AN ASSESSMENT OF COMMUNITY HEALTH IN CRAIGAVON

BRIDGE

Building Communities, Promoting Health

An Assessment of Community Health in Craigavon

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Praxis Mental Health
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ACKNOWLEDGEMENTS

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COMMUNITY INTERVIEWERS

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PROJECT BACKGROUND

Bridge is a 2 year action research project set up to assess the health and social care needs of three communities in the Craigavon Borough:

- North Lurgan
- Corcrain
- Aghagallon

PROJECT AIMS

The Bridge Project has 5 main aims. These are to:

- Identify the perceived health and social care needs within three communities in the Craigavon Borough (North Lurgan, Corcrain, Aghagallon) from the perspective of individuals living in the area and community groups working in the local vicinity.
- Assist each community in prioritising identified areas of need.
- Assist each community in exploring ways to address the identified needs of the community and to develop plans of action which can be sustained by the local community.
- Adopt a holistic approach towards health, with an emphasis on mental health, taking into consideration the relationship between physical health, mental health and social and environmental factors.
- Conduct the project in such a way as to promote the active participation of each community throughout the life of the project.

PROJECT MANAGEMENT

A steering group was set up to oversee the direction of the project. The group comprised representatives from each of the three communities and Praxis Mental Health. Praxis is a voluntary organisation which promotes mental health throughout Northern Ireland.

Funding for the 2-year project was secured from the E.U. Special Programme for Peace and Reconciliation. The steering group maintained overall ownership of the project and Praxis provided day-to-day management and support.

CRAIGAVON BOROUGH

Craigavon is situated on the southern shore of Lough Neagh, approximately 30 miles (50 km) south east of Belfast. The Borough has a population of approximately 78,000 and administers an area of 100 square miles, embracing the towns of Lurgan and Portadown and associated rural areas.

NORTH LURGAN

The area of North Lurgan comprises three Electoral Wards, Drumnamoe, Parklake and Woodvale. The Bridge Project was carried out in the Drumnamoe Electoral Ward, which includes the Kilwilkie and Lurgan Tarry housing developments. The Ward is broken down into

four smaller geographical areas, called Enumeration Districts (ED64-ED67).

CORCRAIN

The Bridge Project included the Corcrain Electoral Ward which comprises five Enumeration Districts (ED44-ED48). However, the Corcrain Ward does not include surrounding housing developments which would generally be regarded by the community as the 'Corcrain area'. Therefore, two housing areas on either side of the Corcrain Ward were also included in the project. These were the:

- Ballyoran housing area (ED23 & ED24 from the Ballyoran Electoral Ward)
- Corcrain/Redmanville housing area (ED16- ED19 from the Ballybay Electoral ward).

Therefore, from the Corcrain area, three Electoral Wards were represented involving a total of eleven Enumeration Districts.

AGHAGALLON

Aghagallon is a rural area stretching along the shores of Lough Neagh. The Aghagallon Electoral Ward comprises eight Enumeration Districts, six of which were included as part of the Bridge Project (ED01-ED06). The two Enumeration Districts which were omitted from the study (ED07 & ED08) are considered by the community be part of the wider North Lurgan area, even though they are included within the Aghagallon Electoral Ward boundary.

DEPRIVATION

The three areas were selected for inclusion in the study, as there was a growing recognition amongst community representatives that the areas experienced high levels of deprivation, stress and isolation. In North Lurgan and Corcrain this was partially attributed to the ongoing political conflict and within Aghagallon there were additional issues associated with living in a rural area. Based on the Robson deprivation index (1991) the three areas fall within the 50% most deprived wards in Northern Ireland. Table 1 provides a breakdown of deprivation rankings across the three areas. The rankings are in relation to 566 Electoral Wards within Northern Ireland as a whole.

Table 1: Deprivation Rankings

	Degree of Deprivation	Depth / Intensity of Deprivation
North Lurgan	131st	230th
Corcrain	69th	141st
Aghagallon	216th	142nd

DEFINING HEALTH

Asking the question 'What is Health?' elicits a wide range of comments and opinions. For example, some individuals may equate health with physical fitness, the ability to run for a certain period of time or participate in a certain sport. For others, health may be primarily about diet, emphasising the importance of eating healthily and being aware of calorie and fat intake. Others may associate health with performing every day activities, such as, going to the supermarket or looking after the family, while for others, health may be having the ability to cope with the pressures of a job or a living situation.

☞ Individuals understand and define health in many different ways

Although there is little consensus about what health is, numerous attempts have been made to define it. These definitions are often based on one of two models of health:

- Firstly, there is the **negative** model, which defines health in terms of the absence of disease and illness. Such definitions view health as the inability to function normally, from a biological standpoint. The focus is on the biological and chemical make-up of an individual. Such definitions have been criticised as being too narrow, arguing that there is more to health than simply 'not being ill'.

- Secondly, there is the **positive** model for understanding health. This model recognises that having good health is more than just the absence of illness. Rather, it emphasises many of the positive aspects of health. The World Health Organisation's (WHO) definition of health is often cited as an example of this positive view of health. It defines health as *'a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity'* (WHO, 1946). While this definition has been criticised on a number of grounds, namely for being too idealist, it encourages individuals to think of health in more holistic terms.

FACTORS INFLUENCING HEALTH

Regardless of how health may be specifically defined, it is generally accepted that there are many factors which can influence an individual's health. This may include a person's age, their family history, their diet and exercise levels, their housing conditions, their income, the accessibility of health services and/or the country in which the person lives. The list seems almost endless. One model which is helpful in trying to understand some of these many influences is the 'Rainbow Model' (Dahlgren & Whitehead, 1991) which displays influences on health in layers, one on top of the other. The model includes the individual (age, gender, genetic make-up); personal behaviour (diet, exercise); social and community influences; working conditions and access to services; economic, cultural and environmental conditions. Each of these factors is influenced and can be influenced by the layers surrounding it.

HEALTH INEQUALITIES

Given that there are many factors that can influence a person's health, it follows that attempts to explain why some individuals have better health than others are complex. What makes one person seem 'more healthy' than another is often attributed to a range of influences. For example, some explanations focus on biological factors, personal lifestyle, the physical and social environment or access to health services. Other theories emphasise the importance of material deprivation such as poverty, poor housing, low wages, unemployment, air pollution, crime and disorder (DoH, 1998).

☞ In Northern Ireland, as elsewhere, being disadvantaged is bad for your health

This latter view, that the material and social environment in which a person lives has a significant contribution on whether a person has good or poor health, has come to the fore within the past few years. This is evidenced in the re-introduction of the *'inequality of health debate'*. This is a long-standing debate which argues that there is a widening health gap between disadvantaged social groups and their more affluent counterparts. A growing body of research points to the fact that people who live in disadvantaged circumstances have:

'more illness, greater distress, more disability and shorter lives than those who are more affluent' (Benzeval et al., 1995).

Within Britain, the 'Black Report' in 1980 placed the whole issue of health inequality in the public domain. Eight years later, the Acheson Report (1988) further highlighted the difference in health experienced between the 'haves' and 'have nots'. For example, in Britain, people in least privileged circumstances are likely to die about eight years earlier than those who are more affluent (Benzeval et al, 1995). In addition, not only is life shorter for people who experience less advantaged circumstances but they also tend to be exposed to '*greater risks of illness and disability during their life'* (Whitehead, 1995).

A similar picture emerges when we look at health reports and statistics from across Northern Ireland. Research shows a strong and positive relationship between a range of indicators of disadvantage (such as not having access to a car, being unemployed, or renting a home) and poor health (such as long-term illness and mortality rates). Inequalities are shown to exist throughout the life span. For example:

- Infant death rates are almost 50% higher in the most deprived group of the population of Northern Ireland compared to the least deprived.

- Children from deprived areas have higher rates of death due to accidents. They are 15 times more likely to die as a result of a house fire than those from the most affluent areas and 7 times more likely to die as a result of a road traffic accident (Campbell, 1999).

- People living in some areas of Northern Ireland have levels of long-term sickness or chronic illness three or more times greater than people living in other areas (Well into 2000, 1997).

Not only has research shown that a relationship between disadvantage and ill health exists, but it states that the relationship is continuous, in that added disadvantage is associated with poorer health (O'Reilly, 1999).

TACKLING HEALTH INEQUALITIES

Trying to address such health inequalities within a given population requires a wide range of policies, strategies and interventions. As such, any successful effort to reduce inequalities in health must be based on *'a broad range of action involving almost every aspect of society'* (Benzeval et al., 1995).

The Green Paper on public health, 'Our Healthier Nation' (DoH, 1998) provides one example of this. It aims to *'improve the health of the worst off in society and narrow the health gap'* by focusing on three key settings: Healthy Schools; Healthy Workplaces; Healthy Neighbourhoods.

Within Northern Ireland, at a policy level, tackling health inequalities has formed part of the DHSS agenda since 1992 where the theme of Targeting Health and Social Need (THSN) was first introduced. The latest publication, the Regional Strategy for Health and Social Wellbeing 1997-2002 has THSN as one of four themes which aims to:

- minimise inequalities in <u>population</u> health and social wellbeing
- minimise inequalities in <u>need</u> for health and social care in Northern Ireland
- minimise inequalities in <u>access</u> to health and social care in Northern Ireland.

In line with these policy statements, a number of funding opportunities and initiatives have also been introduced with a particular focus on health inequalities including, Healthy Cities, Health Action Zones and Healthy Living Centres.

MEASURING HEALTH

In order to determine where to target such initiatives and resources and then to monitor the success of such initiatives in terms of bringing about health improvements, some form of measurement or assessment of health is required. This can take various forms.

Mortality Rates: One of the most commonly used methods for measuring health is to look at the level of mortality (death rates) within a given population. Such figures are useful in identifying geographical areas with high mortality rates, to which resources can then be targeted. Mortality figures are also useful in examining health trends in an area over a period of time. This method of measuring health has the advantage that such statistics are easily accessed and are updated on a yearly basis. However, relying solely on mortality statistics is flawed, in that individuals may experience a chronic or debilitating illness that does not lead to premature death, but

nonetheless causes the individual to experience pain, suffering and a loss of independence.

Morbidity Rates: Therefore, to obtain a more accurate picture of health or ill-health, it is also necessary to examine levels of morbidity (rates of illness). This involves accessing information such as consultation rates, hospital stays, in-patient enquiries and waiting lists. While such information will provide relevant data on levels of ill-health within a given population, it is limited in that many individuals with illnesses will not be admitted to hospital or visit their General Practitioner.

Health Surveys: To supplement these two objective measures of health (mortality and morbidity), information about the health of a population can be obtained via health surveys. A large number of national health surveys are carried out across the UK, including 'The General Household Survey', the 'Health and Lifestyle Survey' and the 'Disability Survey'. Within Northern Ireland, there is the 'Survey of Health and Social Well-being' and surveys within each of the Health Boards, for example the 'Lifestyle Report' (SHSSB, 1992).

Community Health Needs Assessment: In addition to these large scale health surveys, health needs assessments are often carried out at a community level. This can involve assessing health needs within a specific geographical area or amongst a specific group of individuals (for example, ethnic minorities, lone parents, carers or the physically disabled). Such assessments not only provide an indication as to the health of a particular community but also offer information as to the kind of health needs within that community. They provide an opportunity to document existing community services and resources and provide information for planning new service programmes based on the community's needs, interests and resources (Rhodes, 1991). Community health needs assessments are useful for identifying gaps in the delivery of services and barriers to accessing services.

At the centre of a health needs assessment is the active involvement of members of the community in identifying and addressing their health needs. This can take a range of formats such as setting up community forums, eliciting the views of key informants or conducting a field survey. Regardless of the method used, involving the community in identifying health needs is recognised as an essential element to any successful needs assessment exercise. The government document 'Well into 2000' refers to community development as a way of addressing health needs and tackling health inequalities. It defines community development as:

'Supporting local communities to identify the health and social concerns of greatest importance to them and helping them to devise and implement solutions' (Well into 2000).

A community development approach towards identifying health and social care needs forms the background to the Bridge Project.

GEOGRAPHICAL BOUNDARIES

The Bridge project involved a large scale community health survey being carried out within North Lurgan, Corcrain and Aghagallon. Although the project had identified three broad areas to be included in the study, these had to be refined and the exact geographical boundaries determined. This involved breaking the areas down into their Electoral Wards and smaller geographical units called Enumeration Districts.

- Within **North Lurgan**, the Drumnamoe Electoral Ward was selected
- Within **Corcrain**, the Corcrain Electoral Ward plus two housing areas on either side of the Ward were selected
- Within **Aghagallon**, 6 of the 8 Enumeration Districts within the Aghagallon Electoral Ward were selected.

Determining the exact geographical areas to be included was essential for the next stage of the project to take place, that of sample selection.

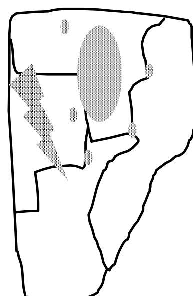
SAMPLE SELECTION

Given the large geographical size of the three areas, it was neither feasible nor necessary to interview every individual about the health needs of their community. Rather, a sample of individuals was selected to be involved in the survey. In order to ensure that those individuals chosen to be interviewed would be representative of the communities as a whole, a random selection procedure was used.

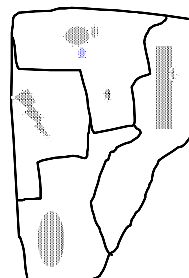
Random sampling is a technique which allows all individuals from the chosen area to have an equal chance of being selected to be involved in the study. Random sampling is not about interviewing the first 100 people you come across in the street, as this would mean that individuals who were at work, on holiday or were housebound would not have an equal chance of being selected. The advantage of using a random sample of individuals is that the sample can be taken as being representative of the community from which it is drawn. In order to obtain a random sample of households within the three areas:

- A complete list of households within each area was obtained.
- Each household was then assigned to its respective Enumeration District and a random sample of households generated within each Enumeration District.

Figure 1: A randomly selected sample across a Ward could result in a cluster of households being selected from only a few areas



A stratified random sample ensures that households are selected from within each District and therefore across the whole Ward



This is a technique known as 'stratified random sampling'. This ensured that households

were selected from across the whole area and not simply a cluster of houses from a few areas (Figure 1).

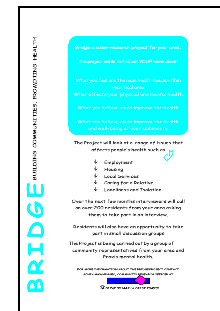
Deciding on the number of households to participate in a study depends largely on the size of the population from which you are taking a sample and also on the resources that are available. Taking these factors into consideration, a 13.5% sample was decided upon. A statistical computer package (SPSS) was used to generate a 13.5% random sample of households within each Enumeration District.

Once the households are selected it is important to ensure that those individuals interviewed from the households are representative of the community. One way in which surveys can be carried out is to interview the first person who answers the door at the selected household. However, this often results in more females being interviewed and also more elderly/ retired individuals. Therefore, it was decided to use a random selection procedure (the KISH grid) to identify an individual from each household to be interviewed. This procedure ensures that males and females from a wide range of ages have an equal chance of being selected. The Bridge project included individuals aged 18 years and over.

INFORMING THE COMMUNITY

Prior to the survey being carried out, each community was informed about the Bridge Project. This was achieved in a number of ways:

- Posters were displayed in key community locations.
- Information leaflets were available in G.P surgeries and community centres.



- An article describing the project was printed in each of the local newspapers.
- Households, which were randomly selected to be involved in the study, were sent a letter explaining the purpose of the study and what taking part would involve.

SURVEY QUESTIONNAIRE

The steering group and other community representatives were consulted regarding topics to be addressed by the survey. This was to assist in identifying topics that were of importance and of relevance to the community to be included in the questionnaire. In addition, community surveys which were carried out in other areas were reviewed. Based on these two sources of information, a draft questionnaire was drawn up and piloted, which involved interviewing eleven individuals from across the three areas. Some changes were made to the questionnaire following the pilot interviews. The resulting questionnaire addressed five main topics:

- Area
- Services/Facilities
- Housing
- Employment

- Personal Health.

The questionnaire comprised mostly 'closed' (e.g. yes/no) and 'ranked' or 'scaled' questions (for example, very satisfied, quite satisfied, quite dissatisfied, very dissatisfied). Where there were a number of responses to choose from, response cards were used to facilitate responses. The questionnaire also included some 'open ended' questions, for example individuals were asked 'why' they gave a particular rating.

In addition to the survey questionnaire, the General Health Questionnaire (GHQ-28) (Goldberg, 1972) was also used. This 28 item questionnaire is a self-administered screening test aimed at detecting psychiatric disorders among respondents in community settings (Goldberg & Williams, 1988). Respondents are asked whether they have experienced a particular symptom in the previous two week period on a 4-point scale.

For example: (GHQ-28 item) Have you recently lost much sleep over worry?

Not at all	No more than usual	Rather more than usual	Much more than usual

COMMUNITY INTERVIEWERS

Much consideration was given as to how best carry out the resident interviews. The advantages and disadvantages of using interviewers from within and outside the area were considered. Community representatives felt that residents would be reluctant to participate in an interview with an '*outsider*', namely an individual who did not come from the local area. Therefore, to encourage resident participation and also to fulfil one of the main aims of the project, that of involving the community throughout the life of the project, a team of community interviewers from the surrounding Craigavon area were recruited and trained to complete the household interviews.

Recruitment and Training: A normal recruitment process was initiated. A community interviewer job description was drawn up, essential and desirable criteria were established, and an advert placed in the local papers and in community/ voluntary group newsletters to recruit a team of community interviewers. In total, 13 individuals were short-listed and invited to attend a 3-day training programme on conducting survey interviews. Two separate training programmes took place, with 7 individuals attending the first programme and 6 individuals attending the second.

The training included both information giving and practical role-play sessions. Individuals were given background information on conducting community surveys, the aims of the Bridge project, and the principles and techniques of interviewing. Issues covered during the information giving sessions included:

- Maximising resident participation
- How to ask questions and appropriate ways of prompting responses
- Accuracy of coding responses
- Confidentiality

- Personal safety.

During the practical role-play sessions each individual had an opportunity to work through each section of the questionnaire as the interviewer and receive feedback from a trained researcher. At the end of the training programme individuals were required to conduct a mock interview where a trained researcher acted the part of a respondent and another researcher observed. The individual was rated on a number of areas, such as their introduction, accuracy of reading questions, following through filtering patterns, the overall pace of the interview, use of prompts and accuracy of coding.

☞ **The practical sessions were arranged as 'triads' where one individual acted as the interviewer, one role-played the respondent and one individual observed**

In total, eleven individuals successfully completed the 3-day training programme and the mock interview. However, after a period of a few weeks four interviewers dropped out (due to personal and /or work reasons) leaving a core team of seven community interviewers.

Interviewers attended a briefing session where they were presented with a certificate of achievement and their interviewer pack. The interviewer pack contained:

- Personal identity card
- Questionnaires
- KISH grids
- Contact addresses of local health organisations
- A list of household addresses
- Calling cards
- A map of the area
- Day-time and emergency contact numbers.

RESIDENT INTERVIEWS

In total, 842 households from across the three areas were randomly selected to be involved in the Bridge project. From these households, 540 individuals agreed to take part in an interview. This represents an overall response rate of 64%.

WRITTEN REPORTS

A separate community report has been written for each area included in the Bridge project. These reports include background information on the community and detailed findings from the survey. The community reports will be of most interest to local groups and organisations providing services within each local area. Copies of the reports can be obtained from community representatives (Appendix 1). This overall report serves to bring together key findings and discussion points from across the three areas.

RESPONSE RATE

A total of 842 houses were randomly selected from the three communities to be involved in the Bridge project. To maximise participation, up to four calls were made to each household in order to secure an interview. Household calls were made on:

- Different days of the week
- Different times of the day
- Included at least one evening/ weekend call.

From the selected households, 540 individuals agreed to take part in a face-to-face interview. This represents an overall response rate of 64%. Response rate was lowest in the rural area (Aghagallon) with 58% of individuals approached participating in the study, compared to 65% in each of the other areas.

Of those interviews obtained, the majority (64%, N=345) were from the Corcrain area. 24% (N=131) of interviews were obtained from individuals residing in North Lurgan and 12% (N=64) from Aghagallon.

The majority of interviews (41%, N=219) were secured on the first call (Table 2). However, a significant percentage were secured on the final call (17%, N=93) demonstrating the benefits of making at least 4 return calls to each household in order to maximise participation.

Table 2: Interviews Secured	
1st call	41% (N=219)
2nd call	27% (N=145)
3rd call	15% (N=83)
4th call	17% (N=93)

Overall, 12% (N=101) of individuals were out at the time the four calls were made. 6% (N=48) of selected houses were empty (either for sale or boarded up) and 1% (N=8) of households could not be located.

NON-PARTICIPATION

Around one in six individuals (17%, N=145) declined to participate in an interview (79 females; 66 males). The main reason given for non-participation was *'not being interested'* in the survey, mentioned by one third (N=48) of individuals. 17% (N=24) stated they did not have time to take part in an interview and 16% (N=23) were unwell at the time the interviewer called. Other reasons, given by individuals who did not participate in the study, included not having any views on health needs, regarding surveys as a waste of time and moving house.

THE SAMPLE

In total, 540 individuals from the three communities agreed to take part in an interview. All interviews were held in the resident's own home and lasted on average 43 minutes. The shortest interview took 20 minutes; the longest lasted 120 minutes.

Age and Gender: 59% (N=319) of individuals interviewed were female and 41% (N=221) were male. Ages ranged from 18 to 93 years, with an average age of 45 years. There was no significant age difference between males and females.

There was good male/female representation across each of the age groups (Fig 2). Almost half of all individuals interviewed (46%, N=249) were aged 39 years or under. Of those aged 60 years and over (N=140) the majority (64%, N=90) were female.

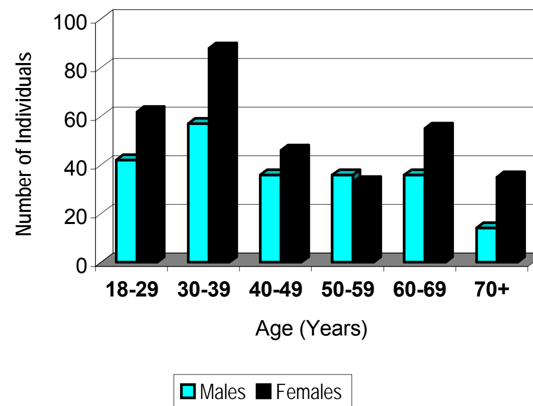


Figure 2 : Age and Gender Breakdown of Sample

Marital Status: 39% (N=211) of individuals interviewed were married and 30% (N=160) were single - never married. 14% (N=75) were widowed and 13% (N=72) were separated/ divorced. 4% (N=22) of individuals interviewed were living with their partner.

Religion: Three-quarters of individuals (N=404) identified their religion as 'Roman Catholic'. 23% (N=125) were 'Protestant' and 1% (N=5) stated 'neither or 'none' with regards to their religious identity. Only 1% (N=6) of individuals were unwilling to answer this question. This is a much lower non-response rate than findings from the Northern Ireland Census (1991), where 7.3% of the population did not answer the voluntary question on religious identity.

Comparison with Census: A breakdown of individuals residing in the Craigavon District at the time of the Census (1991) indicates a similar percentage of individuals aged 39 years and under (45%) as were interviewed as part of the Bridge project (46%). However, a greater percentage of individuals participated in Bridge from the 60-69 age bracket (17%) than is represented in the Census (12%, Table 3). This picture is reversed for the 70+ age group which made up a smaller percentage of the Bridge sample (9%) compared to the Census data for the Craigavon area (12%).

Table 3: Age comparison between Bridge Sample and Craigavon District Population

Age	Bridge Sample	Craigavon District	Difference
18-29	19%	25%	↓
30-39	27%	20%	↑
40-49	15%	18%	↓
50-59	13%	14%	–
60-69	17%	12%	↑
70+	9%	12%	↓

DISCUSSION POINTS

Response Rate: 64% of all residents approached to participate in the study agreed take part in an interview. This response rate is in line with other community health studies. For example, a previous study carried out by

the Southern Health and Social Services Board (1992) reported a response rate of 67% and a community needs survey in Belfast (Murphy, 1995) secured a 65% response rate.

Aghagallon had a lower response rate than the other two areas. This could have been the result of several factors; there was a greater percentage of households where no-one was at home at the times the interviewer called; more people were in employment and therefore difficult to contact and arrange an interview time; a community survey had been carried out in the area a few weeks prior to the Bridge survey taking place; this was the last of the three areas to be surveyed which coincided with the holiday period. (June/July) Each of these factors may have impacted on the response rate within Aghagallon.

Representative Sample: It was important that those individuals who took part in the Bridge study could be regarded as being representative of three communities as a whole. Therefore, a random selection procedure was used:

- Firstly, to select the households to be involved in the study
- Secondly, to select the individual to be interviewed within each household.

Using a random selection procedure (such as the KISH grid) to identify potential interviewees is a more time-consuming, costly exercise compared to other non-random selection methods, for example interviewing the first person who answers the door. Often repeated visits had to be made to the home in order to make contact with the selected person and to arrange a suitable interview time. In fact, 17% of interviews were secured on the fourth call to the home. Using the KISH grid to select an individual to be interviewed also caused some frustration amongst the community interviewers. The interviewers frequently recounted experiences of being met with a refusal from the selected individual whereas another member of the household was eager to participate. On such occasions an interview could not take place as the KISH selection method only permits the identified individual to be interviewed.

Although a more time-consuming and potentially frustrating exercise, using a random selection procedure has the distinct advantage of ensuring representation from across the whole community. Studies that do not randomly select the participants often result in an imbalance of male and female participants. For example, the community needs survey in Belfast (Murphy, 1995) reported a sample comprising 81.5% female and in another community study women outnumbered men by 2:1(Tulle-Winton, 1994). In contrast, the Bridge sample had a more equal balance of male (41%) and female (59%) respondents from across a wide range of ages. Using a random selection procedure allows for general conclusions to be drawn regarding the health and social care needs of the three communities.

AREA AND HEALTH

Individuals were asked some questions about the area in which they lived. This topic was included in order to find out some background information, such as, how individuals had first come to live in the area and the length of time they had lived in the area. It was also of interest to find out how residents viewed their community and what they considered to be the main social and/or economic problems facing their community. This is important as social and economic problems in an area, for example, lack of community facilities, unemployment and high rates of crime, can impact on an individual's physical and mental well-being.

Resident Stability: There was a high level of resident stability within the three communities with 55% (N=295) of individuals having lived in the Craigavon area for twenty or more years. Only 6% (N=34) of individuals had moved to the area within the past 12 months. The two main reasons for having come to live in the Craigavon area were:

- **i.** Being born there (30%)
- **ii.** Allocated a house in the area (27%).

Opinion of the area: Over half of individuals interviewed (52%, N=282) held a positive view of their community, believing it to be a *'good area, a good place to live'*. 35% (N=189) regarded their community as '*good a place as any other'* and 10% (N=53) felt their area was not a good one and they would '*like to be out of there'*. Individuals residing in Aghagallon were significantly more likely to rate their area positively in comparison to the other two communities [X^2=37.553, df=4, p<0.000][1].

Other residents in the area were regarded as being friendly (93%, N=504) and willing to help each other (85%, N=459). This was consistent across the three communities.

Overall, the areas were characterised as being safe places in which to live (83%, N=450), as having potential (81%, N=437) and areas with a good community spirit (80%, N=333).

The majority of individuals from across the three communities (86%, N=464) stated there were inadequate facilities in their area for teenagers.

Two thirds of individuals (N=359) stated that lack of jobs was a problem within their area. Fewer residents in Aghagallon rated lack of jobs as a problem (44%, N=28) compared to North Lurgan, where 76% (N=100) regarded unemployment as a problem [X^2=12.136, df=2, p<0.002].

59% (N=320) of residents perceived alcohol abuse as a rising problem. This was most pronounced in the Corcrain area with 62% (N=215) of individuals interviewed regarding it as a problem.

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[1] This is a statistical test used to determine if the relationship between two variables (for example location and how you view your community) may have occurred by chance. If the p value is less than .005, then we can accept that the difference did not occur by chance.

Overall, 37% (N=199) of individuals stated that drug abuse was a problem in their area. However, this was not held evenly across the three communities. Whereas only 5% (N=3) of individuals in Aghagallon regarded drug abuse as a problem, over half (51%, N=175) of residents in Corcrain rated it as a problem. A significant percentage of individuals from across the three areas (27%, N=146) stated they did not know if drug abuse was a problem within their local area.

Social Problems: Individuals were asked to rate whether they considered a range of social problems to be '*a serious problem in their area'*, a '*problem but not serious'* or *'not at all a problem*' in their community.

Within Corcrain, almost half of individuals interviewed (47%, N=163) believed the threat of sectarian violence to be a serious problem within their community. Sectarian violence was not considered to be a serious problem in either of the other two areas.

Litter and rubbish in the street was regarded as a serious problem in both North Lurgan (36%, N=47) and Corcrain (36%, N=123).

One third (N=110) of residents in Corcrain rated vandalism / hooliganism as a serious problem. This was not regarded as a serious problem in the other two areas.

Joy riding, theft/burglary and gangs of youth were generally not regarded as problems across three areas.

DISCUSSION POINTS

Image of Area: The three communities within Craigavon have received an increasing amount of negative publicity, fuelled by the political situation and the events surrounding 'Drumcree'. As a result, the areas have become somewhat stereotyped as 'trouble spots', characterised by bomb scares, on-going feuds and protests. This is the over arching image perpetrated by the media and absorbed by individuals outside the community. Counter to this, residents purported a positive image of their community highlighting strong feelings of attachment and commitment to the area, with the majority of individuals remaining there for over twenty years. This may be due to the desire and active choice on the part of individuals to remain in the area, or alternatively, that residents have limited opportunities to move away. However, the positive views expressed by individuals, particularly in relation to other residents and the perceived potential of their area would tend to suggest that individuals place a high value on their community and actively choose to be part of it.

Although the communities were regarded positively, residents were not blind to the problems within them. Some of these problems were particular to each area. For example, the threat of sectarian violence was of most concern to residents within Corcrain. However, there were some issues common to

each, namely the lack of teenage facilities and the rise of alcohol abuse with the area.

Lack of teenage facilities: Residents stated that there were inadequate facilities in their community for teenagers. Although each area had a community centre which offered facilities and programmes for the youth, residents felt that the 14+ age group in particular were ill-served. However, when asked to specify what facilities or services were required, residents were vague in their solutions stating '*just something to keep them off the street*', or a '*drop-in or something'*. This demonstrates the need to involve young people, both those who currently engage in available services and the 'non-engagers', in developing and providing services to meet their needs.

Alcohol Abuse: Residents believed there to be a rising problem of alcohol abuse within their community, with some residents specifically referring to the increase in numbers of young people drinking on the street. This may be linked to the previously mentioned problem of lack of facilities for young people in the area.

Across Northern Ireland it is acknowledged that the incidence of alcohol misuse is high and continues to increase, particularly amongst young people. As such, the government's 'Strategy for Reducing Alcohol Related Harm' (2000) has highlighted teenagers and young people as a target group. The strategy aims to develop a '*realistic and non-judgemental programme of Health Education, targeted at individuals aged between 16-25 years*.' The strategy also highlights the need to develop an information and research programme which will provide detailed and up-to-date knowledge of local drinking patterns and behaviours. It is imperative that such information is made accessible to the local community and that the community is involved in addressing the problem in locally appropriate ways.

LOCAL SERVICES / FACILITIES

Individuals were asked to rate on a 4-point scale, ranging from '*very easy*' to '*very difficult*' the accessibility of a range of services/facilities. Overall, residents in Aghagallon reported greater levels of difficulty in accessing community and health services/facilities in comparison to the other two areas.

The majority of residents reported easy access to general community facilities such as the post office (91%, N=493); bus stop (88%, N=475); community centre (83%, N=446); supermarket (80%, N=434).

58% (N=315) reported difficulties in accessing hospital casualty. This was a particular problem in the Aghagallon area with 80% (N=51) of residents stating they found it difficult to get to hospital casualty.

Overall, almost half of individuals interviewed (48%, N=257) experienced difficulties in accessing their doctor's surgery. This ranged from 39% (N=51) in North Lurgan to over two thirds (67%, 43) in Aghagallon.

Access to a chemist was difficult for 61% (N=39) of residents in Aghagallon and one third of residents (N=41) in North Lurgan. The majority of residents in Corcrain (91%, N=314) reported easy access to a chemist.

Community Health Services: Individuals were asked to rate how helpful they felt a range of community health services would be in their local area. Individuals were not asked to state if they personally would use the services. The majority of individuals stated that a drop-in centre (82%, N=441), individual counselling service (76%, N=409) and a peer support group (72%, N=390) would be of benefit to their local community. 69% (N=372) felt a telephone help-line would be useful in their area and 65% (N=351) stated that a befriending service would be beneficial. Overall, residents in Aghagallon rated each of the services to be of less benefit to the community than residents from the other areas.

Most Needed Services: Individuals were asked what they considered to be the 3 most needed services within their community. Overall, 91% (N=490) of individuals mentioned at least one needed service/facility. The most frequently mentioned services included:

- Facilities for Youth (27%, N=130)
- Children's Play Area (26%, N=127)
- Health Centre (24%, N=120).

Transport: Just over half of individuals interviewed (52%, N=283) had access to their own transport. Individuals residing in Aghagallon were significantly more likely to have their own transport (83%, N=53) in comparison to the other two areas [X^2=41.680, df=2, p<0.00]. Corcrain had the lowest level of personal transport (43%, N=148).

Overall, there was poor usage of public transport with 63% (N=342) of individuals stating they 'rarely' or 'never' used public transport. This ranged from 60% of residents in Corcrain (N=207) and North Lurgan (N=79)

to 88% (N=56) of individuals in Aghagallon rarely or never using public transport. As would be expected, car owners used public transport less than individuals who did not have access to their own transport [X^2=132.613, df=5, $p<0.000$]. However, even amongst non-car owners, there was fairly low usage of public transport with 39% (N=100) 'rarely' or 'never' using it. The main reason given for not using public transport was that individuals preferred to use their own personal transport (65%, N=221). Other reasons included:

- Stops not convenient (10%)
- Routes don't meet my needs (9%)
- Service at inconvenient times (9%).

DISCUSSION POINTS

Transport: Individuals residing in Aghagallon were more likely to have access to their own transport compared to the other areas. However, within Aghagallon approximately one in six individuals did not have personal transportation and less than 10% used public transport on a weekly basis. The existing system of public transport was regarded as 'inadequate' and improvements in the current system was mentioned as one of the most needed service/facility within the Aghagallon area. Transportation is a recurring and over-riding issue for rural areas and as stated by Sherlock (1994) '*it is impossible to over-estimate the impact that inadequate public transport has on rural inhabitants'*. One impact of poor transport systems can be the accessibility of services. Within Aghagallon, residents reported greater levels of difficulty in accessing community and health services compared to the other two areas.

Accessibility of Services: A range of innovative approaches aimed at improving the accessibility of services within rural areas has been implemented across the UK. These include operating community transport schemes, accessing volunteer drivers and paying service users with cars to provide transport for others (Sherlock, 1994). Other options involve taking services to people by introducing mobile units and satellite services (Sherlock, 1994).

Another way of placing health services in the heart of communities is through the idea of community pharmacies. The report 'Building the Community - Pharmacy Partnership' (1999) explores the idea of pharmacies making links with their community as a way of providing '*real, significant and ultimately cost-effective long-term health benefits' (*C.P.A.C, 1999). Given that pharmacies are based locally and have a health professional on site, the aim is that community pharmacies will become places where people will increasingly go to receive information and healthcare advise. As residents within each of the areas, particularly in Aghagallon, found it difficult to access their G.P and hospital casualty the idea of community pharmacies merits further exploration.

HOUSING AND HEALTH

Much research has focused on the relationship between housing and health. A general conclusion to be drawn from the research is that housing quality *per se* has a significant impact on an individual's health. Poor housing has been shown to contribute towards poor physical health, including respiratory illnesses and influenza and also poor mental health, such as, increased stress, anxiety and depression (Ambrose, 1996).

Therefore, it was considered important to include a section on housing and housing complaints within the Bridge survey. Individuals were asked about their current housing situation, the number of household occupants, household overcrowding, housing complaints and the impact of such housing conditions on their physical and mental health.

Housing Type: 61% (N=330) of individuals interviewed lived in terrace housing. However, this was not evenly spread across the three areas. Corcrain had a significantly higher level of terrace housing (70%, N=243) in comparison to the other two areas [X^2=196.863, df=8, p<0.000]. In contrast, terrace housing in Aghagallon made up only 23% (N=15) of the overall housing, with the majority of homes being detached (48%, N=31).

Housing Tenure: Overall, just over half of homes (51%, N=278) were being bought with a mortgage. This ranged from a low of 41% (N=140) in Corcrain to a high of 78% (N=50) in Aghagallon. 39% (N=210) of homes were rented from the Housing Executive, three quarters of which (N=158) were situated within the Corcrain area.

Household Occupancy: Table 4 provides a breakdown of household occupancy levels. In total, there were 1562 individuals residing in 540 households giving an average of 2.9 individuals per household. 36% (N=195) of households included children aged 12 years and under. Of these, 43% (N=84) were one parent families (parent either single, separated/ divorced or widowed).

Table 4: Household Occupancy

No of occupants	% of households	
1	26%	(N=139)
2	22%	(N=118)
3	19%	(N=101)
4	16%	(N=86)
5	10%	(N=52)
6	5%	(N=28)
7	2%	(N=10)
8	.5%	(N=3)
9	.5%	(N=2)

1 individual refused to answer the question

Household Overcrowding: 77% (N=415) of homes had a least 3 bedrooms. The majority of individuals (78%, N=421) stated their home was 'just right' for the number of people living there. This was fairly consistent across the three areas, ranging from 73% in North Lurgan to 81% in Aghagallon.

Housing Complaints: Individuals were asked to rate on a 4-point scale (ranging from '*very serious problem*' to '*not at all a problem*') the extent to which they experienced certain

problems with their property. Overall, 34% (N=185) of individuals mentioned one or more household complaints. Of these, three-quarters (N=139) were made by individuals residing in the Corcrain area. The most common household complaints mentioned were with regard to:

☞ In total, 185 individuals mentioned 335 household complaints

- Outside noise (N=80)
- Draughty windows/doors (N=64)
- Damp/condensation (N=33).

The majority of individuals who mentioned household complaints (63%, N=116) felt the housing condition/s had an effect on their physical and/or mental health. Comments included:

'Outside noise levels get on my nerves'
'Fumes from fire affects my breathing'
'Lack of space makes me feel depressed'
'Noise from helicopters cause sleeplessness, worry, and stress'.

DISCUSSION POINTS

Home Ownership: Aghagallon (78%) and North Lurgan (67%) had a higher level of home ownership than the average level within Northern Ireland (63%, The House Condition Survey, 1996). Home ownership within Corcrain (41%) was much lower than the Northern Ireland figure.

Housing Complaints: The House Condition Survey (1996) reported 73% of homes within Northern Ireland had faults with some aspect of their interior or exterior fabric. Findings from the Bridge project indicated a lower level of housing complaints in comparison to these Northern Ireland figures, with just over one third of individuals interviewed mentioning a problem with their property, most of which were considered to be 'quite serious' as opposed to 'very serious'. The majority of housing complaints were mentioned by residents from the Corcrain area. 40% (N=139) of homes from this area highlighted some problem with their property. However, at the time the interviews were carried out the Housing Executive were carrying gout renovations and repairs. The lower level of housing complaints with North Lurgan and Aghagallon is a positive finding reflecting the development of new housing in the areas and Housing Executive homes having undergone recent renovations.

Housing and Health: The relationship between housing and health has recently been formally documented by the Housing Executive in the recent publication 'Housing and Health: Towards a Shared Agenda' (2000). The publication outlines the Executive's commitment to engage and work with the H&PSS, community and voluntary groups with the overall objective of improving the health and well-being of the whole community. A series of 37 recommendations have been made aimed at reducing health inequality through housing inputs, several of which are specifically targeted towards reducing social exclusion.

EMPLOYMENT AND HEALTH

The availability of 'official' data on employment status at a community level is difficult to access, often dated, and can be open to a range of interpretations. In order to obtain an up-to-date assessment of employment activity within the three areas, individuals were asked about their current employment situation. In addition, the relationship between job insecurity, job dissatisfaction, unemployment and ill-health has been well-documented. Therefore, individuals were also asked about the impact of their current employment situation on their physical and mental well-being.

Economically Active: The Census definition (1991) of economically active persons includes those in full-time, part-time, casual employment and individuals on government training schemes. Using this criteria, 40% (N=217) of all individuals interviewed were in employment, 113 males and 104 females (Table 5). Of these, three-quarters (N=162) were in full-time work. 19% (N=42) occupied part-time positions, 5% (N=10) were self-employed and three individuals were on a government employment/training scheme.

Table 5 : Employment Situation

Employed (full, part, self-employed, training)	40%	(N=217)
Retired	24%	(N=130)
Looking after Home/Family	15%	(N=80)
Unable to work because of long-term illness	13%	(N=69)
Registered unemployed	7%	(N=38)
Other (education, unpaid)	1%	(N=6)

The percentage of employed individuals across the three areas ranged from a low of 37% (N=128) in Corcrain to a high of 53% (N=34) in Aghagallon.

The main occupations included factory work, professional occupations, working a trade, manual and clerical work. Two thirds (N=144) of jobs were based in the local area or nearest local town. 16% (N=34) were located outside the Craigavon Borough.

46% (N=98) of individuals had been in their current job for 6 or more years. The majority of individuals (87%, N=187) stated they were satisfied in their current job. Of those who were dissatisfied (N=27), almost all (N=22) felt it had an adverse effect on their physical and/or mental health. Comments included: Low wages and poor job prospects being 'depressing', poor diet due to working patterns and being stigmatised in the work place causing 'pressure'.

The majority of employed individuals (83%, N=177) believed their job to be secure. 13% (N=27) stated their job was insecure. This was observed across a range of occupations. Half the individuals (N=14) believed job insecurity had an adverse effect on their health with

comments including *'worry about the mortgage'*, '*stress*', and '*constant strain'.*

Economically Inactive: Using the same classification system as the NI Census, 59% (N=321) of individuals interviewed as part of Bridge were economically inactive[2]. This is higher than the Craigavon Census figure (1991) of 39.3%.

Of those individuals who were not working because of a long-term illness, looking after the home/family or were registered unemployed, (N=187), over one third (36%, N=67) had been out of work for 11+ years. 6% (N=11) of individuals had never been in a paid job. The main reasons given by individuals for having left their pervious job included:

- Looking after the home (40%, N=70)
- Personal Health (30%, N=52)
- Dismissed/Redundant (13%, N=22).

Individuals were asked if they would like to be in a paid job at present. 55% (N=103) stated they would like to be in paid employment (42 males, 61 females). For individuals who wanted to be in paid employment, factors which they felt would greatly improve their job prospects included:

More jobs in the area	(71%, N=73)
Jobs with flexible hours	(57%, N=59)
Working from home	(47%, N=48)
More qualifications	(47%, N=48)
More training	(45%, N=46).

Voluntary Activity: 8.5% (N=46) of individuals interviewed were involved in voluntary activity. This ranged from 5% (N=3) in Aghagallon to 9% (N=32) in Corcrain.

Of those individuals who were involved in voluntary activity, 63% (N=29) were female and 37% (N=17) were male. Almost all the voluntary work was connected to a formal organisation (N=43), with the majority of individuals (N=22) spending between 1-5 hours per week on their voluntary activity.

DISCUSSION POINTS

Economic Activity: Levels of economic activity were lower amongst both males and females in the Bridge sample in comparison to the whole Craigavon area (Census, 1991). Within the Craigavon area 74.7% of males and 47.9% of females were classified as economically active. This is in contrast to 51% (N=113) economically active males and 33% (N=104) economically active females who participated in the Bridge survey.

Within North Lurgan and Corcrain, less than half of individuals were in employment and over two thirds of individuals rated lack of jobs as a problem within their local area. However, of those who were currently not working (excluding the retired population), 41% stated they did not want to be in a paid job at present.

[2] Based on the Census definition, economically inactive includes individuals looking after the home, long-term sick/disabled, retired, students, unpaid work, those of independent means.

Although residents felt more jobs were needed in their area, of the current pool of individuals available for work, just over half indicated an interest in being in a paid job. This has obvious consequences for investors and employers providing and developing employment opportunities within the area.

It is generally accepted that as part of any successful regeneration programme, employment plays a central role. As stated within the literature '*sustainable regeneration is unlikely unless it creates employment opportunities and community-controlled assets, which can generate income in the long-term*' (Taylor, 1995). However, in addition to providing employment opportunities, it is essential that there is a willing and motivated workforce available to take up the opportunities provided.

The motivation for people to take up employment is a complex issue which involves weighing up several factors. For example, the benefits of getting a job (if the wage is higher than benefit) may be outweighed by the cost of childcare, transport, and also the difficulty of getting back into the benefits system if the job does not work out. Since many jobs on offer are short-term or casual, it is perhaps not surprising if people opt for a lower but dependable income (Taylor, 1995). To make the transition into employment, individuals highlighted the need for training, qualifications and greater flexibility in working patterns.

Voluntary Activity: In a study by Williamson et al.(1995) on volunteering with Northern Ireland, it was estimated that some 200,000 individuals were involved in formal voluntary activity and 600,000 involved in informal voluntary activity. Based on population estimates (NISRA, 1999), this would suggest that within Northern Ireland 15.9% of individuals are involved in formal voluntary activity. Even in comparison to this figure (setting aside the 600,000 who are estimated to be involved in informal voluntary activity), voluntary activity with the three communities is much lower (8.5%).

The Northern Ireland Active Community Initiative, established in July 1999 has the task of '*achieving a more active community by increasing public involvement in community life through volunteering time, other forms of community activity and donating money.*' Promoting volunteering within the three areas will involve several strands, such as actively encouraging involvement in existing and new community initiatives, creating appropriate openings for people to volunteer and sustaining momentum to establish a culture of giving to the community. If such initiatives were effective this would bring benefits both to the volunteer and their local community.

SELF-REPORTED HEALTH

Asking individuals to provide an overall rating of their personal health is commonly included in population and community based health surveys. The question has the advantages of capturing multiple dimensions of health, being easily answered and is a reliable predictor of future morbidity and mortality (Grau et al., 1998). Therefore, individuals were asked to rate their health on a 4-point scale ranging form '*excellent*' to '*very poor*'.

- Over three quarters (77%, N=417) of individuals rated their health positively with 18% (N=98) rating it as 'excellent' and 59% (N=319) as 'fairly good.
- 17% (N=93) of individuals stated they had 'fairly poor' health and 6% (N=30) rated their health as 'very poor'.
- Individuals residing in Aghagallon had the highest level of self-reported health with 92% (N=59) rating their health positively.
- There was no significant difference between males and females in how they rated their health.

Factors Important to Good Health. A range of factors are often associated with having good overall health, such as adequate housing, financial security, daily exercise and access to medical services. Individuals were asked to rate on a 4-point scale how important they considered a range of factors to be in ensuring good health. Living in decent housing and feeling good about yourself were rated by most individuals as being 'very important' (Table 6). Two thirds of individuals (N=358) stated getting enough exercise was very important and 61% (N=330) felt having a healthy diet was very important. Less than half of individuals (43%, N=230) believed being in a paid job was very important to having good overall health.

Females were significantly more likely to rate having support from family and friends as 'very important' (77%) to good health compared to males (66%) ($U=30761.00$, $p<0.000$). Males were more likely to rate being in a job as very important (55%) in comparison to females (35%) ($U=26144.500$, $p<0.000$).

Illness /Disability: Overall, 29% (N=156) of individuals stated they had an illness/disability which affected their day to day living (63 males, 93 females). Aghagallon had the lowest level of reported illness (17%, N=11). This increased to 27% (N=35) within North Lurgan and almost one third of individuals (32%, N=110) in Corcrain reported having an illness/disability. The most common type of illness included arthritis, angina, heart conditions and depression. 28% (N=44) of individuals with an illness/ disability stated they did not receive any

Table 6: Factors Important to Good Overall Health

Factor	%	N
Living in decent housing	79%	(N=428)
Feeling good about yourself	78%	(N=423)
Having adequate income	73%	(N=392)
Access to good health services	72%	(N=389)
Support from family/friends	72%	(N=389)

form of support. 57% (N=89) received support from family members and almost one quarter (24%, N=37) from social services. Only 2% (N=3) of individuals stated they received support from a voluntary organisation.

Levels of Emotional Stress: To obtain an indication of 'emotional stress' levels within the community, individuals were asked to rate how much they had experienced any of the following in the two weeks prior to interview:

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

Three quarters (N=406) of individuals had experienced at least one of the above at least sometimes during the pervious two weeks.

14% (N=75) stated they had experienced none of the above feeling/emotions in the previous two week period (36 males, 39 females).

16% (N=53) of females interviewed had experienced all the emotions/feelings, the majority of whom (N=32) were aged between 18-39 years. 10% (N=21) of all males interviewed had experienced all the emotions/feelings, half of whom were aged under 39 years.

- **Feeling worn out/exhausted**: 61% (N=327) of individuals stated they felt worn out in previous two weeks. For almost one quarter (22%, N=118) this was experienced 'very often'.
- **Sleeplessness**: Almost half (49%, N=267) of individuals interviewed had experienced periods of sleeplessness, 26% (N=142) 'very often' and 23% (N=125) 'sometimes'.
- **Worried/Anxious**: 48% (N=258) had periods of worry and anxiety within the past two weeks, 19% (N=104) 'very often' and 29% (N=154) 'sometimes'.
- **Down/Depressed:** 43% (N=232) of individuals felt down or depressed. For the majority (29%, N=157) these feelings were experienced 'sometimes'.
- **Lonely/Isolation:** Just under one quarter of individuals (24%, N=129) stated they felt lonely/isolated, with most (18%, N=99) experiencing loneliness 'sometimes'.

With the exception of feelings of loneliness/ isolation, females were significantly more likely to experience each of the above feelings/ emotions 'very often' in comparison to males (see Appendix 2a).

There was no significant difference in levels of 'emotional stress' reported between residents in North Lurgan and Corcrain. However, levels of emotional stress within Aghagallon were lower compared to the other two areas. Significantly fewer residents from Aghagallon reported experiencing each of the above feelings/emotions 'very often' in comparison to residents from North Lurgan and Corcrain (Appendix 2b).

The three most common reasons given for experiencing 'emotional stress' were:

- Personal health reasons (37%)
- General family concerns (33%)
- Financial Worries (21%).

Prescribed Medication: Individuals were asked if they had been prescribed various types of medication within the past 12 months.

- Overall, 51% (N=273) of individuals had been prescribed **painkillers** from their G.P in the past year. Females were significantly more likely to have been prescribed painkillers in comparison to males (X^2=9.205, df=1, p<0.002). In addition, individuals who had been prescribed painkillers had a higher average age (48 years) compared to those who had not (42 years) [F=0.827, df=520, p<0.000].

- 21% (N=109) of residents had been prescribed **anti-depressants**, more females than males. Over one quarter (26%) of all females interviewed had been prescribed anti-depressants in the past year in comparison to 13% of males.

- 19% (N=99) of individuals had been prescribed **sleeping pills**. Individuals who had been prescribed the medication were significantly older (average age 54 years) compared to those who had not (average age 43 years) [F=0.155, df520, p<0.000].

- One in ten individuals had been prescribed tranquillisers within the past year.

- There was no significant difference in prescription rates between the three areas, although Aghagallon had slightly lower levels compared to the other two areas (Appendix 2c).

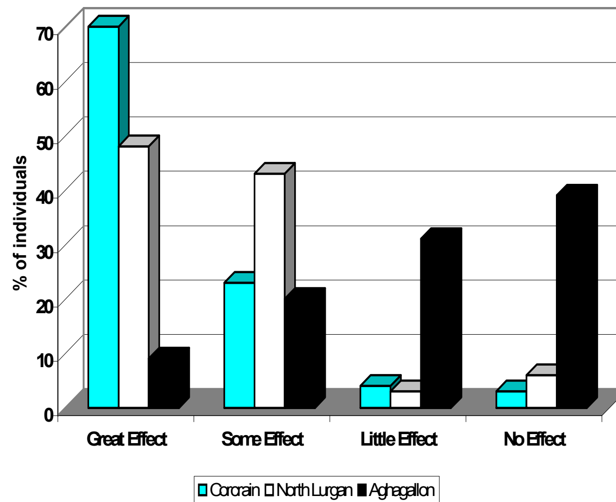
Impact of the Troubles: The Regional Strategy for Health and Social Well-Being 1997-2002 acknowledges that *'individuals have been bereaved or seriously affected both physically and psychologically by the civil unrest in Northern Ireland'.* To determine the impact of 'the troubles' on the residents of the three communities, individuals were asked to rate the effect the troubles had on the health of their community and their own personal health.

Impact on the Community. Overall, 58% (N=305) of individuals stated the troubles had a 'great effect' on the health of their community. However this varied greatly between the areas (Figure 3). The main difference was between Aghagallon and Corcrain. Whereas 70% (N=239) of individuals residing in Corcrain believed the troubles had a 'great effect' on community health only 9% (N=6) of individuals in Aghagallon stated the troubles had a 'great effect' on their community. The majority of individuals in Aghagallon 39% (N=25) stated the troubles had 'no effect' on their community.

Comments from individuals regarding the impact of the troubles on community health focused on a number of areas:

Mental Well-being: By far, the majority of comments on the impact of the troubles on the health of the community were related to its effect on individuals'' mental health. Individuals mentioned heightened levels of anxiety, general feelings of depression regarding the political situation, fear for personal safety, people living on their nerves and high stress levels within the community.

Figure 3: Perceived Impact of the Troubles on Community Health Within the Three Communities



- *Feelings of Isolation*: Individuals, particularly those within Corcrain, referred to the impact the troubles had on social activity, where residents felt 'hemmed in', and experienced social isolation.

- *Attitudes:* Comments focused on how the troubles had caused members of the community to hold negative attitudes towards individuals of the other religion and the erosion of trust between the two communities.

- *Physical Health*: Individuals commented on the increased levels of alcohol and drug abuse as a method of coping with the troubles., the loss of sleep due to political disturbances and physical injuries sustained as a result of the violence.

- *Community Life*: Individuals felt that their community had been thrust into the spotlight and was effected by the continued army and police presence. Some residents referred to the economic impact in terms of increase levels of unemployment and lack of investment.

Impact on Personal Health: Overall, the majority of individuals (46%, N=245) stated that the troubles had 'no effect' on their personal health. Only 13% (N=71) felt the troubles had a great effect on their own health, most of whom were from the Corcrain area (N=57). Comments from individuals who stated the troubles had impacted on their personal health included reference to:

- Heightened levels of anxiety and fear.
- Feelings of depression, sleeplessness and increased stress levels.
- Restricted social activities
- A 'personal story' of how the troubles had impacted their personal health.

Carers: Overall, 10% (N=53) of individuals were caring for a person/s on a regular basis (17 males, 36 females). This ranged from 7% (N=25) in Corcrain to 17% (N=22) in North Lurgan. Over half (57%, N=30) of carers lived in the same household as the person being cared for. The length of time carers had been caring for the individual/s ranged from less than one year (21%, N=11) to over ten years (28%, N=15). 30% (N=16) of carers spent 60+ hours per week carrying out their caring duties.

The majority of carers provided friendship (N=48), emotional / mental health support (N=37) and trips out (N=31) to the person being cared for. In addition, carers provided a range of household duties, such as shopping (N=45), cleaning the home (N=41), cooking (N=39), laundry (N=37), paperwork (N=34), lighting the fire (N=27) and gardening (N=25).

Overall, carers received little support in carrying out their caring tasks:

- Nine carers received information
- Nine carers received practical support
- Two individuals received a respite service
- No-one had used a sitting service
- No-one had attended a support group.

38% (N=20) of carers felt that caring placed additional stress on their relationships with family and friends. Just under half (47%, N=25) felt caring had an adverse effect on their physical and/or mental health where individuals felt '*stressed out*', '*tired*' and had '*no time for self*'.

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

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.

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

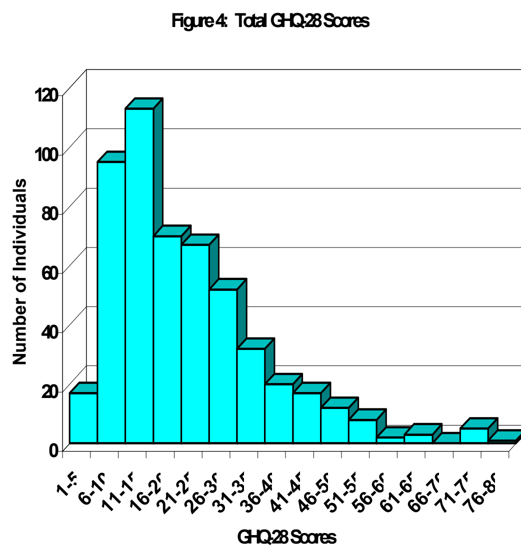
As each scoring method serves different purposes, both methods were used to score the Bridge questionnaires. Overall, 95%

(N=514) of individuals completed the GHQ-28 questionnaire.

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

- The average Bridge score was 21.07
- The lowest score was 1and the highest 78.

It can be seen from Figure 4, that a small percentage of individuals 3% (N=17) reported scores between 1-5. The number of individuals reporting GHQ scores between 6-25 increased, with a peak in scores between 11-15. As GHQ scores further increased, the number of individuals steadily decreased, with only a small percentage of individuals (4%, N=18) reporting scores of 60 and above.



Residents in Aghagallon reported significantly lower GHQ-28 scores (average score 14.63) compared to North Lurgan (average score 21.31) and Corcrain (average score 22.13) (X^2=20.251, df=2, p<0.000).

GHQ Scoring Method: When the GHQ scoring is used, the lowest possible score is 0 and the highest 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 'non-cases'.

When the cut-off point 4/5 (score of 4.5 and over) is used, almost one third (32%, N=164) of individuals could be considered 'cases'.

- Aghagallon had the lowest number of cases (17%, N=10).
- 33% (N=111) of 'cases' were reported in Corcrain.
- 36% (N=43) were reported within North Lurgan.

DISCUSSION POINTS

Self-Assessment of Health: The question 'would you say your health is excellent, good, fair or poor?' has been shown to be as powerful a predictor of mortality as more detailed health status indicators which focus on disease or functional disability (Grau et al., 1998). Obtaining a self-assessment of health

is a valuable tool for providing information about the general health of a community and the prevalence of illness within it.

The majority of individuals interviewed as part of Bridge assessed their health positively, with 77% reporting their health as 'excellent' or 'fairly good'. This is similar to findings from surveys carried out in other parts of the UK; both the Scottish Survey (1995) and the Health and Lifestyle Survey (199) reported that three quarters of individuals rated their health as excellent/very good or good.

Based on this self-rating of health, it could be concluded that, in general, residents within the three areas have good health. However, some degree of caution is required when interpreting these results as people's perception of their own health may be influenced by several factors. For example, some illness, particularly mental ill health may be under reported due to a reluctance to reveal this information. Also, some respondents may be unaware of their medical condition, for example post-natal depression, and therefore fail to rate their health status accurately. In addition, individuals may hold differing expectations as to what constitutes good health. For example, individuals who have a long-term illness may have a lower expectation of good health compared to someone who does not have a medical condition. Therefore, although providing useful information, this self-assessment of health needs to be examined in the light of other sources of information, such as, the rates of illness and disability within the community, levels of emotional stress and rates of prescribed medication.

Illness/Disability: Figures from the Census (1991) indicate that within Northern Ireland 11.8% of the population report having an illness/disability. Within the Craigavon area the figure stands at 12%. Findings from the Bridge survey found that within the three communities there is a much higher rate of illness/disability than both the NI and the Craigavon average. This is particularly pronounced in the Corcrain area of Portadown where levels of illness are over 2.5 times higher than the rest of NI.

Emotional Stress: One in six females and one in ten males experienced high levels of emotional stress. These individuals stated they experienced exhaustion, sleeplessness, anxiety, depression and loneliness in the two weeks prior to the interview. The majority of these individuals were aged between 18-39 years. Women referred to health problems and general family concerns as the main cause of their emotional stress, whereas males were more likely to cite employment issues and financial pressures.

Preventing elevated levels of emotional stress and promoting positive mental and emotional well-being forms the backbone of the document 'Minding our Health' (1999). In outlining a draft strategy for promoting emotional and mental well-being in Northern Ireland, the strategy highlights two main areas of intervention:

i). Life Circumstances **–** providing social and physical environments in society which support positive mental health and prevent poor mental health by assisting people in obtaining sufficient help and resources to support them through challenges or crises and more prolonged difficult periods.

ii). Life Skills –providing education and information to develop a better understanding of mental and emotional health to increase people's skills in managing life events with an emphasis on coping with stress and to help people lead more healthy lives through increasing their self-awareness.

Within the three communities involved in Bridge, such interventions need to focus particularly on young men and women. Females identified health and family as their main concerns, therefore, the issues to be addressed in any intervention programme may relate to health promoting behaviours, pregnancy, post-natal depression and parenting skills. For males, interventions need to focus on issues surrounding unemployment, improving job prospects and managing finances. Given the rise in suicide rates, particularly amongst young males, it is important that mental health promotion is specifically targeted at this group.

Medication: Levels of prescribed medication within the community gives cause for concern. One in every two individuals interviewed stated they had been prescribed painkillers from their doctor in the past 12 months and one in five individuals had been prescribed anti-depressants. It is difficult to find comparison figures regarding the use of medications, particularly painkillers as some studies include over the counter sales. However, as a general point, rates of prescribed medication across the three communities are disconcertingly high and merit further exploration. For example, it would be of interest to compare levels of prescribed medication in the three areas with other parts of Northern Ireland, to explore the reasons behind so many individuals taking painkillers and other forms of medication and to document the process of how such medications are prescribed.

Therefore, although individuals provided a positive self-assessment of their health, there were elevated levels of illness/disability within the three communities in comparison to the rest of Northern Ireland. There were also high levels of 'emotional stress', particularly amongst young men and women, and there was evidence of an over use of prescribed medication.

Impact of the Troubles: Individuals were asked about the impact of the troubles on the health of their community and their personal health. Overall, residents in Aghagallon did not believe the troubles had effected either their community or their personal health. Within North Lurgan and Corcrain, residents felt the troubles had a significant impact on their community, particularly in relation to mental well-being. Residents referred to people feeling 'stressed, on edge, anxious and

depressed'. However, when asked about the impact of the troubles on their personal health, the picture is reversed, with the majority believing the troubles to have had 'little or no impact' on themselves. Within these two areas the message appears to be one of 'the troubles effecting the community and the health of everyone in it, but not me'. Unless residents or family members were personally injured or involved in a political incident, most did not believe they suffered as a result of living in an area which has been effected by the troubles.

General Health Questionnaire: A study carried out by Cairns and Wilson (1984) obtained GHQ-scores from a community sample of 797 Northern Irish adults. Individuals lived in one of two towns that experienced contrasting levels of violence. They were labelled Hightown (high levels of violence) and Lowtown (low levels of violence).

The study found that 32% of individuals residing in an area depicted by high levels of violence (Hightown) could be considered 'potential cases of psychiatric disorder'. Within Lowtown (low violence experienced) the percentage of 'cases' was 21%.

North Lurgan and Corcrain had a higher percentage of 'cases' compared to those found by Cairns and Wilson in Hightown (32%) and Lowtown (21%). Aghagallon had a lower percentage of 'cases' than both Hightown and Lowtown.

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APPENDIX 1: Community Contacts

A separate community report has been written for each area included in the Bridge project. The Corcrain area has been broken down into two reports (Corcrain/Ballyoran and Corcrain/Redmanville) as specific needs and issues were raised within each area. Copies of the community reports can be obtained from community representatives detailed below:

North Lurgan - Sr Philomena Horner, Springwell Centre, Edward Street, Lurgan. Tel:

Corcrain/Ballyoran - Lynn Brandon, Drumcree Community Trust, 3 Ashgrove Road, Portadown. Tel:

Corcrain/Redmanville - Sharon Walls, Corcrain Community Centre, Corcrain Avenue, Portadown. Tel:

Aghagallon - Dolores Kelly, Meadows Day Centre, Bridge Street, Portadown. Tel:

Appendix 2a: Females were significantly more likely to experience feelings of emotional stress 'very often' (excluding feelings of loneliness/isolation) compared to males in the two weeks prior to being interviewed.

% of males and females experiencing emotional stress 'very often'

	Males	Females	Significance
▪ Sleeplessness	19% (N=42)	31% (N=100)	U=29417.500, **$p<0.001$**
▪ Feeling worried/anxious	16% (N=35)	22% (N=69)	U=30051.000, **$p<0.000$**
▪ Feeling lonely/isolated	3% (N=6)	7% (N=24)	No significant difference
▪ Feeling worn out/exhausted	12% (N=26)	29% (N=92)	U=27244.500, **$p<0.000$**
▪ Feeling down/depressed	9% (N=20)	17% (N=55)	U=30462.500, **$p<0.005$**

Appendix 2b: Residents from Aghagallon were significantly less likely to experience feelings of emotional stress 'very often' in comparison to residents from North Lurgan and Corcrain in the two weeks prior to interview.

% of individuals from the three areas experiencing emotional stress 'very often'

	North Lurgan	Corcrain	Aghagallon	Significance
▪ Sleeplessness	31% (N=40)	27% (N=94)	13% (N=8)	X^2=18.621, df=2, **$p<0.000$**
▪ Feeling worried/anxious	24% (N=31)	20% (N=69)	6% (N=4)	X^2=21.756, df=2, **$p<0.000$**
▪ Feeling lonely/isolated	6% (N=8)	6% (N=22)	-	X^2=12.885, df=2, **$p<0.002$**
▪ Feeling worn out/exhausted	25% (N=33)	23% (N=79)	9% (N=6)	X^2=24.508, df=2, **$p<0.000$**
▪ Feeling down/depressed	15% (N=19)	16% (N=54)	3% (N=2)	X^2=16.395, df=2, **$p<0.000$**

Appendix 2c: There was no significant difference in prescription rates between the three areas, although Aghagallon had slightly lower levels compared to North Lurgan and Corcrain.

% of individuals who had been prescribed various types of medication in the past year

	North Lurgan	Corcrain	Aghagallon
▪ Painkillers	52% (N=68)	52% (N=178)	44% (N=27)
▪ Anti-Depressants	21% (N=28)	22% (N=74)	12% (N=7)
▪ Sleeping Pills	17% (N=22)	21% (N=71)	10% (N=6)
▪ Tranquillisers	8% (N=11)	12% (N=42)	3% (N=2)