New Bridge

Findings from a Community Survey

In Gilford

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March 2007

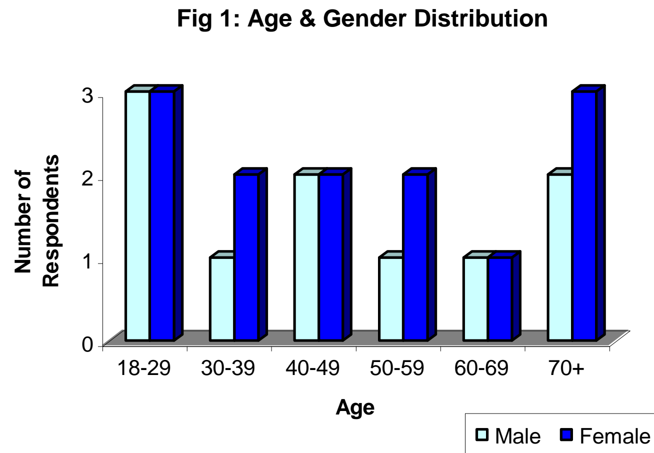
This project is part funded by TASSK Healthy Living Centre, Craigavon & Banbridge Community HSS Trust and The New Opportunities Fund

DEMOGRAPHICS[1]

23 individuals from the Gilford area completed the survey questionnaire. 57% (n=13) were female. 43% (n=10) were male. Their ages ranged from 20 to 81 years, with an average age of 49 years.

There was no significant age difference between male (average age: 48 years) and female (average age: 50 years) respondents (Fig 1).

39% (n=9) of respondents were married/living with a partner; 30% (n=7) were single, never married; 17% (n=4) were widowed; and 13% (n=3) were separated or divorced.



50% (n=11) of respondents identified their religion as 'Protestant', with 41% (n=9) stating 'Roman Catholic'. 2 individuals indicated that they did not practise any religion.

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 (65%; n=15) had lived in the Gilford area for more than 10 years. 35% (n=8) had lived in the area between 1 and 5 years. Various reasons were provided for living in the area, the most common being they were born in the area (48%; n=11) or moving to be close to family or friends (26%; n=6).

Views on the Area

57% (n=13) of respondents indicated that the area they lived in was *' a good area, it is a good place to live'*. 39% (n=9) reported that they *'don't mind the area, it's as good a place as any other'*. Only 1 respondent indicated that the area was *'not a good area, I would like to be out of here'*.

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

A variety of statements were presented and 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, respondents were generally very positive about the area they lived in. Community spirit was described as good, although the majority of respondents felt that too many people were moving in and out of the area. People in the area were also viewed as friendly and willing to help each other. However, just over one third of respondents disagreed with the statement *'I feel safe here'* and one third indicated that the area was not a good place to bring up children.

Alcohol abuse was viewed by many to be rising in the area and just over one third of respondents agreed with the statement that drug abuse was a problem. Noise at night was also identified as a problem by many respondents. Lack of jobs was viewed as a big problem in the area and not enough facilities were available for teenagers. However, despite these problems, the majority of respondents felt the area had 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	48% (n=11)	52% (n=12)			
Alcohol abuse is rising in this area	23% (n=5)	50% (n=11)	18% (n=4)	9% (n=2)	N=1
I feel safe here	17% (n=4)	48% (n=11)	35% (n=8)		
There are not enough facilities for teenagers around here	50% (n=11)	32% (n=7)	18% (n=4)		N=1
This area is changing for the better	9% (n=2)	36% (n=8)	41% (n=9)	14% (n=3)	N=1
There is conflict between old and young	5% (n=1)	33% (n=7)	38% (n=8)	24% (n=5)	N=2
This is a good place to bring up children	25% (n=5)	40% (n=8)	35% (n=7)		N=3
Drug abuse is a problem here		36% (n=5)	36% (n=5)	29% (n=4)	N=9
There are too many people moving in and out of the area	24% (n=5)	57% (n=12)	14% (n=3)	5% (n=1)	N=2
There is a good community spirit here	27% (n=6)	68% (n=15)	5% (n=1)		N=1
Lack of jobs is a big problem here	53% (n=10)	37% (n=7)	11% (n=2)		N=4
This area has a lot of potential	27% (n=6)	68% (n=15)	5% (n=1)		N=1
There is a lot of noise at night here	26% (n=6)	35% (n=8)	17% (n=4)	22% (n=5)	
People around here are willing to help each other	24% (n=5)	71% (n=15)	5% (n=1)		N=2

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.

Theft or burglary and street litter were viewed as serious problems by many respondents. The threat of sectarian violence was least likely to be viewed as a community problem while joy riding and graffiti were generally not viewed as problems. Although vandalism and hooliganism were viewed as a problem by over half of the respondents, they were not viewed as serious problems. 18% (n=4) of respondents from Gilford stated that these problems affected their health, with males (30%; n=3) more likely to indicate that these problems affected their health than females (8%; n=1).

Table 2: Social Issues

	A Serious Problem	A Problem but not Serious	Not a Problem	Don't Know
Vandalism and hooliganism	17% (n=4)	57% (n=13)	26% (n=6)	
Graffiti		23% (n=5)	77% (n=17)	N=1
Theft or burglary	36% (n=8)	41% (n=9)	23% (n=5)	N=1
Litter and rubbish in the street	44% (n=10)	26% (n=6)	30% (n=7)	
Threat of sectarian violence		5% (n=1)	96% (n=21)	N=1
Joy riding	4% (n=1)	4% (n=1)	91% (n=21)	

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 general community facilities, leisure/social facilities and medical facilities.

Table 3: Local Services & Facilities

	Very Easy	Fairly Easy	Fairly Difficult	Very Difficult	Service not Available	D/K or No Answer
Bus Stop	70% (n=16)	17% (n=4)	4% (n=1)	9% (n=2)		
Chemist	70% (n=16)	17% (n=4)	9% (n=2)	4% (n=1)		
Community Centre	14% (n=3)	14% (n=3)		10% (n=2)	62% (n=13)	N=2
Doctor's Surgery	70% (n=16)	17% (n=4)	9% (n=2)	4% (n=1)		
Hospital Casualty		35% (n=8)	39% (n=9)	9% (n=2)	17% (n=4)	
Job Centre	5% (n=1)	29% (n=6)	29% (n=6)	19% (n=4)	19% (n=4)	N=2
Leisure Centre	5% (n=1)	23% (n=5)	32% (n=7)	9% (n=2)	32% (n=7)	N=1
Children's Playground	5% (n=1)	24% (n=5)	10% (n=2)	5% (n=1)	57% (n=12)	N=2
Pensioners' Drop-in	5% (n=1)	5% (n=1)	14% (n=3)	5% (n=1)	71% (n=15)	N=2
Post Office	65% (n=15)	26% (n=6)	9% (n=2)			
Supermarket	52% (n=12)	35% (n=8)	9% (n=2)		4% (n=1)	
Youth Club	6% (n=1)				94% (n=16)	N=6

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

Most respondents could easily access the post office, supermarket and bus stop from their house. However many leisure-type facilities were viewed to be either difficult to get to or not available in the area: community centre; leisure centre; children's playground; pensioners' drop-in; and youth club. The majority of respondents also indicated that a job centre was either not available in their area or difficult to access.

Transport

65% (n=15) of Gilford respondents indicated that they had regular use of their own transport. 80% (n=8) of these respondents were male and 54% (n=7) were female. 39% of respondents used public transport at least once a week, with a further 4% using it 2 to 3 times per month. However, 57% (n=13) either rarely or never used public transport (n=7 or 70% of males and n=6 or 46% of females).

Of the 43% (n=10) of respondents who used public transport, 90% (n=9) used the bus, with 1 respondent indicating that s/he used another type of public transport. No respondents used the train.

The most common reason given by respondents for using their own transport was that they preferred to use their own transport (77%; n=10). Other reasons for not using public transport included the routes not meeting needs (31%; n=3); the service being unreliable (23%; n=3) and not operating at convenient times (23%; n=3). 2 respondents either rarely or never used public transport because the stops were inconvenient and they found it too expensive.

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

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

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

Almost half (49%; n=11) of respondents lived in terraced housing. 22% (n=5) lived in detached housing, with a further 22% (n=5) living in semi-detached housing. 1 respondent lived in a flat/apartment and 1 cited 'other' housing.

Housing Tenure

57% (n=13) of respondents had bought or were buying their home. 22% (n=5) rented their property from the Housing Executive while 13% (n=3) rented privately. 1 individual co-owned their home and 1 indicated 'other'.

Household Occupancy

A total of 48 individuals lived in 23 households, an average of 2.1 individuals per household. 35% (n=8) of respondents lived alone, with a further 39% (n=9) living with 1 other person. 13% (n=3) of households had 3 people living within; 9% (n=2) had 4 people; and 1 household accommodated 5 people. All lived full-time in the home.

Housing and Health

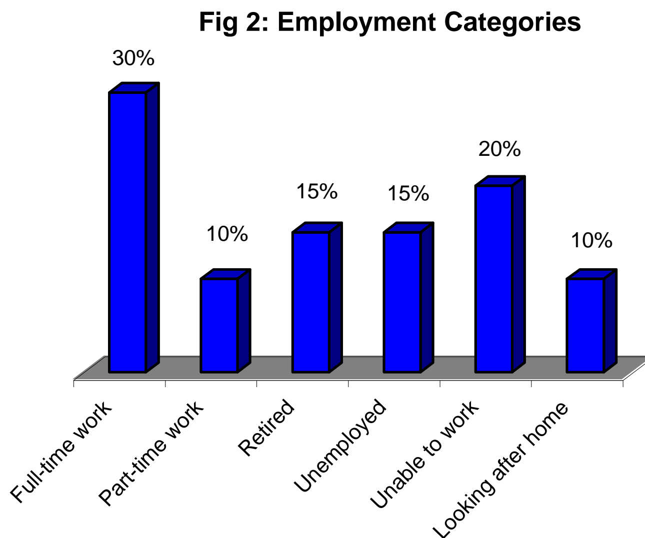
Respondents were asked to rate, on a 4- point scale, the extent to which they experienced a number of housing problems. Very few housing problems were cited by Gilford respondents (Table 4). However, 38% (n=8) indicated that outside noise was either a *'very'* or *'quite'* serious problem. Other serious problems identified were steps into the house (15%; n=3); leaking roof (10%; n=2); and draughty windows (10%; n=2). Only one respondent indicated that housing problems affected his/her health.

Table 4: Housing Problems

	Very serious problem	Quite serious problem	Minor problem	Not a problem	No Answer
Damp/condensation			33% (n=7)	67% (n=14)	N=2
Outside noise	5% (n=1)	33% (n=7)	14% (n=3)	48% (n=10)	N=2
Leaking roof	5% (n=1)	5% (n=1)	5% (n=1)	86% (n=18)	N=2
Draughty windows/doors	10% (n=2)		14% (n=3)	76% (n=16)	N=2
Faulty electrical wiring			5% (n=1)	95% (n=20)	N=2
Inadequate hot water				100% (n=21)	N=2
Poor heating			5% (n=1)	95% (n=20)	N=2
General disrepair			5% (n=1)	95% (n=20)	N=2
Steps into the house	5% (n=1)	10% (n=2)	14% (n=3)	71% (n=15)	N=2
Lack of space			5% (n=1)	95% (n=20)	N=2

EMPLOYMENT

The relationship between employment and health has been well-documented. For example, Faragher, Cass and Cooper (2005)[3] found 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.



Employment data was available for 20 respondents. As indicated in Fig 2, a total of 40% (n=8) of respondents were in employment. 30% (n=6) were in full-time employment (30 hours or more per week) and 10% (n=2) were in part-time employment (less than 30 hours per week).

15% (n=3) of respondents were registered unemployed and 20% (n=4) were unable to work due to long-term sickness or disability. 10% (n=2) indicated that they were looking after the home/family.

15% (n=3) of respondents were retired. 2 had been retired for more than 10 years and 1 had been retired between 6 and 10 years. No respondents were in either full or part-time education.

Economically Active

As indicated above, 40% (n=8) of respondents were employed. More males were in employment than females, with 60% (n=6) of males in either full (40%; n=4) or part-time work (20%; n=2). Only 20% of females were in employment (n=2; both full-time).

Respondents cited a variety of jobs, including a Police Officer, Taxi Driver, IT Manager and Electrician. 2 respondents worked from home, 1 worked within the local area and 1 worked elsewhere in the Banbridge District Council area. 4 respondents worked elsewhere in Northern Ireland.

Time in current job varied, with 25% (n=2) indicating that they had been in their job less than 1 year; 38% (n=3) between 1 and 5 years; 25% (n=2) between 6 and 10 years; and 1 respondent had been in

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[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.*

his/her current job for more than 10 years. 2 employed respondents had been out of work during the last 5 years.

All respondents were either *'quite'* (50%; n=4) or *'very'* (50%; n=4) satisfied in their current job. All respondents also indicated that they thought their job was either *'very'* (50%; n=4) or *'fairly'* (50%; n=4) secure.

Economically Inactive

45% (n=9) of respondents were economically inactive[4] - 30% of males (n=3) and 60% of females (n=6). 22% (n=2; both female) had never had a paid job and a further 22% (n=2; both female) had not been in a paid job for 6 years or more.

Of those individuals who had been in previous employment (n=7), 57% (n=4) had left for medical or personal health reasons (67% males, n=2; 50% females, n=2). A further 29% (n=2) left to look after the home/family (1 male; 1 female) and 1 individual left her previous employment for other reasons

71% (n=5) of individuals not in employment indicated that they would like to be in a paid job. These individuals were asked to indicate what would improve their chances of finding employment. As indicated in Table 5, all indicated that more training and qualifications would improve their chances of finding employment *'a lot'*. More jobs in the area (80%; n=4), more experience (60%; n=3) and improved health (60%; n=3) were also factors that respondents felt would greatly improve their job prospects.

Table 5: Improve Employability

	Improve chances a lot	Improve chances a little	Would not improve chances	Not relevant
More training	100% (n=5)			
More experience	60% (n=3)	40% (n=2)		
More qualifications	100% (n=5)			
Help with child care		40% (n=2)		60% (n=3)
Help looking after sick/elderly person		20% (n=1)		80% (n=4)
Improved health	60% (n=3)	20% (n=1)		20% (n=1)
More information about how to look for jobs	40% (n=2)	60% (n=3)		
More jobs in the area	80% (n=4)	20% (n=1)		
Jobs with more flexible hours	40% (n=2)		40% (n=2)	20% (n=1)
Better transport		60% (n=3)	20% (n=1)	20% (n=1)

[4] 'Economically inactive' incorporates individuals who were either registered unemployed, looking after the home/family or long-term sick. The 3 retired respondents are not included.

Of those who would like to be in a paid job (71%; n=5), 60% (n=3) were *'not very'* confident of getting a job within the next year. 2 respondents indicated that they did not know.

33% (n=3) of respondents indicated that being unemployed had no noticeable effect on their health. 1 male respondent reported that being unemployed affected his mental health, while 56% (n=5) felt it affected both their physical and mental health (2 males; 3 females).

33% (n=3) of respondents reported that being unemployed caused some arguments/tension with family. However the majority (67%; n=6) indicated that being employed did not affect family relationships.

Voluntary Activity

30% (n=7) of respondents were involved in voluntary work – 30% (n=3) of males and 31% (n=4) of females. 71% of voluntary work was connected to an organisation. Hours per week involved in voluntary work varied, although over half of respondents (57%; n=4) indicated that they volunteered for between 1 and 5 hours per week.

Of those respondents who did not volunteer, only 13% (n=2) indicated that they would be interested in volunteering.

PERSONAL HEALTH

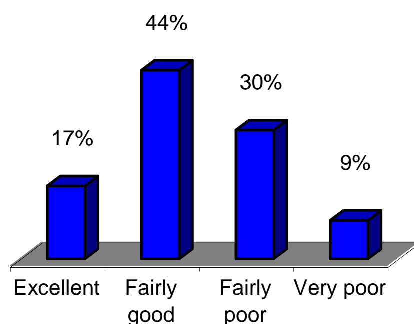
Personal ratings of health are commonly assessed in population and community-based surveys. They have the advantage of capturing multiple dimensions of health, being easily answered and are viewed as a reliable predictor of future morbidity and mortality (Grau et al, 1998)[5]. Therefore, respondents 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'*.

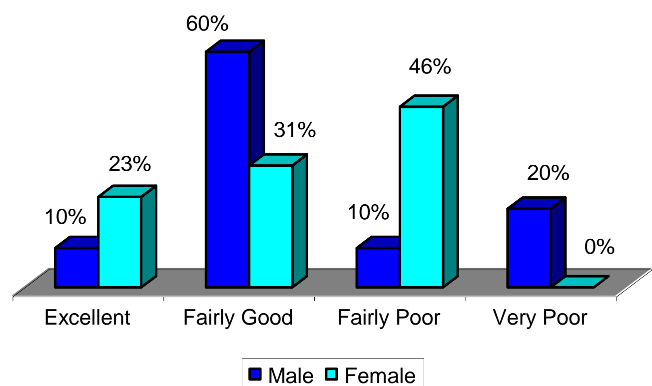
As indicated in Fig 3, the majority of respondents (61%; n=14) reported that they had either *'excellent'* or *'fairly good'* health compared to other people their age. However, 39% (n=9) of respondents rated their health as either *'fairly'* or *'very'* poor.

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. However, males were more likely to rate their health positively (70%; n=7) than females (54%; n=7).

[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.*

Half of all Gilford respondents reported that their health was about the same as a year ago (50%; n=11). 14% (n=3) indicated that their health was either '*somewhat better*' or '*much better*' than a year ago. However, over one third (36%; n=8) 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 each of them were to having overall good health. Responses are summarised in Table 6. The 2 factors most rated as being *'very important'* were having a healthy diet (74%; n=17) and living in decent housing (61%; n=14). Over half of respondents indicated that getting enough exercise (57%; n=13); having access to good health services (57%; n=13); having adequate income (55%; n=12); and having support from family/friends (52%; n=12) were *'very important'* to good overall health.

39% (n=9) of respondents indicated that being in a paid job was either *'not very'* or *'not at all'* important to good health. All those who believed that being in a paid job was important were male.

Table 6: Factors Affecting Health

	Very Important	Quite Important	Not Very Important	Not at all Important	D/K or No Answer
Getting enough exercise	57% (n=13)	44% (n=10)			
Having access to good health services	57% (n=13)	44% (n=10)			
Having a healthy diet	74% (n=17)	26% (n=6)			
Being in a paid job	26% (n=6)	35% (n=8)	26% (n=6)	13% (n=3)	
Feeling good about yourself	48% (n=11)	48% (n=11)	4% (n=1)		
Living in decent housing	61% (n=14)	39% (n=9)			
Having support from family/friends	52% (n=12)	30% (n=7)	13% (n=3)	4% (n=1)	
Having adequate income	55% (n=12)	41% (n=9)	5% (n=1)		N=1
Having time to yourself	26% (n=6)	39% (n=9)	30% (n=7)	4% (n=1)	

Ill Health/Disability

48% (n=11) of respondents indicated that they had a long-term illness or disability that affected their daily life. 30% (n=3) of male and 62% (n=8) of females reported ill health. Arthritis was the most common type of illness. Other illnesses included diabetes, cancer, chronic fatigue M.E. and depression.

18% (n=2) of respondents with an illness/disability were not in receipt of any help or support. The most common type of support for those who did receive it was support from a family member (67%; n=6). 45% (n=4) received help from a voluntary group and 22% (n=2) received support from Social Services. 1 individual received help from a District Nurse and 1 indicated that s/he received help from another person.

46% (n=5) of respondents received support with household chores; 27% (n=3) with emotional/mental health needs; 18% (n=2) with personal care; and 18% (n=2) with paperwork or financial matters. 2 individuals indicated that they received 'other' support. Of those who did not receive support, only 1 indicated that s/he would like to receive support – in household chores.

Emotional Stress

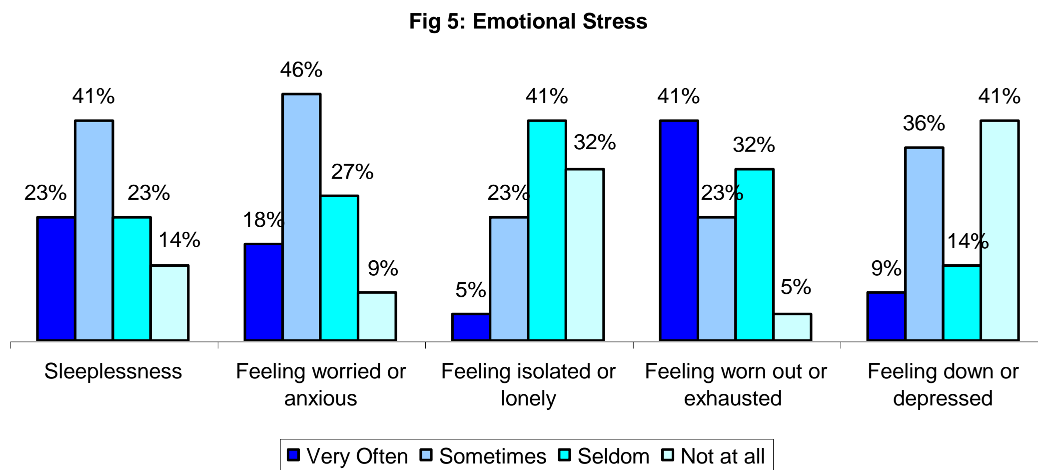
To obtain an overall indication of emotional stress levels within the community, respondents were asked how often, over the previous few weeks, they had experienced:

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

As indicated in Fig 5, emotional stress levels within the sample were high, with over 60% of respondents indicating experiencing sleeplessness (64%; n=14), feeling worried or anxious (64%; n=14), and/or feeling worn out or exhausted (64%; n=14) *'very often'* or *'sometimes'* over the last few weeks. 46% (n=10) reported feeling down or depressed over the previous few weeks. Respondents were least likely to report feeling isolated or lonely, with 28% (n=6) indicating that they had felt this way over the last few weeks.

Overall, females were more likely than males to report feeling worried or anxious (85% or 11 females; 33% or 3 males); to experience sleeplessness (77% or 10 females; 44% or 4 males); and/or to feel worn out or exhausted (77% or 10 females; 44% or 4 males). However, these differences failed to reach statistical significance.

Fig 5: Emotional Stress



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 (58%; n=11)
- Deal with the feelings alone (53%; n=10)
- Try to get out to take their mind off their problems (21%; n=4)
- Seek professional advice (11%); n=2)

No individuals indicated that they would ignore these feelings

Social Support

91% (n=21) of respondents indicated that they had someone to confide in if they had a problem, indicating a high level of support within the community. Over one quarter of individuals (26%; n=6) had

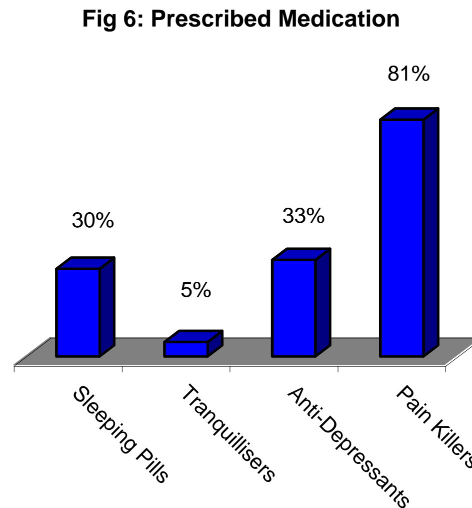
'a lot' of people they could rely on. 44% (n=10) had *'a few'* people they could rely on and 30% (n=7) had *'very few'* people they could rely on. None of the respondents had '*no one'* they could rely on.

Prescribed Medication

Respondents were asked whether they had been prescribed any of 4 types of medication over the past year. As indicated in Fig 6, a high proportion of respondents (81%; n=17) had been prescribed painkillers over the past 12 months. Painkiller prescription was high for both males (89%; n=8) and females (75%; n=9).

One third of respondents (n=7) had been prescribed anti-depressants (females 42%; n=5; males 22%; n=2). 30% (n=6) had been prescribed sleeping pills, with females more likely to be prescribed these (46%; n=5) than males (11%; n=1). 1 individual had been prescribed tranquillisers.

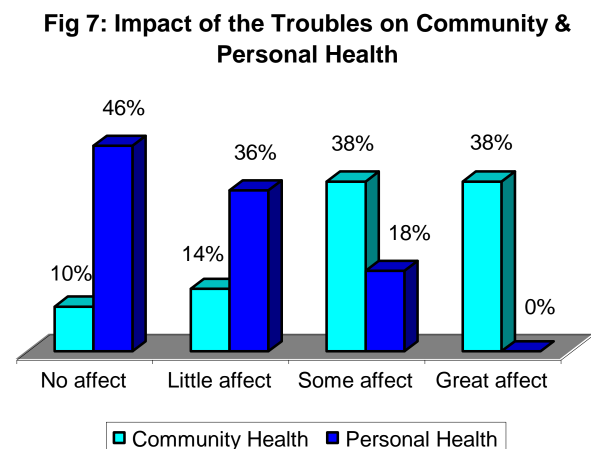
Fig 6: Prescribed Medication



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)[6] 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 the Gilford area, respondents were asked to rate the effect 'the Troubles' had on the health of their community and on their own personal health.

Fig 7: Impact of the Troubles on Community & Personal Health



[6] 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.

As indicated in Fig 7, the majority of respondents reported that 'the Troubles' have had either *'some'* or a *'great affect'* on the health of their community (76%; n=16). However 82% (n=18) indicated that 'the Troubles' did not have any, or had only *'a little'* affect, on their own personal health. No respondents felt that 'the Troubles' have had a *'great affect'* on their own health

CARERS

27% (n=6) of Gilford respondents were caring for a person on a regular basis. All carers were female and all were caring for 1 individual. Carers were either caring for a person with both a physical and a learning disability (50%; n=3) or for an elderly or frail person (50%; n=3).

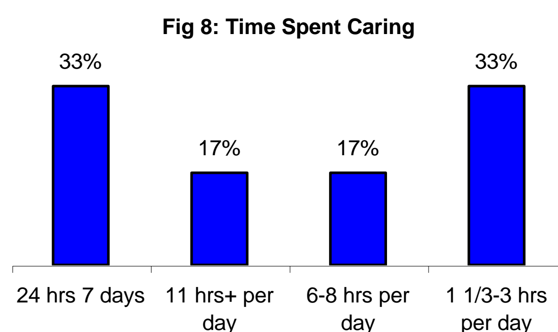
50% (n=3) of carers were caring for a son or daughter, 33% (n=2) were caring for a parent and 1 for a sibling. 83% (n=5) of carers lived in the same household as the person they were caring for. Half of the respondents had been caring for over 10 years (50%; n=3). 33% (n=2) had been caring for between 6 and 10 years and 1 carer had been caring for between 4 and 5 years.

Respondents assisted the person they cared for with a variety of activities. Personal care (83%; n=5) and supervision with medication (83%; n=5) were the most commonly assisted activities. Carers also frequently helped their family member with household chores (67%; n=4) and emotional or mental health needs (67%; n=4). 33% (n=2) of carers helped with paperwork or financial matters.

The majority of carers (83%; n=5) cared 7 days a week. 1 carer cared 3 days per week.

As indicated in Fig 8, one third of carers (n=2) cared for their family member 24 hours a day, 7 days a week. A further 34% (n=2) cared for 6 or more hours a day. A further third of carers (n=2) cared between 1 1/3 and 3 hours per day.

Fig 8: Time Spent Caring



Support

Carers were asked whether they were receiving any support in their caring role. 5 carers provided this information. The majority (83%; n=4) reported receiving support. Many of the carers attended a support group (80%; n=4) and 40% (n=2) reported that they received information. Other support received by individual carers included practical support, a sitting service, and a respite service.

Most support was received from a voluntary group (60%; n=3) and/or a family member (60%; n=3). 40% (n=2) of carers indicated that they received support from Social Services and 1 reported receiving support from a neighbour.

The majority of carers (67%; n=4) indicated that they received enough support in their caring role. 1 carer felt she did not receive enough support and 1 did not know whether she received enough support. 83% (n=5) of carers reported that it was either fairly difficult or impossible to get a break from caring. Only 1 carer indicated that it was easy to find someone to help.

Caring and Health

Only 1 carer indicated that her caring role did not have a negative impact on their health. 67% (n=4) felt that their role as a carer had a negative affect on both their physical and mental health, with a further 1 carer indicating an affect on her physical health only.

Carer opinion was divided on whether being a carer placed additional stress on their relationships with family and friends, with 50% (n=3) indicating some arguments/tension and 50% (n=3) indicating no effect out of the ordinary.

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[7]). 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 two 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.

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

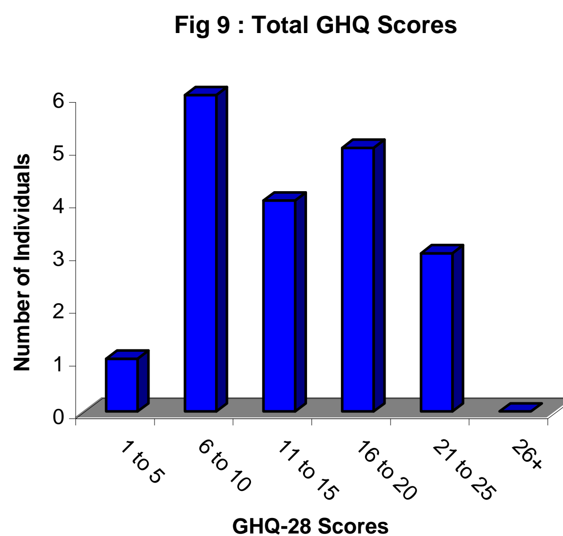
- An alternative scoring method is the 'GHQ scoring method' which involves scoring the scale as either 0 or 1, with the first two responses on the 4-point scale producing a rating of 0 and the last two responses obtaining a rating of 1(0,0,1,1). This method of scoring enables the identification of 'potential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

As each of the scoring methods serve different purposes, both were used to score the questionnaires. GHQ data was available for 19 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 13.95.
- The lowest score was 5.
- The highest reported score was 23.

As indicated in Fig 9, 37% (n=7) of respondents reported GHQ-28 scores between 1 and 10 and 48% (n=9) scored between 11 and 20. Only 16% (n=3) of respondents scored between 21 and 15. No respondents scored above 25 on the GHQ-28.



Females scored slightly higher on the GHQ-28 total score (15.2) than males (12.3). However this difference failed to reach statistical significance.

A study carried out by Cairns and Wilson (1984)[8] 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:

- 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

[8] 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.*

- The average GHQ-28 scores from individuals living in the Gilford area (13.95) is considerably lower than either of these 2 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 in the Gilford sample, 42% (N=8) of individuals can be considered to be 'cases'. This is a higher 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'.