



# Mental health and associated health service use on the island of Ireland

D Tedstone Doherty and R Moran



# HRB Research Series 7

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# About the HRB

The Health Research Board (HRB) is the lead agency supporting and funding health research in Ireland. We also have a core role in maintaining health information systems and conducting research linked to national health priorities. Our aim is to improve people's health, build health research capacity, underpin developments in service delivery and make a significant contribution to Ireland's knowledge economy.

## Our information systems

The HRB is responsible for managing five national information systems. These systems ensure that valid and reliable data are available for analysis, dissemination and service planning. Data from these systems are used to inform policy and practice in the areas of alcohol and drug use, disability and mental health.

## Our research activity

The main subjects of HRB in-house research are alcohol and drug use, child health, disability and mental health. The research that we do provides evidence for changes in the approach to service delivery. It also identifies additional resources required to support people who need services for problem alcohol and drug use, mental health conditions and intellectual, physical and sensory disabilities.

The **Mental Health Research Unit** gathers data on patient admissions, treatment and discharges from psychiatric hospitals and units throughout Ireland. The data collected have been reported in the Activities of Irish Psychiatric Services since 1965 and continue to play a central role in the planning of service delivery. The unit is extending its service to include information about activity in community care settings in order to reflect the changing patterns of care for patients with a mental illness. Multi-disciplinary experts in the unit carry out national and international research and disseminate findings on mental health and mental illness in Ireland. These findings inform national policy, health service management, clinical practice and international academic research.

The **HRB Research Series** reports original research material on problem alcohol and drug use, child health, disability and mental health.

# HRB Research Series publications to date

Ward M, Tedstone Doherty D and Moran R (2007) *It's good to talk: distress disclosure and psychological wellbeing*. HRB Research Series 1. Dublin: Health Research Board.

Tedstone Doherty D, Moran R, Kartalova-O'Doherty Y and Walsh D (2007) *HRB national psychological wellbeing and distress survey: baseline results*. HRB Research Series 2. Dublin: Health Research Board.

Daly A, Tedstone Doherty D and Walsh D (2007) *Re-admissions to Irish psychiatric units and hospitals 2001–2005*. HRB Research Series 3. Dublin: Health Research Board.

Gallagher S, Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Internet use and seeking health information online in Ireland: demographic characteristics and mental health characteristics of users and non-users*. HRB Research Series 4. Dublin: Health Research Board

Tedstone Doherty D, Moran R and Kartalova-O'Doherty Y (2008) *Psychological distress, mental health problems and use of health services: assembling the pieces of support needs for mental health problems in Ireland*. HRB Research Series 5. Dublin: Health Research Board.

Connolly J, Foran S, Donovan A, Carew A and Long J (2008) *Crack cocaine in the Dublin region: an evidence base for a Dublin crack cocaine strategy*. HRB Research Series 6. Dublin: Health Research Board.

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# Executive Summary

There is a lack of population-based survey data to guide mental health policy and health service planning. The information from such surveys provides an evidence base for assessing the mental health status of the population and for health service planning and development.

Prior to the Health Research Board National Psychological Wellbeing and Distress Survey (HRB NPWDS) there was little information available on the mental health of the population of the Republic of Ireland. In the North of Ireland, the Northern Ireland Health and Social Wellbeing Survey<sup>1</sup> provides some information on psychological distress while the ongoing Northern Ireland Study of Health and Stress will in time provide information on the use of health services for mental health problems. Until now there have been no direct comparisons of mental health status in the North (NI) and the Republic of Ireland (ROI) or of the use of their respective health services for mental health problems. A report published in 2002 highlighted the need to assess and monitor mental health on an all-island basis using the same measurement and methodology in both jurisdictions (Barry *et al.* 2002). More recently a report from the SLAN 2007 group highlighted the lack of comparable mental health data across the island of Ireland (Ward 2009). While there has been an increase in the development of cross-border cooperation, little cooperation has taken place to date within the mental health arena (Clarke 2009). Given the similarities in mental health policy in the two areas and the differences in the health systems in terms of payment for services, comparing the mental health status and the use of health services for distress makes for interesting comparisons.

This is the first population-based mental health survey that allows for direct comparisons between the Republic of Ireland and Northern Ireland. It is also the first study to provide important information as to the determinants of the use of GP services for the treatment of mental health problems.

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<sup>1</sup> Northern Ireland Statistics and Research Agency (NISRA). Health and Wellbeing Survey. Available at <http://www.nisra.gov.uk/publications/default.asp64.htm>.

## Method

This survey is the second survey in the HRB NPWDS. The first was carried out in the Republic of Ireland only in 2005/2006 (Tedstone Doherty *et al.* 2008). The present survey, like the first, used a telephone survey methodology of the general population. Telephone numbers were drawn on a random probability basis and quotas were set for age, gender and social class. All interviews were carried out between 21 November and 17 December 2007. The final sample consisted of 965 respondents from the ROI and 1,000 from NI. In line with best practice, the completed sample was reweighted to achieve representativeness of the population from which it had been selected. Perusal, where possible, of relevant population statistics in NI and the ROI showed that the sample was representative of the populations as a whole.

## Key Findings

The key findings from the report are:

### Mental Health

- Respondents in NI showed a higher prevalence of self-reported mental health problems (22%) and a greater proportion perceived their mental health status as less than good (20%) than respondents in the ROI (12% and 15%). These differences remained even after controlling for differences in demographic characteristics between the two samples including marital status, education, employment status, SEG and income.
- Respondents in NI reported more severe limitations in social (NI 4.1%; ROI 1.4%) and physical activities (NI 3.2%; ROI 1.2%) due to mental health problems than respondents in the ROI. This would suggest that respondents in NI perceived their mental health problems as more debilitating than respondents in the ROI.
- Psychological distress, as measured in the last few weeks by the General Health Questionnaire (GHQ12), was similar in both areas, suggesting that current distress levels did not differ (GHQ 12 mean score NI 9.5; ROI 9.6). A total of 12% of respondents in the ROI had a score of 4 or higher on the GHQ12 suggesting moderate to severe distress which compares to 13% of respondents in NI. It is only the one-year prevalence measures that display differences in mental health between the ROI and NI. This highlights the importance of measuring mental health across different time spans.

### Use of psychotropic medication

- There were much higher levels of medication use for mental health problems in Northern Ireland (14%) than in the ROI (6%). Whether the use of this medication is appropriate, given the higher prevalence and greater severity of mental health problems found in the Northern Ireland sample, requires further investigation.

### Use of general practitioners

- The treatment gap for mental health problems would appear to be less in Northern Ireland than in the Republic, as a greater number of people who reported mental health problems in Northern Ireland had attended northern GP services (NI 58%; ROI 43%). However, the severity of the problems is unknown and greater attendance may reflect more severe mental health problems. The reasons why people do not attend the GP when they are experiencing problems need to be investigated. The ongoing morbidity study in NI should provide some further information in this area (Northern Ireland Study of Health and Stress). Unfortunately, as of yet, there is no such study in the Republic.
- More people in NI attended the GP specifically for mental health problems (NI 16%; ROI 10%), but multivariate analysis suggests that these differences are more likely to be related to differences in mental health status than to differences in the jurisdictions, per se.
- Determinants of attendance at the GP for mental health problems included variables that could be considered 'need' factors, for example, perceived mental health status, while 'non-need' factors, such as income, did not remain as significant predictors in the logistic regression model. There were no differences between the actual jurisdictions in the factors that predicted attendance.

### Use of mental health services

- There were no differences in the use of secondary mental health services between Republic of Ireland and Northern Ireland. In line with policy in both areas, the majority of the respondents had received care from outpatient services (5%) with only a small percentage of respondents receiving inpatient care (2%).

### Informal supports

- Both jurisdictions were similar in terms of the most frequently used informal support. Thus, respondents were more likely to avail of, or seek support from, family and friends (13%) in response to psychological distress. Likewise, in both jurisdictions, the two main preferred sources of supports were the GP (77%) and family and friends (76%).

## Discussion and conclusions

These findings provide important information for policymakers and for service providers in terms of service development and delivery. The information presented in the report provides a baseline which can be used for the monitoring of policy and service planning and development and for comparisons between wider social and economic trends. This is particularly important given the financial and economic climate in the North and the South in recent times. A recent EU round table discussion on reducing the psychosocial impact of the financial and economic climate reported that job uncertainty, loss of employment and over-indebtedness are likely to lead to poorer mental health for many people.<sup>2</sup> The discussion highlighted the importance of resilience for mental health and wellbeing. Resilience was defined at an individual level as doing better than expected in the face of adversity and at a community level as the extent to which the community can come together to tackle common problems. It is especially important that initiatives that are relatively inexpensive and most likely to reach the greatest number of people be evaluated for their benefits within an Irish context. Examples would be programmes aimed at increasing mental health awareness, and self and mutual care amongst the general public, thus increasing individual and community capital in support of mental health. The recent information leaflets – Looking after your mental health in tough economic times<sup>3</sup> - produced by the Health Service Executive (HSE) are to be welcomed in this regard. There is a need for cross-border discussions and a population approach to mental health so that changes in policies and health service delivery can be monitored and compared. Furthermore, such a forum could provide an avenue through which innovative approaches and practices can be exchanged. Furthermore there is a need to ensure that mental health appears on the agenda of all government departments. An intersectoral approach needs to be taking so that all policies are conducive to positive mental health.

It is widely accepted that the GP plays an important role in the provision of treatment and care of mental health problems. Initiatives have been implemented in England and in other jurisdictions, such as Australia, to improve the effectiveness and the efficacy of the care provided at primary care level. For information purposes, these initiatives have been described in the body of the report. There is a need to monitor the implementation and evaluation of these initiatives and to consider their usefulness within the Irish setting.

As in other areas, there is a treatment gap evident in both NI and the ROI. This occurs when people who require support for mental health problems do not get the help or support that they need. This can lead to the escalation of problems and has individual, social and economic consequences. Furthermore, the support that people do get may

2 [http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/ev\\_20090427\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20090427_en.htm)

3 [http://www.yourmentalhealth.ie/pdf/suicide\\_brochure.pdf](http://www.yourmentalhealth.ie/pdf/suicide_brochure.pdf)



not be best suited to their needs. The overuse of medication for the treatment of depression has been documented and our findings suggested that a significant number of people had taken prescribed medication for mental health problems in the previous year (Joint Committee on Health and Children 2007). This was most pronounced for NI. We do not know from our survey if the medication was appropriately prescribed but the percentage of respondents receiving medication in the North would appear to be much higher than the average findings for European countries. Our findings and previous reports would suggest the need to monitor the use of psychotropic medication for the treatment of common mental health problems, especially mild to moderate mental health problems.

Finally, the survey allowed for the investigation of factors that determine the seeking of help from the GP, specifically for mental health problems. Only those factors that are related to need for help remained as significant predictors in the final statistical model. These included mental health status, associated limitations in functioning, and previously taking medication for mental health problems. In this analysis there were more similarities than differences between the ROI and NI. Regardless of where the individual was residing or other factors such as age or access to free healthcare, the most important factors determining one's attendance at the GP were those related to the respondents' mental health. Interestingly, this is somewhat in contrast to findings investigating attendance at the GP for physical health problems, where non-need factors were shown to play a role with respondents. This is in line with other research which reports that factors such as income and access to free healthcare can influence attendance (Nolan and Nolan 2007). It is clear that further research needs to address in more detail the relative reasons why people attend the GP for mental and physical health problems. While this survey did not allow for such analysis, the findings suggest that people with mental health problems only seek help when their problems are of such a degree that they are impacting on their day-to-day activities. Using GP services inappropriately is obviously not to be encouraged; however, waiting until problems have escalated to more serious levels is not an efficient use of services. The stigma surrounding mental health may impact on the acknowledgement and ownership of problems and therefore help seeking. If treatment is sought earlier, then simpler and less costly interventions can be sought. Awareness of the importance of seeking help earlier when problems become evident may in the longer term reduce the need for more intensive interventions. However, it must also be acknowledged that GPs may not have the appropriate mental health skills for the treatment of common mental health problems and, worse, may not have access to other health professionals who do have the required skills. In this case, the GP may have no option but to prescribe medication.

This report is the first to provide detailed information on mental health on the island of Ireland and the use of health services and other supports for mental health problems. The findings have shown that mental health problems are more widespread in NI; however, the use of services, especially GP services, is similar. It must also be acknowledged that respondents reported that they were most willing, outside of the formal health service, to use family and friends as supports. The importance of family and friends should not be underestimated, and a recent discussion at EU level highlights the need to develop both individual and community resilience, especially in this climate where unemployment, job uncertainty and debt are widespread. Critical in this context is the need to reduce the stigma associated with mental health problems. Increasing mental health literacy and providing information on ways to deal with early signs and symptoms of distress should help to eradicate some of the stigma associated with mental health problems. Steps have been taking in recent times [e.g. NPWDS I] to provide information on the extent of distress in society, accordingly helping to normalise the reality of psychological distress in everyday life. However, yet more needs to be done in this area, particularly in promoting and harnessing individual and social capital in support of mental health and wellbeing.

# Chapter 1 Introduction

This is the second HRB National Psychological Wellbeing and Distress Survey (HRB NPWDS II). The first survey provided information on psychological wellbeing and distress of the adult population living in private households in the Republic of Ireland. The second in the series, HRB NPWDS II, provides information on psychological wellbeing and distress in the Republic of Ireland (ROI) and Northern Ireland (NI), thus providing information on an all-island basis. The aims of the surveys are to provide information on the psychological wellbeing and distress at a population level and to monitor changes over time.

## Population approach to health and mental health

The absence of a population approach to mental health within the ROI has been highlighted in the most recent national mental health policy document, *A Vision for Change* and also at a European level (European Commission 2005).<sup>4</sup> The report of the European Commission, *Health Status and Living Conditions in an Enlarged Europe* (European Commission 2005), specifically highlighted the dearth of population-based studies on mental health in the EU-28, with Ireland being one of the 12 that did not collect such information. The importance of mental health needs assessments at a population and community level for psychological and emotional distress has been highlighted in the Northern Ireland *Strategy Framework for Adult Mental Health Services* (The Review of Mental Health and Learning Disability, 2005;<sup>5</sup> Bramford Report). Likewise, the need for a population-based approach to general health and wellbeing has been highlighted at a national level in the Republic (National Economic and Social Forum, 2007; Health Service Executive<sup>6</sup>). The population approach adopted by the Health Service Executive (HSE) is based on the model used in the UK (Wanless 2004) and takes a proactive approach to health and wellbeing, with an emphasis on reducing health inequalities. This model involves:

- taking cognisance of the factors that influence health and wellbeing, including socio-economic factors and demographic factors
- placing more emphasis on health promotion and protection in the population
- recognising that everyone has a responsibility to promote and protect their own health and that of others
- acknowledging that the main contact of the individual with the healthcare system is through primary care.

4 [http://ec.europa.eu/health/ph\\_determinants/socio\\_economics/documents/europe\\_rd01\\_en.pdf](http://ec.europa.eu/health/ph_determinants/socio_economics/documents/europe_rd01_en.pdf)

5 [http://www.rmhdni.gov.uk/adult\\_mental\\_health\\_report.pdf](http://www.rmhdni.gov.uk/adult_mental_health_report.pdf)

6 [http://www.hse.ie/eng/HSE\\_FactFile/HSE\\_Approach/Population\\_Health/HSE\\_Model\\_of\\_Care/](http://www.hse.ie/eng/HSE_FactFile/HSE_Approach/Population_Health/HSE_Model_of_Care/)

The importance of population-based survey data for mental health policy and health service planning should not be underestimated. The information from these surveys provides an evidence base for determining the health needs of the population and for health service planning and development. Prior to the HRB NPWDS there was little information available on the mental health of the population. While information was available for inpatient activity in the mental health services, there was little information on services at community level or primary care level. Furthermore, there was little information on the extent of distress in the population, with national data collection concentrated on those who were admitted or discharged from inpatient services. This was, and still remains, a concern within the mental health area, as many of those who are experiencing mental health problems remain untreated. The European Study of the Epidemiology of Mental Disorders (ESEMeD) estimated that only one in four adults with a one-year prevalence of a mental disorder had consulted formal healthcare services (Alonso *et al.* 2002; 2004; Demyttenaere *et al.* 2004). Findings from the first HRB NPWDS showed that 40% of the Irish population who reported mental health problems in the last year did not seek help from the general practitioner (GP) for their mental health problems (Tedstone Doherty *et al.* 2007; Tedstone Doherty *et al.* 2008). The majority of those who do receive treatment do so from the GP, with only a small minority consulting more specialised mental health services. It is estimated that 90% of mental health problems are dealt with by the GP, while 10% are dealt with by specialised mental health services. The HRB NPWDS provided information on the extent of psychological distress and mental health problems at a national level and also on health services use for mental health problems. It was envisaged that this survey would be carried out at regular intervals. The collection of population-based survey data at regular intervals provides a means with which to monitor socio-political developments and the impact of changes in policy or health service delivery on mental health. Furthermore, population-based mental health surveys gather information on socio-demographic factors and other factors that impact on mental health and service use to elicit the important determinants of mental health and help-seeking. A report investigating perceived health on the island of Ireland argued that the most important message to come out of the findings was 'the importance of taking a wide view of health and its determinants' (Balanda and Wilde 2003). The importance of taking a wide view of health to include demographic and socio-economic factors for the development and implementation of policies was highlighted, suggesting that policies and programmes which did not take into account the wider determinants of health would have limited impact.

The most recent general health survey in Ireland included measures of mental health status and wellbeing (SLAN, Department of Health and Children 2009),<sup>7</sup> but did not include any measures of service use for mental health problems. Many European

7 [http://www.dohc.ie/publications/pdf/slan\\_wellbeing\\_report.pdf?direct=1](http://www.dohc.ie/publications/pdf/slan_wellbeing_report.pdf?direct=1)

countries have psychiatric morbidity studies, including Great Britain, Belgium, Bulgaria, France, Germany, Italy, the Netherlands, Northern Ireland, Romania, Spain and Turkey; while Ireland is one of the few European countries that do not have a national mental health morbidity survey. As in the ROI, population-based health surveys have been carried out in NI, which have included measures of mental health (Northern Ireland Survey of Health and Social Wellbeing – NISHSW – 2001).<sup>8</sup> In addition, the ongoing Northern Ireland Study of Health and Stress (NISHS)<sup>9</sup> will investigate the level of psychiatric morbidity and health service use. This is part of the World Health Organisation (WHO) World Mental Health Surveys.

## **An all-island approach to mental health**

Both the HRB NPWDS (Tedstone Doherty *et al.* 2007) and the NISHSW (Miller *et al.* 2003) included the General Health Questionnaire 12 (GHQ 12) as a measure of psychological distress. Although different methods were used for data collection and there was a five-year time difference between the surveys, preliminary comparisons of the level of psychological distress can be made between the two areas. In the HRB NPWDS in the Republic, a total of 12% of the population scored above the threshold for psychological distress (GHQ 12 score of 4 or more; Tedstone Doherty *et al.* 2007), while results from the NISHSW in the North showed that 21% of respondents had scored above the threshold (Miller *et al.* 2003). There are many explanations for the differences in extent of psychological distress, including differences in survey method, levels of deprivation or the effect of the civil unrest experienced by those in the North since 1969 and its aftermath. Although the Good Friday Agreement in 1998 resulted in a cessation of hostilities, the psychological distress experienced during the 'Troubles' could still have been evident three years later in 2001. A study by O'Reilly and Stevenson (2003) showed that the greater the impact of the Troubles on an individual's area of residence or life, the higher the likelihood of psychological morbidity. They proposed from these findings that residents of NI were significantly affected by the Troubles, whether through the violence itself or other elements of the Troubles that impacted on daily living. Recent research, however, would suggest that the civil unrest experienced by those in the North did not have an effect on the level of psychiatric morbidity at a population level compared to other areas within the UK (Murphy and Lloyd 2007). They suggested that adults living in NI had developed coping strategies to moderate the impact of the conflict. Until now there have been no surveys or direct comparisons between the level of distress in NI and in the ROI. The *All-Island Social Capital and Health Survey* in 2003 investigated inequalities in perceived general health (Balanda and Wilde 2003). This report found that, overall, those in the ROI were more likely to perceive their general health as good than people in NI.

8 <http://www.statistics.gov.uk/STATBASE/Source.asp?vlnk=1457&More=Y>

9 <http://www.science.ulster.ac.uk/research/psychology/nishs/>

However, the jurisdictions differed by age and perceived health. Younger people in the ROI were more likely to perceive their general health as good than young people in NI, but older people in NI were more likely to perceive their general health as good than older people in the ROI. Interestingly, there was no difference in perceived mental health between the jurisdictions. The report on *Promoting Mental Health and Social Well-being: Cross-border Opportunities and Challenges* (Barry *et al.* 2002) investigated cross-border collaboration in mental health promotion and the comparability of data sources on population mental health. The report concluded that there was a need to assess and monitor mental health on an all-island basis using the same measurement and methodology in both jurisdictions so that findings are comparable. This conclusion was also reported by the SLAN 2007 group which highlighted the lack of comparable mental health data across the island of Ireland (Ward 2009). The Institute of Public Health in Ireland has established the All-Ireland Health and Social Care Indicator Set (Fahy *et al.* 2008). The purpose of this initiative is to bring together health-related data from a variety of sources, which allows for the aggregation, charting and mapping of the data. Within this database there are indicators of the prevalence of mood and anxiety disorders on an all-Ireland basis. Mood and anxiety disorders were defined by the proportion of people experiencing mood and anxiety disorders, as estimated using prescription data. This indicator showed higher prevalence in NI than the ROI. However, this is a crude measure of the prevalence of mood disorders. Firstly, it only includes those who have sought help and, as stated above, many people with mental health problems do not seek help. Secondly, the healthcare system differs between the jurisdictions (Central Statistics Office – CSO – and Northern Ireland Statistics and Research Agency – NISRA 2008). The Republic operates primarily within a fee-for-service system, while healthcare in Northern Ireland is free at the point of delivery. A previous cross-sectional study in the Republic and Northern Ireland found that a consultation charge inhibited poorer and less healthy patients from seeing their GP, even when steps were taken to ensure that the most vulnerable had access to free healthcare, as in the Republic (O'Reilly *et al.* 2007). In addition, the HRB NPWDS found that cost was the most frequently reported barrier preventing people from seeking help from the GP (Tedstone Doherty *et al.* 2007).

Another difference between the North of Ireland and the South of Ireland concerns the make up of the primary care system. While the attributes of the system are relatively similar, the development of a multidisciplinary primary care service is more advanced in NI than in the ROI. *Primary care – A new direction* was published as a key component of the government's health strategy - *Quality and Fairness – A health system for you* (Department of Health and Children, 2001). The strategy highlighted the importance of primary care as the first and on-going point of contact with health services. It acknowledged the central role played by primary care in a modern health service and the role as gatekeeper to all secondary healthcare systems. A model of primary



care was put forward as was an implementation plan that was to occur on a phased basis. The model included an inter-disciplinary and team based approach to health care. It was proposed that healthcare should be offered by a primary care team in a single location, which include general practitioners, nurses / midwives, health care assistants, physiotherapists, occupational therapists, social workers and administrative assistants. The primary care teams should be supported by a wider primary care network to include professionals such as psychologists, pharmacists, dieticians, community welfare officers, dentists and chiropractors. To date, the implementation of the strategy in terms of the roll out of the primary care teams and networks has been slow. The more recent policy document – *A Vision for Change* – has highlighted that the envisaged primary care model has not been realised within the mental health area. There are few examples of psychiatric-liaisons models in operation between primary care and specialised mental health services in Ireland although there is one area that has a consultation- liaison model in place (Russell *et al.* 2003). The primary care strategy for NI was published by the Department of Health, Social Services and Public Safety in 2005 (Department of Health, Social Services and Public Safety, 2005). The primary care strategy in the North is similar to the Southern primary care strategy in that it recognises primary care as the first point of contact with the health services and promotes an inter-disciplinary and team based approach to primary care. The primary care system is more developed in the North in this respect with many of the primary care practices having access to professionals other than the GP. In terms of mental health, NI has this year introduced a new Directed Enhanced Services for Mental Health within the primary care setting which will see GPs get extra remuneration for mental health. There are also plans to develop a Stepped Care Approach to mental health.

There has been an increase in the development of cooperation in border areas. Cooperation and Working Together (CAWT)<sup>10</sup> is a partnership agreement which aims to facilitate North and South cooperation in the areas of health and social care. In recent years, cross-border research and shared health service provision have been gathering momentum (CSO and NISRA 2008). Developments are evident in the areas of emergency care, GP out-of-hours services, cancer and cardiovascular health. In terms of mental health, a meeting between the health ministers in the North and the South took place in 2003 to discuss the possibility of establishing an All-Island Institute of Mental Health. While the benefits of such an initiative were agreed, it was felt that the ongoing changes in policy and practice were not conducive to the implementation of such an initiative (Clarke 2009). In 2007, two meetings were convened by the Centre for Cross Border Studies involving key stakeholders to discuss the strengthening of cross-border collaboration in mental health services research. While there were no further developments in this area, the Centre of Cross Border Studies produced a seminal report in May 2009 detailing the importance of a cross-jurisdictional

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10 <http://www.cawt.com/default.aspx?CATID=130>

approach to policy and research in mental health – *Mental Health: The case for a cross-jurisdictional approach combining policy and research efforts on the Island of Ireland* (Clarke 2009). The report was based on interviews with key policymakers, practitioners and academics; desk research on policy documents in NI and the ROI; and past, current and ongoing research. The report provides important information on similarities and differences between the North and the South in policy and implementation and in research and development. It concludes by highlighting some of the difficulties in conducting cross-border mental health services research and the importance of having an evidence base to inform policy and practice, using both international literature and local research to address the needs of the population. The author proposes that an all-island mental health services conference would help to develop cooperation between policymakers and researchers across the Island.

This is the first population-based survey looking at the level of psychological distress, mental health and health service use for mental health problems on the island of Ireland. It also provides important information as to the determinants of the use of GP services for mental health problems. Until such a time as there is a national morbidity survey in the Republic, the HRB NPWDS will provide population-based information for this area.

The report begins with a description of the methodology (Chapter 2) and then presents the demographic and socio-economic profile of the study sample, including age, gender, employment, income, and access to free medical care across both jurisdictions (Chapter 3). This is followed by the descriptive data relating to mental health, health status and quality of life (Chapter 4). The following two chapters examine the use of healthcare services and sources of support and willingness to use these supports (Chapter 5) and the predictors of GP use for mental health problems and the factors that prompt people to attend the GP when they are experiencing mental health problems (Chapter 6). The final chapter (Chapter 7) discusses the findings in the context of wider policy and health services planning and development issues. These are discussed in relation to a population health approach that encompasses the prevention and treatment of mental health problems for the whole population.



## Survey aims and objectives

The aim of this phase of the HRB NPWDS was to evaluate and compare the mental health of the adult population in the ROI and NI and related health service use for mental health problems. The specific objectives of this report were to:

- identify the level of psychological distress in the Republic and Northern Ireland
- describe the level of self-reported mental health problems in each jurisdiction
- describe the level of health service use, including primary and secondary mental health services in the Republic and Northern Ireland
- describe the use of professionals or support persons for mental health problems
- compare self-reported psychotropic medication use in each jurisdiction
- examine the demographic, socio-economic and health status predictors of psychological distress
- discuss these findings within the context of wider policy and health service development and planning.

# Chapter 2 Methods

## Background

The HRB NPWDS II repeated measures from the first survey in the series, including socio-demographic information, mental and physical health measures and health service use measures (Tedstone Doherty *et al.* 2007). The HRB NPWDS received ethical approval from the HRB Research Ethics Committee. Measures used in the HRB NPWDS II are detailed below and specific items are presented in Appendix 1. Similar to the methodology of the first HRB NPWDS, the HRB NPWDS II was a telephone survey. A professional survey company, Millward Brown IMS, was contracted by the Mental Health Research Unit (MHRU) of the HRB to carry out the survey as part of their monthly omnibus survey. A merged dataset, weighted for both jurisdictions, was returned to the MHRU. The data were analysed using SPSS 15 by researchers in the MHRU.

## Fieldwork

All interviews were carried out between 21 November and the 17 December 2007. Telephone interviews were carried out by social survey interviewers employed by Millward Brown IMS using a computer-aided telephone interview system. In line with normal survey protocol, the interviewers stressed to respondents that any information obtained during the interview would be confidential, that it would be used for research purposes only and that they were free to withdraw from the interview at any time. In addition, interviewers were provided with protocols in the unlikely event that the respondents became distressed during the interview.

## Sampling frame

The survey was designed to yield a representative sample of the population, aged 18 years and over and living in the ROI and NI. An electronic version of the eircom phonebook was used as the sampling frame in the ROI, while a random digit dialling sample for NI was purchased from a leading provider of sampling solutions in NI. In both areas, procedures were adopted to ensure that all ex-directory numbers are captured, and quotas were set to ensure representation of the areas. The quotas set for the ROI were based on the Joint National Readership Survey (sample size circa 7,000), which allows profiling of the age, gender and social class of the landline population of Ireland. The 2001 Northern Ireland Census was used to set the quotas for the North, allowing profiling of the gender, age and social class of the population in Northern Ireland. In the ROI, quotas for directory area (01, 02, 04, 05, 06, 07, 09), gender (male, female), age (15–24, 25–34, 35–49, 50–64, 65+) and social class (SEG; AB, C1, C2, DE, F)

were applied to ensure representation. Quotas for the NI sample are also set for region (Belfast City, North, South, West), gender (male, female), age (16–24, 25–34, 35–54, 55+) and social class (ABC1, C2, DE) to ensure that the overall sample is representative of the NI adult population. In both jurisdictions those aged less than 18 years of age were deleted from the databases, thus resulting in a final sample aged 18 years and over. The final sample consisted of 965 respondents from the ROI and 1,000 from NI. Perusal, where possible, of relevant population statistics in NI and the ROI showed that the sample was representative of the populations as a whole (see Appendix 1).

## Response rate

Table 2.1 presents the response figures and refusal figures for NI and the ROI. The response rate for the ROI was lower than the response rate for NI. These findings are similar to the response rates in the Eurobarometer study (ROI – 33%, NI – 43%; European Commission 2006). In addition, other studies have found that response rates for research are higher in NI (Muldoon *et al.*).<sup>11</sup> This difference perhaps reflects the greater willingness of people in NI to participate in surveys. The response rate for the ROI is lower than the response rate for the first survey in the HRB NPWDS (48%; Tedstone Doherty *et al.* 2007). Nevertheless, the response rate is acceptable and is representative of the population as a whole (see Chapter 3). However it must be noted that we had no information on those who refused to participate and may have differed from those who did respond. For example, it is possible that those less willing to participate in the survey were more likely to have mental health problems (de Graaf, personal communication).

**Table 2.1** Sample breakdown (response rate)

	Republic of Ireland	%	Northern Ireland	%
Successful interview	1,000	30.5	1,000	49.1
Refused on principal	2,278	69.5	1,037	50.9
Total	3,278	100.0	2,037	100.0

## Measures

Comprehensive socio-demographic information was recorded on the core instrument of the Millward Brown IMS and was available for analysis by the MHRU. Included were household size; age of respondent; gender; highest level of educational attainment; social class; marital status; household income and work status. In addition, information on county of residence, population size of location in which the respondent resided and healthcare coverage (whether covered by free medical care / private healthcare

11 <http://www.legacyofthetroubles.qub.ac.uk/LegacyOfTheTroublesFinalReport.pdf>

insurance) was collected. The following sections detail the items included in the MHRU questionnaire (see Appendix 1).

### **General Health Questionnaire**

The short version of the General Health Questionnaire (GHQ 12) was used as a measure of psychological distress. This questionnaire has been widely used as a screening measure to assess psychological distress in community samples (e.g. Shaw *et al.* 1999; Muldoon *et al.* 2005). Previous research has shown the validity of the questionnaire to be high, with issues such as age, gender and educational level having no significant effect on the validity of the GHQ (Goldberg *et al.* 1997).

Two methods were used for scoring the GHQ 12. The bimodal method, commonly referred to as the GHQ scoring method, scored items on a scale of 0-0-1-1, with a score range of 0–12, while the Likert scoring system scored items on a scale of 0-1-2-3, with a score range of 0–36. It is preferable to use the Likert scoring system when comparing the severity of distress between groups as it gives a less skewed distribution of scores (Goldberg *et al.* 1997). The Likert scoring method was used in this report to compare the severity of the distress between the Republic of Ireland and Northern Ireland.

The GHQ 12 scores were classified using the bimodal method for the calculation of point prevalence, with the higher conservative score of four and above used as the cut-off score to indicate probable psychiatric morbidity; this is in line with previous research in the UK (National Centre for Social Research 2004; Northern Ireland Statistics and Research Agency 2002). The lower threshold score of two and above was used as a psychological distress predictor in the multiple regression analysis to identify the predictors of GP use for mental health problems.

### **Self-perceived health status and quality of life in the last year**

A subjective measure of mental health problems in the previous year was included in the questionnaire. Respondents were asked if they had suffered from mental, nervous, or emotional problems in the previous year; they were also asked to rate their mental health during the previous year on a five-point scale from 'very poor' to 'very good'. The other two self-reported measures included respondents' ratings of their physical health status in the previous year, and their quality of life in the previous year on a five-point scale from 'very poor' to 'very good.'

### **Limitations in functioning**

Respondents were asked two items in relation to functional limitations due to mental health problems – one relating to social activities and one relating to physical activities. Respondents rated the items on a five-point scale ranging from no limitations to extreme limitations.

### **Use of general practice services over the previous year**

In order to measure the level of help sought for both physical and mental health problems, respondents were asked how many times (if any) they had seen a general practitioner (GP) for physical problems in the last 12 months. They were also asked how many times (if any) they had spoken to a GP about being anxious or depressed, or about mental, nervous, or emotional problems in the last 12 months.

It was considered useful to explore possible barriers to seeking help from GPs, especially as both jurisdictions have different healthcare systems. To do so, respondents were asked if any of the following prevented them from seeing a GP in the past 12 months: transportation; cost of visit; it takes too much time; embarrassment / feeling awkward; it's not helpful; too ill; anything else; nothing prevented me.

### **Use of mental health services over the last year**

In order to measure the level of use of professional mental health services, respondents were asked whether (yes / no question) they had been in contact with any outpatient clinic, day centre, day hospital or inpatient psychiatric hospital or unit in the last 12 months.

### **Use of professionals / support persons in the last year and perceived effectiveness**

To assess the level of use of professionals / support persons and their perceived effectiveness, respondents were asked if they had been in contact with any of the following in the previous 12 months: psychiatrist, nurse, psychologist, social worker, counsellor, psychotherapist, clergy, alternative / complementary practitioner, family / relatives / friends, the Internet, and other. If the answer to any of these was positive, respondents were asked to rate how effective each professional / support person had been for them on a four-item scale from 'very effective' to 'not at all effective'.

## **Use of prescribed and non-prescribed medication in last year and perceived effectiveness**

To explore the patterns of use of prescribed medication for mental or emotional problems and its perceived effectiveness, respondents were asked if they had taken any prescribed medication for a mental, nervous, or emotional problem in the last 12 months. Those who had used prescribed medication were asked to rate the effectiveness on a four-point scale from 'very effective' to 'not at all effective'. An option of 'don't know' was also available.

## **Preference for services if required in the future**

As one of the aims of the study was to explore the patterns of help-seeking for mental health problems in the general population and the willingness to use various services, respondents were asked if they would be willing to contact any of the following professionals / support persons in the future if they were experiencing mental, nervous, or emotional problems: family / relatives / friends, GP, psychiatrist, nurse, psychologist, social worker, counsellor, psychotherapist, clergy, alternative practitioner, Internet, other, and none of these.

## **Interpretation of results**

Quotas were employed to ensure that the samples were representative of the population from which they had been selected, as described above. Data are rounded to the nearest one decimal place. The valid response for each question has been used (i.e. includes only those who answered the question). Weighted percentages are reported in all tables and graphs unless otherwise stated.

## **Format of the report**

The main aim of the study is to report on the data collected in the HRB NPWDS II. The following section will provide a descriptive account of the demographic and socio-economic profile of the two samples. The body of the report is presented in three main sections. The first will provide the analysis of the mental health data – psychological distress, self-reported mental health problems and the self-reported use of prescribed medication for mental health problems. The second will provide a description of the use of health services and supports for mental health problems across the two jurisdictions. The final section will provide a multivariate analysis of the factors that predict attendance at the GP for mental health problems. For ease of reading, a brief summary of the main findings in each section of the report will be provided at the beginning of the section. The final chapter of the report will provide an overview of the main findings and the implications for policy and practice.

# Chapter 3 Socio-demographic background information of sample

This chapter reports on the socio-demographic distribution of the ROI sample and the NI sample. A total of 1,965 respondents were included in the final survey; 1,000 from NI and 965 from the ROI. The final section of the chapter reports on comparisons between the census information of both jurisdictions, where this information was available.

## Brief summary

There are some noteworthy differences between the samples, which to a large degree reflect population differences. Most notably, there were significant differences in marital status, highest level of education attained, current work status, social class and income, which are reflected in the census data from the two areas. Compared to respondents from the ROI, a greater proportion of the NI respondents were in the eldest age category, retired, had completed primary education only and were in the lowest monthly income category. It is important to keep in mind that these differences may impact on the level of distress and health status. Nevertheless, these differences are also reflected in the census data from the populations as a whole (CSO and NISRA 2008). These population statistics show a greater proportion of people in the 65 years and over age group in NI (14%) compared to the ROI (11%). It is argued that this is 'due to fertility levels which are below replacement level and increasing life expectancy' (CSO and NISRA 2008). A greater proportion of respondents in NI were divorced than in the ROI. The divorce legislation was only enacted in the ROI in 1997 and the divorce rate, although increasing slowly, is still below that in NI (CSO and NISRA 2008). A greater proportion of people in Northern Ireland had attained lower levels of education than in the Republic. However, there were similar levels in each jurisdiction that had attained a third-level education. This may reflect the older sample of Northern Ireland and / or the greater difficulty of keeping young adults in further education in the North. Census data have shown that while there are similar numbers taking the Leaving Certificate in the ROI as sitting the Junior Certificate there are lower numbers in NI going on to sit the advanced level examinations (CSO and NISRA 2008). There were also more respondents retired in the North than in the ROI, again probably reflecting the older age pattern of the respondents. There were more respondents self-employed in the ROI than in NI and a greater proportion working in domestic duties. Similar to the findings in this report, the census comparisons show that there are more people involved in domestic duties in the ROI than in NI and a greater proportion of respondents reporting long-term sickness or disability in NI than in the ROI (CSO and NISRA 2008). A greater proportion of the sample in NI reported the lowest weekly income, while a greater proportion of those in the South



reported the highest weekly income. This difference also needs to take into account the lower cost of living in the North and lower income levels (CSO and NISRA 2008). In 2006, the gross weekly income for full-time and part-time workers in the ROI was €579.0 and the corresponding figure for NI was £322.7. In contrast to the findings for income and education, analysis of the social class variable showed that overall there were more respondents in the higher social classes in NI than in the ROI. There were more respondents in the skilled working class and lower grade working class in the ROI. These findings may reflect the high increase in the percentage of people in the ROI working in construction, which rose from 7.8% in 1996 to 13.4% in 2006 (CSO and NISRA 2008). In 2006 in Northern Ireland, over one-third of those in employment worked in the public sector, compared to just over one-fifth in the Republic (Clarke, 2008). Overall, the differences in the socio-demographic profile of the ROI and NI samples here are reflective of the differences found in the comparisons of the census data between the North and the South of Ireland, adding greater confidence that the samples are representative of the populations as a whole.

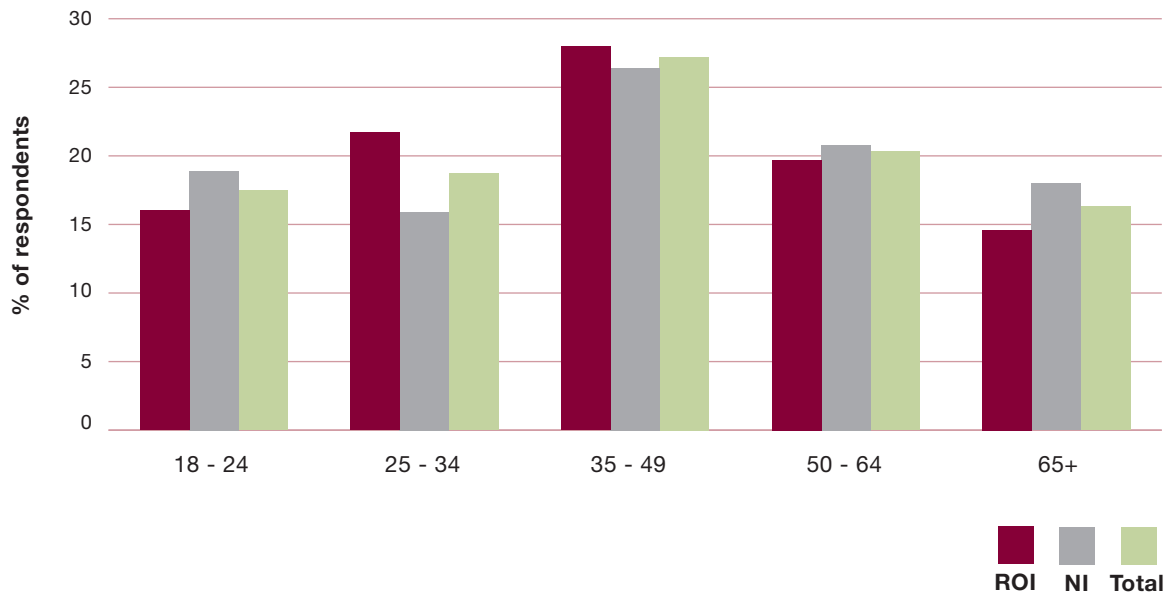
Regarding the representativeness of the samples, the weighting procedure was used to ensure that the samples were representative of the general population. To assess the representativeness of the samples, the NPWDS II was compared to the ROI census 2006 and the NI census 2001. The comparisons showed few differences in age, gender, marital status, employment and urbanisation. While there were slight differences in education and socio-economic class, these variables were not directly comparable. Nevertheless, these differences must be kept in mind when investigating the health of the jurisdictions. Under- or over-representation of certain groups can lead to overestimation or underestimation of distress. These factors reflect the findings from the census data from the North of Ireland and the Republic of Ireland, and this is discussed in more detail in Chapter 7.

## Gender and age

There was no significant difference in the gender distribution between the respondents in NI and the ROI, with slightly more females in each group (ROI:  $n = 491$ , 50.9%; NI:  $n = 520$ , 52.0%), nor were there statistically significant differences in age by jurisdictions.

While the average age of the respondents in NI and the ROI did not differ, there was a significantly greater proportion of the ROI sample in the 25–34 year age category than in NI, and a greater proportion of the sample in the 65+ age category in NI than in the ROI ( $\chi^2 (4) = 15.33$ ,  $p = 0.004$ ). However, the pattern of the age profile of both samples was similar, with the highest proportion of the respondents in the 35–49 year age category. Figure 3.1 presents the age distribution for the ROI and NI samples and for the total sample.





**Figure 3.1** Weighted percentages of age groups by jurisdiction

### Marital status

The samples differed in marital status: a higher proportion of the NI sample (n = 186, 18.7%) reported being widowed / divorced / separated than in the ROI (n = 99, 10.3%), while a slightly higher proportion of the ROI (n = 552, 57.3%) sample reported being married or living as married than their counterparts in NI (n = 505, 50.9%);  $\chi^2(2) = 28.42, p < 0.001$ . There were almost equal proportions within each jurisdiction reporting that they were single (NI: n = 302, 30.4%; ROI: n = 313, 32.5%).

To investigate whether the differences arose in the widowed / separated / divorced category, the proportions of the ROI and NI samples falling into each of the three separate categories were analysed. The analysis showed significant differences between the samples in the widowed, separated and divorced categories ( $\chi^2(2) = 12.44, p = 0.002$ ). Of the NI sample, 53.5% (n = 99) were widowed, 33.5% (n = 62) were divorced and 13.0% (n = 24) were separated. The corresponding proportions for the ROI sample were 67.7% (n = 67), 14.1% (n = 14) and 18.2% (n = 18). These findings show that the greatest difference between the jurisdictions was in the divorced category. The divorce legislation was only enacted in the ROI in 1997, and although increasing, divorce levels are still below those in NI (CSO and NISRA 2008).

## Education

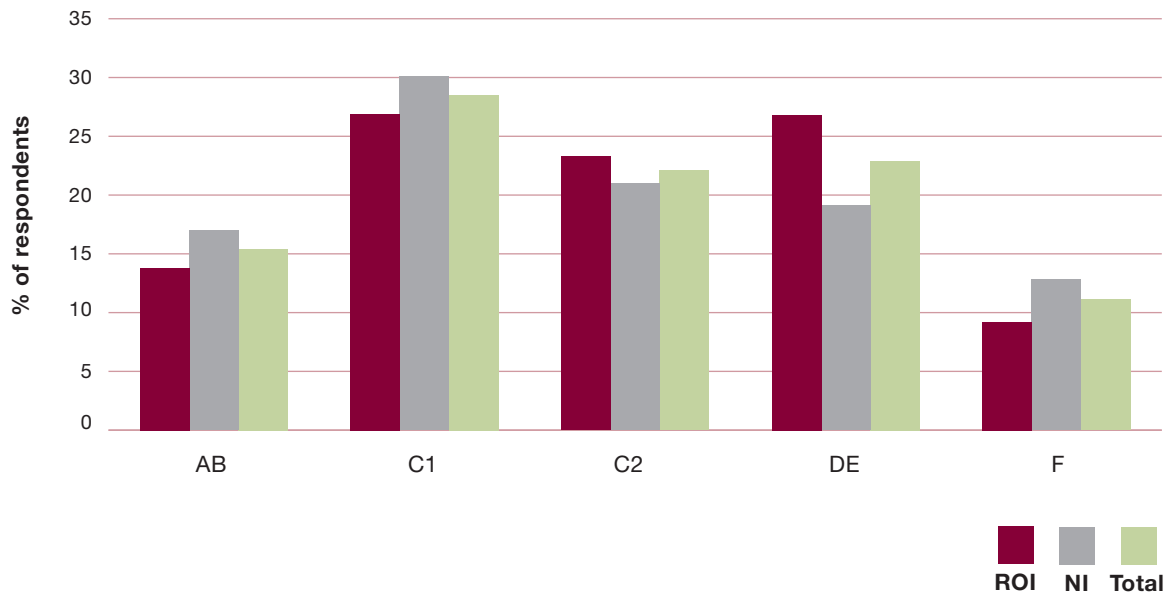
The completed level of education was coded into three levels – primary level, secondary level and third level and above. There were significantly more respondents from NI (n = 128, 13.1%) who reported primary level as the highest level of education than in the ROI (n = 81, 9.1%), and significantly fewer of the respondents in NI reported having secondary level education (NI: n = 471, 65.8%; ROI: n = 435, 70.5%). Approximately one-fifth of respondents in each jurisdiction reported having a third-level education (NI: n = 377, 20.9%; ROI: n = 381, 20.4%). These findings are reflected in comparisons of the census data between the jurisdictions. Census data showed that there are fewer people going on to take advanced level examinations in secondary level education in NI than in the ROI (CSO and NISRA 2008).

As expected, those who had higher levels of education had higher levels of household income ( $\chi^2(12) = 252.8, p < 0.001$ ). A total of 36.5% (n = 120) of those with a third-level education had a household income of less than €3,000 per month, while 87.2% (n = 151) of those with a primary level of education had a monthly income of less than €3,000 per month. Of those with a secondary level of education, 68.9% (n = 693) had an income of less than €3,000 per month.

## Socio-economic class

Figure 3.2 shows the reported socio-economic class<sup>12</sup> of the respondents in the ROI and NI. There were significant differences between the groups ( $\chi^2(4) = 24.43, p < 0.001$ ). There were slightly greater proportions of the NI respondents in the upper / middle class, skilled working class and large / small farmers than in the ROI. However, the ROI had more respondents in the DE category (other / lower-grade working class). Generally, there was a higher proportion of respondents categorised in the two higher classes in NI (n = 471, 47.1%) than in the ROI (n = 393, 40.7%). Half of the respondents in the ROI fell into the skilled working class or the lower working class category (n = 483, 50.1%). These findings may reflect the high increase in the percentage of people in the ROI working in construction, which rose from 7.8% in 1996 to 13.4% in 2006 (CSO and NISRA 2008). In 2006 in Northern Ireland, over one-third of those in employment worked in the public sector, compared to just over one-fifth in the Republic, which may account for the higher percentage of respondents in the upper or middle classes (Clarke, 2008).

12 Socio-economic class defined by UK National Statistics Office (UK NSO). Categorisation is based on occupation, qualification and size of company. This is in comparison to the categories used by the Central Statistics Office in Ireland which codes occupation to socio-economic group so that categorisation is based on occupation only. Categories in the UK NSO socio-economic class include: AB = upper / middle class; C1 = lower middle class; C2 skilled working class; DE = other / lower-grade working class; F = large / small farmers



**Figure 3.2** Weighted percentages of respondents' socio-economic class by jurisdiction

### Current work status

Table 3.1 shows the current work status of the respondents across the jurisdictions. There was a significant difference in the current work status of respondents in NI and the ROI ( $\chi^2(8) = 81.04, p < 0.001$ ). The major differences occurred mainly in three categories. There were significantly more respondents from the Republic working as full-time housewives ( $n = 122, 12.6\%$ ) than in the North ( $n = 68, 6.8\%$ ). Likewise, there were more respondents self-employed in the ROI ( $n = 80, 8.3\%$ ) than in NI ( $n = 28, 2.8\%$ ). In contrast, there was a significantly higher proportion of the NI ( $n = 243, 24.5\%$ ) sample retired than in the Republic ( $n = 157, 16.3\%$ ). Regarding those who reported permanent unemployment (NI:  $n = 39$ , ROI:  $n = 12$ ), there were no significant differences between the jurisdictions in the reasons for permanent unemployment or in the average number of years unemployed. Of all those who reported permanent unemployment, 43.1% ( $n = 22$ ) reported that this was due to sickness and 37.3% ( $n = 19$ ) that it was due to disability, and 19.6% ( $n = 10$ ) reported 'other' as the reason. Overall, the average length of time of permanent unemployment was 8.25 years (range 0–25 years; SD 7.13).

**Table 3.1** Weighted percentages (n) of respondents by current work status by jurisdiction\*

	ROI	NI	Total
Housewife (full-time)	12.6 (122)	6.8 (68)	9.7 (190)
At school	0.9 (9)	2.3 (23)	1.6 (32)
Full-time student (third level)	8.0 (77)	6.5 (65)	7.3 (142)
Temporarily unemployed (actively seeking work)	2.9 (28)	2.3 (23)	2.6 (51)
Permanently unemployed	1.2 (12)	3.9 (39)	2.6 (51)
Retired	16.3 (157)	24.5 (243)	20.4 (400)
Employed full-time (30 hours or more)	37.3 (360)	38.4 (381)	37.8 (741)
Employed part-time (8–29 hours per week)	12.4 (120)	12.4 (123)	12.4 (243)
Self-employed	8.3 (80)	2.8 (28)	5.5 (108)
Totals	100.0 (965)	100.0 (993)	100.0 (1,958)

\*Totals may not add due to weighting

## Monthly net household income

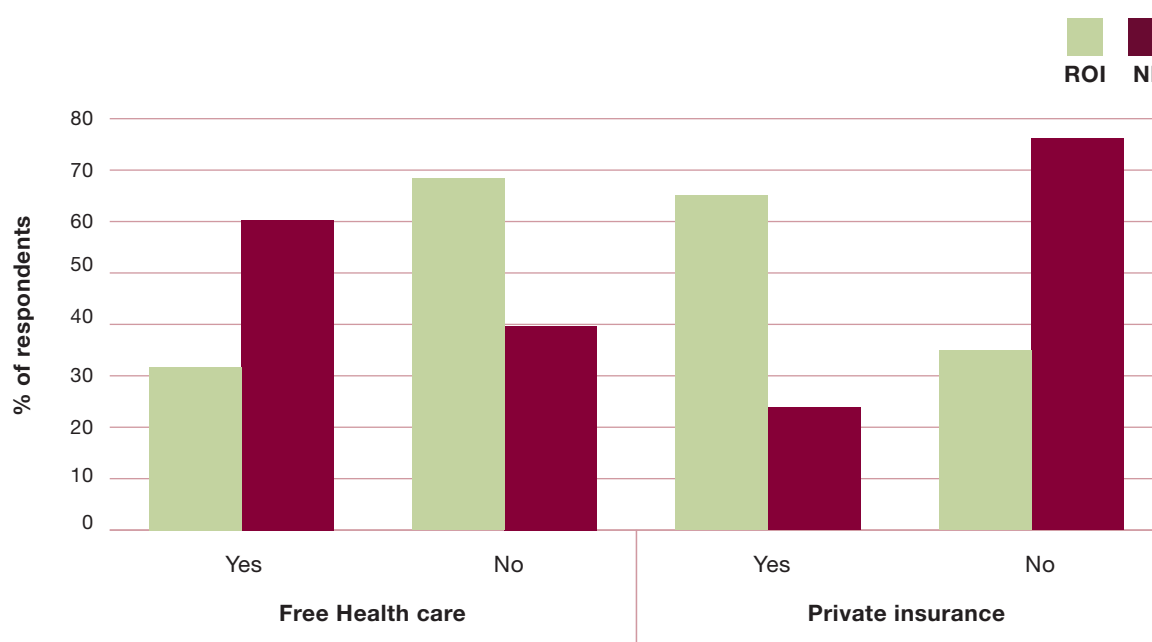
Respondents were asked about their monthly net household income. The significant differences between NI and ROI samples were most evident in two extreme categories – a net monthly income of less than €1,200 and a net monthly income of more than €5,000 ( $\chi^2 (6) = 30.18, p < 0.001$ ). The pattern of results suggested that a greater proportion of the respondents in NI ( $n = 171, 24.2\%$ ) were earning less than €1,200 than respondents in the ROI ( $n = 127, 15.8\%$ ), while a greater proportion of those in the ROI ( $n = 126, 15.7\%$ ) were earning €5,000 or over than of those in NI ( $n = 64, 9.1\%$ ).

Visual binning, using equal percentiles, was employed to reduce income levels into three categories – low, medium and high – for further analysis. Low income was defined as a monthly income of less than €1,599 a month, medium income was defined as €1,600–€3,599 per month and high income was defined as €3,600 or above per month. Significant differences remained following visual binning between NI and the ROI ( $\chi^2 (2) = 18.58, p < 0.001$ ). This comparison mirrored the above results, with little difference in the middle income between the jurisdictions (ROI:  $n = 307, 38.1\%$  vs NI:  $n = 286, 40.5\%$ ) and the greatest differences apparent in the highest and lowest levels (low = NI:  $n = 273, 38.7\%$  vs ROI:  $n = 255, 31.7\%$ ; high = NI:  $n = 147, 20.8\%$  vs ROI:  $n = 243, 30.2\%$ ).

The relationships between income and gender and income and age group were examined across the jurisdictions. There was no significant relationship between gender and income in either jurisdiction, but a significant relationship between age group and income was evident in both samples (NI  $\chi^2 (8) = 130.6, p < 0.001$ ; ROI  $\chi^2 (8) = 40.4, p < 0.001$ ). Older age group (65+) was associated with low monthly household income (less than €1,599).

## Healthcare payment systems

As mentioned above, the two jurisdictions have different arrangements regarding payment for healthcare services. While the majority of people in the ROI are not entitled to free healthcare, healthcare in NI is free at the point of delivery. Respondents were asked if they had access to free healthcare and also if they had private healthcare insurance. Figure 3.3 shows the analysis of this data by jurisdiction, which reflects the healthcare system that operates within the regions. The majority of the respondents in the ROI have no access to free medical care at the GP level (n = 632, 68.3%) whereas those in NI do (n = 603, 60.3%;  $\chi^2(1) = 158.24, p < 0.001$ ). Very few respondents in NI (n = 239, 23.9%) have private medical insurance whereas over two-thirds (n = 601, 65.0%) of those in the ROI have private health insurance ( $\chi^2(1) = 329.59, p < 0.001$ ). Figures for the ROI reflect national figures, whereby approximately 30% of the population are entitled to public health services free of charge (Nolan 2008), and it is estimated that over 50% of the population have private health insurance (report for the Department of Health and Children 2007).<sup>13</sup>



**Figure 3.3** Weighted percentages of respondents who have access to free medical care and private health insurance by jurisdiction

## Urbanisation

Respondents were also asked the size of the location in which they resided. This was then recoded into urban and rural areas using the definition of urban / rural by McGee

<sup>13</sup> Report from the Private Health Insurance Advisory Group for the Minister of Health and Children, 2007. Full report available from [http://www.dohc.ie/publications/pdf/Private\\_Medical\\_Insurance%20in%20Ireland.pdf?direct=1](http://www.dohc.ie/publications/pdf/Private_Medical_Insurance%20in%20Ireland.pdf?direct=1)

*et al.* (2005) of a population of less than 1,500 being defined as rural and a population of 1,500 or greater being defined as urban. There were significantly more of the respondents reporting that they lived in rural areas in the ROI (n = 369, 39.3% vs n = 217, 24.0%), with a greater proportion of respondents from NI (n = 687, 76.0% vs n = 570, 60.7%) reporting that they resided in urban areas ( $\chi^2 (1) = 10.40, p = 0.001$ ).

## **Representativeness of the sample for the general population**

In order to get a gross estimation of the representativeness of the sample for the general population, descriptive comparisons were made for each jurisdiction with the corresponding census data where this was available. The NI sample data was compared with the most recent NI census data of 2001. The ROI data was compared with the most recent census data of 2006. Given that the sample data was weighted to represent the census data it was envisaged that the sample data should be comparable to the census data. However, the census data was not directly comparable to the sample data due to different classifications. For example, some of the ROI and NI census data are classified for aged 15 years and over, while the data for the HRB NPWDS II were classified for aged 18 years and over. Categories that were not directly comparable are indicated by a superscript letter, and an explanation of the differences is given at the bottom of the table. Table 3.2 presents the percentage comparisons for the ROI and Table 3.3 shows the comparisons for the NI data.

The ROI HRB NPWDS II data reflected the data that were directly comparable to the census data, including gender, age, marital status, employment and urbanisation. The data for the education variable shows differences between the census data and the HRB NPWDS II data. However, the census data were calculated on aged 15 years and over while the NPWDS II data was for aged 18 years and over. Furthermore, the census data are calculated as follows – primary level (includes primary and lower secondary); secondary level (includes higher secondary and third non-degree) and third level (includes degree and diploma levels). This differs from the primary and secondary level as defined in the NPWDS II, whereby primary is primary level only and secondary includes lower level and higher level secondary. These were calculated together to make the data more comparable. Third level also differs and, as can be seen from the table, the NPWDS II reports a higher percentage of third-level education. This may be due to the fact that third level in this case includes non-degree levels and also that the sample includes only those over the age of 18. Finally, there would appear to be an over-representation of the higher classes and a lower representation of the lower classes in the NPWDS II. This could possibly be a result of the methodology of the survey. Those who are less well off may be less likely to have a home telephone or could be less willing to complete a telephone survey.

**Table 3.2** Percentages for comparison between HRB NPWDS II and ROI Census Data 2006

	ROI census data	ROI NPWDS II	Differences
<b>Gender</b>			
Female	50.4	50.9	0.5
Male	49.6	49.1	0.5
<b>Age</b>			
18–39	47.0	45.4	1.6
40–46	38.4	40.3	1.9
65+	14.6	14.3	0.3
<b>Marital status</b>			
Married / remarried	48.8	53.0	4.2
Single	40.0	36.0	4.0
Separated / divorced	5.2	3.4	1.8
Widowed	5.9	7.2	1.3
Single / separated / widowed / divorced	51.6	46.9	4.7
<b>Education<sup>a</sup></b>			
Primary and secondary	64.9	79.6	14.7
Third	15.6	20.4	4.8
<b>Employment<sup>b</sup></b>			
Employed	57.1	54.0	3.1
Unemployed	5.3	6.4	1.1
Sick / disability	4.1	4.0	0.1
Student	10.4	9.6	0.8
Retired	11.2	11.4	0.2
Domestic duties	11.4	14.5	3.1
Other / unspecified	0.4	Not available	N/A
<b>Socio-economic class</b>			
Upper class AB	13.7	20.8	7.1
Middle class C1, C2	51.8	52.8	1.0
Lower class and farmers	34.5	26.5	8.0
<b>Urbanisation</b>			
Urban (pop 10,000 or more)	48.7	49.7	1.0
Rural (not urban)	51.3	50.3	1.0

<sup>a</sup> ROI census data are classified for aged 15 years and over while NPWDS II data are classified for aged 18 years and over.

<sup>b</sup> Data source – NICA EU and UK Census 01

Similar to the ROI comparisons, the NI sample seems reasonably representative of the NI population as measured in the 2001 census. Gender, age, marital status, socio-economic class and urbanisation are similar for the census and the NPWDS II. However, as above, education differs. Again, this may be due to the calculation of education which was over 18 years for the NPWDS II and over 15 years for the census data. The employment figure also differs, with a much lower percentage of the NPWDS

II reporting sickness / disability than in the census. There is also a difference in the percentage of retired people, with a much higher percentage reporting retirement in the NPWDS II than in the census. Keeping in mind that the last census in NI was in 2001, the percentage of those in sickness or disability may have dropped or some of these individuals may have moved into the retired category. This requires further investigation. While under-representation of those who are sick or disabled may lead to an underestimation of distress, the over-representation of the retired group may lead to an overestimation.

**Table 3.3** Percentages for comparison between HRB NPWDS II and NI Census Data 2001

	NI census data	NI NPWDS II	Differences
<b>Gender</b>			
Female	52.0	52.0	0.0
Male	48.0	48.0	0.0
<b>Age</b>			
18–39	40.7	41.6	0.9
40–46	41.1	39.9	1.2
65+	18.1	18.5	0.4 Marital status
Married / remarried	51.2	50.4	0.8
Single / separated / widowed / divorced	48.8	49.1	0.3
<b>Education<sup>a</sup></b>			
Primary and secondary	84.2	79.1	5.1
Third	15.8	20.9	5.1
<b>Employment<sup>a</sup></b>			
Employed	55.8	53.2	2.6
Unemployed	4.1	3.0	1.1
Sick / disability	9.3	3.3	6
Student	8.1	8.8	0.7
Retired	11.0	24.3	13.3
Domestic duties	7.4	6.8	0.6
Other / unspecified	4.3	0.6	3.7
<b>Socio-economic group</b>			
Upper class AB	15.0	17.0	2
Middle class C1, C2	51.0	51.1	0.1
Lower class and farmers	34.0	31.9	2.1
<b>Urbanisation<sup>b</sup></b>			
Urban (pop 10,000 or more)	53.7	51.4	2.3
Rural (not urban)	46.2	48.6	2.4

<sup>a</sup> NI census data are classified for aged 15 years and over while NPWDS II data are classified for aged 18 years and over.

<sup>b</sup> Data source – NICA EU and UK Census 01



# Chapter 4 Mental health, health status and quality of life

The main objective of this chapter is to present the analysis of the comparisons between NI and ROI respondents on the level of psychological distress and self-reported mental health problems. Measures of self-reported physical health and quality of life of adults in the ROI and NI were also collected in the survey as these measures are known to be associated with mental health. The analysis of these measures is also presented here.

## Brief summary

To summarise, findings revealed that mental health problems are more frequently reported in NI than in the ROI and self-perceived mental health status is lower in the North of Ireland than in the South. Even after controlling for differences in demographic characteristics between the two samples, using logistic regression, those in NI were 1.5 times more likely to report mental health problems in the previous year and 1.7 times more likely to report less than good mental health. However, current psychological distress, as assessed by the GHQ 12, was similar in NI and the ROI. This highlights the need to monitor longer-term mental health as well as transient mental health status. Significantly fewer respondents in the ROI reported experiencing limitations in social and physical activities due to mental health problems than in NI. For those who were experiencing limitations in both physical and social activities, those in the North perceived that they were experiencing more severe limitations than those in the Republic. The findings also showed that more people living in Northern Ireland perceived their general health and quality of life as 'less than good' compared to people living in the Republic.

## Mental health

As mental health was the primary interest of this survey, there were a number of measures included to assess the mental health of the respondents. These were aimed at investigating self-perceived mental health status in the previous year, self-reported mental, nervous, or emotional problems in the previous year, and current psychological distress (within the last few weeks). In addition, two measures to assess the impact of mental health problems on functioning of the individuals were included. These measures assessed limitations in social functioning and limitations in physical functioning due to mental health problems.

Overall, the majority of respondents perceived their mental health status as good or very good (n = 1,605, 83.6%) in the previous year, with 4.5% (n = 87) perceiving their mental health as poor or very poor and 11.9% (n = 228) as fair. Likewise, the majority of the respondents reported that they did not experience a mental, nervous, or emotional problem in the previous year (n = 1,561, 81.3%), with 18.7% (n = 359) reporting that they had experienced a problem. Current psychological distress was measured using the GHQ 12, which measures distress in the last few weeks. The scores of the GHQ 12 were recoded into three categories – scores of 0–1 indicating no psychological distress, scores of 2–3 indicating mild psychological distress, and scores of 4 and above indicating moderate to severe psychological distress. The majority of the respondents reported no psychological distress in the last few weeks (n = 1,410, 76.4%). However, there was a significant proportion of the respondents showing signs of mild (n = 207, 11.2%) or moderate to severe distress (n = 228, 12.4%). In terms of the limitations in social and physical functioning due to a mental, nervous, or emotional problem, the majority of the respondents had not experienced any limitations (social: n = 1,678, 87.5%; physical: n = 1,689, 88.4%). In total, 222 respondents reported some limitations in physical activities and 239 reported some limitations in social functioning. Table 4.1 shows the breakdown of the extent of limitations in social and physical functioning for ROI and NI respondents and for the total sample.

**Table 4.1** Weighted percentages (n) of respondents in the ROI, NI and total sample by extent of limitations in social and physical functioning due to mental health problems\*

	Social % (n)			Physical % (n)		
	ROI	NI	Total	ROI	NI	Total
<b>None</b>	89.2 (819)	86.0 (859)	87.5 (1,678)	89.5 (820)	87.2 (869)	88.3 (1,689)
<b>Mild</b>	5.8 (53)	4.8 (48)	5.3 (101)	5.9 (54)	4.9 (49)	5.4 (103)
<b>Moderate</b>	3.6 (33)	5.1 (51)	4.4 (84)	3.4 (31)	4.6 (46)	4.0 (77)
<b>Severe</b>	1.1 (10)	2.7 (27)	1.9 (37)	0.9 (8)	2.3 (23)	1.6 (31)
<b>Extreme</b>	0.3 (3)	1.4 (14)	0.9 (17)	0.3 (3)	0.9 (9)	0.6 (12)
<b>Total</b>	100.0 (918)	100.0 (999)	100.0 (1,917)	100.0 (916)	100.0 (996)	100.0 (1,912)

\*Totals may not add due to weighting

### NI / ROI differences

The perceived mental health status of respondents was recoded into two categories – ‘less than good’ and ‘good to very good’ mental health in the previous year. There was a significant difference between those in the ROI and those in NI ( $\chi^2 (1) = 24.68, p < 0.001$ ). A greater proportion of those residing in the North of Ireland reported less than good mental health over the previous 12 months (n = 204, 20.4%) than those residing in the Republic of Ireland (n = 111, 12.0%). Further analysis using logistic regression to control for differences in the demographics of the samples was carried out on perceived

mental health status. The variables entered in the regression were those which showed differences in the socio-demographic variables – marital status, employment status, education, SEG and income. The difference in jurisdiction remained significant even after controlling for demographic differences (Jurisdiction  $p < 0.001$ ). Those who lived in NI were 1.7 times more likely to perceive their mental health as less than good than those in the ROI.

There were significantly more respondents in NI reporting mental health problems in the previous year than ROI respondents ( $\chi^2 (1) = 16.83, p < 0.001; n = 222, 22.2\%$  vs  $n = 137, 14.9\%$ , respectively). As in the analysis of the self perceived mental health status, a logistic regression model was run to control for the differences in the socio-demographic variables. The difference in self reported mental health problems remained significant after controlling for the differences in the demographic characteristics between the samples (Jurisdiction  $p < 0.001$ ). Respondents in NI were 1.5 times more likely to report mental health problems than respondents in the ROI.

Analysis of the psychological distress scores showed no significant difference in current psychological distress levels between the respondents in the North (mean 9.53, SD 4.5) and respondents in the Republic (mean 9.6, SD 4.5;  $t (1841) = 0.415, p = 0.678$ ), suggesting that the level of psychological distress does not differ between the two jurisdictions. Likewise, the analysis of the proportion of people experiencing no distress and mild or moderate to severe levels of psychological distress did not show significant differences between the jurisdictions ( $\chi^2 (2) = 1.51, p = 0.469$ ; see Table 4.2).

**Table 4.2** Weighted percentages (n) of respondents in the ROI and NI by levels of psychological distress (GHQ 12)\*

	ROI % (n)	NI % (n)	Total % (n)
0–1 absence of distress	77.7 (699)	75.2 (711)	76.4 (1,410)
2–3 mild distress	10.7 (96)	11.7 (111)	11.2 (207)
4+ GHQ 12 moderate to severe distress	11.7 (105)	13.0 (123)	12.4 (228)
Total	100.0 (900)	100.0 (945)	100.0 (1,845)

\*Totals may not add due to weighting

Table 4.1 shows the extent of the limitations in social and physical functioning for the respondents in NI and ROI due to mental health problems. Analysis of the data showed significant differences in both the limitations in physical activities ( $\chi^2 (4) = 11.51, p = 0.021$ ) and the limitations in social activities ( $\chi^2 (4) = 16.59, p = 0.002$ ). Overall, although quite small percentage differences, significantly fewer of the respondents in the ROI reported experiencing limitations in social and physical activities than in NI. In both social limitations and physical limitations the respondents in the ROI showed significantly more mild limitations than NI respondents, while NI respondents showed

significantly more moderate to severe limitations. The results suggest that respondents in NI not only experience more limitations in both social and physical functioning than ROI respondents but also that, among those who are experiencing limitations, adults in the North perceive these limitations as more debilitating than adults in the ROI.

## Health status

Respondents were asked to rate their physical health in the last year on a five-point scale from very poor to very good. Only a small percentage of respondents rated their physical health as very poor (n = 38, 2.0%) or as poor (n = 125, 6.5%) in the previous 12 months. Over one-third of the respondents rated their physical health status as good (n = 726, 37.8%) or very good (n = 697, 36.3%), while 17.4% (n = 335) reported fair physical health in the previous year. Overall, the majority of the respondents perceived that they had 'good or very good' physical health (n = 1,423, 74.1%), while just over one-quarter (n = 497, 25.9%) perceived that they had 'less than good' physical health.

### NI / ROI differences

For comparison purposes the ratings were recoded into two levels – 'less than good' and 'good or very good' physical health. Very poor, poor and fair were recoded as 'less than good', and 'good' and 'very good' were recoded into one category – 'good or very good'. There was a significant difference between the samples ( $\chi^2 (1) = 25.21$ ,  $p < 0.001$ ). Ten per cent more of those living in the North of Ireland reported 'less than good' physical health than those living in the Republic. In total, 20.7% (n = 190) of those in the ROI reported 'less than good' physical health, while 30.7% (n = 307) of those in NI did so. Thus, almost 80% (n = 730) of those in the ROI perceived their physical health as 'good or very good' compared to 70% (n = 693) in the North.

## Quality of life

Overall, the majority of the participants reported good or very good quality of life (n = 1,543, 80.3%), while only 4.9% (n = 95) reported poor or very poor quality of life, and 14.7% (n = 283) perceived their quality of life as fair.

### NI / ROI differences

As with physical health status, the quality of life measure was recoded into two categories of 'less than good' and 'good or very good'. Again, there were significant differences between those living in the North and those living in the Republic of Ireland ( $\chi^2 (1) = 12.86$ ,  $p < 0.001$ ), with a significantly higher proportion of NI respondents reporting 'less than good' quality of life (n = 228, 22.8%) than ROI respondents (n = 150, 16.3%).

# Chapter 5 Use of healthcare and support services and willingness to use supports

Data regarding the use of health services, professionals and other supports for mental health problems are presented in this chapter. In addition, the barriers preventing the use of primary care are presented as well as the willingness to use supports in the future.

## Brief summary

To summarise, a greater proportion of respondents in the ROI reported attendance at general practice for physical health problems, while a greater proportion of respondents in NI reported attendance at general practice for mental health problems. Regarding the two most frequently reported barriers for attending general practitioners, those in NI reported time and embarrassment while those in the ROI reported cost and time.

There were no significant differences in the proportion of respondents reporting attendance at any of the mental health services. In general, approximately 5% (n = 98) attended outpatient clinics, with 2% (n = 33) or less of respondents reporting attendance at inpatient services.

Psychotropic medication use was much higher in NI than in the ROI, with almost 14% (n = 135) of respondents in NI reporting use in the last year, while just under 6% (n = 53) in the ROI reported use in the last year.

The supports used in the previous year for mental health problems were similar between jurisdictions, with family and friends being the most frequently reported support. Two significant differences arose, with NI respondents reporting greater use of the clergy and ROI respondents reporting greater use of the Internet and alternative / complementary therapists. The willingness to use supports was similar between the jurisdictions, with family and friends and the GP the most frequently reported. In line with actual use the findings show that those in NI are more willing to use the clergy as a support than in the ROI.

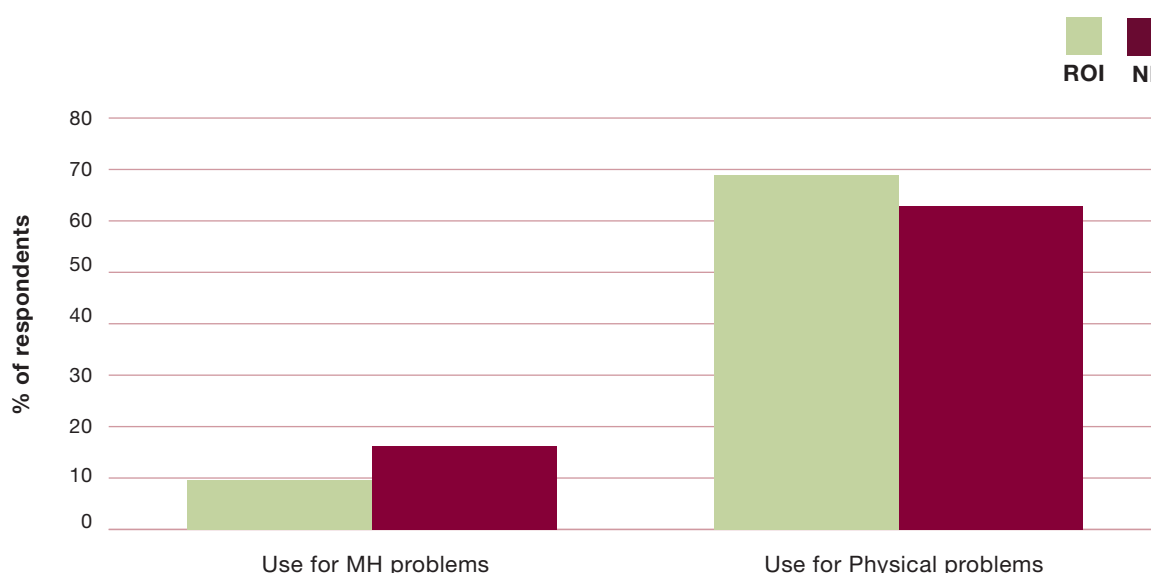
## General practice use

Of the total sample, 1,263 (65.8%) had attended the GP at least once for physical health problems and 252 (13.1%) had attended the GP for mental health problems. The average attendances per person of those who had attended the GP for physical health problems was 3.6, while the average number of times for attending the GP for mental health problems was 3.8 per person. As expected, these findings demonstrate that more people visit the GP for physical health problems than for mental health problems.

### NI / ROI comparisons

Figure 5.1 shows that significantly more of the respondents in the ROI (n = 634, 69.0%) had attended the GP for physical health problems in the last year than in NI (n = 629, 62.9%;  $\chi^2(1) = 7.88, p = 0.005$ ). For those who had attended the GP for physical health problems, those in the North of Ireland had attended on average more often (mean 3.9) than those in the South of Ireland (mean 3.3). Differences in the average number of attendances were small but statistically significant ( $t(1246) = -2.46, p = 0.01$ ).

Regarding use of general practice for mental health problems, a different pattern of use emerges (see Figure 5.1). Significantly more of the respondents in NI had attended the GP for mental health problems (n = 163, 16.3%) in the last year than in the ROI (n = 89, 9.7%;  $\chi^2(1) = 18.29, p < 0.001$ ). Interestingly, investigation of the average number of visits for those who attended the GP in the previous year showed no significant differences between those in NI (mean 4.0) and those in the ROI (mean 3.5).



**Figure 5.1** Weighted percentage of respondents using GP services for mental health problems and physical health problems over a one-year period by jurisdiction



Another interesting finding in relation to use of GP services was the NI / ROI differences in those who reported mental health problems in the last year. For those who reported mental health problems in the previous year there was no significant difference between the proportion of people in NI (n = 183, 82.4%) and in the ROI (n = 106, 77.4%) who reported using GP services for physical health problems. There was a significant difference in the proportion of people reporting mental health problems between the North and the Republic using GP services for mental health problems ( $\chi^2(1) = 7.22, p = 0.007$ ). In the ROI, a total of 43.1% (n = 59) of those who reported mental health problems had attended the GP at least once in the last year, while in NI, 57.7% (n = 128) of those with mental health problems in the last year attended the GP for this reason.

These results present some interesting findings in relation to the pattern of use of general practice services for physical health problems and mental health problems. Although more people in the ROI attend the GP over a one-year period, the level of use is the same in both jurisdictions, at an average of approximately three times per person per year. In contrast to this, a greater proportion of people in NI attend the GP for mental health problems than in the ROI and this may reflect the higher number of people in NI who have experienced mental health problems in the last year.

## **Barriers to the use of general practice services**

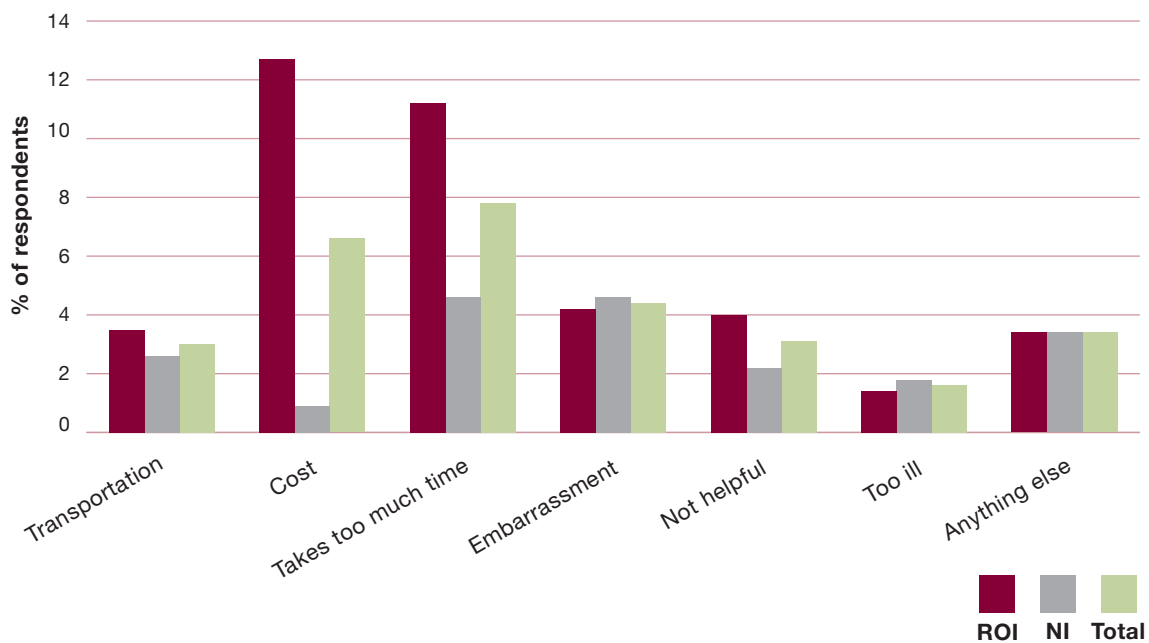
Respondents were provided with a list of six possible barriers that may have prevented them from seeing a GP in the previous year. Interestingly, a high proportion of the sample (78.6%; n = 1,507) reported that nothing had prevented them from seeing a GP in the previous year. Figure 5.2 presents the proportion of the sample reporting yes to any of the six barriers. Overall, the three most frequently reported barriers were: it takes too much time to visit the GP; cost of visiting the GP; and embarrassment, or feeling awkward.

### **NI / ROI comparisons**

There was a significant difference in the reported barriers preventing attendance at the GP between NI and the ROI ( $\chi^2(1) = 31.37, p < 0.001$ ). In NI a total of 83.6% (n = 836) reported that nothing prevented them from attending the GP in the previous year, while fewer respondents in the ROI reported no barriers (n = 671, 73.1%). These findings suggest that general practice services may be perceived as more accessible in the North than in the Republic. There were also differences in the perceived barriers preventing access to the GP between NI and the ROI. As can be seen from Figure 5.2, the two most frequently reported barriers for those in the ROI was cost followed by the amount of time that it takes to attend the GP. The two most frequently reported barriers for those residing in NI were time and embarrassment or feeling awkward. As

expected, significantly more respondents in the ROI (n = 117, 12.7%) reported cost as a barrier, with less than 1% (n = 9) of respondents in NI reporting cost as a barrier ( $\chi^2 (1) = 109.41, p < 0.001$ ). This probably reflects the different healthcare payment systems in place, where in NI healthcare is free at the point of delivery while in the ROI the majority of people have to pay for primary care services. Of those who had reported that cost was a barrier in the ROI, 80% (n = 93) did not have a medical card that allows for free primary healthcare. Furthermore, significantly more respondents in the ROI (n = 103, 11.2%) felt that the time that it takes to visit the GP prevented them from attending in the previous year than respondents in NI (n = 46, 4.6%;  $\chi^2 (1) = 29.27, p < 0.001$ ). Finally, there was also a significant difference in the proportion of respondents in the ROI reporting that they perceived the GP more unhelpful than in NI (n = 37, 4.0% vs n = 22, 2.2%;  $\chi^2 (1) = 5.37, p = 0.02$ ).

These findings show that while the majority of people do not perceive barriers to accessing GP services in NI and the ROI, a greater proportion of those in the ROI perceive barriers to access than in NI. In addition, the perceived barriers differ between the jurisdictions, with respondents in the ROI seeing cost, time and the helpfulness of the GP as barriers more frequently than respondents in NI. These findings suggest that the GP services are perceived more positively and regarded as more accessible in the North than in the Republic.



**Figure 5.2** Weighted percentage of respondents reporting barriers to accessing GP by jurisdiction



## Mental health service use

Respondents were asked to indicate if they had attended any of the four mental health services in the previous year: outpatient, day centre, day hospital and inpatient services. Of the total sample, 5.1% (n = 98) reported attending outpatient services, 1.9% (n = 36) reported attending day centres, 1.3% (n = 25) reported attending a day hospital and 1.7% (n = 33) reported attending an inpatient unit (see Table 5.1).

### NI / ROI comparisons

Table 5.1 shows the proportion of respondents reporting attendance at least once at one of the four mental health services components for each jurisdiction. There were no significant differences in the proportion of respondents attending any of the mental health services in the last year between NI and the ROI. These findings suggest that similar proportions of individuals at the population level are getting referred to secondary mental health services by the GP. In addition, the findings from the ROI reflect findings from the first NPWDS. Given the small sample sizes in these analyses no further analysis was carried out on this data.

**Table 5.1** Weighted percentage (n) of respondents reporting attending mental health services components in the last year by jurisdiction

	ROI % (n)	NI % (n)	Total % (n)
<b>Outpatient</b>	5.0 (46)	5.2 (52)	5.1 (98)
<b>Day centre</b>	1.6 (15)	2.1 (21)	1.9 (36)
<b>Day hospital</b>	1.3 (12)	1.3 (13)	1.3 (25)
<b>Inpatient</b>	2.2 (20)	1.3 (13)	1.7 (33)

## Psychotropic medication use

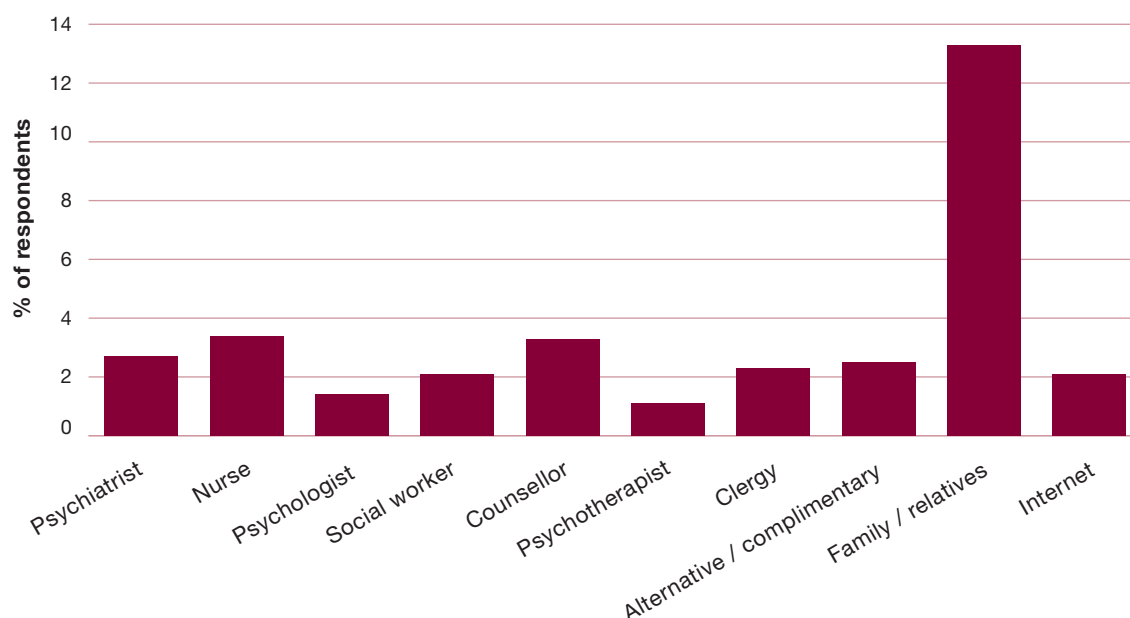
Respondents were asked if they had taken any prescribed medication for a mental, nervous, or emotional problem in the previous year. Overall, 9.8% (n = 188) of respondents had taken such medication. Of these, 42.8% (n = 81) had found the medication very effective, 34.2% (n = 65) found the medication moderately effective, 12.7% (n = 24) reported the medication as slightly effective and 7.0% (n = 13) reported it as not at all effective. A total of 3.4% (n = 6) did not know if the medication was effective or not.

## NI / ROI comparisons

Over twice as many people in NI than in the ROI reported being prescribed medication for a nervous, mental, or emotional problem in the previous year ( $\chi^2 (1) = 32.2, p < 0.001$ ). A total of 13.5% (n = 135) of NI respondents reported that they had been prescribed medication in the previous year compared to just 5.8% (n = 53) of those in the ROI. This difference remains even when only those who reported mental health problems in the previous year are included in the analysis ( $\chi^2 (1) = 14.05, p < 0.001$ ). Interestingly, of those who had experienced a mental health problem in the previous year in NI, 51.1% (n = 113) had been prescribed psychotropic medication, while the corresponding figure for the ROI was 30.9% (n = 42). There were no NI / ROI differences in the perceived effectiveness of the medication.

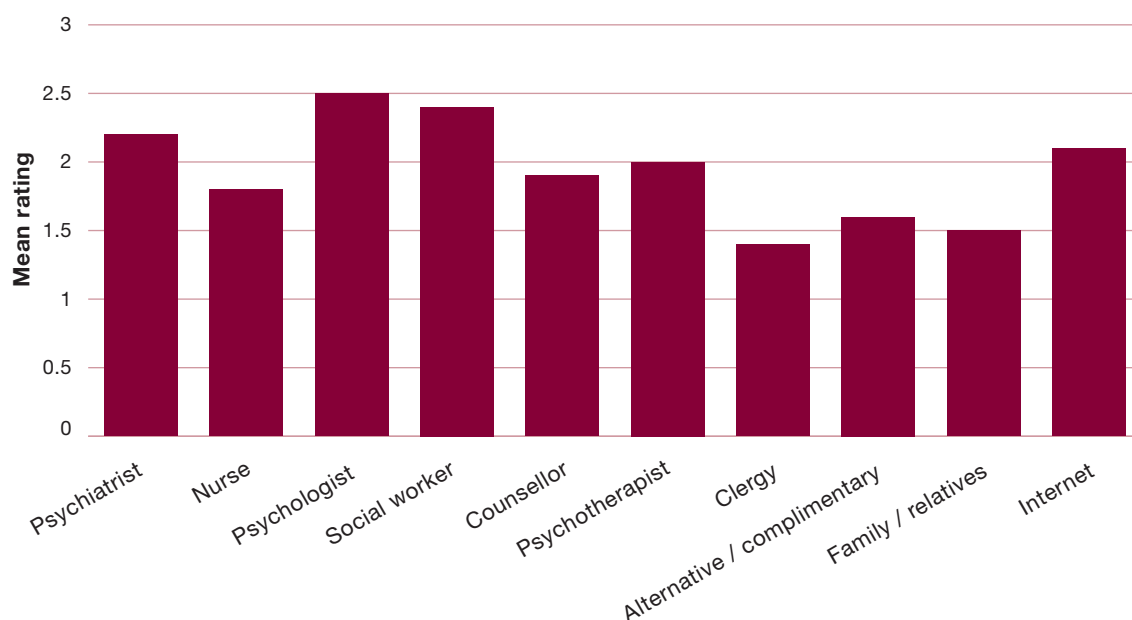
## Use of health professionals and others for mental, nervous, or emotional problems

Figure 5.3 shows the proportion of respondents that used each of the professionals or supports for mental health problems in the previous year. A total of 80.1% (n = 1,535) of the sample had not used any of the supports. As can be seen from the graph, the most widely used support was informal support from family and friends, with 13.3% (n = 255) of respondents reporting that they had used this form of support in the previous year. Few respondents used other forms of supports.



**Figure 5.3** Weighted percentage of respondents reporting use of professionals or supports for mental health problems in the previous year

The perceived effectiveness of the supports used was also assessed. Figure 5.4 depicts the mean effectiveness of the sources of supports used in the previous year for mental health problems. It is important to keep in mind that, given the small numbers reporting use of the supports, there are small numbers in each of the categories.



**Figure 5.4** Mean effectiveness rating for the sources of supports used in the previous year

### NI / ROI comparisons

There were few differences between the proportion of respondents from NI and from the ROI reporting that they had used professionals or supports in the previous year for mental health problems, with 79.4% (n = 728) of respondents in the ROI and 80.8% (n = 808) in NI reporting that they had used none of the supports. Analyses showed that a significantly greater proportion of the respondents in NI (3.3%, n = 33) used the clergy as a support than in the ROI (n = 12, 1.3%;  $\chi^2(1) = 8.25$ ,  $p = 0.004$ ). A significantly greater proportion of the respondents in the ROI used the Internet (n = 27, 2.9% vs n = 13, 1.3%;  $\chi^2(1) = 6.33$ ,  $p = 0.012$ ) as a support for mental health problems or alternative or complementary practitioners than in NI (n = 32, 3.5% vs n = 16, 1.6%;  $\chi^2(1) = 7.07$ ,  $p = 0.008$ ). Again, however, the numbers are very small in these categories.

As well as assessing the actual use of supports and professionals, as above, respondents were asked what supports and professionals they would be willing to use if they were to experience mental health problems. The two most frequently reported supports that would be used were family and friends or the GP. This was followed by psychiatrist, counsellor and psychologist, but to a much lesser extent. These findings highlight the importance of friends and family as informal supports for mental health problems as well as the formal support of the GP.

# Chapter 6 Use of GP services for mental health problems

The above chapter provided a description of the use of the GP and other supports specifically for mental health problems. The findings clearly show that there is a difference between the North and the South in relation to the use of GP services for mental health problems. Proportionately more people in the North use the GP for mental health problems than in the Republic, although for those who did contact the GP there was no difference in the rate of attendances between the jurisdictions.

The following chapter will further explore the use of GP services for mental health problems. It will begin by examining the descriptive statistics on GP visiting patterns in the North and in the South of Ireland. We will investigate GP visitation patterns by socio-economic factors and health factors. Cross-tabulations will be carried out to investigate the relationship between each of these variables and attendance at the GP. Some of these factors relate to the extent to which the individual 'needs' the services, while others are relate to 'non-need' factors (Nolan *et al.* 2007). Need factors include those that relate to health status, or in other words, the factors that cause you to 'need' to go to the GP. Those with poor health will need to use health services more often than those with good health. Non-need factors include things like education, economic factors, and location of household. If healthcare service is based on 'needs' alone, then these factors should not impact on use. If these factors do impact on use, then there may well be issues of equity and accessibility within the health services. What we are interested in is how these variables relate to visiting patterns and whether the non-need factors impact on GP use for mental health problems. This is the first known Irish survey to address the use of GP services for mental health problems specifically. The use of GP services for physical health problems has been documented in previous work (see Nolan *et al.* 2007). While it is not the primary aim of this survey to address the determinants of physical health, this data was available in the current survey. Therefore, it was analysed for comparison purposes with the data relating to visitation for mental health. The final model of predictors of attendance for physical health is presented following the analysis of the data for mental health.

## Brief summary

The final model of the predictors of attendance at the GP for mental health problems included only six variables, with these variables predicting almost 56% of the variance. The variables that remained in the model were defined as 'need' factors or factors that should influence your attendance at the GP, such as your health status, i.e. they had to do with the individual's 'need' to attend the GP services for mental health problems,

such as low perceived mental health status, limitations in activities or the use of psychotropic medication. In addition, if the individual had used GP services for physical health problems or had used other supports, these were also significant predictors of the use of GP services for mental health problems. These findings suggest that the factors that should influence seeking help do predict attendance. The factors that should not influence your attendance at the GP, such as your income or employment, did not in this instance predict attendance at the GP for mental health problems. The proposed wider implications of these findings in terms of equity and accessibility of GP services for mental health problems are discussed in the final chapter.

The next section of the chapter investigates the independent effects of factors that were significant in the cross-tabulations on GP use for mental health problems. As many of the individuals and household characteristics, such as age and income, are correlated, we need to look at the independent effects of these factors. For example, while there may be a relationship between medical eligibility and service use this may be due to the older age group or poorer mental health status. Multivariate analysis would allow us to determine the effects of free medical care while controlling for all other variables. Logistic regression is used to estimate the relationship between specific factors (predictors) and some outcome measure. In other words, logistic regression is a statistical technique that can be used to predict a particular outcome. In this instance we will use logistic regression to predict whether someone is likely to use GP services specifically for mental health problems. We want to know which variables are important in determining whether a respondent will attend the GP for mental health problems. The question is whether demographic, socio-economic or health status variables are the most important in predicting GP use. We also want to know if living in the North or the South of Ireland impacts on the use of GP services for mental health problems. The first step in this analysis is to assess the cross-tabulations for the influence of the individual variables on attendance at the GP for mental health problems. Variables that show a significant effect are then entered into a regression model which assesses the independent effects of these variables while controlling for the other significant variables. The initial step (cross-tabulations) is presented first, followed by the final regression model.

## **Descriptive statistics on GP visiting patterns for mental health problems**

The following analysis presents the findings of the cross-tabulations of GP service use by socio-demographic and health variables for the total sample including NI and ROI.

The results for the analysis of GP service use for mental health problems by socio-economic and demographic variables are presented in Table 6.1 and the results for the

health variables are presented in Table 6.2. The tables show the weighted percentages of the respondents who had attended the GP for mental health problems at least once by the socio-economic, demographic and health variables and the significance of the chi-square analysis.

The chi-square analysis showed some interesting general findings. They suggest that, overall, socio-economic and demographic variables are correlated with attendance at the GP for mental health problems (see Table 6.1). However, for the total sample, access to free medical care and urbanicity did not influence attendance. As healthcare is free at the point of contact in NI one would not expect these factors to influence attendance at the GP. However, the finding is in contrast to previous findings for the Republic of Ireland, which have shown that eligibility for free healthcare was related to use of GP services, with those who had free access more likely to attend services (Nolan 2008). The findings also suggest that living in urban or rural area does not influence attendance at the GP. Interestingly, the jurisdiction in which the respondent lived had a highly significant influence on attendance at the GP for mental health problems. As shown in the previous analysis, a greater proportion of those living in NI had attended the GP in the previous year for mental health problems than in the ROI. In addition, health variables, perceived barriers and use of other supports appear to influence attendance at the GP for mental health problems (see Table 6.2). As expected, these variables have a highly significant impact on attendance at the GP for mental health problems.

As mentioned above, bivariate cross-tabulations do not control for the influence of other variables. So, for example, the significant influence of jurisdiction on attendance at the GP may be due to differences in other variables between the respondents such as perceived health status, and therefore multivariate analysis was used to investigate the impact of the significant variables while controlling for the other variables.

**Table 6.1** Weighted percentages (n) of total respondents who had attended the GP for mental health problems by socio-economic and demographic variables

	Attended (n = 251)	Did not attend (n = 1,667)	Significance level
<b>Gender</b>			0.015
Female	14.9 (148)	85.1 (846)	
Male	11.1 (103)	88.9 (821)	
<b>Age</b>			0.001
18–39	10.9 (89)	89.1 (724)	
40–64	16.5 (125)	83.5 (631)	
65+	10.1 (31)	89.9 (276)	

**Table 6.1** Weighted percentages (n) of total respondents who had attended the GP for mental health problems by socio-economic and demographic variables (*continued*)

<b>Marital status</b>			0.000
Married / cohabitating	11.7 (121)	88.3 (909)	
Separated / divorced / widowed	22.8 (64)	77.2 (217)	
Never married	11.0 (66)	89.0 (534)	
<b>Education</b>			0.003
Primary	18.8 (40)	81.2 (173)	
Secondary	13.3 (169)	86.7 (1,099)	
Third	9.0 (35)	91.0 (352)	
<b>Employment</b>			0.000
Employed / retired / training / education	11.2 (182)	88.8 (1,448)	
Unemployed / sickness / domestic duties	24.1 (68)	75.9 (214)	
<b>Monthly income</b>			0.005
Low income (€1,599 or less)	15.7 (83)	84.3 (445)	
Medium income (€1,600–3,599)	13.5 (80)	86.5 (513)	
High income (€3,600+)	8.5 (33)	91.5 (357)	
<b>Access to free healthcare</b>			NS
Yes	13.1 (117)	86.9 (778)	
No	13.2 (135)	86.8 (888)	
<b>Urbanicity</b>			NS
Urban (pop. > 1500)	13.6 (167)	86.4 (1,060)	
Rural (pop. < 1500)	11.7 (67)	88.3 (504)	
<b>Socio-economic group (SEG)</b>			0.001
AB upper / middle class	9.4 (28)	90.6 (269)	
C1 lower middle class	14.4 (79)	85.6 (468)	
C2 skilled working class	9.4 (40)	90.6 (387)	
DE other working class / lower grade	14.4 (63)	85.6 (374)	
F all farmers	19.9 (42)	80.1 (169)	
<b>Jurisdictions</b>			0.000
ROI	9.7 (89)	90.3 (829)	
NI	16.3 (163)	83.7 (837)	

**Table 6.2** Weighted percentages (n) of respondents who had attended or did not attend the GP for mental health problems by health variables

	<b>Attended (n = 251)</b>	<b>Did not attend (n = 1667)</b>	<b>Significance level</b>
<b>Physical health status</b>			0.000
Less than good	25.8 (128)	74.2 (369)	
Good or very good	8.7 (123)	91.3 (1,295)	
<b>Mental health status</b>			0.000
Less than good	46.0 (144)	54.0 (169)	
Good or very good	6.7 (107)	93.3 (1,495)	
<b>Quality of life</b>			0.000
Less than good	32.4 (122)	67.6 (255)	
Good or very good	8.4 (129)	91.6 (1,411)	
<b>Limitations in physical activities</b>			0.000
No limitations	7.7 (130)	92.3 (1,559)	
Some limitations	53.8 (120)	46.2 (103)	
<b>Limitations in social activities</b>			0.000
No limitations	7.0 (118)	93.0 (1,560)	
Some limitations	56.1 (134)	43.9 (105)	
<b>Attendance at GP for physical health problems</b>			0.000
Never	3.5 (23)	96.5 (632)	
At least once	18.1 (229)	81.9 (1,034)	
<b>Barriers to use of GP services</b>			0.000
No barriers	10.5 (158)	89.5 (1,350)	
One or more barriers	22.9 (94)	77.1 (316)	
<b>Prescribed medication for mental health problems</b>			0.000
No	6.3 (108)	93.7 (1,613)	
Yes	75.0 (141)	25.0 (47)	
<b>Psychological distress in last few weeks (GHQ 12)</b>			0.000
Yes (score 2+)	35.1 (153)	64.9 (283)	
No (score < 2)	6.0 (84)	94.0 (1,326)	
<b>Use of other supports</b>			0.000
No	5.4 (83)	94.6 (1,452)	
Used one or more	44.1 (168)	55.9 (213)	



## Multivariate analysis of the use of GP services for mental health problems

Logistic regression analysis was used to explore the influence of identified health, demographic and socio-economic factors on respondents' attendance at the GP for mental health problems. Health, demographic and socio-economic variables that were found to be statistically significant at 0.05 levels in cross-tabulations were included in the multivariate logistic regression analysis.

Due to a relatively high number of variables it was decided to perform automated model-building for the prediction of attendance among respondents. Likelihood ratio (LR) forward selection and backward elimination with a significance level for inclusion of 0.15 (Norusis 2006) were used for this purpose. Likelihood ratio (LR), beta weights and significance level (Norusis 2006) were checked for model-building. The Hosmer and Lemeshow tests were used to evaluate the fit of the models. Both methods of model-building resulted in very similar final models, and results from the likelihood ratio forward selection are presented below.

There were a total of 18 variables entered in the analysis of attendance at the GP for mental health problems. These included all the significant socio-economic and demographic variables (see Table 6.1) and the significant health variables (see Table 6.2) and socio-economic group. Table 6.3 presents the final model of attendance at a GP for psychological problems. As can be seen from the model six variables remained. These included perceived mental health status in the previous year, limitations in physical activities, attendance at the GP for physical health problems, the use of psychotropic medication in the previous year, significant psychological distress in the previous few weeks and the use of other supports for mental health problems. Interestingly, none of the socio-economic or demographic variables remained in the model, and this is discussed in further detail in the next chapter. The Nagelkerke  $R^2$  value of 0.557 (Cox and Snell  $R^2 = 0.297$ ) indicated that almost 56% of the variance in attendance at a GP for a mental health problem was explained by the combination of the six remaining variables. The Hosmer-Lemeshow test result of 0.351 confirmed that the model had a good fit.

Not surprisingly, the use of prescribed medication in the previous year was the strongest predictor of attendance at the GP for mental health problems, with those who had been prescribed medication over 12 times more likely to have attended. Attendance at the GP for physical health problems also had a large influence on attendance for mental health problems, with those who had attended for physical health being almost five times more likely to have attended for mental health problems. The third strongest predictor of attendance at the GP was the use of other supports. Respondents who had used one or more of the other supports for mental health problems were over three times more likely to use the GP. The previous chapter highlights the range of supports that are included. To summarise, these supports included a range of medical

professionals (e.g. nurse, psychiatrist), allied health professionals (e.g. psychologist, social worker) and informal supports (e.g. family and friends, Internet). Given the small numbers using the individual supports, the variable was categorised into a broad category of use or non-use, regardless of the source of the support. While the use of supports is broadly classified, the findings may suggest that if help is sought, regardless of who it is sought from, you are more likely to seek help from other sources. As expected, perceived mental health status in the previous year predicted use of GP services for mental health problems, with those who perceived their mental health as less than good being almost three times as likely to use the GP than those who perceived their mental health as good or very good. This was followed by limitations in physical activities, with those who had limitations over twice as likely to attend the GP than those who did not experience limitations. Finally, the last predictor of attendance was recent psychological distress. Those who had experienced distress in the past few weeks were just over twice as likely to have attended the GP for mental health problems as those who did not experience distress.

**Table 6.3** Logistic regression final model predicting attendance at a GP for mental, nervous, or emotional problems on the basis of socio-economic, demographic and health variables

Predictors	B	S.E.	Odds Ratio	95% CI	Sig.
<b>Psychotropic medication in previous year</b>					
(Reference: no medication)					
Prescribed medication	2.51	0.24	12.41	7.75, 19.88	0.000
<b>Attendance at GP for physical health problems</b>					
(Reference: no attendances)					
Attended once or more	1.59	0.30	4.92	2.73, 8.88	0.000
<b>Use of other supports</b>					
(Reference: no)					
Used one or more	1.26	0.21	3.55	2.35, 5.36	0.000
<b>Mental health status</b>					
(Reference: good or very good)					
Less than good	0.95	0.22	2.60	1.67, 4.07	0.000
<b>Limitations in physical activities</b>					
(Reference: No limitations)					
Some limitations	0.90	0.24	2.47	1.53, 3.99	0.000
Psychological distress					
(Reference: no distress)					
Distress (GHQ 12 score > 2)	0.76	0.21	2.15	1.41, 3.27	0.000
<b>Constant</b>	-4.90	0.31	0.007		0.000

## Multivariate analysis of the use of GP services for physical health problems

For comparison purposes, the data from the use of GP services for physical health problems was subjected to the same analysis as the data from the use of GP services for mental health problems. The following analysis presents the findings of the cross-tabulations for the total sample.

The results for the analysis of GP service use for physical health problems by socio-economic and demographic variables are presented in Table 6.4 and the results for the health variables are presented in Table 6.5. The tables show the weighted percentages of respondents who had attended the GP for physical health problems at least once by the socio-economic, demographic and health variables and the significance of the chi-square analysis. As in the previous analysis, all variables that were significant in the chi-square were entered into the regression model.

**Table 6.4** Weighted percentages (n) of total respondents who had attended the GP for physical health problems by socio-economic and demographic variables

	<b>Attended (n = 1,263)</b>	<b>Did not attend (n = 702)</b>	<b>Significance level</b>
<b>Gender</b>			0.002
Female	67.6 (683)	32.4 (328)	
Male	60.8 (580)	39.2 (374)	
<b>Age</b>			0.000
18–39	59.6 (424)	40.4 (288)	
40–64	63.5 (592)	36.5 (340)	
65+	76.9 (247)	23.1 (74)	
<b>Marital status</b>			0.015
Married / cohabitating	62.9 (664)	40.4 (288)	
Separated / divorced / widowed	71.9 (205)	36.5 (340)	
Never married	63.3 (247)	23.1 (74)	
<b>Education</b>			NS
Primary	61.6 (172)	38.4 (107)	
Secondary	64.9 (842)	35.1 (456)	
Third	64.1 (248)	35.9 (139)	
<b>Employment</b>			0.000
Employed / self-employed	59.6 (651)	40.4 (441)	
Retired / training / education / domestic duties	70.4 (537)	29.6 (226)	
Unemployed / sickness	68.6 (70)	31.4 (32)	

**Table 6.4** Weighted percentages (n) of total respondents who had attended the GP for physical health problems by socio-economic and demographic variables (*continued*)

<b>Monthly income</b>			0.028
Low income (€1,599 or less)	70.5 (372)	29.5 (156)	
Medium income (€1,600–3,599)	63.0 (373)	37.0 (219)	
High income (€3,600+)	67.7 (264)	32.3 (126)	
<b>Access to free healthcare</b>			NS
Yes	65.5 (586)	34.5 (309)	
No	65.7 (677)	32.3 (126)	
<b>Urbanicity</b>			NS
Urban (pop. > 1500)	64.7 (813)	35.3 (444)	
Rural (pop. < 1500)	65.4 (384)	34.6 (203)	
<b>Socio-economic group (SEG)</b>			NS
AB upper / middle class	60.4 (183)	39.6 (120)	
C1 lower middle class	62.5 (350)	37.5 (210)	
C2 skilled working class	64.8 (282)	35.2 (153)	
DE other working class / lower grade	66.8 (300)	33.2 (149)	
F all farmers	68.2 (69)	31.8 (69)	
<b>Jurisdictions</b>			0.005
ROI	69.0 (634)	31.0 (285)	
NI	62.9 (629)	37.1 (371)	

**Table 6.5** Weighted percentages (n) of respondents who had attended or did not attend the GP for physical health problems by health variables

	<b>Attended (n = 1,263)</b>	<b>Did not attend (n = 702)</b>	<b>Significance level</b>
<b>Physical health status</b>			0.000
Less than good	82.9 (413)	17.1 (85)	
Good or very good	59.6 (847)	40.4 (575)	
<b>Mental health status</b>			0.000
Less than good	77.1 (243)	22.9 (72)	
Good or very good	63.4 (1,018)	36.6 (588)	
<b>Limitations in physical activities</b>			0.000
No limitations	63.4 (1,070)	36.6 (619)	
Some limitations	84.2 (187)	15.8 (35)	
<b>Limitations in social activities</b>			0.000
No limitations	63.3 (1,062)	36.7 (616)	
Some limitations	84.1 (201)	15.8 (35)	

**Table 6.5** Weighted percentages (n) of respondents who had attended or did not attend the GP for physical health problems by health variables (*continued*)

<b>Attendance at GP for mental health problems</b>			0.000
Never	9.1 (23)	39.6 (679)	
At least once	90.9 (229)	60.4 (1,034)	
<b>Barriers to use of GP services</b>			0.000
No barriers	62.4 (941)	37.6 (567)	
One or more barriers	78.5 (322)	62.4 (941)	
<b>Prescribed medication for mental health problems</b>			0.000
No	63.6 (1,094)	36.4 (627)	
Yes	87.8 (166)	12.2 (23)	
<b>Psychological distress in last few weeks (GHQ 12)</b>			0.000
Yes (score 2+)	77.2 (336)	22.8 (99)	
No (score < 2)	62.1 (875)	37.9 (534)	
<b>Use of other supports</b>			0.000
No	62.3 (957)	37.7 (578)	
Used one or more	80.1 (305)	19.9 (76)	

There were a total of 15 variables entered in the analysis of attendance at the GP for physical health problems. Table 6.6 presents the final model of attendance at a GP for physical health problems. As can be seen from the model eight variables remained. The Nagelkerke R<sup>2</sup> value of 0.170 (Cox and Snell 0.122) indicated that 17% of the variance in attendance at a GP was explained by the combination of the remaining variables. The Hosmer-Lemeshow test result of 0.760 confirmed that the model had a good fit.

In contrast to the model predicting attendance at the GP for mental health problems, some demographic and economic factors remained in the model predicting attendance for physical health problems. This replicates previous findings (Nolan *et al.* 2007). Although the factors relating to health were the strongest predictors in the model, age, employment, income, and place of residence also stayed in the final model. To summarise the findings in relation to the demographic and economic predictors, those who were older were more likely to attend the GP than those who were younger; those who were retired, in education or in training, or involved in household duties were more likely to attend than employed persons; people with lower household income were less likely to attend than those with higher income levels, and people in NI were less likely to attend than people in the ROI.

The key finding for the purposes of this report is that factors over and above the 'need' factors influenced attendance at the GP for physical health but not for mental health. Notwithstanding this it is also clear from the analysis that the model predicting attendance for mental health is a much stronger model, predicting almost 56% of the variance. The model for physical health predicted much less of the variance at 17%, suggesting that other factors that are not included in the survey may be important factors influencing attendance at the GP for physical health.

**Table 6.6** Logistic regression final model predicting attendance at a GP for physical health problems on the basis of socio-economic, demographic and health variables

Predictors	$\beta$	S.E.	Odds Ratio	95% CI	Sig.
<b>Age (Reference: 18–39 years)</b>					
40–64 years	0.55	0.13	1.06	0.82, 1.36	0.672
65+ years	0.46	0.23	1.58	1.00, 2.49	0.048
<b>Employment status</b>					
(Reference: employed)					0.005
Unemployed / sickness	-0.12	0.30	0.89	0.49, 1.61	0.696
Retired / training / education / domestic duties	0.49	0.16	1.63	1.20, 2.21	0.002
<b>Income (Reference: high income)</b>					
Low income	-0.30	0.16	0.74	0.58, 1.01	0.064
Medium income	-0.28	0.14	0.76	0.57, 1.00	0.057
<b>Jurisdiction</b>					
(Reference: ROI)					0.008
NI	-0.32	0.12	0.73	0.58, 0.92	
<b>Attendance at GP for mental health problems</b>					
(Reference: no attendances)					0.001
Attended once or more	1.77	0.28	5.86	3.36, 10.19	
<b>Mental health status</b>					
(Reference: good or very good)					0.022
Less than good	-0.49	0.21	0.61	0.40, 0.93	
<b>Physical health status</b>					
(Reference: good or very good)					0.001
Less than good	1.25	0.18	3.48	2.44, 4.94	
<b>Barriers to attending the GP</b>					
(Reference: one or more barriers)					0.000
No barriers	-0.65	0.16	0.52	0.38, 0.72	
<b>Constant</b>	1.01	0.19	2.75		0.000

As mentioned above, it is interesting that none of the socio-economic or demographic factors remained in the final model for mental health, but did for physical health. The wider implications of these findings are discussed in Chapter 7. To summarise here, the overall findings suggest that 'need' factors such as subjective mental health status, objective experience of psychological distress, and the effect of mental health on physical activities influence attendance at the GP for mental health. In contrast, 'non-need' factors such as economic status, gender or age do not influence attendance for mental health problems. It would appear, at least from these findings, that internal factors within the individual influence attendance rather than external factors in the environment. Furthermore, the findings suggest similarities between NI and the ROI rather than differences in the use of the GP for mental health problems. As the 'jurisdictions' variable did not remain in the final model, the differences in attendance at the GP were explained more by differences in the health status of the respondents than the area where they lived, per se. In contrast to this, the predictors of attendance at the GP include the 'non-need' factors of income and employment status. Furthermore, the jurisdiction variable remained in the model, with those in NI 1.3 times less likely to attend the GP for physical health problems than their ROI counterparts. This is interesting given that healthcare is free in NI and therefore one would expect that demand would be greater. Nevertheless, the findings suggest that this is not the case. Other factors that may impact on attendance at the GP in the North of Ireland are discussed in the Chapter 7.

# Chapter 7 Discussion and conclusions

The primary aim of this survey was to investigate the differences in the mental health and health service use for mental health problems between Northern Ireland and the Republic of Ireland. To summarise the findings, there was no difference in current levels of psychological distress between the respondents in NI and ROI. However, people in the North of Ireland had lower perceived mental health than those in the South and also more Northern Irish respondents reported mental health problems in the previous year than those in the Republic. These differences remained significant even after controlling for demographic differences in marital status, education, employment status, SEG and income. The findings suggest that while levels of psychological distress in the last few weeks do not differ between the jurisdictions, one-year prevalence measures of self-reported mental health problems do differ. It is important to note here the difference in the measures used. The self-report measure is subjective, while the GHQ measure of level of distress is a more objective measure of the symptoms of psychological distress. In addition, the reference periods of the measures differ. Previous research on one-year prevalence measures in health status has shown significant differences between the North and the Republic of Ireland, while there were no significant differences in general mental health as measured in the previous four weeks (Balanda and Wilde 2003). Thus, the findings of this report are supported by previous research.

## Factors related to use of GP services for physical health problems

Concerning GP use for physical health problems, a greater proportion of respondents in the ROI attended the GP for physical health problems than in the North. However, for those who had attended at least once, those in the North attended more frequently. Given the structure of the health services in the North where attendance is free at the point of contact, it would be reasonable to assume that more people would attend than in a system where the majority of respondents must pay for service, as in the ROI. One explanation as to why they do not do so is that the waiting times in the North for attending the GP are longer than in the ROI (Galway *et al.* 2007). The survey by Galway *et al.* investigated access to primary healthcare in the ROI and NI and found that satisfaction with GP practices was higher in the ROI than in NI, as were scores relating to access to GP services. The findings showed that 68.8% of respondents in the ROI could get access to any doctor on the same day compared to just 30.9% of respondents in NI. Only 4.2% of respondents in the ROI had to wait two or more working days to see any doctor compared to 31.2% in Northern Ireland. The waiting time to see a doctor



of choice proved even more problematic for Northern respondents. In the Republic of Ireland, 40.1% of respondents were able to see their doctor of choice on the same day, while only 12.7% of respondents in the North were able to do so. It is possible that the long wait to attend the GP may inhibit the inappropriate use of the free GP service in Northern Ireland; whereas in the ROI the waiting time is shorter for a GP appointment and therefore people are more likely to attend as soon as they are experiencing physical health problems. Further analysis of this data showed that a greater proportion of those with free access in the ROI (74%; 241 / 292) attended the GP for physical health than those who had to pay for the service (66%; 419 / 632;  $p = 0.03$ ) and also had a significantly higher average number of attendances (4.3 visits versus 2.7 visits;  $p < 0.001$ ). These figures show the importance of investigating service use for those who have access to free healthcare compared to those who do not have free access. In terms of attendance at the GP for physical health problems it would seem that time, as in waiting times, and cost, as in fee for service, are factors that may influence the decision to attend the GP. The analysis of the barriers preventing attendance at the GP for either physical or mental problems reflects this. Those in the North of Ireland reported 'takes too much time' and embarrassment as the two most frequent barriers to GP attendance, while those in the ROI reported cost and taking too much time most frequently. Data from a Scottish qualitative study highlighted that perceived waiting times for appointments affected consulting intentions for GP visits, especially when the symptoms were unclear or perceived as trivial (Campbell *et al.* 2006). Data for the ROI from a European study, the EU-SILC 2004, showed that the three main reasons why people did not consult the GP and other medical professions were cost, waiting lists, and could not take time off work. Furthermore, O'Reilly *et al.* (2007) in a cross-border study reported that 18.9% of respondents in the Republic reported a medical problem in the previous year, but had not seen the GP because of cost. Finally, the results showed that for those who had attended in the North or the South of Ireland, those in the North attended more frequently, i.e. those who did not have to pay a fee for service. Furthermore, just looking at the findings from the ROI and comparing those who had to pay for the service with those who had not, again it was the respondents who had free access that attended more frequently. While this survey does not enable us to investigate why this would be, it does highlight the possible effects that a fee for service may have on the frequency of attendance at the GP. Nolan and Nolan (2007) suggest that income effects the individual's decision to consult the GP, but does not affect the frequency of attendance. They argue that this represents the 'principal-agent' view of the decision-making process, whereby the doctor makes the decisions regarding future attendances. If this is correct, then our findings suggest that the doctor may be more willing to refer public patients for repeat attendances as they do not have to pay for services and less inclined to refer those who have to pay for repeat consultations.

## Factors related to use of GP services for mental health problems

In contrast to the findings for GP use for physical health problems, the use of GP services for mental health problems showed a different picture. Firstly, respondents in NI attended more often than those in the ROI and secondly, there were no differences in the frequency of attendance for those who had attended in the previous year. This may reflect the higher level of mental health problems in the North and the lower perceived mental health. Of those who reported experiencing mental health problems in the previous year, a higher proportion in NI had attended the GP for mental health problems than in the ROI. Two possible interpretations of these findings are put forward. One is that respondents in NI experienced more severe mental health problems in the previous year, thus requiring support from the GP. The other is that people in NI are more likely to visit their GP when they are experiencing mental health problems and that unmet need is greater in the ROI than in NI. Comparisons between those with free access to the services and those who did not have free access to care in the ROI also painted a slightly different picture to that for attendance for physical health. Unlike for physical health, the proportion attending for mental health problems did not differ between those with free access (9.9%; 29 / 292) and those who had to pay a fee for the service (9.5%; 60 / 632). Of those who had attended the GP for mental health problems those with free access to services did not attend more frequently than those who did not have free access. The comparison of these findings with the physical health data suggests that the decision to attend for common mental health problems may not be affected by waiting times or costs as much as the decision to attend for physical health problems.

## Factors that impact on help-seeking

Most often, common mental health symptoms tend not to require immediate treatment, are not readily identifiable and are unlikely to abate within a few days, unlike many of the symptoms of common physical health problems, and therefore by the time people go to the GP they can be already experiencing significant problems. Thus, the decision to attend is likely to be influenced more by factors related to need than to extraneous factors. Our multivariate analyses supported these findings. In these analyses none of the factors that one would consider as non-need factors such as age, income and employment stayed in the final model predicting attendance at the GP for mental health problems. The only factors that stayed in the model are factors that are intuitively related to need – for example, perceived low mental health status, activity limitations due to mental health difficulties, and recent psychological distress. Interestingly, being on medication was the most important predictor of attendance at the GP. This can be interpreted as a positive finding if it means that those who were taking medication for mental health problems were being monitored frequently.

However, we do not know if they were just returning for a repeat prescription rather than a consultation to monitor the individual or if the prescription was appropriate in the first place. The over-use of medication by GPs has been highlighted recently and is discussed in more detail below. Finally, the use of other supports also predicted attendance at the GP. While we cannot say if people attended the GP first and were referred to others or if it was the other direction, with other supports directing people to the GP, it does highlight that those who are seeking help from whatever sources, whether formal or informal, are also more likely to attend the GP. Primary care services in NI are more likely to include professionals other than the GP. Therefore people with mental health problems may have greater access to a range of professionals. However our findings would suggest that NI respondents are not using other professionals more frequently. Given the developments of the new initiatives in Primary Care in the North – Directed Enhanced Services and Stepped Care – it is likely that these services will result in enhanced treatment and care of mental health problems. There have been little developments in the ROI for the treatment of common mental health problems. For those with more enduring problems, a consultation-liaison model is suggested whereby the psychiatrist meets with the GP to discuss and advice on the treatment and care of specific individuals.

These findings are interesting in that they suggest that the determinants of the decision to consult the GP for physical health problems may differ from the decision to consult the GP for mental health problems. Why would it be that the decision to consult for mental health problems is based on healthcare need as opposed to financial or other non-need factors, while these non-need factors affect the decision to consult for physical health problems? In the Irish context (ROI), previous research, which has included measures of health as well as demographic and socio-economic factors, has found that measures of perceived health status, distress and chronic illness remain in the model with other socio-economic and demographic variables, predicting decision to consult (Nolan & Nolan. 2007). Nolan and Nolan point out the possibility that the measures used to assess health status may not be sensitive enough to identify differences, which may lead to an overestimation of the effect of free access to the GP. However, given that the findings have been replicated using various measures, this seems unlikely. The literature would suggest that there are factors such as lack of knowledge of mental health problems, an understanding of mental health services provided by complex health systems (mental health literacy) and stigma that prevent attendance at the GP (Schomerus and Angermeyer 2008; Komiti *et al.* 2006). Mental health literacy is generally low and many people are not aware of what or when symptoms of stress require treatment and care (Jorm 2000). Even when people are aware that they require support they may not know from whom this support should be sought. Jorm (2000) argues that low mental health literacy may hinder public acceptance of evidence-based treatments for mental health problems and may limit

effective self-help and support from others. The 'Stress Control Model'<sup>14</sup> developed as part of the STEPS programme in Scotland is aimed at improving mental health literacy. Basically it is a psycho-educational programme which provides information on psychological distress and coping strategies to improve people's ability to deal with stressful events or transient mental health problems. This is a community-based initiative that does not require any formal referral. The programme is advertised in community settings as well as in health centres, is less formal than conventional services, and can facilitate many people at one session. Unfortunately, there has as yet been no formal evaluation of the programme, but preliminary findings suggest that it has benefits for those who participate.

The stigma surrounding mental health issues may also discourage people from seeking help (Komiti *et al.* 2006; Schomerus and Angermeyer 2008). In fact, Vogel and Wade (2009) point out that the stigma surrounding mental health problems is one of the most common reasons for not seeking help. This stigma is associated with the rejection of those with mental illnesses who are perceived as different, unacceptable or dangerous. There is also public stigma associated with seeking help for less severe psychological problems (Jorm and Wright 2008). Recently, it has been argued that there is a much more potent stigma that may be directly related to help-seeking (Vogel and Wade 2009). Self-stigma is thought to be an internal form of stigma whereby the individual perceives the act of seeking professional help for distress as a threat to their self-worth and as a weakness of character (Vogel *et al.* 2006). Lin and Parikh (1999) found that embarrassment and being viewed as unbalanced, prevented people from seeking help for psychological problems. Self-stigma is thought to be even more pronounced for those with less severe problems, in such situations where counselling or therapy is viewed as a voluntary activity to prevent the escalation of problems rather than a necessary activity for more severe problems (Vogel and Wade 2009). Vogel and Wade also argue that self-stigma is related to cultural and gender-role norms. The treatment gap for mental health problems is widely acknowledged and shows that many people do not seek help when faced with mental health problems. Our findings showed that of those who reported mental health problems, 57% in the ROI and 42% in NI had not sought help from the GP. These figures correspond to international figures (Demyttenaere *et al.* 2004). The failure to seek help may lead to the escalation of problems and the need for more intensive interventions at a later date. Given the lack of knowledge and awareness, it may be that by the time the individual makes the decision to contact the GP for help, mental health problems have escalated to the extent that they are impacting on the individual's daily living activities and perceived health status. Thus, it is these factors that determine the decision to contact the GP rather than non-need factors such as income and access to free medical care. Increasing education and awareness of mental health problems and the available

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14 <http://www.glasgowsteps.com/>

sources of informal and formal supports would help inform people of when and who they should contact when experiencing distress. Regarding differences between the North of Ireland and the Republic, the multivariate analysis suggested that they are more similar than different in terms of contacting the GP for mental health problems. When all the other factors were controlled for, there were no differences in the predictors of the decision to attend between the jurisdictions. Separate regression models for NI and the ROI confirmed these findings, with none of the socio-economic or demographic factors remaining in the final models.<sup>15</sup>

## **Use of formal mental health services**

There were no differences in the level of use of specialised mental health services such as outpatient clinics, day centres, day hospitals or inpatient facilities in the ROI and NI. In both jurisdictions the general practitioner is the gatekeeper to secondary specialised services. The results would suggest that in both areas the majority of common mental health problems are treated in primary care and referral to secondary care is low, as would be expected. This is in line with policy recommendations which suggest that the majority of mental health problems should be treated in primary care. For those with more severe problems that require referral to secondary mental health services, policy asserts that the majority should be treated in outpatient or community settings rather than inpatient care (Department of Health and Children 2006; The Bamford Report 2005). Our findings from both the North and South of Ireland would appear to reflect the policy of community-orientated mental healthcare. While we cannot be certain of the appropriateness of inpatient care for those who have availed of this care, it is clear that larger numbers are receiving treatment in community settings or outpatient care. We can only assume that those who are receiving inpatient treatment are the most severe cases.

## **Use of medication for mental health problems**

A greater proportion of NI respondents reported having been prescribed psychotropic medication in the previous year than respondents in the ROI. The finding replicates previous findings of higher prescribing of psychotropic medication in the North of Ireland than in the Republic (National Advisory Committee on Drugs and Public Health Information and Research Branch 2009) where the one-year prevalence rates in the ROI for sedatives and tranquillisers was 4.7% and 9.1% for antidepressants and 9.2% and 9.1%, respectively, for the North of Ireland. This compares to our study of 5.8% for the use of any psychotropic medication in the ROI and 13.6% for NI. The Eurobarometer studies surveyed prescribed drug use for psychological and emotional health problems in the previous 12 months across Europe (European Commission 2006). On average,

<sup>15</sup> Due to space limitations these analyses were not included in the body of the report. However, they are available from the author on request.



7% of respondents had taken drugs for these purposes, slightly less than the findings from our survey (9.6%). An Oireachtas report from the ROI highlights the inappropriate use psychopharmacology, lack of training and education on psychopharmacology for practitioners, the conflict of interest due to the major role that the pharmaceutical companies play in the training and education of practitioners and the promotion of medication, and the lack of alternative treatments available, including the need for more psychologists and counsellors (Joint Committee on Health and Children 2007). A term that has been used increasingly in the area of mental health is the 'medicalisation of society'. It has been argued that problems are becoming increasingly controlled by medication and that there is a 'pill for every ill' (Conrad 2007). There has been a rise in the use of antidepressants over the last 20 years and there are a number of reasons, both positive and negative, as to why this is so. These include the increased recognition of depression by the general public and medics, the development of antidepressants marketed as having fewer and milder side effects and, more ominously, the aggressive marketing efforts by the drug industry (Knapp *et al.* 2007). There are benefits in that people who seek help for depression may now get some treatment and presumably relief in the form of medication. However, there are also negative consequences – the main one of which is the prescription of medication to people without due indications and the neglect of other modes of treatment. Lack of knowledge and the aggressive marketing of medication may prompt practitioners to prescribe medication and patients to expect prescriptions as opposed to alternative therapies (e.g. counselling) or any therapy at all. It is argued that psychotropic drugs for mental health problems are often cheaper to deliver than labour-intensive treatments such as self-help techniques, stepped care models and cognitive behavioural therapy (Pilgrim and Rodgers 1999). Although we do not know if medication was appropriate for the individuals in this survey, the evidence-based stepped care model argues that medication should only be prescribed for those with moderate to severe problems and only after other interventions have been tried (British Psychological Society and Royal College of Psychiatrists 2004). This is also supported by a publication by Kirsh *et al.* (2008) who concluded that antidepressants outperformed a placebo only in those with the most severe depression. In an Irish context, the latest policy document, *A Vision for Change* (Department of Health and Children 2006), recommended that 'all individuals should have access to a comprehensive range of interventions in primary care'. However, development of primary care services in Ireland has been slow, with few primary care teams and networks in full operation. To date, no research has identified treatment options available for those with mental health problems in the primary care setting, yet experience suggests that the range of treatment options is narrow and access to allied health professionals limited (Department of Health and Children 2006). Furthermore, in a survey of GPs it was highlighted that GPs themselves felt that they needed more mental health skills training and increased access to counsellors and psychologists (Copty and Whitford 2005). Following on from the recommendations from the Copty

and Whitford (2005) report the HSE provided a training resource for the delivery of mental healthcare at primary care level to all GPs – *Mental Health in Primary Care*. In addition, the Irish College of General Practitioners and the HSE enrolled a Director of Mental Health Project in June 2008 to lead the development of mental health in primary care. The full implementation of the HSE Transformation Programme 2007–2010 should streamline services and enhance the various treatment and care options available with the primary care teams and networks.

## **Sources of support used for mental health problems**

In terms of the use of other supports and professionals for mental health problems, our findings show that, overall, the use of other supports is low in NI and the ROI. Approximately one in five of the respondents had used one or more of the supports listed, with the vast majority in both jurisdictions using the supports of families and friends. Overall, less than 2% had used a psychologist in the previous year and just over 3% had used the support of a counsellor. Whether this is due to a shortage of allied health professionals, the lack of access to such professionals, or to societal or individual characteristics, such as stigma or low mental health literacy, is unknown. However, investigation in the current study of the willingness to use such professionals during times of distress shows that over 40% of the respondents would be willing to do so. The major difference between NI and the ROI in terms of the use of supports was that the NI respondents used the clergy more often, while the ROI used the Internet more often. However, it must be remembered that while these differences were significant, the proportions using such supports were very low. In both jurisdictions family and friends were the most frequently used supports and, along with GPs, these were the supports that the majority of respondents would be most willing to use. These findings highlight the importance of informal supports such as friends and families as well as the GP as the main sources of supports for common mental health problems.

## **Models of care for mental health treatment**

These findings have highlighted a number of issues relevant to the treatment and care of mental health problems in the community. They highlight the importance of the use of formal and informal supports, the importance of the GP, and the necessity to monitor the extent and appropriateness of the use of medication for common mental health problems. The traditional model, and the one that is most commonly used in Ireland, for providing mental healthcare in primary care consists of two components of care delivered by the general practitioner in the first instance and referred to specialist care as a secondary intervention. This model has a number of limitations. Firstly, GPs have little knowledge of the assessment and treatment of mental health problems. Secondly, they have limited access to other allied health professionals that are better equipped

to deal with a range of mental health problems. Thirdly, the interface between primary care and secondary mental health services needs development in terms of referral pathways, discharge plans and continuity of treatment. These limitations can result in inappropriate care and treatment, undue suffering due to unmet care needs and unnecessary escalation of mental health problems, inappropriate referral to secondary care services and lack of continuity in care. These factors impact on the individual and society, with resulting health, social and economic costs.

An alternative model of care has been put forward in recent times. The stepped care model for the treatment of common mental health problems has been implemented in various Trusts in the UK and benefits have included reduced waiting times, increased minimal interventions and thus a reduction in unmet needs, reduced referral rates to secondary care, tailored treatment to individual need, and greater choice and accessibility for those who experience mental health problems (Stericker and Shaw 2007). The stepped care approach has an additional level over and above the traditional model at which minimal interventions are implemented before referral to secondary care. Within the stepped care model specialist interventions are only initiated when more simple interventions do not result in positive change. Treatment is based on the severity of the problems. The model is used to address problems from the sub-clinical level to more enduring mental health problems and includes care and treatment at primary care level and secondary care level. Figure 7.1 details the steps and the main provider at each of the levels of service provision. The first two steps in this model relate to primary care. Steps three and four relate to care and treatment provided by primary care but, if necessary, with input from secondary mental health services in the form of case conferences and advice on case management. Step five in the model relates to care at the secondary level. A small minority of those experiencing distress will require this level of specialised care.

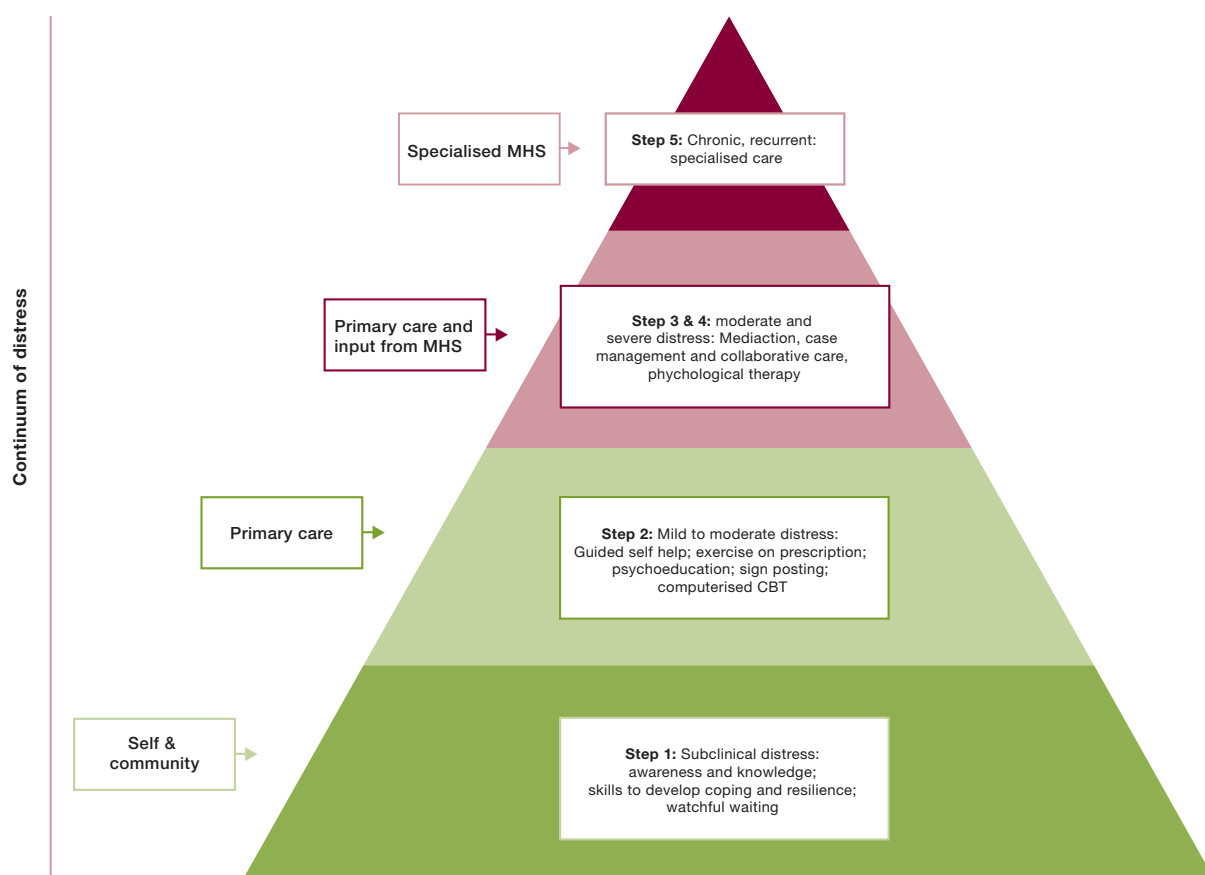
Service provider	Level of distress	Steps of care
Secondary mental health services	Chronic, recurrent, atypical refractory	<b>Step 5:</b> specialised care
		<b>Step 4:</b> medication, case management and collaborative care, psychological therapy
Primary care	Severe	<b>Step 3:</b> medication, case management and collaborative care, psychological therapy
Primary care	Moderate	<b>Step 2:</b> guided self-help, exercise on prescription, psycho-education, sign posting, computerised CBT
Primary care	Mild to moderate	
Primary care	Sub-clinical	<b>Step 1:</b> watchful waiting

**Figure 7.1** Overview of the stepped care model<sup>16</sup>

16 Adapted from the Improving Primary Care Mental Health Services – A Practical Guide, CSIP/NIMHE



Results from the present research, relating to levels of psychological distress among the general population, and findings relating to help seeking, suggest that the stepped care model could be usefully expanded to include informal interventions and supports in the community. Figure 7.2 illustrates this expanded model of care that incorporates a population approach to mental health.



**Figure 7.2** Expanded stepped care model to include a population approach to mental health

The milder levels of distress which do not need support from formal care could be alleviated through interventions aimed at increasing self-awareness and self care such as the Stress Control model. Furthermore adoption of a robust intersectoral approach to planning such as that adopted in the WHO 'Healthy Cities' initiatives could help provide people with the resilience and coping mechanisms to deal with stress and prevent the escalation of problems to levels that require formal input. A report from the Future Vision Coalition<sup>17</sup> in the UK on the development of for mental health care in the UK, also highlights the need for inter agency collaboration to promote and foster wellbeing. The report argues that all departments and public bodies need to ensure that

<sup>17</sup> The Future Vision Coalition includes a number of government and other mental health agencies. The report was published in July 2009 and sets out the case for investing in mental health and aims to put mental health on the agenda in all areas in government. The report is available at <http://www.iimhl.com/iimhlupdates/20090730a.pdf>.

their actions promote mental wellbeing. The report also highlights the need to build resilience at the community level to help people deal with stress during tough times. In addition, the need for early intervention is highlighted to prevent the escalation of problems.

The current model of care within Ireland is the traditional model whereby the general practitioner acts as the gatekeeper to secondary care. No research has yet identified treatment options available within the primary care setting, yet experience suggests, as indicated previously, that the range of available treatment options is scarce as is the access to a range of allied health professionals. In recent times, the UK has initiated a programme – Increasing Access to Psychological Therapies (IAPT) – which aims to increase access to psychological therapies that offer treatment, ranging from short therapeutic sessions for mild problems to longer therapeutic approaches for those with moderate to severe problems. This hub and spoke model consists of a physical location for the administration of the IAPT programme, but suggests that most therapy takes place outside this location in primary care or other health and social services. A report produced by Lord Layard and colleagues argued that this approach will lead to improved access for those who traditionally do not seek help, resulting in economic benefits that would offset the costs of providing incapacity benefits and reduced productivity in those with selected mental health difficulties of working age (Layard *et al.* 2007). Pilot sites that have implemented stepped care show that this model of care can be successfully implemented in the UK and has resulted in a number of benefits for service providers and service users. While difficulties with the Layard initiative have been highlighted,<sup>18</sup> such as an overly optimistic assessment of the effectiveness of psychological treatments and viewing intense but normal sadness as an illness, it will be interesting to monitor the implementation and evaluation of the pilot sites.

The Australian government funded a programme of care that aimed to improve mental health primary care; this continues to be implemented across Australia. The programme was named Better Outcomes in Mental Health Care (BOiMHC) and had five interconnected components (Hickie and Groom 2002). The five components were:

- Education and training for general practitioners – this training had three levels which included an introduction to the BOiMHC programme, training for the three-step mental health process, and training in the provision of focused psychological therapies
- The three-step mental health process – a framework for general practitioners to manage mental health problems

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18 See articles by Marzillier and Hall, Gilbert, and Casement in *The Psychologist* (2009) 22(5)

- Focused psychological strategies – delivered by the general practitioner in planned sessions and including psycho-education, cognitive behavioural therapy and interpersonal therapy
- Access to allied psychological services – direct referral for general practitioners to allied health professionals such as social workers and psychologists
- Access to psychiatric support (the consultation–liaison model), whereby psychiatrists attend case conferences with general practitioners and provide advice on patient management

This model of care also incorporates a stepped care approach, with care and treatment tailored to the individual. However, the programme differs slightly from the UK model outlined above whereby Australian GPs provided psychological therapies in most instances rather than training healthcare workers to different skill levels as in the UK context.

Given the similarities of the Australian and Irish health services, some lessons can be learnt from the implementation of the Australian model (Pirkis *et al.* 2006). Commonalities in the Australian and Irish health services include the public and private mix in the provision of healthcare services and the make up of the primary care services (e.g. healthcare system, financing, ratio of primary care physicians to specialists, patient lists). In addition, changes in the delivery of healthcare and in the delivery of mental healthcare are similar in both areas, e.g. a major reform programme is happening in primary care to ensure that it is the linchpin of health services; and greater collaboration between primary care and secondary care is advocated for mental healthcare along with a greater emphasis on community mental healthcare. General practitioners who participated in the Australian BOiMHC programme were reimbursed for training and for delivering focused psychological strategies. It will be interesting to monitor the advances in the implementation of this initiative and to evaluate its suitability within the Irish context.

## Key findings

To summarise, the main findings have highlighted some interesting differences and similarities between the North of Ireland and the Republic of Ireland in terms of mental health problems and the use of health services and supports for mental health problems.

- 1 Respondents in NI showed a higher prevalence of self-reported mental health problems and lower perceived mental health status in the previous year than those in the ROI. These differences remained significant even after controlling for demographic differences in marital status, education, employment status, SEG and income.
- 2 For those who reported mental health problems, respondents in NI reported more severe limitations in social and physical activities than those in the ROI. This would suggest that Northern Irish respondents had more severe mental health problems than those in the ROI.
- 3 There were much higher levels of medication use for mental health problems in Northern Ireland than in the ROI. Whether the use of this medication is appropriate due to the higher prevalence and greater severity of mental health problems in Northern Ireland requires further investigation.
- 4 The treatment gap for mental health problems would appear to be less in Northern Ireland than in the Republic where a greater number of people who reported mental health problems had attended the GP. However, the severity of the problems presented to GPs is unknown and greater attendance may reflect more severe problems. The reasons why people do not attend the GP when they are experiencing mental health problems need to be investigated. The ongoing morbidity study in NI should provide some information in this area (Northern Ireland Study of Health and Stress). Unfortunately, as of yet, there is no such study in the Republic.
- 5 Distress as measured in the last few weeks by the GHQ is similar in both areas, suggesting that current distress levels do not differ. It is only the one-year prevalence measures that highlight differences in mental health between the ROI and NI, with respondents in NI reporting higher levels of perceived poor mental health. This highlights the importance of measuring mental health across different time spans.
- 6 More people in NI attended the GP specifically for mental health problems than did respondents in the ROI, but this seems to be related to differences in health status.
- 7 Determinants of attendance at the GP for mental health problems included

variables that could be considered 'need' factors, while 'non-need' factors, such as income, did not remain in the model. There were no differences between the jurisdictions in the factors that predicted attendance. This is in contrast to attendance at the GP for physical health, where factors that are not directly related to need, such as income, influenced attendance. In addition, the jurisdiction in which the individual lived influenced attendance at the GP for physical health problems.

- 8 Both jurisdictions were similar in terms of the most frequently used informal support of family and friends and in terms of willingness to use supports. Family and friends and the GP were reported as the supports people were most willing to call on if experiencing emotional distress. While the use of informal supports was low, the willingness to use a range of supports was evident. Whether help-seeking intentions result in actual help-seeking behaviour requires further investigation.

## Policy implications

These findings provide important information for policy development and for service providers in terms of service development and delivery. Information such as that provided in this report is particularly important given the financial and economic climate in the North and the South in recent times. A recent EU round table discussion on reducing the psychosocial impact of the financial and economic climate reported that job uncertainty, loss of employment and over-indebtedness are likely to lead to poorer mental health for many people.<sup>19</sup> The discussion highlighted the importance of resilience for mental health and wellbeing. Resilience is defined at an individual level as doing better than expected in the face of adversity, and at a community level as the extent to which the community can come together to tackle common problems. It is especially important that community initiatives that are relatively inexpensive and most likely to reach the greatest number of people are evaluated for their benefits within an Irish context. In line with the report from the Centre for Cross Border Studies (Clarke 2009), there is a need for cross-border cooperation and a population approach to mental health so that changes in policy implementation and health service delivery can be monitored and compared. Furthermore, such a forum may provide an avenue in which innovative approaches and practices can be exchanged.

The main implications of the findings from the present study are presented below.

- 1 There is a need to increase awareness of mental health problems. This would go some way towards acknowledging the level of distress in the community and may have the effect of reducing the stigma associated with mental health

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<sup>19</sup> [http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/ev\\_20090427\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20090427_en.htm)

problems. Some work has already begun in this area, with recent media coverage of levels of distress found in Irish population samples, serving to normalise distress as an integral aspect of the human condition. Such coverage needs to be continued and evaluated to assess the impact on the population.

- 2 The use of medication for mental health problems needs to be monitored and assessed to ensure that it is appropriately prescribed. Furthermore, there needs to be a range of treatments available in primary care that are best placed to address a range of mental health problems from mild to severe. The initiative that is currently being implemented in the UK – Increasing Access to Psychological Therapies – should be monitored to evaluate, both economically and clinically, the cost-benefit ratio of implementing such an initiative within the Irish context.
- 3 There is a need to address the treatment gap revealed in this study and investigate more fully why people do not seek help for mental health problems. There is also a need to improve mental health literacy across the Island of Ireland. This requires public education and awareness of what sources of support are available for mental health problems, when help should be sought and at what level and how it can be accessed. This information should be circulated as widely as possible so that all members of the community have access to it.
- 4 Mental health literacy encourages people to be vigilant in relation to their mental health and alert to signs and symptoms of distress; and to apply self-care techniques and seek help when it is required. Early detection and help-seeking will prevent problems from escalating unnecessarily. It is also important to highlight the role of informal supports such as family and friends. It is necessary to encourage the use and development of informal supports at an individual and community level. Building individual and community social capital to support mental health through intersectoral planning can be a cost-effective means of improving societal mental health.
- 5 The factors that play an important role in attendance at the GP for mental health problems appear to relate to the health of the individual rather than financial or demographic factors. The findings suggest that, regardless of whether one has to pay for the service or not, people will attend the GP based on their mental health status and the limitations that these problems are causing in their everyday activities. They are also more inclined to seek help from the GP if they are currently taking prescribed medication or getting other supports for mental health problems. These findings are interesting as they suggest that people only seek treatment from the GP for mental health problems based on ‘need’ as opposed to other factors such as the ability to pay. However, they may also suggest that people may delay seeking help for mental health problems until



they are impacting significantly on their everyday functioning. If this is the case then seeking help at an earlier stage may have reduced the impact on everyday functioning. Again, these findings highlight the need to create an awareness of mental health problems and available supports and treatments as early in the distress process as possible.

## Limitations

As with all surveys, there are a number of limitations with the current one. Firstly, data were collected via a telephone survey of private households. Consequently, those who are most vulnerable to distress, e.g. homeless persons, are likely to have been excluded. Secondly, the measures were designed to measure mental health and health service use. Given the cost and, more importantly, time constraints imposed on the survey, important measures that may impact on help-seeking, such as severity of problems and stigma, were not included in the survey. Nevertheless, the findings do present original research findings on levels of psychological distress in the ROI and NI and on important factors that influence health status, quality of life, and mental health and related help-seeking behaviour. More detailed, comprehensive and costly surveys, such as the WHO Mental Health Surveys, provide detailed clinical, psychological and service use information on mental health at the population level. To date, there is no such survey in the ROI, but the findings from the survey in NI are eagerly awaited. Finally, although similar to previous survey response rates, the response rate in the ROI was lower than in NI. It is important to highlight that those who refused to participate may have differed on some critical variable than those who did participate. For example, those who did not participate may have higher levels of distress than those who did participate. This is however unlikely given that these findings regarding extent of distress and mental health problems are similar to previous findings adding confidence to the validity and reliability of our findings.

To conclude, in the current financial and economic climate mental health problems are likely to increase. This has been acknowledged at the EU level with the round table discussion on reducing the psychosocial impact of the financial and economic crisis in April 2009. It has also been acknowledged at the national level with the production and circulation of information leaflets by the HSE - Looking after your mental health during tough economic times - in July 2009. It is important that levels of psychological distress continue to be monitored in the face of changing economic and social circumstances. The HRB National Psychological Wellbeing and Distress rolling programme is due to cease in 2010 with the closure of HRB internal research services in the context of the new HRB Strategic Plan 2010–2014. It is hoped that Irish researchers will continue this work which can inform intersectoral policy development into the future.

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# Appendix 1

## HRB NPWDS II questionnaire used in the Republic of Ireland and Northern Ireland Survey

I would now like to ask you some questions about your physical and psychological health and your use of health services. I will be asking you some questions about how you have been feeling over the last while. For example, if you have experienced anxiety or depression or any other mental, nervous, or emotional problems. I will also be asking you about services that you may or may not have used in the last year (e.g. GP, counsellor, psychologist, psychiatrist) and if you are currently taking any medication for mental, nervous, or emotional problems. I would like to inform you that all the information you provide is confidential. The information will be used for research purposes only and you are free to stop the interview at any time.

**Q1 Are you covered by a medical card, either in your own name or through someone else's card?**

- 6 Yes, holder of medical card
- 7 Yes, on someone else's card
- 8 Not covered

**Q2 Are you covered by private health insurance, either in your own name or through another family member? By private health insurance, I mean VHI, BUPA, Quinn Direct or any other health insurance company/occupational scheme.**

- 1 Yes, in own name
- 2 Yes, through family member
- 3 Not medically insured

**Q3 How would you rate your mental health in the last 12 months? *READ OUT***

- 1 Very Poor
- 2 Poor
- 3 Fair
- 4 Good
- 5 Very Good
- 6 Refused
- 7 Don't know

**Q4** How would you rate your physical health in the last 12 months? **READ OUT**

- 1 Very Poor
- 2 Poor
- 3 Fair
- 4 Good
- 5 Very Good
- 6 Refused
- 7 Don't know

**Q5** How would you rate your quality of life in the last 12 months? **READ OUT**

- 1 Very Poor
- 2 Poor
- 3 Fair
- 4 Good
- 5 Very Good
- 6 Refused
- 7 Don't know

**Q6** In the last 12 months, have you experienced any mental, nervous, or emotional problems; for example, anxiety or depression?

- 1 Yes
- 2 No
- 3 Don't know
- 4 Refused

**Q7** I am now going to read out a numbers of ways that people can sometimes feel and I would like you to tell me if you have felt this way over the past few weeks. Over the last few weeks, have you:

**a** Been able to concentrate on what you're doing: **READ OUT SCALE**

- 1 Better than usual
- 2 Same as usual
- 3 Less than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**b Lost much sleep over worry. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know

**c Felt that you are playing a useful part in things. *READ OUT SCALE***

- 1 More so than usual
- 2 Same as usual
- 3 Less so than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**d Felt capable of making decisions over things. *READ OUT SCALE***

- 1 More so than usual
- 2 Same as usual
- 3 Less so than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**e Felt constantly under strain. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know



**f Felt you couldn't overcome your difficulties. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know

**g Been able to enjoy your normal day-to-day activities. *READ OUT SCALE***

- 1 More so than usual
- 2 Same as usual
- 3 Less so than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**h Been able to face up to your problems. *READ OUT SCALE***

- 1 More so than usual
- 2 Same as usual
- 3 Less so than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**i Been feeling unhappy or depressed. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know

**j Been losing confidence in yourself. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know

**k Been thinking of yourself as a worthless person. *READ OUT SCALE***

- 1 Not at all
- 2 No more than usual
- 3 Rather more than less usual
- 4 Much more than usual
- 5 Refused
- 6 Don't know

**l Been feeling reasonably happy, all things considered. *READ OUT SCALE***

- 1 More so than usual
- 2 Same as usual
- 3 Less so than usual
- 4 Much less than usual
- 5 Refused
- 6 Don't know

**Q8 Have you experienced limitations in physical activities in the last year because of mental, nervous, or emotional problems? *PROBE TO SCALE***

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme
- 6 Refused
- 7 Don't know

**Q9** Have you experienced limitations in social activities in the last year because of mental, nervous, or emotional problems? By this I mean activities involving friends, family or others.

- 1 None
- 2 Mild
- 3 Moderate
- 4 Severe
- 5 Extreme
- 6 Refused
- 7 Don't know

**Q10** In the last 12 months, how many times have you seen a GP for physical problems? **[Numeric box]**

**Q11** In the last 12 months, how many times have you spoken with a GP about being anxious or depressed, or about mental, nervous, or emotional problems? **[Numeric box]**

**Q12** In the past 12 months have any of the following factors prevented you from seeing a GP? **READ OUT**

- 1 Transportation
- 2 Cost of visiting doctor
- 3 It takes too much time
- 4 Embarrassment / feeling awkward
- 5 It's not helpful
- 6 Too ill
- 7 Anything else
- 8 Nothing prevented me from seeing a GP
- 9 Refused

**Q13** Have you at any time in the last 12 months been in contact with any of the following mental health services? **READ OUT**

- 1 Outpatient clinic
- 2 Day centre
- 3 Day hospital
- 4 Inpatient psychiatric hospital / unit
- 5 None of these:
- 6 Refused

**Q14** I am going to read out types of supports that can be used for help with a mental, nervous, or emotional problem. Could you tell me if you have used any of these in the last 12 months for help?

- 1 Psychiatrist
- 2 Nurse
- 3 Psychologist
- 4 Social worker
- 5 Counsellor
- 6 Psychotherapist
- 7 Clergy
- 8 Alternative / complementary practitioner
- 9 Family / relatives / friends
- 10 Internet
- 11 Other
- 12 Refused
- 13 None of these

***ASK FOR EACH SERVICE USED AT Q.14***

**Q15** How effective was x service?

- 1 Very effective
- 2 Moderately effective
- 3 Slightly effective
- 4 Not at all effective
- 5 Don't know
- 6 Refused

***ASK ALL***

**Q16** Did you take any prescribed medication for a mental, nervous, or emotional problem in the last 12 months?

- 1 Yes
- 2 No
- 3 Refused
- 4 Don't know

***IF YES, ASK***

**Q17 How effective was this medication?**

- 1 Very effective
- 2 Moderately effective
- 3 Slightly effective
- 4 Not at all effective
- 5 Don't know

***ASK ALL***

**Q18 Suppose you were suffering from significant mental, nervous, or emotional problems, would you use any of the following supports? READ OUT**

- 1 Family/relatives/friends
- 2 General practitioner
- 3 Psychiatrist
- 4 Nurse
- 5 Psychologist
- 6 Social worker
- 7 Counsellor
- 8 Psychotherapist
- 9 Clergy
- 10 Alternative practitioner
- 11 Internet
- 12 Other (please specify)
- 13 None of these
- 14 Refused
- 15 Don't know

# Appendix 2

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