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A community needs assessment for rural mental health promotion

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Abstract

This paper describes the needs assessment phase of a mental health promotion programme for rural communities in Ireland. As part of a larger study encompassing four rural communities, a cross-sectional study of the mental health beliefs and perceptions of 1014 people was carried out. Employing a combination of interviewer-administered questionnaire and the vignette method, the needs assessment explores the levels of awareness, current practices, attitudes and stigma concerning depression and suicide among a randomly selected quota sample of community members. Lower levels of awareness, less confidence in dealing with mental health issues, negative attitudes to help-seeking and social stigma emerge as particular issues for men and the under 40 age group. Women were found to have more positive attitudes generally, were more likely to use informal social support networks and were more open about discussing mental health matters. The predominant interpretation of the depression vignette was to view it as a mental health problem with good prospects for recovery given appropriate help. Social relationships, negative thinking patterns and social stresses were perceived as being particularly important in explaining the origins of depression. The implications of the findings for planning the intervention phase of the project are considered.

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Introduction

The mental health promotion project described here forms part of a larger health promotion initiative with agri-workers and small rural enterprises. This project involves a needs assessment at two levels. First a national survey of a quota-controlled sample of the general public ($n = 2500$) was undertaken to examine current levels of health and safety practice together with attitudes and barriers to health-promoting actions (Hope *et al.*, 1999). Focus groups with representatives of farming organizations were also carried to explore issues of particular concern. Based on the findings from the baseline survey and the focus groups, two broad areas were identified for interventions; general health and safety issues (e.g. chemical and machine safety and lifestyle practices), and mental health promotion programmes. The next stage of the needs assessment involved carrying out an in-depth study of the attitudes, perceptions and current practices of rural residents concerning mental health, and health and safety issues. For this purpose a community-based approach was adopted and four rural communities were selected at random from the district electoral division areas representative of the four regional provinces of the Republic of Ireland. This paper concerns itself with the mental health promotion aspect of the study and focuses on the findings from the mental health needs assessment.

Findings from focus groups conducted with members of the farming community during the baseline study highlighted concern in relation to rural isolation, depression and suicide. These concerns mirror the findings from the recent Report

of the National Task Force on Suicide in Ireland (Department of Health, 1998) which points to a significant rise in the male suicide rate over the last 20 years, particularly among the 15–24 age group. Suicide is now the second most common cause of death among young men in Ireland. As found in other countries, farmers rank among the occupational groups with high rates of suicide in Ireland (Nic Daeid, 1997). The development of effective strategies for promoting positive mental health in rural communities was, therefore, identified for the intervention phase of the project.

The needs assessment study was designed to gain an understanding of how mental health issues are interpreted and dealt with in the context of rural community life. Drawing on previous research, community perceptions and beliefs are considered to play a key role in informing the objectives, content and medium of community intervention strategies (Barry, 1998). In addition, the assessment of community beliefs helps to ensure that the intervention strategies will be both meaningful and relevant to the target audiences. As pointed out by Nettekoven and Sundberg (Nettekoven and Sundberg, 1985), community norms and values must be allowed to help shape rural mental health promotion programmes if they are to be acceptable to the communities they are intended to serve. The principle of community involvement and participation was, therefore, identified as being critical from the outset of the programme.

A review of the literature points to the fact that the majority of studies on public attitudes have been concerned primarily with issues of social acceptance and rejection of people with mental health problems. Relatively few needs assessment studies exploring public perceptions and attitudes concerning mental health at the community level have been reported in the literature despite the increasing emphasis on community-based approaches. However, a number of studies have examined perceptions and attitudes of the general population as part of the evaluation of national mental health campaigns. For example, prior to the launching of the British Defeat Depression Campaign in 1991, a survey of over 2000 people throughout the UK was carried out to determine public attitudes towards depression. The findings from this study suggest that stigma is still associated with depression and there is a certain ambivalence among members of the public about consulting professional help sources (Priest *et al.*, 1996). Sogaard and Fonnebo (Sogaard and Fonnebo, 1995) surveyed a stratified sample of the Norwegian public prior to and following a nationwide mass-media mental health campaign. This study reported a number of significant changes in knowledge, openness about mental health issues and attitudes to help-seeking following the campaign. However, significant differences between socio-demographic groups remained after the campaign.

McKeon and Carrick (McKeon and Carrick, 1991) carried out a survey of attitudes to depression with a nationally representative sample of Irish people. Attitudes to depression were found to be quite positive, with 71% regarding depression as being treatable. Stress, in the form of family and work pressures, was considered to be the most frequent cause of depression. While 81% of the sample regarded depression as requiring active intervention, only 17% mentioned the GP as a source of treatment. A number of socio-demographic differences in expressed attitudes between rural and urban respondents and different age groups were also reported. Barry (Barry, 1994) used vignette methodology in conjunction with a standardized attitude scale to explore the structure and determinants of community perceptions of mental health issues among members of a rural community in the West of Ireland. The findings from the vignette studies indicated that different types of mental health problems occasion different sets of beliefs, and that lay beliefs have a complex structure and resemble formal models of mental disorder in their content. Depression was perceived mainly from a psychosocial perspective with relationship problems and stressful life events most frequently attributed as causal explanations. Both the GP and psychiatrist were recommended as help sources, and the majority considered a full recovery from depression as being possible.

From the literature it would appear that awareness raising and destigmatization have a significant role to play in mental health promotion programmes. There are few reports in the literature of mental health awareness and promotion programmes being implemented at the local community level. Such programmes require in-depth studies to examine socially shared beliefs, how they arise and change over time, how they vary between social groups, and how they relate to mental health behaviour. The present study set out to examine these issues by carrying out a cross-sectional study of the attitudes, beliefs and practices of the residents of four rural communities. The purpose of the needs assessment study is two-fold; to inform the development of appropriate interventions and to provide pre-intervention data against which to measure the success of the intervention strategies.

Method

Design

The design of the needs assessment study forms part of the larger study design which will now be briefly described. The overall study employs a quasi-experimental design, systematically evaluating the impact of health promotion programmes on health attitudes, behaviours and practices in selected intervention and control sites in a rural setting. Four geographically distinct rural communities were randomly selected for participation in the study. Within each of the four geographical regions or provinces in the Republic of Ireland, counties were matched in terms of farm size and economic size unit. A rural district (population between 750 and 2000) was then randomly selected from the rural electoral divisions list within each of the four regions. The design of the intervention phase of the study will involve two of the communities receiving mental health promotion interventions with the other two communities receiving interventions on more general health and safety issues. This comparative quasi-experimental design will permit the specific impacts of the mental health and the health and safety programmes to be rigorously evaluated. The option of a non-intervention control site was not considered ethically feasible, given the involvement of each of the communities in the needs assessment phase and the expectation of some follow through on the issues raised.

The needs assessment study entails carrying out an in-depth cross-sectional survey on both health and safety and mental health issues across all four participating communities. The organization of the needs assessment was carried out in close collaboration with the community groups who facilitated planning and helped notify the local communities of the timing of the data collection. The active engagement of the communities in the needs assessment phase is regarded as being particularly important as it lays the groundwork for community participation in the development of the project as a whole and sets the stage for collaboration between the researchers and the community. Based on feedback and discussion of the needs assessment findings in each community, the specific focus of the interventions will be determined.

Sample

The District Electoral Divisions (DED) list was used as the sample frame to randomly select a rural community with less than 1500 population within each of the four geographical regions. The sample calculation estimate was based on the figures for the overall project, anticipating a sample size that would be adequate to detect a 10% increase in chemical and machinery safety practices. This resulted in a sample of 250 people in each community. A systematic framework based on geographical spread within a 5 mile radius of each community was used to randomly select households. This resulted in every second house in the village areas and every house in the open countryside being approached by the researchers. Anyone present over the age of 15 years in each of the households was deemed eligible to complete the questionnaire, with a ceiling of up to four members from each house. Quota sampling procedures were used, stratifying according to age and sex.

Community needs assessment measures

The mental health measures were included as part of the larger survey encompassing health and safety, and consisted of a series of both closed- and open-ended questions on 'emotional health'. Two methods of data collection were used: an interviewer-administered questionnaire and the vignette method. The questionnaire items consisted of a series of Likert-type attitude scales addressing the areas of depression and suicide as well as more general 'emotional health' matters. These items were adapted from existing measures (Sogaard and Fonnebo, 1995), and explored levels of awareness, current attitudes and practices, sources of information, and perceived barriers and benefits of services.

The vignette which was developed and tested in a previous study (Barry and Greene, 1992) portrays a person experiencing depression and is written in non-technical language (see Appendix 1). The vignette was administered to a randomly selected sub-sample of 100 people from two of the four rural communities. For this sub-group, the vignette was followed by open-ended questions concerning recognition, interpretation, causal explanation, treatment and prospects of recovery for the problems depicted in the story. Of the 100 people who received the vignette, half the sample received the vignette portrayed as female while the other half received the vignette depicted as male. For the purposes of analysis, data collectors ensured that an equal number of male and female respondents received both male and female versions of the vignette.

Results

Sample

With a response rate of 71%, a total sample of 1014 people was surveyed across the four communities. All refusals were replaced by calling to the next house. In the majority of households (74%) only one respondent completed the survey. The socio-demographic characteristics of the total sample and the sub-sample of 100 people who were interviewed using the vignette are displayed in Table I. There is a slight over-representation of women in the overall sample. The majority of the sample had received secondary level education and 30.5% were classified as being of higher social class status. The classification of social class is based on the Central Statistics Office (Central Statistics Office, 1986) publication on classification of occupations.

Table I. *Socio-demographic profile of participants in the study*

	Overall sample (N = 1014)		Vignette sample (N = 100)	
	N	%	*N*	%
Sex				
male	398	39.3	38	38
female	616	60.7	62	62
Age				
<40	475	46.8	36	36
40+	539	53.2	64	64
Highest level of education attained				
primary	295	29.1	43	43
secondary	494	48.7	40	40
third level	220	21.7	17	17
Social class profile[a]				
social class 1–3	309	30.5	30	30
social class 4–6	240	23.7	33	33
undetermined	465	45.8	37	37

[a]The social class profile of the sample was determined according to occupation (Central Statistics Office, 1986). Based on the six category scale, the social class groups are split into social class 1–3 (professional/non-manual) and social class 4–6 (manual).

Survey findings

This paper concentrates on the mental health findings from the four communities in order to establish the overall picture concerning rural perceptions and attitudes. Differences between the four communities will not, therefore, be reported here. Examination of the influence of socio-demographic variables concentrated on age, sex and education levels. The variable social class was not included due to the large number of non-responses (coded as undetermined) from those in home duties who did not provide details of spouse's occupation. For the purpose of this analysis age was purposely

dichotomized into over and under 40 years in order to explore the differences across the age groups. Data analysis involved the use of either the χ^2 statistic or ANOVA depending on the level of the data. Descriptive data and χ^2 values for the categorical variables are presented in Table II. Table III presents the means and summary ANOVAs for attitudinal items according to socio-demographic group using a 2×2×3 (age×sex×education) factorial design.

Levels of awareness

The majority of respondents (86.4%) were aware that the level of suicide had risen in Ireland in the past decade. As shown in Table II, this was particularly the case among women, respondents over 40 years of age and those with higher levels of education. Concerning personal worries about depression, some 13% of the sample described themselves as being either 'very' or 'somewhat worried' about becoming depressed, with a further 24% reporting being 'a little worried'. Women were significantly more likely to report a personal vulnerability to depression than men (see Table II). Respondents were also questioned about their level of concern in relation to suicide, depression and access to mental health services in rural areas (see Table III). Levels of concern were highest in relation to suicide (77%), followed by depression (71%) and access to mental health services (53%). Analysis of the influence of the demographic variables revealed that men and the under 40 age group expressed significantly lower levels of concern about rates of suicide. In relation to depression, concern levels were again significantly lower among men, the under 40 age group and respondents with lower levels of education. Concern about access to mental health services in rural areas was found to be significantly higher among women in comparison to men.

Attitudes to help-seeking

Respondents' views concerning willingness to seek professional help and the perceived effectiveness of professional help were also elicited (see Table III). The majority of respondents reported having 'no hesitation' in consulting a GP (69%), a psychiatrist (53%) or a psychologist (52%) for depression. A further 41% reported 'no hesitation' in consulting the Samaritans. However, overall there were relatively high levels of 'uncertain' responses in relation to this question (23–27%), which suggests that at least a sizeable proportion of respondents were somewhat unsure about taking up these services. The under 40 age group were less willing to consult all four help sources for depression in comparison to older respondents. Likewise, men expressed more reluctance about consulting a GP and a psychologist than did women. With regard to education, an interesting result emerged in that respondents with lower levels of education reported greater willingness to consult a psychiatrist than those with higher levels of education. Willingness to consult the Samaritans also revealed a sex by education interaction effect ($F = 3.25$, $P < 0.05$), showing that males with higher levels of education were less likely to consult the Samaritans.

Respondents were also questioned concerning their perceived confidence in offering advice to someone who is depressed. Overall, 53% of the sample reported that they would find it either 'difficult' or 'very difficult' to advise someone with depression and 71% reported perceived difficulty in advising someone who was suicidal. ANOVA analysis of the demographic effects revealed a sex by age interaction effect ($F = 6.67$, $P < 0.01$), suggesting that males under 40 years would find it significantly more difficult to offer advice to someone who is depressed. Likewise, in terms of advising someone who was suicidal, those under 40 years of age reported lower levels of confidence in comparison to older respondents.

With regard to perceptions of the effectiveness of the services, 71% considered the psychiatrist to be effective in treating depression and 60% the GP. However, a relatively high percentage of respondents (22%) reported being 'uncertain' concerning the effectiveness of both. No significant demographic effects were found in relation to the perceived efficacy of the psychiatrist. A significant sex by education interaction effect ($F = 5.41$, $P < 0.01$) emerged in relation to the GP, suggesting

Table II. *Awareness and willingness to confide in others: difference in percentage response frequencies by socio-demographic groups*

	Age			Sex			Educational Level			
	<40 (n = 475)	40+ (n = 539)	χ^2	Male (n = 398)	Female (n = 616)	χ^2	1 (n = 295)	2 (n = 494)	3 (n = 220)	χ^2
Knowledge of increasing rates of suicide	85.2	91.8	10.60**	85.7	90.6	5.58*	89.5	86.4	93.0	6.80*
Worried about becoming depressed	41.9	37.3	2.12	34	43.3	8.35**	34.4	40.8	43.7	4.76
Disclosed to family members in the last month	55.9	52.1	1.48	40.7	62.5	45.72***	44.2	55.9	62.4	18.24***
Disclosed to others outside the family in the last month	51.9	43.8	6.53**	35.7	55.7	38.13***	37.1	47.5	62.5	32.04***

Due to some missing data, the n size will vary slightly across the cells.
*$P < 0.05$, **$P < 0.01$, ***$P < 0.001$.

Table III. *Differences in mean (SD) responses to attitudinal items by socio-demographic characteristics of respondents*

	Age			Sex			Educational Level			
	<40 (n = 475)	40+ (n = 539)	F	Male (n = 398)	Female (n = 616)	F	1 (n = 295)	2 (n = 494)	3 (n = 220)	F
Level of concern (5 = very concerned)										
suicide	3.67 (1.02)	4.04 (0.94)	35.83***	3.75 (1.08)	3.94 (0.93)	12.05***	3.96 (1.00)	3.80 (1.02)	3.90 (0.91)	NS
depression	3.54 (1.01)	3.81 (0.98)	26.29***	3.54 (1.06)	3.78 (0.96)	15.07***	3.68 (1.04)	3.66 (1.02)	3.76 (0.92)	3.70*
access to mental health services	3.32 (1.06)	3.28 (1.12)	NS	3.19 (1.12)	3.37 (1.07)	7.25**	3.22 (1.19)	3.28 (1.07)	3.45 (1.01)	NS
Attitudes to help-seeking 'no hesitation in consulting' (5 = strongly disagree)										
GP	2.50 (1.12)	2.02 (0.98)	26.70***	2.32 (1.10)	2.20 (1.06)	5.82*	1.96 (0.98)	2.34 (1.07)	2.41 (1.13)	NS
Psychiatrist	2.81 (1.12)	2.42 (1.09)	13.52***	2.64 (1.14)	2.59 (1.11)	–[a]	2.35 (1.07)	2.67 (1.12)	2.80 (1.14)	–[a]
Psychologist	2.72 (1.06)	2.51 (1.08)	4.81*	2.77 (1.09)	2.52 (1.05)	15.76***	2.47 (1.08)	2.66 (1.05)	2.69 (1.09)	NS
Samaritans	3.00 (1.09)	2.80 (1.15)	5.65*	2.96 (1.15)	2.86 (1.11)	–[a]	2.81 (1.18)	2.93 (1.12)	2.93 (1.06)	–[a]
Perceived confidence in offering advice (5 = very difficult)										
depressed person	3.44 (1.07)	3.20 (1.16)	–[a]	3.37 (1.13)	3.28 (1.12)	–[a]	3.31 (1.17)	3.39 (1.10)	3.16 (1.10)	NS
suicidal person	4.13 (0.98)	3.79 (1.09)	18.67***	3.92 (1.08)	3.97 (1.03)	NS	3.83 (1.08)	4.04 (1.01)	3.90 (1.11)	NS
Perceived effectiveness of professional help (1 = very effective)										
GP	2.63 (1.01)	2.41 (1.03)	NS	2.56 (1.06)	2.48 (1.01)	–[a]	2.34 (1.09)	2.59 (1.00)	2.57 (0.98)	–[a]
psychiatrist	2.26 (0.90)	2.18 (0.93)	NS	2.26 (0.96)	2.19 (0.89)	NS	2.13 (0.93)	2.25 (0.92)	2.25 (0.88)	NS

Due to some missing data, the n size will vary slightly across the cells

[a]Significant interaction effects are reported in the text.

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

that males with higher education were less likely to report that consulting a GP for depression would be effective.

Current practices—dealing with depression and suicide

In terms of advising a person with depression, respondents were presented with a list of options from which they could choose. Some 35% recommended talking to someone close and 34% recommended contact with the GP. In relation to the other options, 12% endorsed seeing a psychiatrist, 10% advised 'pull yourself together', 6% recommended the Samaritans and 2% suggested asking a member of the clergy for help. Collapsing the response categories into professional and non-professional help sources, significant age and education effects were found. The under 40 age group were more likely to recommend talking to someone close in comparison to older respondents, who in turn were more likely to recommend professional help ($\chi^2 = 13.45$, $P < 0.001$). Examination of the significant education effect suggests that respondents with higher levels of education were more likely to recommend talking to someone close while those with primary education only were more likely to recommend relying on self-help methods ($\chi^2 = 46.25$, $P < 0.001$).

Concerning respondents' willingness to confide in others about their joys and sorrows, 53% reported discussing matters with their family in the past month, while 47% reported talking with people outside their family. As shown in Table II, women and those with higher levels of education were found to be significantly more likely to have discussed personal concerns with both their family and with others outside their family. A significant age effect was also found with 52% of respondents under 40 years of age having disclosed to people outside the family in comparison to 44% of older respondents ($\chi^2 = 6.53$, $P < 0.01$).

Social stigma

Respondents were asked about their readiness to talk openly about someone close to them receiving help for depression. Of the three closed-ended options given, 27% reported that they would talk openly, 11% reported that they would keep it hidden and 40% would talk to close friends. Men were found to be significantly more likely to 'keep it hidden' in comparison to women ($\chi^2 = 33.83$, $P < 0.0001$). Respondents under 40 years of age ($\chi^2 = 31.12$, $P < 0.001$) and those with higher levels of education ($\chi^2 = 22.59$, $P < 0.001$) were more likely to talk to close friends.

Concerning barriers to seeking professional help, in response to an open-ended question over half the respondents (62%) indicated that there was nothing that would prevent them personally from seeking help. Of those who did offer possible barriers, 12% referenced the social stigma surrounding mental health services, e.g. feeling ashamed that people would be talking about you and also a sense of embarrassment and fear about the social and employment consequences for oneself and one's family. The remaining responses referred to: distrust of the services (4%), not recognizing the need for help and spontaneous remission (4%) such as believing that 'things would cure naturally'. Respondents of higher levels of education ($\chi^2 = 55.27$, $P < 0.0001$) and those under 40 years of age ($\chi^2 = 37.61$, $P < 0.0001$) were found to be more likely to report barriers to service take up, in particular the barrier of social stigma.

Communication

The most commonly mentioned sources of influence in relation to people's views and beliefs about mental health matters were as follows: 41% cited the family, 27% the GP, 12% a friend and 5% the psychiatrist. Less frequently mentioned were media celebrities (3%), the public health nurse (2%) and the clergy (2%). Respondents' views about the best way of delivering messages on mental health matters to the community were also sought. The most popular channels of communication were: TV (21%), the local radio (16%), brochures (15%), local talks (11%) and other people locally (10%).

Vignette study findings

Responses to the open-ended questions were subject to content analysis, establishing coding reliabil-

Table IV. *Vignette data: frequency of open-ended response categories*

	N	%
Interpretation of problem ($N = 134$)[a]		
mental health	65	48.51
personality	38	28.36
social	16	11.94
physical	6	4.48
don't know	9	6.72
Causal explanation ($N = 157$)*		
interpersonal problems	64	40.76
stressful life events	36	22.93
personality problems	27	17.20
physical	14	8.92
miscellaneous	7	4.46
don't know	9	5.73
Perceived seriousness ($N = 100$)[a]		
yes	77	77.00
no	19	19.00
don't know	4	4.00
Prospects of recovery ($N = 130$)[a]		
positive	90	69.23
even chance	6	4.62
negative	20	15.42
don't know	7	5.38
other	7	5.38

[a]N = total response set for the question.

ity with an independent rater on 10% of the responses. The method of analysis employed is based on that reported in Barry and Greene (Barry and Greene, 1992). The unit of analysis is the response theme; therefore, the value of N of the total response set varies and is often greater than the number of individual respondents.

Recognition and interpretation

In reaction to the depression vignette, the majority of respondents (49%) interpreted the case as a mental health problem, using words such as 'depressed', 'nerve problems' and 'mental' to describe the case. Only two respondents speculated that the vignette actor was 'nearly suicidal'. As shown in Table IV, other interpretative categories included personality factors such as the vignette actor's negative disposition, negative outlook on life and poor self esteem. The vignette was also interpreted as being a case of social isolation and loneliness (12%); 'a lonely, sad life', 'I think he's isolated'. A minority of responses referred to a physical problem such as 'poor health' or simply ageing. Since the frequencies of each category were relatively small, for the purpose of statistical analysis only recognition of the case as depression was compared with other variables. The sex and education of respondents were found to influence recognition. Females were more likely than males to recognize the vignette actor's problem as depression ($\chi^2 = 7.75$, $P < 0.01$), as were those with a higher level of education ($\chi^2 = 13.26$, $P < 0.01$).

Causal explanation

Four categories of causal explanation emerged in response to the question; 'What do you think causes James/Margaret to feel this way?' (see Table IV). The most frequently cited explanation (41%) attributed the problem to interpersonal difficulties such as loneliness and isolation or general lack of contact with others, e.g. 'keeping too much to himself', 'being too much on her own', 'not going out enough'. It is interesting to note that when the vignette actor was portrayed as male (James) he was seen as a single man who had relationship problems and needed a girlfriend. When portrayed as female (Margaret), she was more likely to be perceived as being a married woman whose relationship difficulties arose from a 'bad marriage', 'family problems' or having a young family. Other causal explanations included personality problems (17%), e.g. negative thinking style such as having a negative outlook on oneself and life generally, were mentioned. Less sympathetic responses were also included in this category such as being 'too self-centred' and respondents criticized the person for not trying hard enough. Attributions to negative life events such as exam failures, unemployment and financial difficulties accounted for a further 23% of the responses. Physical health problems such as 'lack of nutrients' or 'women's problems' were also cited (9%). There were no statistically significant associations between perceived causes of the problem and respondents' socio-demographic characteristics.

Perceived seriousness

In response to the question 'Do you think the problem is serious?', 77% responded positively. Analysis of the demographic effects revealed that those with higher levels of education were more likely to perceive the depression as being serious (Kruskal–Wallis $H = 18.94$, $P < 0.01$), as were females ($\chi^2 = 4.35$, $P < 0.05$).

Advice, prospects and public reaction

The most popular advice offered to the vignette actor was to ask a GP for help (30%), followed by helping themselves (28%); 'take every day as it comes', 'make more friends', 'get out of the house' or, more harshly, 'stop thinking about himself—think about others'. Of the remaining responses 23% recommended talking to someone close and 24% recommended professional help, e.g. from a psychiatrist, counsellor or the Samaritans. Respondents' perceptions of the prospects for recovery were quite positive (69%). Many of the responses included the qualification that a good recovery was contingent on receiving appropriate help coupled with individual resolve, with one respondent remarking that 'if she doesn't get help it may lead to suicide'. Only three respondents felt that the vignette actor would not recover regardless of any intervention. Males were significantly more optimistic about the vignette actor's prospects for recovery ($\chi^2 = 6.3$, $P < 0.05$) as were those with higher levels of education ($\chi^2 = 6.26$, $P < 0.05$). Concerning perceptions of how the vignette actor would be viewed in the local community, 44% of the responses were positive suggesting a supportive and sympathetic reaction. However, 27% of responses were categorized as negative with strong reactions such as 'avoid her like the plague', suggesting that people 'wouldn't bother with someone like that', because they would think 'he's just a mental case' or because they simply do not understand depression. Apart from the causal explanations, there were no significant differences in respondents' reaction to the male and female versions of the vignette.

Discussion

The needs assessment study highlights a number of interesting findings concerning the perceptions of depression and suicide among the four rural communities. While overall levels of awareness concerning depression and suicide appear to be high, there were significant differences across socio-demographic groups. Men, the under 40 age group and respondents with lower levels of education were significantly less concerned about current levels of suicide and depression, and men were less concerned than women about access to services. Clearly, given the increasing rates of suicide for younger males, the intervention programme needs to address levels of awareness among men and the younger members of the community.

In terms of dealing with depression and suicidal behaviour, the predominant response was to recommend talking to someone close and/or to consult the GP. However, it is also clear that even when the problem may be recognized, many respondents feel uncomfortable and lacking in confidence about how best to deal with depression and suicide and what advice to give. This was particularly the case for younger respondents and men. Given the reluctance of both younger respondents and men to contact the services, enhancing the possibilities for informal or peer support would appear to be critically important.

Concerning openness about mental health matters and utilizing informal support networks in rural communities, this study found that women were more likely to confide in family members and others about emotional matters than were men. This finding is in keeping with the results from a parallel study in a rural community in Northern Ireland (Barry *et al.*, 1999). Sogaard and Fonnebo (Sogaard and Fonnebo, 1995) in their Norwegian survey also report that men were significantly less likely to confide in others about emotional matters in comparison to females. The implications for men's help-seeking and emotional well-being are clearly highlighted.

Regarding attitudes to help-seeking, willingness

to consult professional help sources and belief in their effectiveness were generally positive. However, the significant socio-demographic effects are noteworthy in that younger respondents and men had less positive attitudes to consulting professional help sources. The effects in relation to education levels suggest that while respondents with higher levels of education are more aware of mental health issues they appear to be more cautious about using the services and are less convinced of their effectiveness. It would be interesting to explore these issues in more detail, particularly given the key role played by the GP as a first point of contact in rural communities. Findings from the present study suggest that the issue of stigma, in particular for younger respondents and those with higher education levels, may also play a role in their general reluctance to take up services.

Immediate social contacts such as family and friends appear to be very influential in relation to people's beliefs and perceptions concerning mental health. With regard to health professionals, the local GP was cited as the main influence. In real terms, the degree of contact with mental health professionals in rural communities is likely to be low; therefore, the more informal, local socially shared attitudes and beliefs would appear to be the prime influences. In reaching the community members, the local media, such as radio and local papers, emerge from the survey as desirable channels to use together with 'word of mouth' in the community.

The vignette method emerges as a useful methodology, eliciting interesting findings concerning the perceptions of depression. In keeping with earlier findings (Barry and Greene, 1992) psychosocial explanations were most salient in explaining the possible origins of depression. Social relationships, particularly around the lack of social contact due to isolation and loneliness, were perceived by rural respondents as being particularly important. Respondents appeared to relate quite well to the vignette character, however, it could be argued that the reactions to the case are removed from both a personal and local context. Use of the vignette within a focus group method may offer valuable insights into how interpersonal dynamics affect attitudes and expressed beliefs. It may be desirable for future studies to attempt to ground the research in the actual experiences of respondents within the family or local community setting. Clearly, in any such effort, ethical issues of anonymity and sensitivity would be critically important.

The needs assessment study has attempted to combine the use of closed-ended interviewer-administered questions with the vignette method in exploring the structure and range of perceptions concerning mental health among rural residents. The prime purpose of this first stage analysis of the data is to inform the intervention process by examining the effects of the socio-demographic variables on expressed attitudes and perceptions in the community samples. However, the data do afford the opportunity to model the inter-relationship of the attitudinal variables using more sophisticated statistical techniques. Given the multi-layered sampling approach adopted in this study, sampling issues need to be considered. The generalizability of the findings is constrained by the small area cluster approach used. However, the DEDs were randomly selected and are representative in demographic terms. Concerning the representativeness of the sample within the individual communities, the DED areas selected were quite small (below 1500) and, therefore, within any given area households had a high probability of being selected. In all, a total of 1769 houses were approached across the four communities. It should also be noted that the rural villages are laid out so that there is a reasonable socio-economic mixture in the areas covered. Within households the majority (74%) had only one respondent so clustering within households was not an inordinate influence. There is a slight over-representation of women in the sample, however, this was the case across the four comparison communities so there is no internal bias within the sample. Further, it is likely that women are significant decision makers about health matters and this is important in itself in establishing baseline attitudes.

Conclusions

The exploration of local community beliefs and perceptions provides a framework within which to ground the development of the intervention programme and provides an insight into the socially shared understandings of depression and suicide in these rural communities. While examining mental health attitudes and beliefs at the wider community level, the findings point to significant differences between socio-demographic groups which will need to be addressed in the planning of the intervention programmes. For example, levels of awareness, social stigma and attitudes to help-seeking emerge as particular issues for men and the under 40 age group. Likewise, the use of informal social support mechanisms and enhancing openness and increased confidence about mental health matters need to be emphasized. The more positive attitudes among women could also be reinforced in supporting the development of local programmes. The intervention phase of the study will now seek to build on this needs assessment, actively engaging the communities in the planning and implementation of the local intervention programmes.

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Appendix 1: depression vignette

Let me tell you about Margaret Molloy. She can see no meaning in her life anymore, she sees herself as a failure and feels there is very little to look forward to. She finds it difficult getting up in the morning as the idea of facing another day often seems too much. Activities that she enjoyed in the past, she no longer finds interesting and she rarely bothers to go out anymore and meet other people. She often finds herself overcome with a feeling of sadness and can't stop herself from crying. Sometimes she thinks about ending it all as she feels it may be the only way out. (Male version portrayed as James Molloy)