25% (n=3)	25% (n=3)		50% (n=6)	
More qualifications	33% (n=4)		8% (n=1)	50% (n=6)	N=1
Help with child care	25% (n=3)	8% (n=1)		58% (n=7)	N=1
Help looking after sick/elderly person	8% (n=1)			83% (n=10)	N=1
Improved health	58% (n=7)	8% (n=1)		25% (n=3)	N=1
More information about how to look for jobs	8% (n=1)	42% (n=5)		50% (n=6)	
More jobs in the area	50% (n=6)			50% (n=6)	
Jobs with more flexible hours	42% (n=5)	8% (n=1)		50% (n=6)	
Better transport	33% (n=4)	17% (n=2)		50% (n=6)	

<u>Voluntary Activity</u>

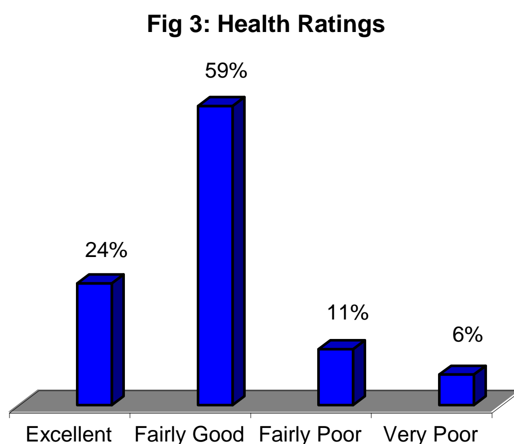
17% (n=11) of respondents were involved in voluntary work – 17% (n=4) of males and 16% (n=7) of females. 90% (n=9) of voluntary work was connected to an organisation. Hours per week involved in voluntary activity varied. Of those respondents who did not volunteer, only 9% (n=5) indicated that they would be interested in volunteering. 4% (n=2) did not know whether they would like to volunteer.

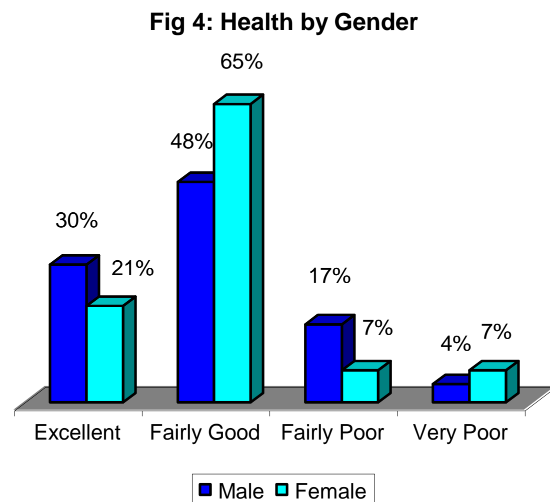
PERSONAL HEALTH

Personal ratings of health are commonly assessed in population and community-based surveys. They have the advantage of capturing multiple dimensions of health, being easily answered and are viewed as a reliable predictor of future morbidity and mortality (Grau et al, 1998)[5]. Therefore, respondents were asked to rate their general health, compared to people of their own age, on a 4-point scale ranging from *'excellent'* to '*very poor'*.

As indicated in Fig 3, the majority of respondents (83%; n=55) reported that they had either *'excellent'* or '*fairly good'* health compared to other people their age. 17% (n=11) of respondents rated their health as either *'fairly'* or *'very'* poor.

Fig 4 presents personal health assessment by gender. There were no significant gender differences between males and females in how they rated their overall health.





The majority of Banbridge respondents (71%; n=47) reported that their health was about the same as a year ago. 9% (n=6) indicated that their health was *'somewhat better'* than a year ago. 20% (n=13) of respondents felt that their health was either *'somewhat'* or *'much worse'* than a year ago.

Factors Affecting Health

Respondents were presented with a list of attributes associated with good health and asked to rate how important they felt each attribute was to having overall good health. Responses are summarised in

[5] Grau, L., West, B. & Gregory, P. (1998). 'How Do you Feel?: Self-reported health as an indicator of current physical and mental health status.' *Journal of Psychosocial Nursing, Vol 36, 6, pp25-30.*

Table 6. The 2 factors most rated as being *'very important'* were having access to good health services (88%; n=58) and having a healthy diet (83%; n=55). Living in decent housing (77%; n=51), having adequate income (73%; n=48) and feeling good about yourself (71%; n=47) were also viewed by many to be *'very important'* to good overall health.

24% (n=15) of respondents indicated that being in a paid job was either 'not very' or *'not at all'* important to good health. The majority of these respondents were female (n=13).

Table 6: Factors Affecting Health

	Very Important	Quite Important	Not Very Important	Not at all Important	D/K
Getting enough exercise	64% (n=42)	32% (n=21)	5% (n=3)		
Having access to good health services	88% (n=58)	12% (n=8)			
Having a healthy diet	83% (n=55)	14% (n=9)	3% (n=2)		
Being in a paid job	40% (n=25)	36% (n=22)	21% (n=13)	3% (n=2)	N=4
Feeling good about yourself	71% (n=47)	24% (n=16)	5% (n=3)		
Living in decent housing	77% (n=51)	21% (n=14)	2% (n=1)		
Having support from family/friends	64% (n=42)	20% (n=13)	17% (n=11)		
Having adequate income	73% (n=48)	24% (n=16)	3% (n=2)		
Having time to yourself	46% (n=30)	34% (n=22)	19% (n=12)	2% (n=1)	N=1

Ill Health/Disability

30% (n=20) of respondents indicated that they had a long-term illness or disability that affected their daily life. 26% (n=6) of male and 33% (n=14) of females reported ill health. Arthritis was the most common type of illness. Other illnesses included anxiety, heart problems and mental health problems.

40% (n=8) of respondents with an illness/disability were not in receipt of any help or support. Of the 12 individuals who did receive support, the most common type of support was support from a family member (67%; n=8). 50% (n=6) indicated that they received help from another person. 1 received support from Social Services and 1 from a neighbour. No respondents received support from a voluntary group.

40% (n=8) of respondents received support with household chores; 25% (n=5) with emotional/mental health needs; 20% (n=4) with paperwork or financial matters; and 15% (n=3) with personal care. Of those who did not receive support, 3 indicated that they would like to receive support with paperwork or financial matters; 2 with emotional/mental health needs and 1 with household chores.

Emotional Stress

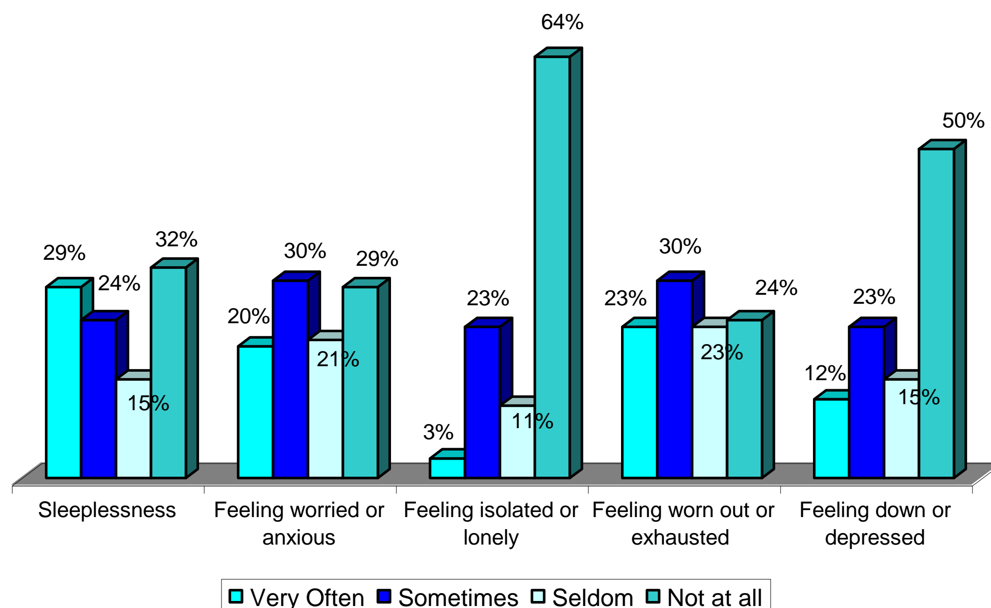
To obtain an overall indication of emotional stress levels within the community, respondents were asked how often, over the previous few weeks, they had experienced:

- Sleeplessness
- Feeling worried / anxious
- Feeling lonely / isolated
- Feeling worn out / exhausted
- Feeling down / depressed.

As indicated in Fig 5, over 50% of respondents indicated that they had experienced sleeplessness (53%; n=35) and/or feelings of exhaustion (53%; n=35) either *'very often'* or *'sometimes'* over the last few weeks. Half of respondents reported feeling worried or anxious (50%; n=33) and 35% (n=23) reported feeling down or depressed over the previous few weeks. Respondents were least likely to report feeling isolated or lonely, with only 24% (n=17) indicating that they had felt this way over the last few weeks.

Significant gender differences were observed in 2 areas of emotional stress. Females were significantly more likely to report feeling anxious or worried[6] and worn out or exhausted[7] than males.

Fig 5: Emotional Stress



[6] Mann Whitney U Test: U=287.00; Z=-2.89; p<0.005 (two-tailed)
[7] Mann Whitney U Test: U=280.50; Z=-2.98; p<0.005 (two-tailed)

Respondents who expressed experiencing any of the above feelings were asked how they would normally deal or cope with these feelings. The most frequent ways were:

- Talk to a family member or friend (52%; n=24)
- Deal with the feelings alone (39%; n=18)
- Try to get out to take their mind off their problems (22%; n=10)
- Seek professional advice (17%; n=8)
- Take prescribed medication (17%; n=8)

11% (n=5) of individuals indicated that they would ignore these feelings.

Social Support

94% (n=61) of respondents indicated that they had someone to confide in if they had a problem, indicating a high level of support within the community. 35% (n=23) had *'a lot'* of people they could rely on. 59% (n=38) had *'a few'* people they could rely on and 5% (n=3) had *'very few'* people they could rely on. 1 respondent had '*no one'* s/he could rely on.

Prescribed Medication

Respondents were asked whether they had been prescribed any of four types of medication over the past year. As indicated in Fig 6, a very high proportion of respondents (66%; n=43) had been prescribed painkillers over the past 12 months. Almost one quarter (24%; n=16) of respondents had been prescribed anti-depressants. 21% (n=14) had taken prescribed sleeping pills and 11% (n=7) had taken prescribed tranquillisers.

There were no significant gender differences in prescribed medication use (Fig 7).

Fig 6: Prescribed Medication

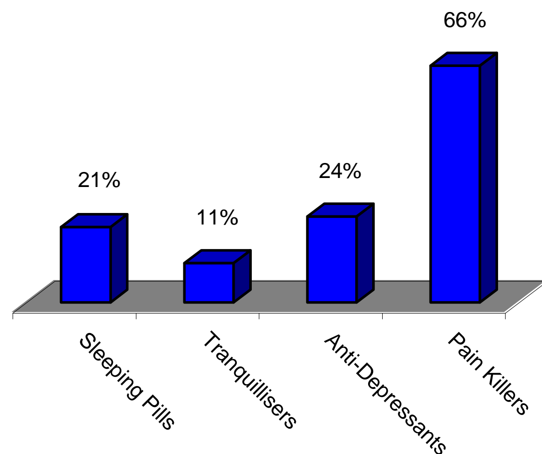
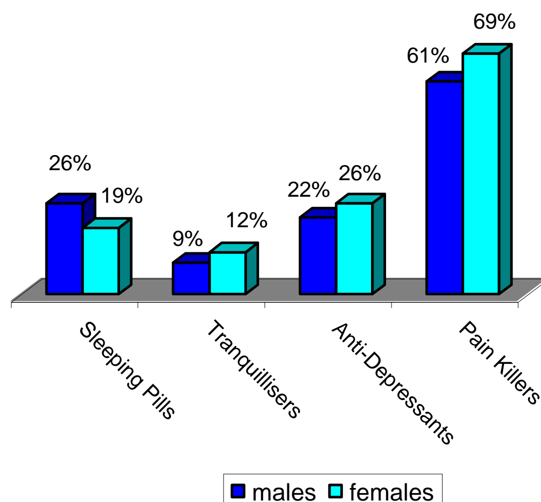


Fig 7: Gender Differences in Prescribed Medication

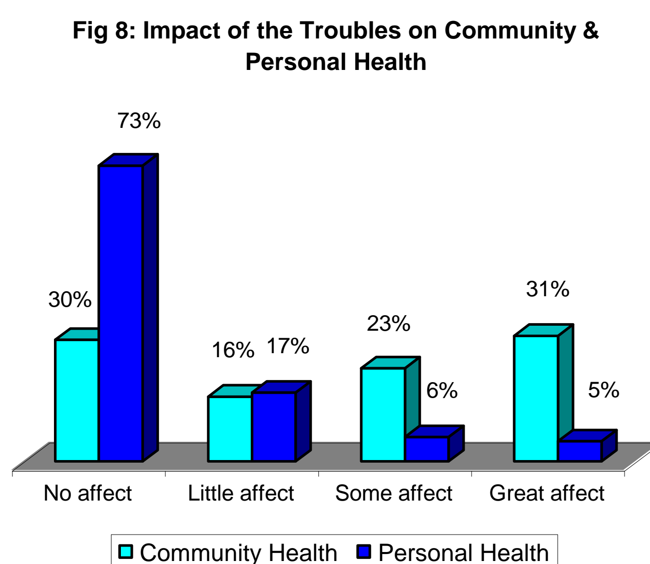


IMPACT OF 'THE TROUBLES'

It is widely acknowledged that 'The Troubles' have had a negative affect on the mental and physical health of individuals and communities across Northern Ireland. For example, Smyth, Morrissey and Hamilton (2001)[8] reported that a higher proportion of people living in areas of high intensity violence reported having poorer health than those living in areas of low violence. To determine the impact of 'The Troubles' within Banbridge, respondents were asked to rate the effect 'The Troubles' had on the health of their community and on their own personal health.

As indicated in Fig 8, over half of respondents (54%; n=35) reported that 'The Troubles' have had either *'some'* or a *'great affect'* on the health of their community. However, 90% (n=59) indicated that 'The Troubles' did not have any, or had only *'a little'* affect on their own personal health. Only 3 respondents felt that 'The Troubles' have had a *'great affect'* on their own health.

Fig 8: Impact of the Troubles on Community & Personal Health



CARERS

21% (n=14) of Banbridge respondents were caring for a person on a regular basis. The majority were caring for one person (93%; n=13) although one individual was caring for 2 people. 11 carers were female and 3 were male. The individuals being cared for were described as having a range of needs and/or disabilities. These are summarised in Table 7 below.

Table 7: Needs/Disabilities of Individuals Being Cared For

Elderly	N=2	Physical Disabilities	N=2
Physical Illness	N=2	Learning Disability	N=1
Learning Disability & Mental Illness	N=1	Physical Disability & Physical Illness	N=1
Physical Illness & Mental Illness	N=1	Learning Disability & Other illness/disability	N=1
Physical Disability & Learning Disability	N=1	Other Illness/Disability	N=3

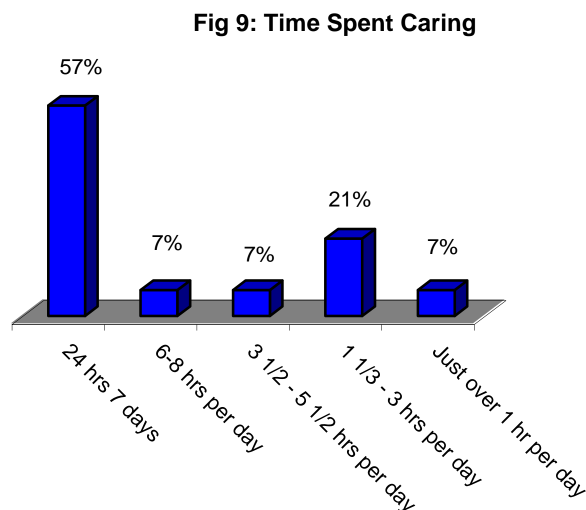
[8] Smyth, M., Morrissey, M. & Hamilton, J. (2001). Caring Through the Troubles: Health and Social Services in North and West Belfast. Derry/Londonderry: Institute for Conflict Research.

36% (n=5) of carers were caring for a son or daughter, 29% (n=4) were caring for a wife/husband or partner and 2 for a parent. 1 carer was caring for a sibling and 1 for an aunt/uncle. 1 carer was caring for 2 'in-laws'.

71% (n=10) of carers lived in the same household as the person they were caring for. Half of the respondents had been caring for over 10 years (50%; n=7). 36% (n=5) had been caring for 5 years or less, and 2 individuals had been caring for between 6 and 10 years.

Respondents assisted the person they cared for with a variety of activities. Household chores (71%; n=10) and supervision with medication (64%; n=9) were the most commonly assisted activities. Carers also frequently helped their family member with emotional or mental health needs (50%; n=7) and paperwork or financial matters. 43% (n=6) of carers helped with personal care.

The majority of carers cared 7 days a week (79%; n=7). 2 cared 5 days a week and 1 cared 3 days a week.



As indicated in Fig 9, over half of carers cared 24 hours a day, 7 days a week (57%; n=8). 21% (n=3) cared between 1 1/3 and 3 hours per day. 1 cared just over 1 hour per day, 1 for 3 ½ to 5 ½ hours per day and 1 cared for 6-8 hours per day.

Support

5 carers indicated that they were receiving support in their caring role. 1 received 3 types of support (practical support, information and respite) and 2 received 2 types of support (1 received practical support and information; 1 attended a support group and indicated receiving 'other' support). 1 carer indicated receiving practical support only and 1 indicated 'other' support only.

60% (n=3) of carers indicated that they received support from Social Services, with 1 of these carers also receiving support from a voluntary group. 2 reported that they received support from a family member and 1 received support from a neighbour.

The majority of carers (57%; n=8) indicated that they received enough support in their caring role. However, 43% (n=8) carers felt they did not receive enough support.

Caring and Health

43% (n=6) of carers indicated that their caring role had a negative impact on their health. 2 felt that their role as a carer had a negative affect on their physical health and 2 indicated that it affected their mental health. 2 carers reported that caring had an affect on both their physical and mental health.

The majority of carers indicated that being a carer did not place additional stress on their relationships with family and friends (86%; n=12). Only 2 carers reported that their caring role caused some arguments/tension.

GENERAL HEALTH QUESTIONNAIRE

The General Health Questionnaire is a self-administered screening test aimed at detecting psychiatric disorders among respondents in community settings (Goldberg & Williams, 1988[9]). It is a widely used questionnaire having been employed in a range of clinical studies (for example, individuals with diabetes, individuals recovering from a stroke). It has been used across a range of occupational groups (for example, teachers, pharmacists, and nurses) and also within special interest groups (for example, teenagers, lone parents, and disabled individuals).

The GHQ-28 involves asking individuals whether they have experienced a particular symptom in the previous two-week period. Responses are rated on a 4-point scale. There are 2 main ways in which to score the scale:

- One is the 'Likert method' where the 4-point scale is scored from 0 to 3 (0,1,2,3). This scoring method allows for an average GHQ-28 score to be calculated.

- An alternative scoring method is the 'GHQ scoring method' which involves scoring the scale as either 0 or 1, with the first 2 responses on the 4-point scale producing a rating of 0 and the last 2 responses obtaining a rating of 1(0,0,1,1). This method of scoring enables the identification of 'potential cases of psychiatric disorder'.

[9] Goldberg, D. & Williams, P. (1988). A User's Guide to the General Health Questionnaire. NFER-NELSON.

As each of the scoring methods serve different purposes, both were used to score the questionnaires. GHQ data was available for 63 respondents.

Likert Scoring Method: When the GHQ-28 is scored on a scale from 0 to 3, the lowest possible score is 0 and the highest possible score is 84.

- The average score from individuals who completed the questionnaire was 10.94
- The lowest score was 5.
- The highest reported score was 32.

As indicated in Fig 10, 57% (n=36) of respondents reported GHQ-28 scores between 0 and 10. A further 38% (n=24) scored between 11 and 20, with only 6% (n=3) of respondents scoring 21 or above. No respondents scored above 32 on the GHQ-28.

Females scored slightly higher on the GHQ-28 total score (average score 11.6) than males (average score 9.7). However, this difference failed to reach statistical significance.

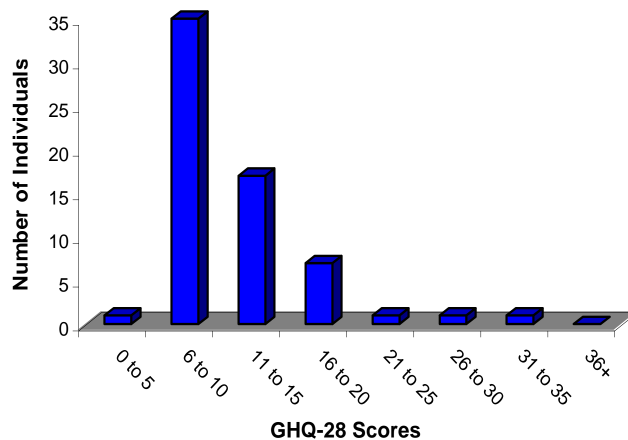


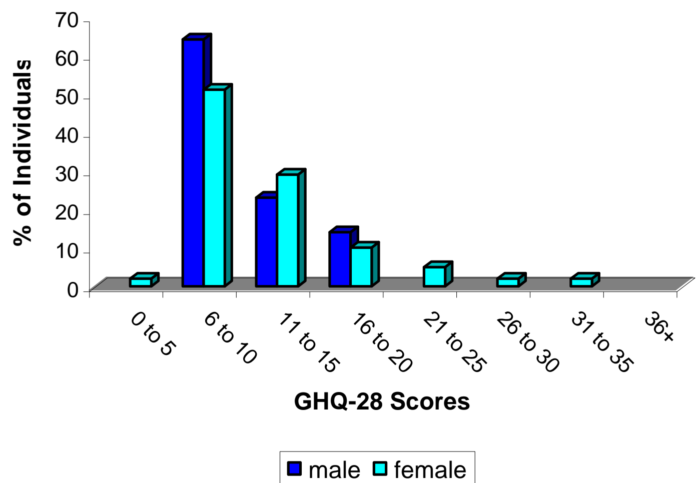
Figure 11 displays the distribution of GHQ scores for male and female respondents. Both sets of scores are clustered between 6 and 20, although the female scores reflect a greater spread.

A study carried out by Cairns and Wilson (1984)[10] obtained GHQ-30 scores from a community sample of 797 Northern Irish adults.
Individuals lived in 1 of 2 towns that experienced contrasting levels of violence. These were labelled Hightown (which experienced a high level of sectarian violence) and Lowtown (which experienced a low level of sectarian violence). The study found that:

[10] Cairns, E. & Wilson, R. (1984). 'The Impact of Political Violence on Mild Psychiatric Morbidity in Northern Ireland.' *British Journal of Psychiatry, 145, pp 631-635.*

- Individuals who lived in Hightown reported an average GHQ-30 score of 23.50

- Individuals who lived in Lowtown reported a lower average GHQ-30 score of 20.87



The average GHQ-28 scores from individuals living in the Banbridge area (10.94) is considerably lower than either of these two scores.

GHQ Scoring Method:

When the GHQ method of scoring is used, the lowest possible score is 0 and the highest possible score is 28. A cut-off score between 4 and 5 is used to calculate the number of 'cases' in a given population. A 'case' is a term attached to those individuals who have a higher score than the cut-off point and could therefore be considered 'potential cases of psychiatric disorder' (Felicia et al., 1988). Individuals with total scores below the cut-off point are considered to be 'non-cases'.

When the cut-off point between 4 and 5 (scores of 4.5 and over) is used with the Banbridge sample, only 11% (N=7) of individuals can be considered to be 'cases'. This is a lower percentage of 'cases' than that found by Cairns and Wilson, where 32% of individuals in Hightown were considered to be 'cases' and 21% of individuals in Lowtown were considered 'cases'.