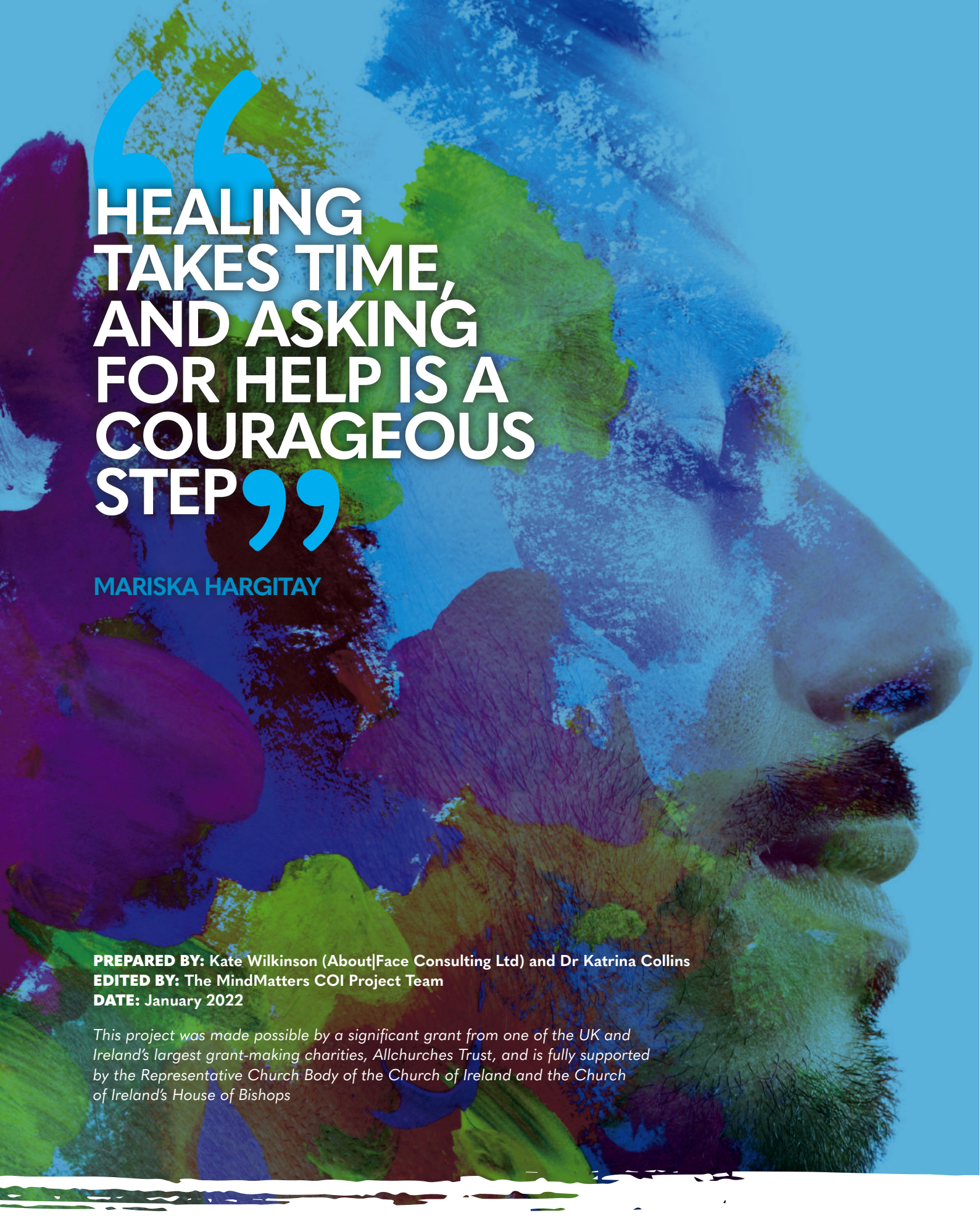
MindMatters COI

BASELINE ASSESSMENT

TECHNICAL REPORT



“HEALING TAKES TIME, AND ASKING FOR HELP IS A COURAGEOUS STEP”

MARISKA HARGITAY

PREPARED BY: Kate Wilkinson (About|Face Consulting Ltd) and Dr Katrina Collins
EDITED BY: The MindMatters COI Project Team
DATE: January 2022

This project was made possible by a significant grant from one of the UK and Ireland's largest grant-making charities, Allchurches Trust, and is fully supported by the Representative Church Body of the Church of Ireland and the Church of Ireland's House of Bishops

ALLCHURCHES TRUST LIMITED®
OWNERS OF ECCLESIASTICAL INSURANCE GROUP

DR KATRINA COLLINS
CONSULTANCY SERVICES

about|face

CONTENTS

MindMatters COI

EXECUTIVE SUMMARY

This is the comprehensive MindMatters COI phase one research report. A summary report is also available and can be accessed from the project website at: *https://mindmatters.ireland.anglican.org*

In autumn 2020, the Church of Ireland announced a major, three-year, all-island, mental health promotion programme MindMatters COI. Funded by Allchurches Trust, supported by the House of Bishops and led by the Representative Church Body, a number of project objectives were agreed:

- *To promote positive mental health across all parishes and dioceses in the Church of Ireland and wider community across both jurisdictions*
- *To equip and empower clergy effectively to support the mental health of their communities*
- *To establish sustainable links between the Church and the wider mental-health community, within both the voluntary and statutory sectors*
- *To assess and share learnings, and to embed overarching and evidence-informed approaches to mental health in the Church*

The research phase of this project is divided in two. Phase One commenced in January 2021 and Phase Two will commence in early 2023. This report provides a high-level overview of Phase One of the project.

The objectives of Phase One are:

- *To complete a baseline, strengths-based assessment (research) to explore the awareness and understanding of, and attitudes towards, mental health within the Church of Ireland*
- *To undertake a literature review which can be used to inform data collection and analysis, and enable contextualisation of the findings*
- *To prepare two reports: an Executive Summary and a Technical Report (this document)*
- *To conduct a sub-study with lay members of the Church of Ireland aged 13 – 25 years (Winter 2021 / Spring 2022)*

PROJECT GOVERNANCE

Four separate but interrelated groups were established: the Project Group, the Advisory Group, the Ethics Group and the Communications Group.

LITERATURE REVIEW

The aim of the Literature Review was to identify gaps in academic research, knowledge and understanding of mental health within church communities. This involved searching for, and reading, relevant literature (both grey and empirical) on the role of the Church of Ireland in promoting positive mental health. A systematic review approach was adopted – the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) method. This has the key purpose of critically and objectively synthesizing available information and evidence regarding mental health promotion in faith-based communities. In the MindMatters COI study, the primary objective is stated as reaching a position of being able to

'Describe existing attitudes towards and understandings of mental health across both jurisdictions and include best practice initiatives which demonstrates the contribution the Church can make in promoting positive mental health'.

Taking account of the primary objective, two distinct outputs were identified which directed the search strategy:

- *Attitudes and understanding of mental health across both jurisdictions*
- *Best practice initiatives which demonstrate the potential contribution of the Church in promoting positive mental health*

Programmes identified in the literature using the PRISMA methodology found 21 faith-based examples that met the review criteria.

The key points from the literature review are:

- *Across the two jurisdictions, the responses to mental health are almost identical within contextual nuances*
- *Church provides a place where people can connect with others as well as receive assistance, warmth and kindness (Gallet, 2016)*
- *Church lay members are likely to experience challenges and concerns across the mental health continuum from mental health literacy, promotion, intervention and post intervention (Grcevich, 2018)*
- *Response to stigma in mental health requires a 'unified response in efforts to educate, inform, support and work together in addressing issues in a more proactive manner' (Reese, 2019)*
- *Church leaders are often considered from a public health point of view 'first-responders' or 'gatekeepers' when individuals or families experience mental health problems (APA, 2018)*
- *Church sermons where mental health messages or issues are spoken about are likely to be an infrequent part of religious discussions (LifeWay, 2016)*
- *There may be an increase in COVID-19 related religious struggles among various religious groups and subsequent mental health-related problems, including depression, anxiety, PTSD, and suicidality (Lee, 2020)*
- *The literature review identified a range of faith-based initiatives in churches nationally and internationally. Best practice examples included internal church-focused programmes to support targeted individuals, and specific initiatives that took a more generalist or universal approach*
- *Every church should have a wraparound mental health plan that is aligned to the working of Jesus Christ (Reese, 2018)*
- *The 'Gift of Time' was a key theme in a number of church-based initiatives, not only in mental health, but in other public social issues (Simons, 2017)*

BASELINE ASSESSMENT

The objectives of the MindMatters COI Baseline Assessment were closely aligned to the Phase One objectives, and the overarching Baseline Assessment research question was agreed as:

"What are the mental health awareness levels and attitudes to Mental Health in COI lay members and clergy?"

The two sampling units were COI clergy and COI lay members aged over 18. There are in the region of 375,400 Church of Ireland lay members across the island of Ireland, across 11 dioceses, with over 500 stipendiary clergy.[1] The Baseline Assessment encompassed all clergy and all active church lay members. It was assumed that 15% of the Central Statistics Office membership number of 375,400 are active lay members - i.e. 56,310, with 22% under age 18, making the active adult membership 43,922. The sample size and target response rates were based on this number. The sample sizes and target response rates were calculated using widely accepted and best practice models.

[1] *There were 12 dioceses at the time of the survey. However, since the amalgamation of Tuam, Killala and Achonry and Limerick and Killaloe, there are now 11 dioceses*

For each sampling unit, a survey and focus groups were the agreed consultation methods. All 12 bishops were also interviewed separately.

The two surveys included the same questions with some additional questions for the clergy:

1. **About the respondent (including clergy specific questions)**
2. **About Mental Health - awareness**
3. **About Mental Health - attitudes (Vignette)**

An ethics form was submitted covering all elements of the Baseline Assessment methodology.

The Baseline Assessment consultation took place between 1st May and 30th June 2021 and was actively supported by the project Communication Group to raise awareness of the project and encourage participation in the surveys and the focus groups. This included communications through COI social media and print publications, as well on the project website. The impact of COVID-19 on the response rates was also taken into consideration.

BASELINE ASSESSMENT HEADLINE THEMES AND FINDINGS

The key themes and findings by sampling unit are presented in the report, with the full findings in the appendices.

MAIN FINDINGS

INTERVIEWS WITH BISHOPS

- *Faith is important for both physical and mental health*
- *There is a level of stigma around mental health in the Church, reflective of that in wider society*
- *Skills required by clergy to respond to the mental health needs of their parishioners should be reinforced and developed, and clergy must be careful not to act outside the boundaries of their own competence*
- *The reluctance of some clergy to speak openly about mental health, both generally and personally needs to be addressed*
- *Self-care of the Bishops and their clergy was perceived as critical*
- *Bishops see their primary role as enabling and encouraging clergy to create and foster a culture of openness and transparency around mental health issues*

SURVEY FINDINGS

MEMBERS' SURVEY

A full analysis to all questions can be found in Appendix One of this report. As is illustrated, four key themes emerged. These will form the basis of the Church of Ireland's approach to promoting positive mental health:

- *The prevalence of stigma around mental health*
- *The importance of connections for good mental health*
- *The role of the clergy*
- *The importance of faith*

Stigma around mental health issues

Stigma-related factors were perceived as being major barriers in discouraging people from seeking support for mental health issues. Over 60% of respondents cited stigma-related factors[2] as barriers to seeking support from healthcare professionals (63%) and clergy (62%). Just under half of respondents (49%) saw stigma as a factor in not seeking support from family.

Importance of connections

The importance of strong connections to family and friends was emphasised. In responding to a question (MQ34) about how certain mental health issues could be prevented, 45% cited connections as the most important factor. This echoes the findings of the report by the New Economic Foundation[3] which lists 'Connect' as one of the *Five Ways to Wellbeing*.

The role of the clergy

The literature suggested that members of faith communities were often more likely to seek support for mental health issues from a member of the clergy or equivalent faith leader than from a medical professional. In this survey, where the question ranked 1-10 as most likely source of support, clergy were ranked 9th out of 10 (MQ18).

The importance of faith

Almost 90% of respondents felt that their faith is important to their mental health (MQ23), a finding which agrees with much of the literature.

CLERGY SURVEY

A total of 290 clergy participated in the survey and the full report on their responses is contained in Appendix One. The key themes to have emerged are:

- *The existence of stigma around issues of mental health*
- *The importance of faith for positive mental health*
- *The need for clergy to develop the skills required to support parishioners with mental health issues*
- *The need for the Church to support the mental health needs of the clergy*

Stigma around mental health issues: More than two-thirds of clergy felt that stigma-related factors would discourage people from seeking support for mental health issues from family (67%) or a member of the Clergy (67%). Over half (58%) felt that it would stop people seeking the support of a medical professional.

Importance of faith: The great majority of clergy (88%) felt that their faith was important to their own mental health (CQ23).

Skills required to respond to needs of parishioners: Opinions were divided as to whether clergy have the skills required to support a parishioner experiencing a mental health issue (CQ15), with 40% agreeing that they had and 29% disagreeing. Almost a third (32%) neither agreed nor disagreed.

Need for the Church to support the mental health of clergy: More than twice as many clergy disagreed (46%) as agreed (21%) with the statement 'The Church of Ireland provides me with good support for my own mental health'. The remaining 33% neither agreed nor disagreed.

CONCLUSIONS

The research suggests that the most effective contribution that the Church can make in promoting positive mental health is by concentrating, in the first instance, on four key areas:

- *Reducing stigma*
- *Promoting connections*
- *Providing clergy with additional training and support*
- *Exploring additional faith-based supports for mental health.*

[2] *'Stigma-related factors' are a combination of 'stigma', 'embarrassment', 'fear' and 'clergy attitude'.*
[3] *New Economic Foundation: d80eba95560c09605d_uzm6b1n6a.pdf (neweconomics.org)*

BACKGROUND AND CONTEXT

As the comprehensive MindMatters COI phase one research report, this document provides a robust strengths-based research base that will enable the Church of Ireland to make evidence-informed decisions about the provision of mental health support for both clergy and church lay members.

In autumn 2020, the Church of Ireland announced a major three-year, all-island, mental health promotion project entitled 'Mental Health Promotion across the Church of Ireland and Wider Community', which has subsequently been renamed MindMatters COI. The aim of the project, funded by Allchurches Trust, is to raise awareness of, and respond to, the mental health needs of Church of Ireland clergy and lay members across the island of Ireland.

The overall aims of MindMatters COI are:

- *To promote positive mental health across all parishes and dioceses in the Church of Ireland and wider community across both jurisdictions*
- *To equip and empower clergy to support effectively the mental health of their communities. This will commence following the baseline study and will be measured by research into the impact of training engagements with specific agreed mental health programmes that show evidence of skill and attitudinal changes*
- *To establish sustainable links between the Church and the wider mental health community, within both the voluntary and statutory sectors. This will be measurable by an increase in effective models of partnership across the Church of Ireland at project end*
- *To assess and share learnings, and to embed strategic cohesive approaches to mental health in the Church, measurable by:*
  - *Final Project Report including key recommendations*
  - *A framework to support the future development of a cohesive, sustainable, mental health strategy for the Church of Ireland developed through the medium of an all-island mental health conference attended by key stakeholders, other churches and government bodies*

The research components for the project is split into two phases. Phase one, from January 2021 – Spring, 2022 and Phase two, commencing in Spring 2023.

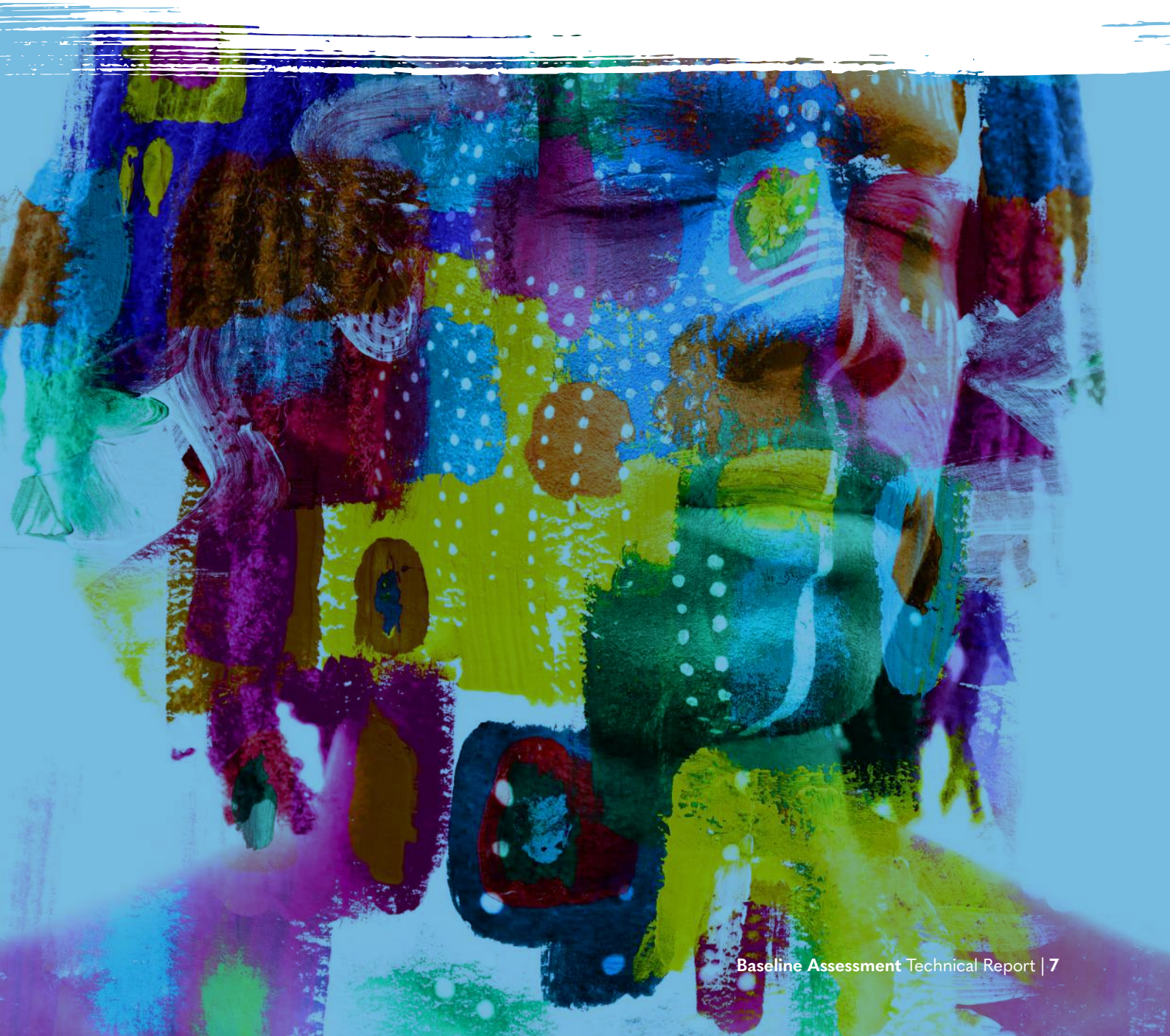
Phase One Objectives:

- *To complete a baseline, strengths-based assessment of awareness and understanding of, and attitudes towards, mental health within the Church of Ireland, using both qualitative and quantitative methods. A participative consultation approach was used with relevant stakeholders*
- *To undertake a literature review to describe existing attitudes towards and understandings of mental health across both jurisdictions. This was used to explore findings in the literature in relation to findings in the consultation (where comparable) and to identify evidence-based best practice initiatives which demonstrate the contribution a church can make in promoting positive mental health*
- *The preparation of the Phase One project report to include:*
  - *Evidence-based literature review*
  - *Consultation design and methodology*
  - *Analysis of consultation surveys*
  - *Analysis of interviews and focus group information gathered from stakeholders (lay members, clergy and Bishops)*
  - *Presentation of the key consultation findings*

Youth Research Sub-Study. As the phase one research progressed, the decision was made to carry out an additional and separate sub-study for young COI lay members (two age cohorts: 13 – 18 and 19 – 24). The researchers will collaborate with COI Diocesan Youth Officers supported by the Project Group and Advisory Group, and will produce a separate, companion, report by early 2022.

Phase Two Objectives:

- *To conduct and produce an evaluation of the impact the MindMatters COI project has had on awareness and attitudes in the context of mental health within the Church of Ireland (representative sample, qualitative and quantitative methods) and other tools as recommended by the researcher*
- *To develop a final project report to include key findings, analysis and key recommendations*
- *Planning and delivering an all-island conference to discuss the project and its outcomes*
- *To build a framework to support the future development of a cohesive, sustainable, mental health strategy for the Church of Ireland*



PROJECT GOVERNANCE

MindMatters COI has a strong governance and project management structure to ensure adherence to the project objectives and compliance with the ethical considerations related to the project. Four separate but interrelated groups were put in place; the Project Group, the Advisory Group, the Ethics Group and the Communications Group. The purpose and member of each group is described below.

PROJECT GROUP

The Project Group was established at the start of the work with membership from across the Church of Ireland. The role of the Project Group was to work closely with the researchers and provide input, guidance, and decision-making across all elements of Phase One of the project.

Table One: Membership of the Project Group

Most Rev Pat Storey	**Bishop of Meath and Kildare, Chair of the Project Group**
Rebekah Fozzard	Project Manager, Representative Church Body (RCB)
Eddie Hallissey	Human Resources Manager and project communications lead (RCB)
Robert Dunne	Safeguarding Officer (Republic of Ireland) and training lead (RCB)
Margaret Yarr	Safeguarding Officer, Northern Ireland (RCB)
Christine Cody	Vetting Liaison (Republic of Ireland) (RCB)

ADVISORY GROUP

The role of the Advisory Group was to provide oversight and guidance for Phase One of the project. The group provided constructive feedback on the Baseline Assessment methodology including the survey design, focus group structure and questions. The Advisory Group also provided feedback on the Baseline Assessment findings prior to the submission of the report.

Table Two: Membership of the Advisory Group

Most Rev Pat Storey	**Bishop of Meath and Kildare, Chair of the Advisory Group**
Professor Gerard Leavey	Director of the Bamford Centre for Mental Health and Wellbeing, University of Ulster
Professor James Lucey	Medical Director, St. Patrick's University Hospital Dublin and Clinical Professor of Psychiatry
Professor Jim Campbell	School of Social Policy and Social Work and Social Justice, University College Dublin
Dr Jill Hendron	(retired) School of Communication and Media, University of Ulster

All members of the project group are also members of the Advisory Group.

ETHICS GROUP

The Ethics Group was established in March 2021 with the purpose of:

- *Supporting the MindMatters Advisory Group, Project Group and research consultants in all matters relating to the ethical considerations with the MindMatters Project*
- *Providing an ethical input into project engagement and consultation methodologies and processes*
- *Providing guidance on data gathering and storage processes, informed consent and other potential ethical dilemmas*

Table Three: Membership of the Ethics Group

Professor Jim Campbell	**School of Social Policy and Social Work and Social Justice, University College Dublin, Chair of the Ethics Group**
Dr Betty Hilliard	(retired) School of Sociology, University College Dublin
Rev Stephen Farrell	Provincial and Diocesan Registrar, United Dioceses of Dublin and Glendalough
Rebekah Fozzard	Project Manager, Representative Church Body (RCB)

COMMUNICATIONS GROUP

The Communications Group was established to support the awareness raising of the project consultation process and was in place from late April until early July 2021. The Group met weekly to review survey response management, response levels and communications opportunities.

Table Four: Membership of the Communications Group

Eddie Hallissey	**Human Resources Manager and Chair of Project Communications**
Peter Cheney	Press Officer, Representative Church Body (RCB)
Lynn Glanville	Diocesan Communication Officer, United Dioceses of Dublin and Glendalough
Andrea Bridge	Vetting Liaison (Republic of Ireland) (RCB)

> **"CHURCH COMMUNITIES ARE OFTEN ABLE TO REACH MINORITY, NEGLECTED AND UNDERSERVED POPULATIONS BECAUSE OF THEIR BELIEF SYSTEMS THAT VALUE HEALTHY BODY, MIND, AND SPIRIT."**
>
> **KOSMIN & KEYSAR 2009**

LITERATURE REVIEW

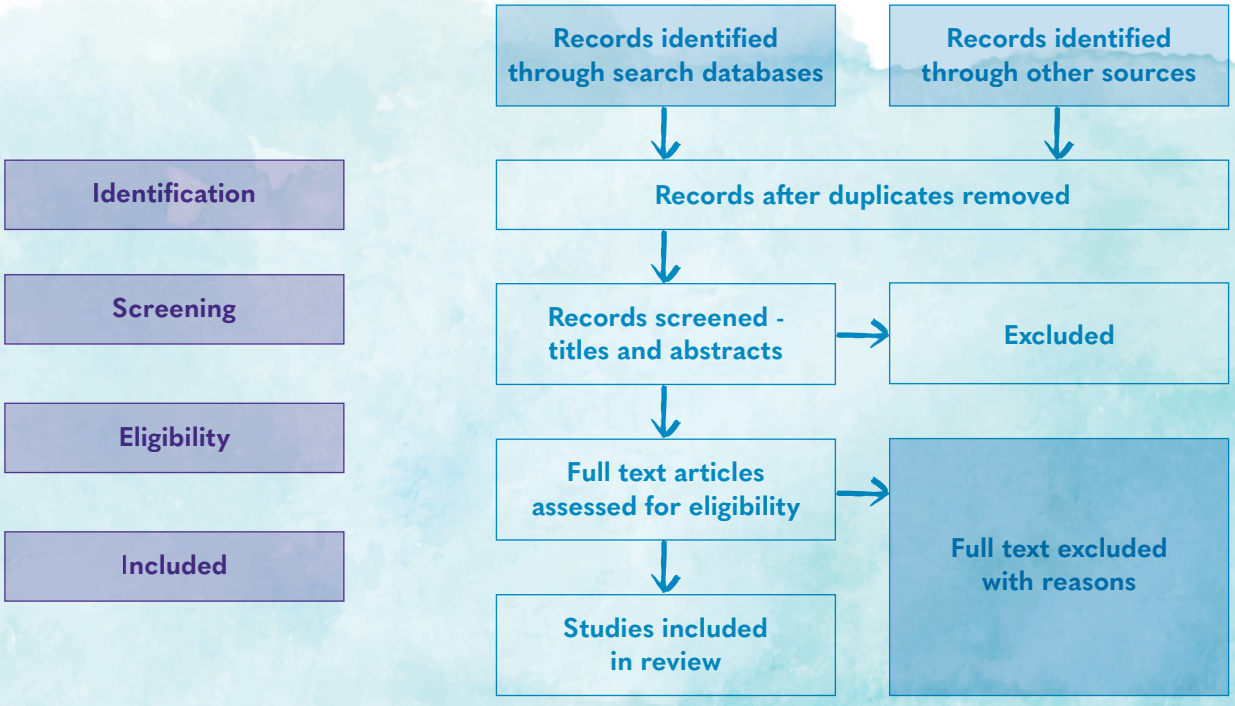
LITERATURE REVIEW METHODOLOGY

A systematic review approach was adopted. This has the key purpose of critically and objectively synthesising available information and evidence regarding mental health promotion in faith-based communities. A multi-step process was undertaken to guide a rigorous review of material (both grey and empirical). This included:

- *Identifying well-defined focused relevant questions*
- *Developing a detailed review protocol with strict inclusion and exclusion criteria*
- *Systematic literature searches of multiple databases and unpublished data (where key sources have been identified in consultation with the COI)*
- *Study of identification and systematic data abstraction using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) framework*
- *Applying an evidence standards framework (Nesta)*

The Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) method was followed. It provides evidence-based minimum sets of items for reporting in systematic reviews. For the purpose of this review, it led to a two-level data search using databases containing peer-reviewed papers and grey material searches (includes non-peer reviewed material that contributes to practice and learning). This was followed for both parts of the identified research objective. The PRISMA process is detailed in Figure 1 using a flow diagram format.

Figure 1: PRISMA (Preferred Reporting for Items for Systematic Review and Meta Analyses) Flow Diagram of Review *(Page et al, 2021)*



LITERATURE REVIEW RESEARCH OBJECTIVE

In the MindMatters COI study, the primary objective stated was to:

'Describe existing attitudes towards and understandings of mental health across both jurisdictions and include best practice initiatives which demonstrates the contribution that the Church can make in promoting positive mental health'.

Taking account of the primary objective, two distinct outputs were identified which directed the search strategy:

- *Attitudes and understanding of mental health across both jurisdictions*
- *Best practice initiatives which demonstrate the potential contribution of the Church in promoting positive mental health*

As expected, some studies revealed an overlap between attitudes to and understanding of mental health with programmatic or practice responses in church communities.

LITERATURE REVIEW CRITERIA

Based directly on the primary research objective, the searches were required to contain the key search terms in the title and/or abstract. These were divided into key search categories relevant to the research objectives (Table One). The literature review sought studies that have been conducted internationally and nationally (peer-reviewed and grey material) from the year 2010 to 2020. Seminal pieces of work outside of this ten-year period were added to the search records.

An additional layer was considered within the search process that took account of the impact of COVID-19 on the mental health of the population, and the ability to deliver mental health promotion. The literature review also explored a number of early peer-reviewed and grey material that has considered mental health implications of the pandemic.

Table One: Literature Review Search Strategy Terms

Mental health Terms	Religion/Faith Terms	Population	Setting	Intervention Terms	Related Outcomes
Mental health	Religion	Clergy	Church	Early Intervention	Stigma
Mental health literacy	Theology	Congregation	Dioceses	Promotion	Healing
Emotional wellbeing	Church of Ireland	Adult	Community	Prevention	Resilience
Mental health problems	Anglican communions	Vulnerable	Parish	Postvention	Coping skills
Stigma	Faith	At risk		Programme	Support
Attitudes	God	Young People		Supports	Connectedness
Understanding				Services	Empowered
Awareness				Signposting	Informed

KEY POINTS FROM THE LITERATURE REVIEW

ATTITUDES AND UNDERSTANDING OF MENTAL HEALTH ACROSS BOTH JURISDICTIONS

There are two separate government and legislative frameworks supporting mental health policies: the streams of implementation and intention providing responses to mental health are almost identical. The contextual nuances of each territory have been described below to provide the background against which the MindMatters COI Project, its consultation phase, and planning of initiatives takes place.

Northern Ireland (NI)

The evidence suggests that Northern Ireland has the highest prevalence of mental illness in the UK (Bunting et al, 2012). With a 30-year legacy of conflict ('The Troubles'), psychiatric morbidity is 25% higher than in rest of the UK (O'Neill & Rooney, 2018). Mental illness health has been reported as the single largest cause of ill health and disability in Northern Ireland (Betts & Thompson, 2017). The history of the Troubles is acknowledged as having a substantial and long-lasting impact on mental health in Northern Ireland. 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles (Bunting et al, 2012). Furthermore, socio-economic deprivation and high rates of mental and physical illness co-occur in the areas most impacted by the violence (Heenan & O'Neill, 2019).

The trauma experienced in Northern Ireland has been cited as a contributing factor to the high suicide rates in the region. The suicide rate is higher than the rate in the rest of the UK and the Republic of Ireland at 29.1 for men and 8.5 for women per 100,000. Men aged 35-39 are the highest of all age groups at 56.1 per 100,000 (Scowcroft, 2017). The lasting impact of trauma from conflict exposure was highlighted in a World Mental Health Survey (2019), which found that mental illness in Northern Ireland was in the top three of countries who participated. Additionally, 8.8% of those surveyed had post-traumatic stress disorder (PTSD), which was recorded as the highest of all countries in the study (Appleby, 2018). Concerns about violence from paramilitary activity in the form of 'punishment beatings' continue today despite a reduction in the number of paramilitary attacks. Research has pointed to this experience as an antecedent to suicide (O'Neill & O'Connor, 2020).

There are similar population risks for mental health problems in NI as in other countries including the Republic of Ireland. However, it would be neglectful to ignore the cultural and social ramifications of trauma as a result of conflict on the island of Ireland, not only on the people of NI but on those who live in the border counties of the Republic of Ireland.

Republic of Ireland (ROI)[4]

According to an OECD (Organisation for Economic Co-Operation and Development) report in 2018, mental health problems cost the Irish economy over €8.2 billion annually. It emerged that rates of depression were above European averages for both men and women, with Ireland having one of the highest rates of mental illness in Europe. ROI was ranked third out of 36 countries which participated in the study. Conversely, suicide rates are lower with ROI ranked 23rd out of 30 compared to other European countries (Eurostat, 2017).

In the strategic document 'Sharing the Vision: A Mental Health Policy for Everyone', the Government set out the national framework and objectives to implement a ten-year response to mental health in Ireland. The core values of this document are strongly aligned to the ethos and values noted as critical to any church-based mental health initiative. These include: respect; compassion; equity and hope (Department of Health, 2020).

MENTAL HEALTH AND THE CHURCH

The local church is a place where people can connect with others as well as receive assistance, warmth and kindness particularly during times of distress (Gallet, 2016). It has been suggested that the strength of churches is their ability to connect with local communities, and through resources such as volunteers

[4] The Church of Ireland is an all-island body which predates partition. To avoid confusion therefore the terms 'Republic of Ireland' and 'Northern Ireland' are used to distinguish between the two jurisdictions which share the island.

and pastoral care, a civic engagement is created which extends to support networks and the growth of social capital in those communities (Schneider, 2006). Churches have been described as the social glue or cement that holds civil society and its members together (Beck, 2010; Putnam, 2000).

The specific role of faith communities has been identified as being four-fold (Schneider, 2006):

- *A spiritual well for participants*
- *A source of community providing social and critical supports to church members who seek help*
- *Fosters social capital among active lay members*
- *A source of empowerment and change for transformation at the individual, organisational, and community level*

While the primary function of the Church is to encourage and nurture the spiritual health of the congregation and its clergy, pastoral care and ministries of support are viewed as a natural outcome of the teachings of the Christian faith. One of these ministries of care in the Church is in creating an inclusive and receptive environment of all Christ's children.

The ecosystem and social structure within a church community offers an opportunity to reach a cross section of society, with health and mental health responses. The all-encompassing nature of the Church as an institution serving participants from all age, socioeconomic, and ethnic/racial groups, makes comprehensive health interventions in faith communities a potentially effective conduit to deliver health interventions (Peterson et al., 2002). Churches provide an environment where multiple generations and social groups regularly interact over time within an established social framework (Kosmin and Keysar 2009; The Pew Forum on Religion and Public Life 2008). Furthermore, church communities are often able to reach minority, neglected, and underserved populations because of their belief systems that value a healthy body, mind, and spirit (Kosmin & Keysar 2009).

Church lay members are likely to experience challenges and concerns across the mental health continuum from mental health literacy, promotion, intervention and postvention. It has been suggested that the role of the Church in offering pastoral care, spiritual guidance and support is dependent on a number of factors that are linked to the ethos required for compassion and healing. An examination of good practice has resulted in seven strategies for an inclusive mental health initiative that is faith-based using the acronym TEACHER (Grcevich, 2018):

T: Assemble your TEAM
E: Create welcoming ENVIRONMENTS
A: Focus on ACTIVITIES essential for spiritual growth
C: COMMUNICATE effectively
H: HELP families with needs
E: Offer EDUCATION and support
R: Empower people to assume RESPONSIBILITY

These principles are noted in a number of church-based approaches and initiatives to promote awareness and understanding of mental health from a Christian perspective and respond with the values and teaching of their faith. The link between religiousness, spirituality and mental health, suggests that lay members of the Church may be confronted with existential questions. The response and attitude of the Church to mental health suffering may be to provide a perspective of hope, relief, coping, or meaning in life (Braam, 2017).

Interestingly, the research on health promotion programmes in churches has primarily been conducted in African-American populations (Johnston et al 2017), including mental health issues in this population (Bryant et al. 2013; Holt et al. 2013; McCabe et al. 2012; Williams et al. 2014). The current literature review supports this finding.

STIGMA, MENTAL HEALTH AND THE CHURCH

The key to unlocking stigma is awareness, understanding and inclusion (Stetzer, 2016). It has been argued that mental health awareness begins with pastoral leadership. With congregations likely to look

to their faith and their church for spiritual guidance in times of distress, there are growing expectations and responsibilities on the Church to respond. In this respect, it has been put forward that a response to stigma in mental health requires a 'unified response in efforts to educate, inform, support and work together in addressing issues in a more proactive manner' (Reese, 2019). This may take different forms including external partnerships and collaborations to build and strengthen referral pathways, assist in referrals, offer continued education and engage further in healthier dialogues around positive mental health and mental health problems.

CLERGY AND CHURCH LAY MEMBERS

In a survey of 217 American Protestant senior pastors as part of the 'State of the Church Study' (Barna, 2020), 30% reported feeling well-equipped to help congregants deal with matters of mental or emotional health. Further examination of the data about the extent to which Church leaders could help people who present with mental or emotional problems found that three in ten pastors (30%) say they feel 'very well-equipped'. The majority (64%) felt 'somewhat equipped', with a remaining six percent stating they are 'not well-equipped'.

Church leaders from a public health point of view are often considered 'first-responders' or 'gatekeepers' when individuals or families experience mental health problems. It has been suggested that 'in that role they can help dispel misunderstandings, reduce stigma associated with mental illness and treatment, and facilitate access to treatment for those in need' (APA, 2018). For that reason, the position they hold, and the influence they can have on response and recovery, requires knowledge, understanding, capacity and resources to offer useful guidance and support. In this regard, strengthening the skills of clergy is one area in the literature that has received attention with the development of initiatives and availability of programmes for faith-based responses to mental health.

Additionally, research has indicated that church sermons where mental health messages or issues are spoken about are likely to be an infrequent part of religious discussions. This may be beyond the skill set of each individual member of the Clergy, but points to the importance of ethos and culture of the church environment. It is about the communication, tone, language, prevailing attitude and values distilled through church leadership. In a study of mental health in sermons, it emerged that the frequency of discussions ranged from several times a month to once a year or never (LifeWay, 2016):

Several times a month – 3%
About once a month – 4%
Several times a year – 26%
Once a year or rarely/never – 66%

For lay members of the congregation, seeking support in church for mental health and mental health problems may bring a sense of hope, but also fear. The LifeWay study engaged with both clergy and church lay members to align the perceptions about mental health in their religious communities. It emerged that while 68% of clergy stated that the Church maintains resources on mental health for its parishioners, only 28% of lay members were aware of these. It suggests that the communication and presentation of support for mental health problems may require alignment to reduce disparities between church leadership and the membership.

COVID-19, MENTAL HEALTH AND THE CHURCH

People often use their religion to cope with adversity (Pargament, 2001). Prayers are said to ask for relief, understanding, and comfort. Research has recorded that people struggling with cancer, death in their close family, or severe illness are more religious, including in the times of natural disaster, where people are found to pray more intensely (Bentzen, 2019).

In 2020 COVID-19, daily data on Google searches for 95 countries found Google searches for prayer to be the highest level ever recorded (relative to all Google searches). More than half of the world population had prayed for an end to the Coronavirus. One of the most searched-for prayers in March 2020 was the 'Coronavirus prayer', which asks God for protection against the Coronavirus, as well as

prayers to stay strong, and prayers to thank nurses for their efforts (Bentzen, 2020). In addition, searches for terms such as God, Allah and Mohammad increased significantly in this period suggesting that the COVID-19 pandemic encouraged religious coping in the faith-community.

The pandemic has affected religious practice and traditions in a number of ways, including the cancellation of live religious services, the closing of religious schools, cancelling of pilgrimages and prohibiting of group interactions during festivals and celebrations (Dein et al, 2020). It was reported in one of the initial studies about the impact of COVID-19 that higher levels of struggle with religious belief were associated with elevated scores on a Coronavirus Anxiety Scale (Lee, 2020). It has been suggested that in these findings, and, potentially in other studies, there may be an increase in COVID-19 related religious struggles among various religious groups and subsequent mental health-related problems, including depression, anxiety, PTSD, and suicidality (Lee, 2020).

FAITH AND MENTAL HEALTH

This literature review identified a range of faith-based initiatives in churches nationally and internationally that confirm previous findings from studies that faith and mental health approaches can be categorised in five distinct groups (Meadows Mental Health Policy Initiative). These highlight how churches have responded to mental health:

- *Educate faith communities to increase mental health literacy and awareness*
- *Equip congregations for mental health ministry (develop their capacity to support recovery and wellness in individuals with mental health problems)*
- *Engage faith communities as partners in efforts to improve mental health system access and performance*
- *Establish system-level efforts to promote faith and mental health collaboration*
- *Embed mental health services in faith communities*

Studies that have explored the structure and content of programmes have highlighted key facets that are commonly linked to best practice in faith-based health and mental health programmes (Peterson et al. 2002; APA, 2020). These are proposed when planning a response or considering further extensions to existing work. These key factors include:

- *Partnerships*
- *Positive health values*
- *Availability of services (the amount and type of services)*
- *Access to facilities (ease of accessibility in terms of cost, time, referral route)*
- *Community-focused intervention*
- *Health behaviour change*
- *Supportive relationships*

It has been argued that despite the fact that each of the seven key elements can be found individually in the literature, there is a call for greater emphasis on incorporating a number of the features into one mental health initiative to improve the efficacy of the programme (Johnston et al, 2017).

THE CHURCH

The literature suggests that every church should have a mental health plan that is aligned to the working of Jesus Christ (Reese, 2018) with a wraparound approach which connects mental health resources, organisations and agencies using a collaborative approach to partnership. The sense of belonging is a key feature of faith communities where opportunities to connect, engage, assume meaningful roles, experience the transcendent, and build genuine social relationships, are all possibilities. These features and quality of a church have been described as a healthy church environment where individuals struggling with mental health are welcomed, offered hope and practical help (Reese, 2018).

THE CLERGY

The clergy vocation is unique in its diverse range of professional responsibilities. Clergy are inherently exposed to a lifestyle that is hectic, fragmented, and emotionally challenging, and has little structure or predictability (Lindholm et al, 2014). The prospects for church leaders and clergy to support people with mental illnesses to achieve recovery in the faith community and wider community are substantial. This can be further augmented through collaborative working with mental health providers and other agencies that can deliver evidence-based and clinically necessary treatment and supports.

The literature reports that among the benefits of clergy and church supporting parishioners in mental distress is the reduction in restrictions by which many health services are bound and thus an ability to serve the needs of the whole person (Simmons, 2017). Furthermore, it has been suggested that health partnerships with churches benefit from the added value of time, bringing an element of a quality service which ordinary public health services are not always able to provide. The 'Gift of Time' was a key theme in a number of church-based initiatives not only in mental health but in other public social issues (Simons, 2017).

THE CONGREGATION

Church lay members or laity are some of the terms used to describe people who identify with a particular faith and are likely to be active lay members of that church. Findings from the literature review suggest that programmes or approaches to support mental health and promote positive mental health take different forms. It emerged that best practice examples included internal church-focused programmes to support targeted individuals [those who are seeking support for mental health issues]. There were specific initiatives that took a more generalist or universal approach to encourage any member of their church community to seek support initially from them for spiritual guidance with their mental health concerns. The other way of working described in the literature was to create a mental health ministry and peer support networks by having a stigma free or healthy congregation. These were models of working aligned to Christian values of compassion, openness and non-judgemental attitudes to fellow church lay members.

SUMMARY OF LITERATURE REVIEW FINDINGS

Programmes identified in the literature using the PRISMA methodology found 21 faith-based examples that met the review criteria. The sub-study which examined church-based mental health initiatives for children and young people identified six that met the review criteria.

The literature review highlighted a range of programmes and initiatives that aim to promote positive mental health and support lay members of the congregation and clergy with mental health problems. International examples pointed to clergy-specific, congregation-specific and collective programmes (both congregation and clergy) that were embedded in faith principles and ethos. These were across the lifespan, with some tailored to younger lay members of the congregation to promote positive messages about mental health.

> **"EVERY CHURCH SHOULD HAVE A MENTAL HEALTH PLAN THAT IS ALIGNED TO THE WORKING OF JESUS CHRIST."**
>
> **REESE, 2018**

RESEARCH DESIGN

This assessment provides data and information on the project research objective that will inform the next stage of the project in planning and delivering mental health programmes and interventions. A follow-up consultation will take place in 2023 [Phase Two] after the implementation of the planned interventions, using the same methodology. The findings from both phases will be compared.

The overall approach to the baseline assessment was developed by the researchers in close consultation with the Project Group, overseen by the Advisory Group. The approach was strengths-based and collaborative at all time, valuing the skills and experience of everyone involved. The methodology was directly informed by the findings of the Literature Review.

BASELINE ASSESSMENT RESEARCH QUESTION

The objectives of the MindMatters COI Baseline Assessment were closely aligned to the Phase One objectives, and the overarching Baseline Assessment research question was agreed as:

"What are the mental health awareness levels and attitudes to Mental Health in COI lay members and clergy?"

The objectives of the Baseline Assessment were:

1. *To raise awareness of the MindMatters COI Project, mental health, and to start a conversation with clergy and membership that will potentially change the way people think about mental health*
2. *To design and implement a strengths-based consultation approach for the Clergy and active COI lay members that will:*
   - *Obtain an understanding from as many active church lay members and COI clergy as possible on their mental health literacy, awareness and attitude*
   - *Determine what mental health support the Clergy and COI membership are aware of, and have accessed;*
3. *To ensure all Data Protection and GDPR regulations are complied with on the collection, collation and storage of Baselines Assessment response data*

BASELINE ASSESSMENT METHODOLOGY

BASELINE ASSESSMENT SCOPE

There are in the region of 375,400 Church of Ireland lay members across the island of Ireland - 126,400 in the Republic of Ireland and 249,000 in Northern Ireland. There are 12 dioceses[5], over 450 parishes and over 500 stipendiary clergy. The Baseline Assessment encompassed all clergy and all active church lay members. For the baseline assessment, based on the direction of the Project Group, it was assumed that 15% of the Central Statistics Office membership number of 375,400 are active lay members - i.e. 56,310, with 22% under age 18, making the active adult membership 43,922. The sample size and target response rates were based on this number. The Representative Church Body was not included in the scope of the Baseline Assessment.

[5] *There were 12 dioceses at the time of the survey. However, since the amalgamation of Tuam, Killala and Achonry and Limerick and Killaloe, there are now 11 dioceses.*

BASELINE ASSESSMENT SAMPLING UNITS AND FRAMEWORK

Two sampling units were agreed for the consultation: the COI clergy and the COI lay membership over age 18. Careful consideration was given to the consultation sampling framework to ensure representation controlling for demographics and geography, and for the Clergy the primary role and other roles they may hold within the Church. The sampling framework included (adjusted as required for each unit):

- *Location by diocese*
- *Gender*
- *Age range*
- *Marital status*
- *Disability*
- *Sexual orientation*
- *Ethnicity*
- *Nationality*
- *Employment status*
- *Educational attainment level*
- *Household type/Family by family cycle/One parent families*
- *Rural/Urban*
- *Mental health awareness/Training completed*
- *Attendance/engagement with church and church activities*

CONSULTATION SAMPLE SIZES AND TARGET RESPONSE RATES

Statistically valid sample sizes were calculated for both sampling units, using a confidence interval of 5%. It was agreed to calculate the members' sample sizes at a jurisdictional level, rather than for the island of Ireland, in order to ensure sufficient representation across both jurisdictions. The sample size for the whole COI active member population would have been 381 against an NI sample size of 380 and a ROI sample size of 375.

The sample size for the membership survey was based on the assumption that 15% of the Central Statistics Office COI membership are active lay members, and this was the number used for the overall population size.

The Project Group agreed to a standard target response rate of 23%, whilst acknowledging that this may be challenging to achieve.

Table Two shows the calculated sample size and target response rates for the clergy and membership surveys.

Table Two: Survey Sample Sizes and Target Response Rates per sampling unit

Audience	Confidence Level/Interval	Population Size	Calculated Sample Size	Target Response No. (23%)
Clergy[1]	95%/5%	600[1]	234	138
Lay Membership[2] Northern Ireland Republic of Ireland	95%/5%	43,922[2] 28,989 14,966	- 380 375	10,102[3] 6,667 3,442

[1] Based on clergy numbers provided by the COI
[2] Lay membership from census: 375,400 (249,000: Northern Ireland, 126,400 ROI). Assume 15% are active lay members = 56, 310 less 22% under age 18 = 43,922)
[3] This figure is calculated using a statistical formula, taking account of the defined confidence level and interval, and good practice standards in survey responses (23%)

CONSULTATION METHODOLOGY

A strengths-based approach was used for the consultation using three methods: surveys, focus groups for the lay members and clergy, and one-to-one interviews with the 12 bishops. The Bishops were also encouraged to complete the clergy survey prior to their interview. Due to the global pandemic, all focus groups and all but one of the interviews were conducted online using video conferencing technology.

Surveys

The lay membership and clergy surveys were designed taking account of good practice in survey design, and they also aligned with the forthcoming national HSE Mental Health survey to facilitate any future cross-comparisons between the general public and a faith-based community. All consultation documents and surveys were written in accessible and easily understood language. Data was gathered at a diocesan level to ensure anonymity.

The two surveys included the same questions with some additional questions for the clergy:

About the respondent [Clergy-specific questions]
About Mental Health awareness
About Mental Health attitudes (Vignette)

The vignette approach was used to explore attitudes to mental health in the survey. Vignettes are short stories about a hypothetical person, traditionally used within research on sensitive topics (Gourlay et al, 2014). The vignette used 'Sarah's story', was adapted with permission from published research[6], and was created using best practice guidelines in developing a story that respondents reviewed, and then were asked questions about.

Both surveys were piloted with a small number of the sampling unit, and the feedback was taken account in the final survey design. For the member survey, a paper version was designed and was available upon request from the Representative Church Body.

Focus Groups

All Focus Groups were conducted online and were open to all clergy or lay members across the island of Ireland. There were no jurisdictional or diocesan restrictions placed on attendance. Each focus group was one hour and a maximum of eight participants per session was set. A question set with follow-up questions was prepared by the researchers, aligned for clergy and lay members, and the researchers facilitated the sessions. On the advice of the Advisory Group, separate male and female focus groups were held for lay members. With the agreement of participants, the focus groups were recorded and then transcribed for analysis. During the consultation it became apparent that there was a specific group that required their own focus groups: clergy spouses. With the agreement of the Project Group, separate focus groups for clergy spouses were held.

[6] *All of us? An exploration of the concept of mental health literacy based on young people's responses to fictional mental health vignettes, Irish Journal of Psychological medicine (2015) 32, 129-136.*

Table Three shows a summary of the focus groups

Focus Group Type	Target/Actual	Date	No. of participants
Lay members (male)	12/4	16/06/2021	3
Lay members (female)		04/06/2021	3
		09/06/2021	6
		17/06/2021	7
Clergy	12/2	09/06/2021	5
		23/06/2021	1
Clergy spouse	0/4	23/06/2021 (am)	3
		23/06/2021 (pm)	7
		24/06/2021	3
		30/06/2021	3

Given the small number of focus groups it is important to be mindful of the weighting given to the feedback from this consultation method. Further, it is important to note that the focus groups were self-selecting and views recorded are not representative of the overall sampling unit. There were 19 participants in the member focus groups, six clergy and 16 clergy spouses.

Bishop Interviews

All ten bishops and two archbishops were interviewed. The interviews were one hour in length, and the question set aligned with the focus group question set.

ETHICAL OVERSIGHT

Following discussion with the Project Group and Advisory Group, it was agreed there was a requirement for a distinct and separate ethical guidance group due to the extent of the project baseline assessment activity, and to ensure that all ethical considerations were reviewed and a process for ethical compliance was put in place. The presence of an Ethics Group adds weight to the overall outputs and findings from the project. The Ethics Group was established and comprised of three external reviewers led by a member of the Advisory Group. A rigorous review and feedback process was undertaken in which the research consultants submitted, revised and re-submitted an ethics form and supplementary material before the consultation process could begin.

A detailed ethics form was submitted to the panel for review and included the following components:

- *Project title*
- *Principal Investigators/contact details*
- *Aims and objectives*
- *Project details*
- *Methodology*
  - *Purpose*
  - *Design*
  - *Sample*
  - *Data collection tools*
  - *Pilot of data collection tools*
  - *Data collection methods*
  - *Data analysis*
- *Participant profile*
- *Recruitment strategy*

- *Dissemination of research findings*
- *Investigator's qualification, experience and skills*
- *Risk management*
- *Support for participants*
- *Project management and oversight*
- *Conflict of interest disclosures*
- *Treatment of personal data*
- *Data storage, security and disposal*
- *Funding*

Additional materials that accompanied the ethics form included:

- *Plain language statement*
- *Informed consent*
- *Assent form and plain language statement for children*
- *Survey*

BASELINE ASSESSMENT CONSULTATION AND AWARENESS RAISING

The member and clergy consultation period ran from 1st May to 30th June 2021. Access to the surveys was through the project website. All communications were branded with the MindMatters logo, COI logo and Allchurches trust logo. Articles and reminders about the project were communicated both before and during the consultation process through the following COI Communications structures:

- *Church of Ireland Gazette*
- *Church of Ireland Website*
- *Church of Ireland Twitter*
- *Church of Ireland Facebook*
- *MindMatters COI Website*
- *Monthly Church of Ireland e-zine (in some dioceses)*
- *Monthly Diocesan Magazines (in some dioceses)*
- *Parish notices/bulletins/social media*

It was important to be aware of the potential impact of COVID-19 on participation and response rates, as church services had not resumed during the consultation period. This limited the opportunities to raise awareness and participation in the consultation.

SURVEY RESPONSE MANAGEMENT

During the consultation period, a weekly meeting was held with the Project Communications Group to review survey response rates and agree on actions to encourage responses. The decision was made not to undertake targeted communications in any jurisdiction or diocese, as this would skew the results and not present a true picture of interest and engagement in the project. However, when conducting one-to-one interviews with the Bishops, the researchers did ask the Bishops to encourage responses in their diocese. The researchers developed a Survey Response Management spreadsheet to monitor response rates for the member and clergy survey at a diocesan level against both the target sample size per diocese and the target response rate per diocese.

DATA ANALYSIS

This section presents an overview of the data analysis approach for both the quantitative and qualitative feedback for the two surveys, focus groups, and bishops' interviews. The overall response data is also given in this section.

MEMBER SURVEY RESPONSES

Overall, the sample size target for each jurisdiction was reached:

- *ROI Sample size target: 375, actual responses: 902*
- *NI sample size target: 380, actual responses: 420*

In nine of the 12 dioceses, the target sample size was reached, with 50% or over of the sample size reached in the remaining three dioceses. In relation to the 23% response rate, this was not reached and the response rate was 12.4%. At a diocesan level, the target 23% response rate was reached in four of the 12 dioceses.

CLERGY SURVEY RESPONSES

Overall, the sample size target of 234 was reached with 290 responses from the clergy: 158 from ROI and 132 from NI. In ten of the 12 dioceses, the target sample size was reached, with 64% or over of the sample size reached in the remaining two dioceses. In relation to the 23% response rate, this was exceeded with an overall response rate of 48%, with the target response rate achieved in all 12 dioceses.

QUANTITATIVE ANALYSIS METHODOLOGY

The approach to the quantitative analysis is presented below:

- *Data was cleaned and incomplete respondents removed along with those not providing consent*
- *Single frequency counts for each question in both the lay member and clergy survey were calculated and transposed to percentages*
- *The data was carved to enable analysis by diocese for each question*
- *Contingency tables were produced to facilitate the interpretation of response proportions within and across groups*
- *Findings are presented in a range of forms e.g. graphs, tables and graphics*

QUALITATIVE ANALYSIS METHODOLOGY

In the lay member survey, there were 16 questions with a qualitative response, three as 'Other' responses to a quantitative response, and the rest as a text response.

In the clergy survey, there were 15 questions with a qualitative response of which three were 'Other' responses, and the rest as a text response.

The Framework Method was used for the thematic analysis of the qualitative data. This approach is appropriate for the analysis of textual data where it is required to compare and contrast data by themes across many responses.

The Framework Method involves the following steps:

- *Transcription (where required e.g. focus groups)*
- *Familiarisation (obtaining an overview of feedback)*
- *Coding*
- *Development of an analytical framework*
- *Charting data into the framework matrix*
- *Interpreting the data*

The analysis was undertaken in three stages with a process that included a check for inter-rater reliability:

1. Each response was read and all separate elements of feedback were added to the primary spreadsheet with the number of responses (single count) for each issue. The totals for each issue were calculated (by diocese and overall cohort)
2. Each response was coded with initial primary thematic headings
3. A second review of the codes was carried out to reduce the number of codes where possible
4. The % responses for each code were calculated and presented in both graphical and tabular format

Note: Those with only one mention that did not fit into an existing category were coded as 'Other'.

It is important to note that even with the robust Thematic Analysis Framework the research team used, in addition to the inter-rater reliability checks, there is still a small element of subjectivity in the analysis of the qualitative data. There is however a clear trail between the raw qualitative data and the final themes and findings as described above. Table Four shows the full scope of the qualitative responses that were analysed.

Table Four: Scope of qualitative responses analysed for surveys

Member Survey Question	No. Responses	Clergy Survey Question	No. Responses
Q16	688	Q24 (Mental health awareness courses)	15
Q17 (Other)	56	Q25	13
Q18 (Other)	23	Q26 (Other resources)	24
Q20 (Other organisation)	95	Q29	98
Q23 (Course to help others)	273	Q30	99
Q24 (Mental Health awareness courses)	291	Q31	228
Q25	947	Q38	206
Q32	910	Q39	209
Q33	884	Q40	204
Q34	866	Q41	209
Q36	884	Q42a	226
Q36a	831	Q42b	226
Q36b	820	Q42c	226
Q36c	831	Q42d	226
Q36d	817	Q43	205
Q37	839		
TOTALS:	**10,055**		**2,414**
GRAND TOTAL OF QUALITATIVE RESPONSES ANALYSED:			**12,469**[1]

[1] *For many of the 12,469 responses, there were multiple pieces of information to be analysed and coded.*

FOCUS GROUPS AND BISHOP INTERVIEWS

The same analytic process was applied to qualitative data gathering from all focus groups and one-to-one interviews. Using the Framework Method, responses were collated, reviewed and coded against themes created from the qualitative analysis of response in the survey. In the event that a response could not be coded under the existing themes a new category was created, if the number of responses could support the formation of the category. This was particularly the case with clergy spouse focus groups. As participants were asked about the role of a clergy spouse in addition to the other set questions, this warranted new categories in the Framework.

A high degree of caution has been applied in the interpretation of the focus group findings given the small sample size of the three different groups; lay member, clergy, and clergy spouse. Overall, there was significant overlap in the responses of focus group participants to the qualitative survey themes. Using a ranking system to determine the most frequently cited viewpoint, the most common and agreed themes have been presented in the report.

RESEARCH FINDINGS

This section provides the key themes and findings from the consultation with each graph illustrated in the Appendices. As demonstrated below, the Baseline Assessment findings are presented by sampling unit, with the Bishops' feedback presented within the clergy sampling unit.

CHURCH OF IRELAND LAY MEMBERS

MEMBER SURVEY

Member Survey Headlines

- *1,317 total responses, 1,247 responses after data cleaning*
- *The required number of responses by jurisdiction for a statically valid sample size was met, based on a NI active member population of 28,989 and an ROI member population of 14,966, requiring 380 responses from NI (actual responses = 420), and 375 from ROI (actual responses 902)*
- *Proportionally higher level of response rate from ROI (68%) than NI (32%)*
- *69% female, 30% male and 1% prefer not to say*
- *94% of white ethnicity*
- *59% hold third level qualifications*
- *83% of respondents aged 45 or over*

Member Survey Demographic Themes

- *Higher response rate from ROI than NI (% of population and responses)*
- *High level of COI volunteering*
- *Most respondents were aged 45 and over (83%)*
- *Most respondents were female (69%)*
- *High educational attainment (59% hold third level qualifications)*
- *94% were of white ethnicity*

Church Participation

Attendance:

- *90% attend church at least monthly*
- *56% attend weekly*
- *13% more than once a week*
- *11% fortnightly*
- *10% monthly*
- *1% never*

Engagement: *88% of lay members engage in church activities outside of church services (frequency of engagement):*

- *1% highly engaged*
- *23% very engaged*
- *30% moderately engaged*
- *25% a little engaged*
- *12% not engaged*

Areas of engagement (volunteering)

A high level of engagement was reported by lay members in both attending church services, involvement with church activities outside of services, and in volunteering roles. This indicates that those who responded to the consultation are active church lay members who may be more responsive to church requests and willing to engage in church-led activities generally.

The top five volunteering roles are:

- *Church roles (12%)*
- *Youth activities (12%)*
- *Select Vestry member (11%)*
- *Church worship role (9%)*
- *General help (6%)*

Member Survey - headline themes

- *Faith and prayer are important for good mental health*
- *Connections matter in seeking support and having good mental health*
- *Self-care is important for good mental health*
- *Members do not seek support from the clergy due to fear, embarrassment, stigma, issues of trust and attitudes to mental health (Sarah's story)*
- *Mental health problems do exist and require professional help*
- *Members believe that they are more understanding and tolerant of mental health problems than other people*

Member survey - other themes

- *Members seek support from a variety of sources and recognise that there are many ways to support good mental health*
- *A lower proportion of members (compared with clergy) have undertaken mental health training*
- *Family and friends are important sources of support for people with mental health problems*
- *People often do not seek professional help due to stigma, fear and embarrassment*
- *People often do not help from clergy due to capacity, trust and attitude, as well as fear, stigma and embarrassment*
- *People may not seek help from friends and family due to fear, embarrassment and stigma*
- *Attitudes differ between how members treat people who have disclosed that they have mental health issues compared to those who have not disclosed and/or do not have any current mental health issues*
- *There is good awareness of mental health issues and the possible causes*
- *It was recognised that mental health can be affected by personal circumstances and other challenges*
- *There is a good understanding of care pathways for mental health problems (to GP)*
- *COVID-19 has had a significant impact on people's mental health*

MEMBER FOCUS GROUPS

When asked about the importance of faith and spirituality to mental and physical health, there was an almost unanimous finding on its level of importance, the role faith plays when lay members face life challenges and how 'turning to God' provides what was described as an 'anchor' in their lives. The central role of faith and spirituality was of similar significance in the focus groups as it was in the survey responses.

> **I JUST WANTED TO SAY THAT THE ELEPHANT IN THE ROOM IS BISHOPS OF ALL DENOMINATIONS, FOR EXAMPLE, IN OUR NORTHERN PROVINCE, IGNORING THE FACT THAT GENERATIONS UPON GENERATIONS ARE COPING WITH POST-TRAUMATIC STRESS DISORDERS FROM THE TROUBLES THAT HAVE CAUSED IMMEASURABLE MENTAL HEALTH DIFFICULTIES AND THEY HAVE NEVER ADDRESSED IT.**
>
> **QUOTE FROM FOCUS GROUP PARTICIPANT**

Discussion about stigma of mental health in the Church of Ireland was viewed by the majority of participants as a significant issue. While there was acknowledgement of stigma in society generally, the focus of stigma in the Church was attributed in the main to clergy and the wider Church's attitude to mental health. With a small sample size, the representation of this view should be considered in the context of qualitative findings from the survey, where clergy attitude to mental health was also featured.

Following from this, lay members in the focus groups made a number of suggestions about the potential role of the Church in offering guidance and support to someone with a mental health issue. This included:

- *Providing clergy with the information to signpost to external professional services, and the confidence to offer it*
- *Creating a more open culture where there is greater capacity to listen and to provide proactive support to people with mental health issues*
- *Increase awareness of mental health among lay members who are more actively involved in the Church*
- *Promote messages about acceptance and looking out for fellow Church lay members*
- *Listen and support on the person's terms not to be determined by the Church*
- *Promote the message 'It is ok not to be ok' in relation to everyone's mental health*

Specific actions that involved sermons and church services were discussed by the focus group participants. There was a collective agreement that clergy themselves showing vulnerability and willingness to be open may encourage others to share. Mental health training was seen as an important resource for clergy to have in order to recognise signs and symptoms, and to signpost and guide someone in distress with mental health issues. Member-based activities were also proposed and included: prayer groups, support groups, small group work and opportunities to connect meaningfully with others. This theme of connection was very strong in the survey responses about how to both prevent, and respond, to mental health issues.

Although questions were asked about the role of clergy in supporting others with mental health issues, there was a very clear message from respondents about clergy self-care. Recognition of the pressure put on clergy and their position within a parish was acknowledged as something that needs a structure of support at parish and diocesan level. Discussion about clergy being more open and showing their own vulnerabilities was balanced with the necessity of parishioners being receptive, supportive and compassionate. Lay members in focus groups spoke about clergy being unable to talk about mental health and the culture within the Church not necessarily providing the environment that would encourage rather than silence.

> **IT'S SO EASY TO SAY, AH, WELL, THAT'S THE RECTOR'S JOB, YOU KNOW. AND I THINK ISN'T IT EVERYBODY'S ROLE, ISN'T IT EVERYBODY'S RESPONSIBILITY TO A CERTAIN EXTENT TO LOOK AFTER YOUR NEIGHBOUR, ETC?**
>
> **QUOTE FROM FOCUS GROUP PARTICIPANT**

> I SUPPOSE FOR ME I THINK THE FUNDAMENTAL PART OF THE ROLE IS TO BE AS GOOD OF A SPOUSE AS POSSIBLE.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

CLERGY SPOUSE FOCUS GROUPS

These were closed groups in that only clergy spouses could attend. The majority were female spouses (n=14) with three male spouses participating in the discussions.

When asked about the role of a clergy spouse there were two distinct but agreed descriptions. The role of spouse rather than clergy spouse was viewed as taking precedence with adjectives such as 'collaboration', 'partnership', 'unity' being used to describe their marriage. A number of participants had not married a member of the clergy as this call to serve emerged later in the marriage. Exploring the changes this brings about in the union was talked about but ultimately came back to the theme of marriage, partnership and unity.

The other aspect of the role of clergy spouse was steeped in the history of the role and expectations from parishioners and the Church itself. A unified theme from the participants was about there not being a definite 'job description' when in the role of clergy spouse. It was suggested this was influenced by the legacy of previous clergy spouses and the precedents they set. Parishes with more traditional populations were cited as having greater expectations on the degree of involvement of the clergy spouse in parish life. Some lay members of the group provided examples of tasks and expectations being outlined to them when they arrived at a new parish. This example was a familiar experience to the majority of focus group attendees.

In relation to expectations, a situation was mentioned of the spouse not being a member of the Church of Ireland but married to a Church of Ireland clergy person. Assumptions were made about the faith journey of the spouse, which led to feelings of isolation and lack of support. This point was made in discussion about the culture in which mental health is received and responded to. Clergy spouses in this focus group highlighted the lack of support for clergy families, which, at best, is dependent upon a particular bishop or at worse, completely absent. It led participants frequently to request acknowledgement of the impact of clergy life on families, the clergy member themselves, their spouse and their children. Support systems for the family were largely sourced by the family and primarily outside of parish life. This was viewed as very important to ensure the family were not open to judgement within the parish. There was an active protective function that the clergy spouses spoke about in protecting their spouse, themselves and their children.

Clergy self-care and support was a pertinent theme in all of the clergy spouse focus groups. This centred on the nature of clergy work, its lack of boundaries and exposure to trauma. In particular, the last 18 months dealing with COVID-19 deaths, funerals and losses, was described as having a 'collective trauma' among the clergy. One participant reflected on the impact of COVID-19 on their spouse by saying;

> SINCE COVID WE HAVE HAD 17 FUNERALS WHEN THERE WOULD NORMALLY BE 3-4 IN A YEAR AND DOING THIS ALONE JUST ADDS TO THE TRAUMA.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

In this regard, clergy support was seen in the form of mandated supervision or continuous professional development to give a space to clergy to debrief and process the volume of emotional stresses they take on from others. Clergy spouses did not generally believe their spouse was supported by the Church and it would require structures and requirements to be put in place to create a culture of better self-care.

> **I THINK IT'S REALLY IMPORTANT THAT WE MODEL BEING REALLY OUR AUTHENTIC SELVES. SO OFTEN WE'RE MEANT TO BE—YOU KNOW, WE MOVE INTO A PARISH, WE DON'T ACTUALLY BRING WITH US OUR OWN FAMILIES OR ANYBODY, AND YET WE'RE MEANT TO BE ABLE TO LEAD AND GUIDE AND MINISTER AS IF WE'RE SUPERHEROES.**
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

Considerations about how clergy can help their parish with mental health issues led to suggestions that were cultural, personal and practical. Proper training on mental health was proposed alongside relevant and up-to-date referral routes and signposting. The culture in which church communities exist, was viewed as needing to be more welcoming, inclusive and open to create a safe space for sharing. The final point was about messages on mental health to be upfront, clear language to be used and clergy to be encouraged to model authenticity. An assimilation of a number of similar points highlighted that clergy should not present themselves as 'superhuman,' but as 'human,' with the same vulnerabilities as all others, vulnerabilities which faith can support, but not on its own.

> **I THINK IT'S VERY IMPORTANT THAT THE CHURCH IS VERY UP FRONT AND CENTRE ABOUT MENTAL HEALTH AND ABOUT AWARENESS AND, YOU KNOW, THAT IT'S NOT SOMETHING THAT'S HIDDEN AWAY BUT IT'S SOMETHING THAT IS OPENED UP FOR PEOPLE.**
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

A small number of examples were provided about how clergy are supported but this was often mediated by the way in which the diocese managed their clergy and supports offered. Clergy spouses did indicate that the stress of relocating was also linked to the nature of the diocese and how clergy families were looked after.

CLERGY

CLERGY SURVEY

Clergy Survey Headlines

- *298 total responses, 292 responses after data cleaning*
- *The required number of responses for a statistically valid sample size was 234 (based on a clergy population of 600)*
- *Equal response rate across the jurisdictions (54% ROI, 46% NI)*
- *72% were male, 27% female and 1% prefer not to say (80% of clergy population is male)*
- *86% of respondents aged 45 and over*
- *Most are in full time stipendiary positions (72%)*
- *Most are married (79%)*
- *91% were of white ethnicity*

Clergy Survey – headline themes

- *Clergy believe they have a good awareness of signs and symptoms of mental health issues*
- *Prayer is the most important support for clergy if they have a mental health issue*
- *Faith supports good mental health*
- *Stigma around mental health is an issue across the Church*
- *The Church needs to provide improved mental health supports for clergy*
- *Clergy find that lay members do not often seek support from them (clergy) for mental health issues*
- *Most clergy do not mention mental health in their sermons more than twice a year*

Clergy survey - other themes

- *Clergy are divided on whether they have adequate knowledge and skills to adequately support a lay member with mental health difficulties*
- *The Church has a role in supporting people with mental health issues*
- *There are many factors that support good mental health and clergy seek support from a variety of sources*
- *More clergy have completed mental health awareness and support training than lay members*
- *COVID-19 has had a significant impact on people's mental health*

CLERGY FOCUS GROUPS

The participants in the clergy focus groups provided a more in-depth and personalised account about understanding, awareness and attitudes to mental health in the Church of Ireland. Caution was applied in the generalisation of themes given the small sample size; however, the intimacy of the discussions facilitated opportunities for lived experiences to be shared confidentially.

As with other responses in the survey and focus groups, faith and spirituality were central tenets of the participants' lives, particularly in times of stress. It was agreed that faith provides 'balance', 'a sense of purpose and meaning to life' and 'focuses the mind'. Clergy in the focus groups indicated that faith is not just for difficult times but a constant in their lives. Prayer and connectedness to God was viewed as the 'pillar of guidance and direction' in both their personal and professional life. In this respect, they did not see a distinction in the role of faith between physical and mental health, as faith is holistic and about all aspects of the person.

> I GENUINELY SOMETIMES STRUGGLE TO SEE HOW PEOPLE WITHOUT FAITH CAN KEEP GOING.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

Discussions about stigma around mental health in the Church reflected the responses and themes which emerged from the survey. In this regard, stigma was an issue in the Church, as it is in society, but focus group lay members talked about the role church and clergy themselves have to play in promoting positive and negative messages about mental health. The point was made that clergy give the impression they are without challenge or stress and life is continuously positive. It was suggested that the parishes would benefit from a more open, authentic presentation of self. However, this was also cautioned against because of concerns the Church itself would prevent progression and would be unsupportive. It was acknowledged though that support has been available for some but is very much dependent on the diocese the clergy are in.

> I SUPPOSE THERE'S A STIGMA AROUND MENTAL HEALTH IN SOCIETY IN GENERAL, SO WHY WOULD THE CHURCH OF IRELAND BE ANY DIFFERENT?
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

> IT REALLY DEPENDS ON WHERE YOU ARE BUT THERE IS A DEFINITE WORRY THAT IF YOU DISPLAY ANY VULNERABILITIES AROUND MENTAL HEALTH THEN YOU WILL NOT PROGRESS.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

Speaking further about clergy wellbeing, suggestions were made about how to provide support to themselves and their families. This included: supervision, continuous professional development, counselling and direct support for clergy families, who are key to clergy wellbeing.

Personal experiences were shared about the stress of ministry, which was linked to the continuous nature of the role and expectations from the parish. The 'power and influence' of the congregation over clergy was highlighted at each discussion and linked to the level of demand placed on the Clergy. This particular aspect of clergy life was identified as a stressor.

Reviewing how clergy can support someone with a mental health issue, it was suggested that training on how to respond and when to refer would provide greater confidence in their pastoral capacities. Having agreed standardised key messages that were church-wide was viewed as critical to addressing stigma and equipping clergy with the tools needed to offer guidance. Being open and honest was raised again but only with the security of a supportive structure collectively available throughout the Church. As with other focus groups the message 'It is ok not to be ok' resonated with clergy, including the admission that there is a self-responsibility for clergy to look after their mental health, as they would do for their spiritual wellbeing.

> A LOT OF THE ISSUES THAT CLERGY CERTAINLY SUFFER MENTAL HEALTH OR ILLNESS FROM ARE A DIRECT RESULT OF WHAT THEY'VE GONE THROUGH IN MINISTRY. SO, I REALLY THINK IT HAS TO COME FROM GRASSROOTS AND THAT'S WHY I THINK THIS INITIATIVE IS SO IMPORTANT.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

BISHOP INTERVIEWS

The Bishops responded to nine questions that were aligned to the clergy and member focus group questions. This section summarises their responses.

All of the Bishops agreed that faith is important for both physical and mental health, with some stating that you cannot separate physical and mental health, as they are so closely linked. Other themes around faith and mental health were the importance of having faith to draw on in challenging times, and faith is one aspect of supporting good mental health (for those that have a faith), as it provides a sense of meaning and hope. However, it was acknowledged that stigma around mental health may make people turn to their faith more than for physical health issues.

Generally, the Bishops acknowledged to varying degrees that there is some level of stigma around mental health in the Church, although some suggested that the level of stigma was not greater than in broader society. All acknowledged that they have a role in addressing this issue as leaders of the Church, and that the Church needs to be more open and more transparent about acknowledging and talking about all aspects of mental health. Other comments were that the COVID-19 pandemic has helped some people talk more openly about mental health. There were also some comments regarding stigma within the Church around sexuality which can and does impact on the mental health of lay members and clergy.

In relation to the Church providing guidance and support to clergy and lay members with a mental health issue, the main responses related to providing signposting to available supports and services. Most were very clear that clergy must not act outside their own area of competence, recognising the limitations of the role and their own personal limitations, although it is important that clergy provide pastoral care within the boundaries of their role. The Bishops felt that lay members would approach clergy who they feel will listen to them, but this is not all clergy, by any means. It is important to equip the Clergy with knowledge, skills and competence to recognise the signs and symptoms of mental health issues in parishioners, and to act to provide support.

The key messages that the Church should promote about mental health are that it is normal to experience mental health issues, that the Church will listen, that you are not alone and that it matters to God who you are and how you're feeling. It is also important to communicate the message about not feeling guilty about having mental health issues – being a Christian does not exempt you from such issues. Consideration should also be given to messages about looking out for fellow parishioners.

> MINISTERS OF THE GOSPEL HAVE A ROLE TO ACTUALLY DEBUNK THE NONSENSE THAT'S BUILT UP AROUND MENTAL HEALTH FEARS.
>
> QUOTE FROM FOCUS GROUP PARTICIPANT

In relation to how church services and sermons can be used to promote positive mental health, many of the Bishops suggested interpreting the stories of the Bible for positive mental health (there are people in the scriptures with mental health issues), and include these in the sermons, liturgy and prayers. The services and sermons should also be used by all clergy to raise the overall importance of mental health, and the awareness of signs, symptoms, and signposting. The services and sermons should convey God's message of love and acceptance. The Bishops agreed that they need to lead by example with this and be a 'gateway and not a bottleneck'.

It is important for the Bishops as episcopal leaders in the Church to actively work to remove the barriers to increasing awareness and understanding about mental health in the Church. They acknowledge that the main barrier is stigma around mental health in the Church. This reflects the stigma in society on the island of Ireland, and the bishops can also consider how to play the same role, addressing the same issue, in broader society. A key element in this is avoiding simplistic hermeneutics which fail to capture the compassionate approach found in scripture to those experiencing mental health issues.

When asked about church activities to support positive mental health, some Bishops mentioned their use of the Diocesan Bishop's Fund to support clergy and clergy spouses (in some cases) if they were facing mental health challenges. Activities and events linked to World Mental Health Day were mentioned, as well as clergy webinars on self-care through THRIVE.
Some Bishops also shared examples of local activities that are not explicitly identified as mental health activities, but that do have a positive impact on mental health, e.g. Seniors' Groups, Walk and Talk Groups, Parent and Toddler Groups, which all link back to the theme of connecting with people.

The main supports that the Bishops think are required in order to respond to a parishioner with a mental health issue are signposting information and developing or reinforcing the awareness, skills and confidence in both clergy and lay members to look out for the signs and symptoms of mental health issues, and proactively to offer support and/or signposting. This will require training interventions. A very important part of this is the bishops' own self-care and that of their clergy. Concern was expressed about the reticence of some clergy to speak openly about mental health both generally and personally, and this needs to be addressed.

When asked about their role in terms of supporting both clergy and lay members in promoting positive mental health in their own diocese and across the Church, the Bishops indicated that see their primary role as enabling and encouraging clergy to create and foster a culture of openness and transparency around mental health issues. There is also the need for the Bishops to work together and support each other in leading on the next phase of this project. They need to be accessible to both the clergy and lay members and to lead by example in the next phase of MindMatters COI.

CONCLUSIONS

The findings from the surveys, focus groups and Bishop interviews were collectively reviewed by the consultants and the Project Group to draw conclusions that will inform Phase Two of the MindMatters COI Project. The literature review and consultation serve as foundations for the development and implementation of a response action plan in the Church of Ireland on mental health awareness, understanding and attitude, which will guide the interventions and activities to improve clergy and member awareness and understanding of mental health, and address issues of mental health stigma in the Church of Ireland.

Six overarching themes were identified as key areas of interest:

- *Confirmation that mental health is a valid concern for the Church*
- *Confirmation that mental health stigma is an issue in the Church of Ireland*
- *Awareness of mental health across the Church is broadly positive*
- *Attitudes to mental health suggest they influence behaviour*
- *Confirmation that faith is an important contributor to good mental health*
- *COVID-19 has a negative impact on good mental health*

The research suggests that the most effective contribution that the Church can make in promoting positive mental health is by concentrating, in the first instance, on four key areas:

- *Reducing stigma*
- *Promoting connections*
- *Providing clergy with additional training and support*
- *Exploring additional faith-based supports for mental health*

This report is a pivotal document in the discussion, design and delivery of interventions and activities to promote positive mental health, and respond to mental health issues across the island of Ireland for both clergy and lay members of the Church of Ireland.

> **"CHURCH COMMUNITIES ARE OFTEN ABLE TO REACH MINORITY, NEGLECTED AND UNDERSERVED POPULATIONS BECAUSE OF THEIR BELIEF SYSTEMS THAT VALUE HEALTHY BODY, MIND, AND SPIRIT."**
>
> **KOSMIN & KEYSAR 2009**

> **"THE KEY TO UNLOCKING STIGMA IS AWARENESS, UNDERSTANDING AND INCLUSION."**
>
> **STETZER, 2016**

APPENDICES

APPENDIX ONE

CHURCH OF IRELAND LAY MEMBER SURVEY: QUESTIONS AND RESPONSES

SECTION ONE: ABOUT YOU

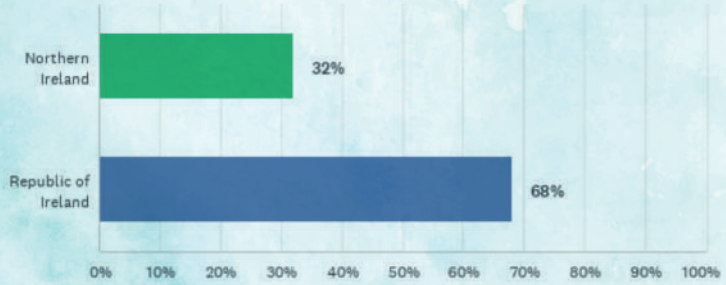
MQ1: Consent.

1,247 respondents consented to participating in this survey whilst 99 respondents did not consent.

MQ2: Which jurisdiction do you live in?

According to the most recent census data, there are 375,400 Church of Ireland members across the island of Ireland, around 34% (126,400)[7] of whom live in the Republic of Ireland and 66% (249,000)[8] in Northern Ireland. These proportions were almost exactly reversed in the survey, with 68% of respondents being from the Republic of Ireland and 32% from Northern Ireland.

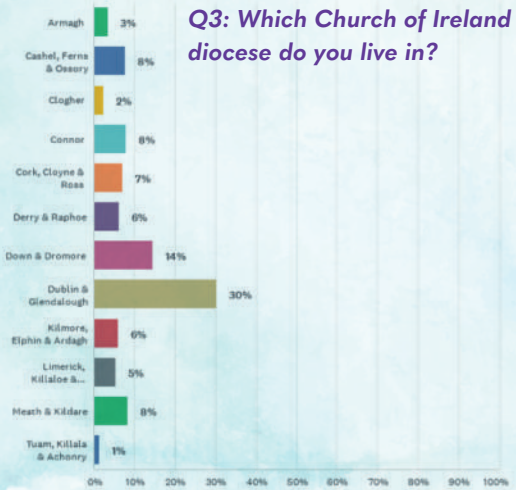
Q2: Which jurisdiction do you live in?



MQ3: Which Church of Ireland diocese do you live in?

The 2013 Church of Ireland census[9] reported that the greatest number of church goers were to be found in the dioceses of Down and Dromore (22%) and Connor (19%). However, these dioceses only represented 14% and 8% of respondents respectively. By contrast, Dublin and Glendalough has 12% of church goers but provided 30% of respondents, whilst Meath and Kildare has 3% of church goers and provided 8% of respondents.

Q3: Which Church of Ireland diocese do you live in?

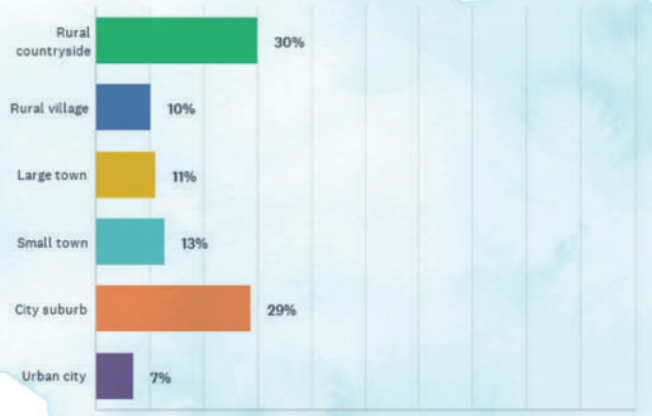


[7] *Religion - Other Christian - CSO - Central Statistics Office*
[8] *https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/2011-census-results-key-statistics-northern-ireland-report-11-december-2012.pdf*
[9] *https://www.ireland.anglican.org/cmsfiles/pdf/Synod/2015/reports/CensusBooklet.pdf*

MQ4: Which of the following best describes where you live?

In 2019 the CSO reported[10] that approximately 31% of the population of the Republic of Ireland live in 'rural' areas, including those living in towns with a population of less than 1,500. This is similar to the figure for Northern Ireland which NISRA reports as 35%. In our survey, 53% of respondents live in the rural countryside, a rural village or a small town.

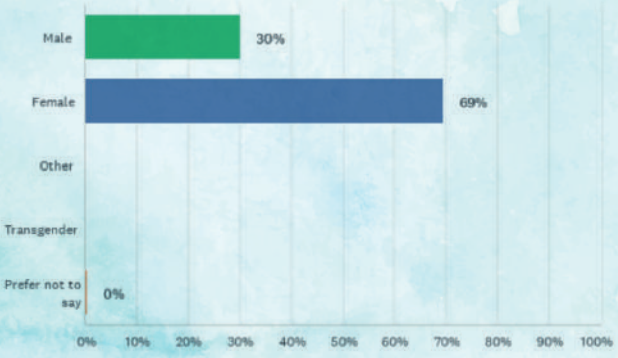
Q4: Which of the following best describes where you live?



MQ5: What is your gender?

The 2013 Church of Ireland census found that 57% of 'worshippers' were female and 43% male. There was a significantly greater disparity in the respondents to the survey with women outnumbering men by 69% to 30%.

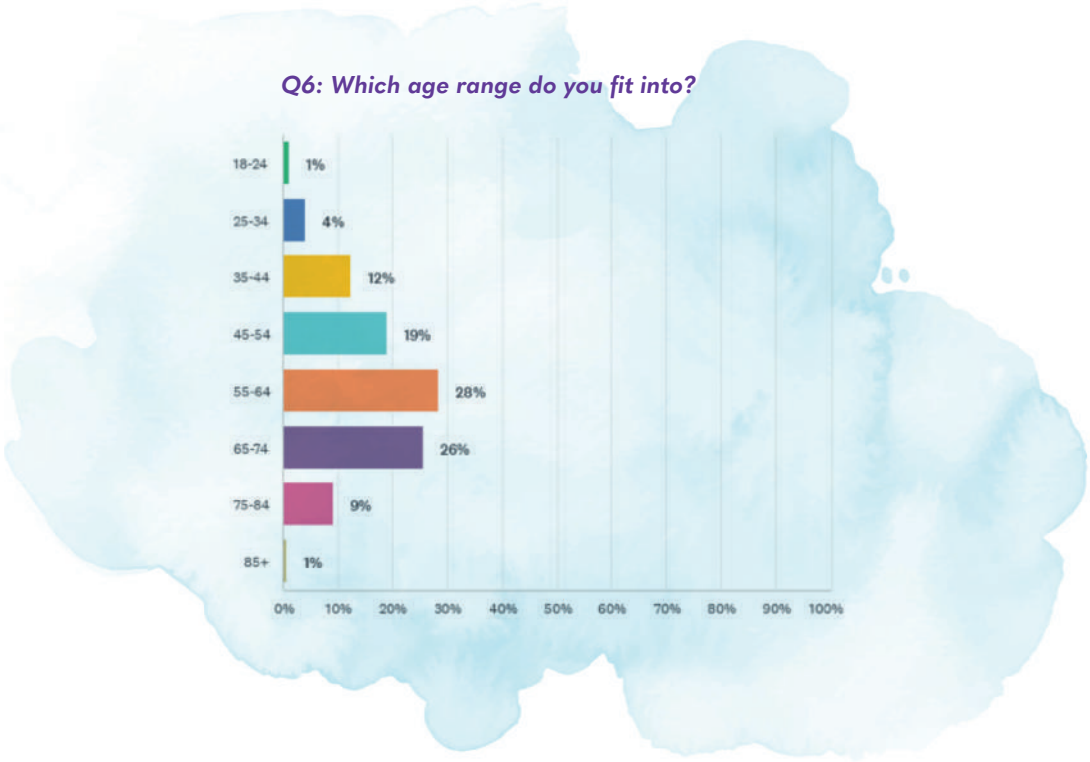
Q5: What is your gender?



[10] *Introduction - CSO - Central Statistics Office*

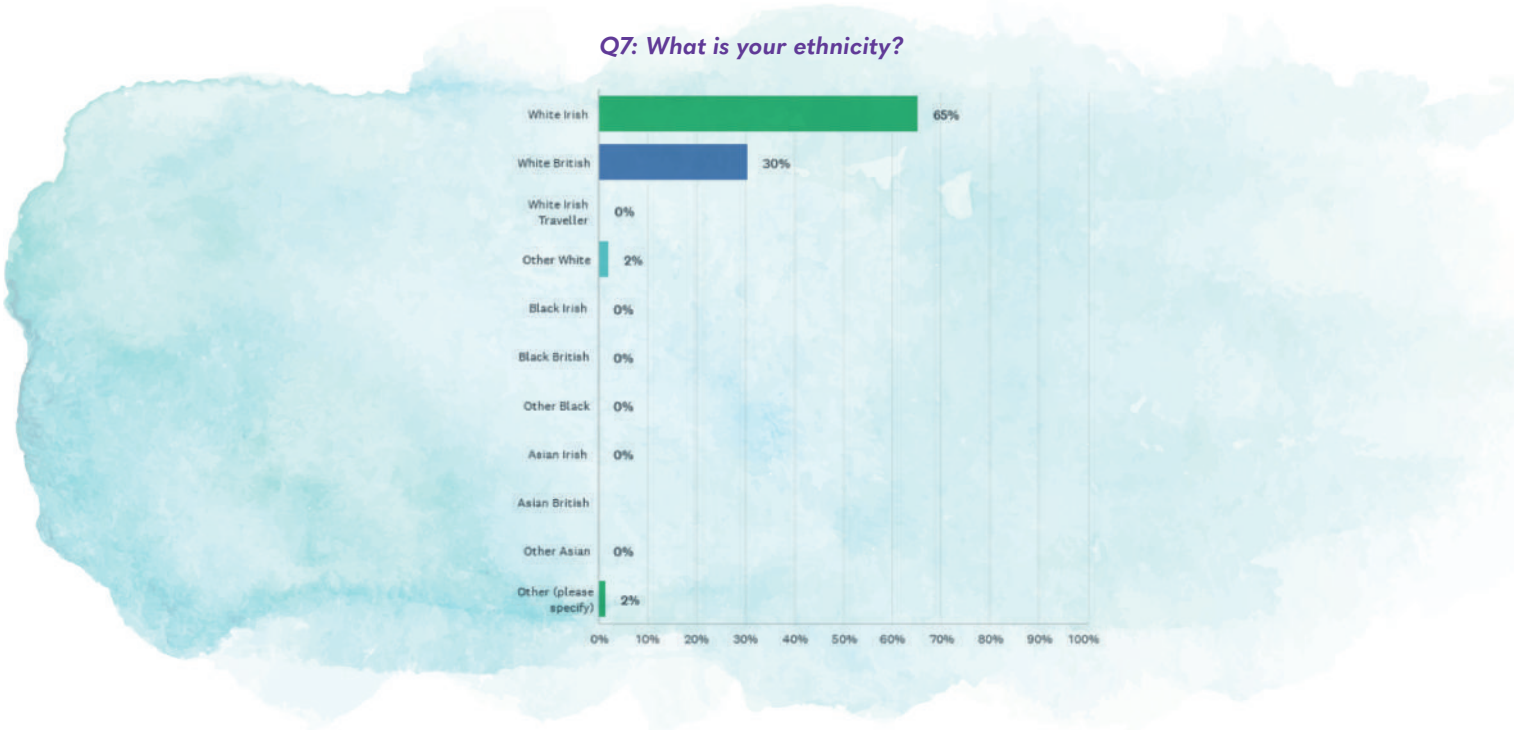
MQ6: Which age range do you fit into?

The Church of Ireland census (2013) found that around 58% of 'worshippers' in 2013 were 46 years of age or older. This compares to approximately 83% of survey respondents reporting their age as 45 or older. It should be noted that the survey was limited to those members who were at least 18 years of age which would exclude 22% of worshippers identified in the census.



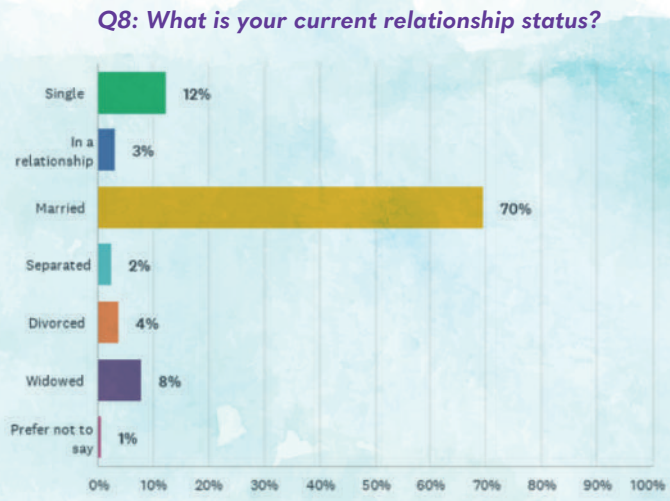
MQ7: What is your ethnicity?

The survey respondents were overwhelmingly white, with 97% identifying as 'White Irish', 'White British' or 'Other White'.



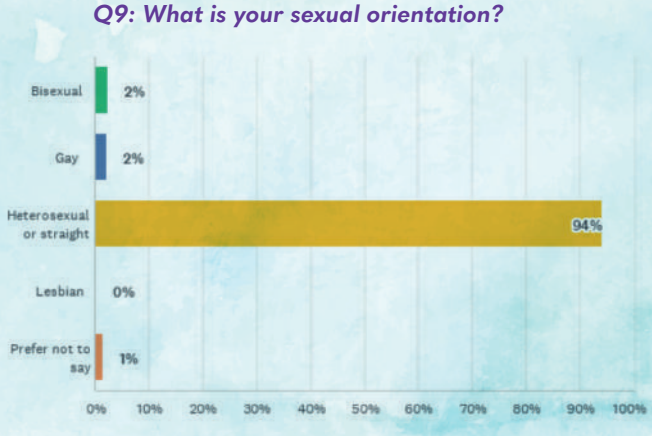
MQ8: What is your current relationship status?

The great majority of respondents reported being married (70%) with a further 14% being divorced, separated or widowed. Only 12% were single, with another 3% in a relationship.



MQ9: What is your sexual orientation?

95% of respondents identified as heterosexual or straight with a minority (2%) identifying as gay or bisexual (2%). Whilst there are no figures for the percentage of the overall population in Ireland identifying as non-heterosexual, estimates of the LGBT+ community from 15 other OECD countries range from 1.2% to 3.8% of the population[11].

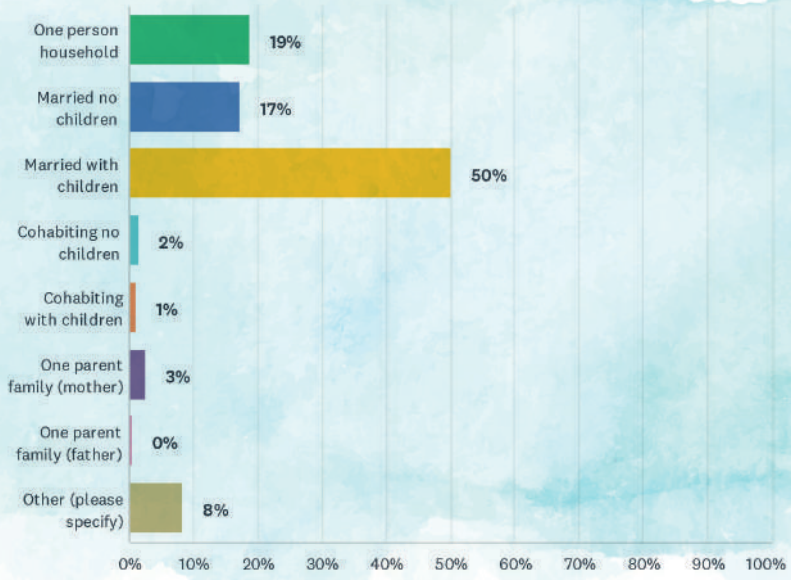


[11] *https://data.oireachtas.ie/ie/oireachtas/libraryResearch/2019/2019-06-28_l-rs-infographic-lgbt-community-in-ireland-a-statistical-profile_en.pdf*

MQ10: Which of the following best describes your household?

Half of the respondents reported being married with children. A further 19% were married with no children whilst 17% live in a one-person household.

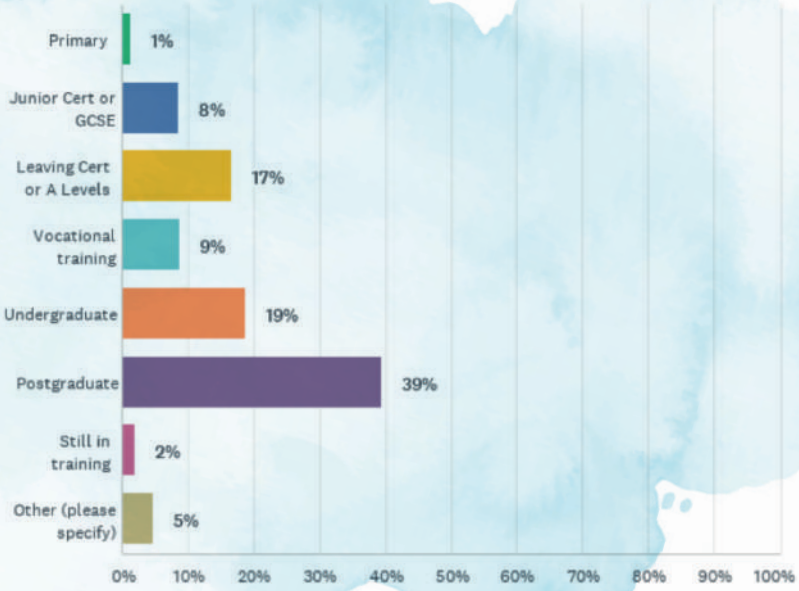
Q10: Which of the following best describes your household?



MQ11: At what level did you leave education?

58% of respondents' report having a primary or post-graduate qualification. The OECD reports that 43% of adults (aged 25-64) in both the UK and Ireland have attained tertiary education[12].

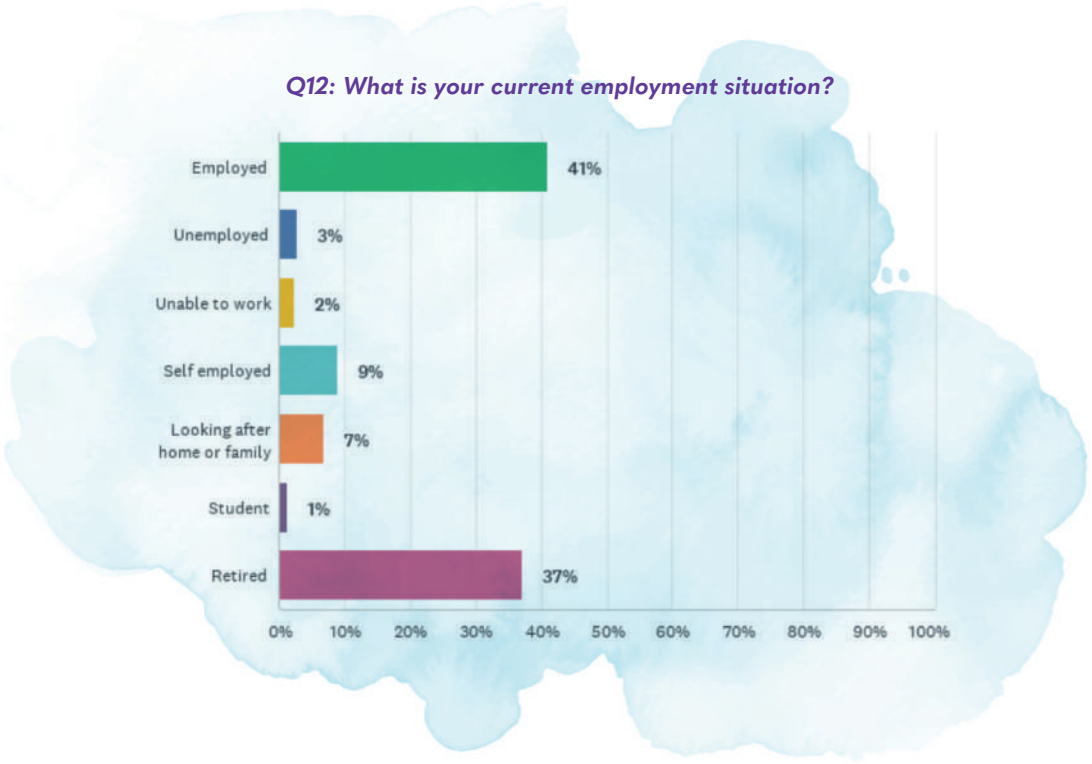
Q11: At what level did you leave education?



[12] *https://www.oecd-ilibrary.org/docserver/eag-2016-en.pdf?expires=1637142180&id=id&accname=guest&checksum=63C6E14D31A96B7EE82BE99EF3FB5E2D*

MQ12: What is your current employment situation?

The greatest number of respondents were either employed (41%) or retired (37%). 3% were unemployed which is roughly comparable to the general unemployment rate in Northern Ireland (4.1%) and considerably lower than that in the Republic of Ireland (7.1%) in June 2021.



MQ13: Are you registered disabled?

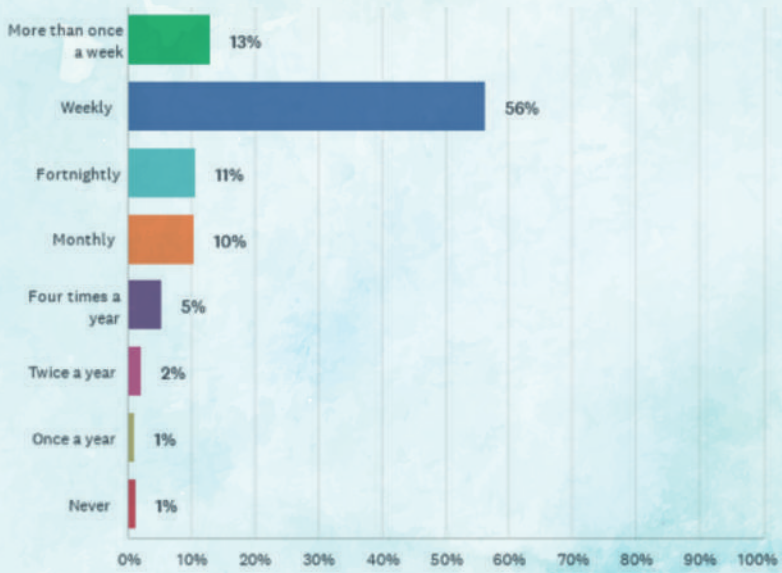
4% of respondents responded 'Yes' to this question. According to the 2016 CSO census[13], 13.5% of the population of the Republic of Ireland reported having a disability whilst in 2017 the Northern Ireland Labour Force Survey[14] stated that 21.7% of the population has a disability.

[13] *Disability - CSO - Central Statistics Office*
[14] *Disability | Department for Communities (communities-ni.gov.uk)*

MQ14: Approximately how often do you attend church services, including online services?

The respondents report a relatively high level of church attendance, with 56% attending at least weekly. According to the Church of Ireland Census in 2013, average attendance at weekly services was approximately 15.5% of the total Church of Ireland population.

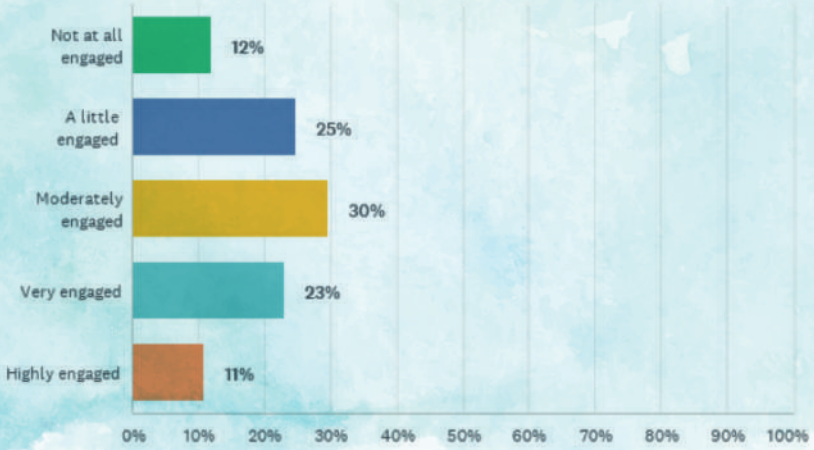
Q14: Approximately how often do you attend Church services, including online services?



MQ15: How engaged are you with church activities outside of church services?

Just over a third of respondents (34%) described themselves as being very engaged or highly engaged with church activities, with an additional 30% describing themselves as engaged.

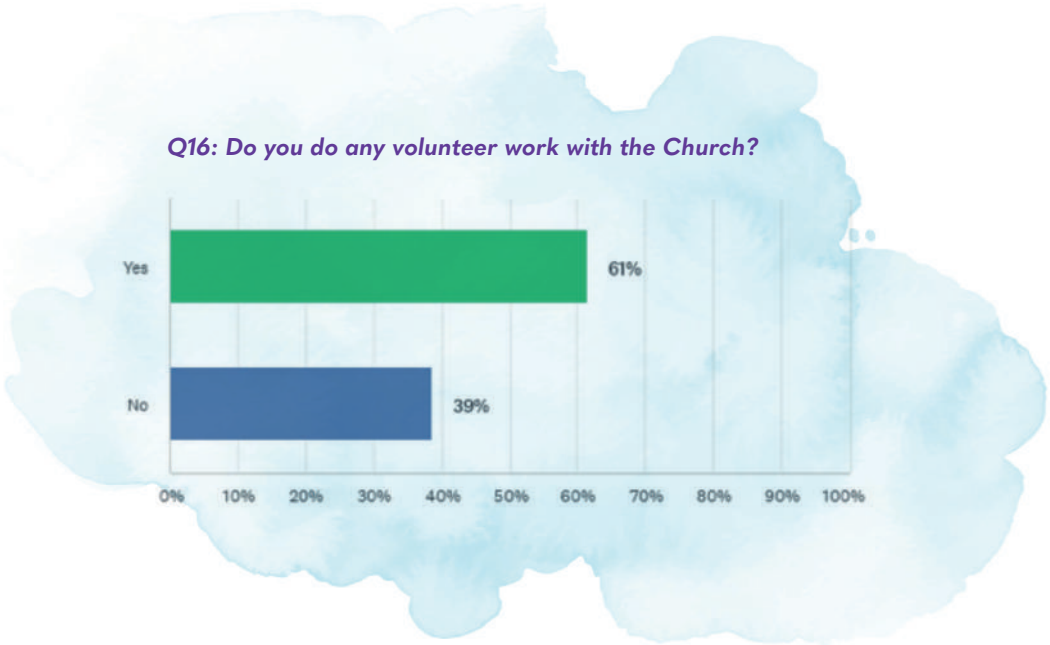
Q15: How engaged are you with church activities outside of church services?



MQ16: Do you do any volunteer work with the Church?

More than half of respondents (61%) engage in volunteer work with the Church.

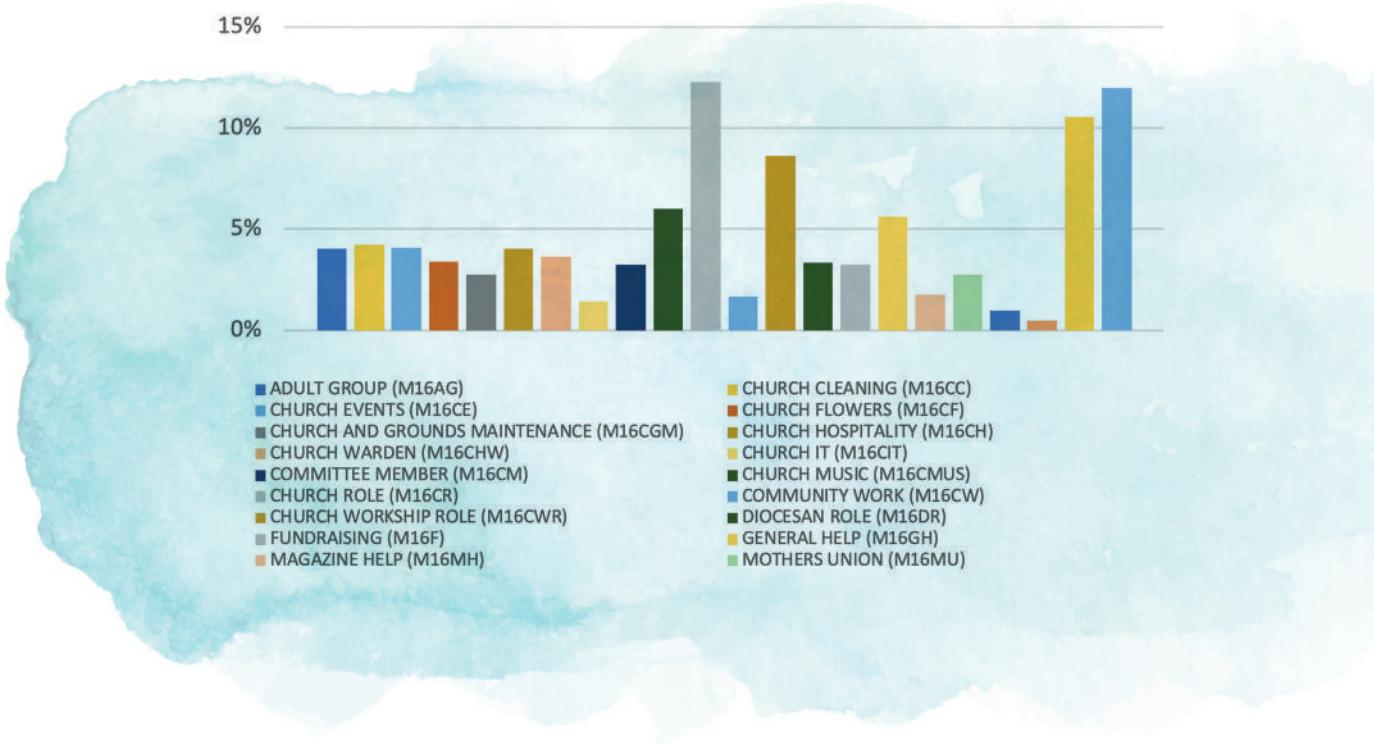
Q16: Do you do any volunteer work with the Church?



MQ16a: If you do volunteer, please tell us what you do

The most popular forms of volunteering were Church Role (12%), Youth Activities (12%) and being a member of a Select Vestry (11%).

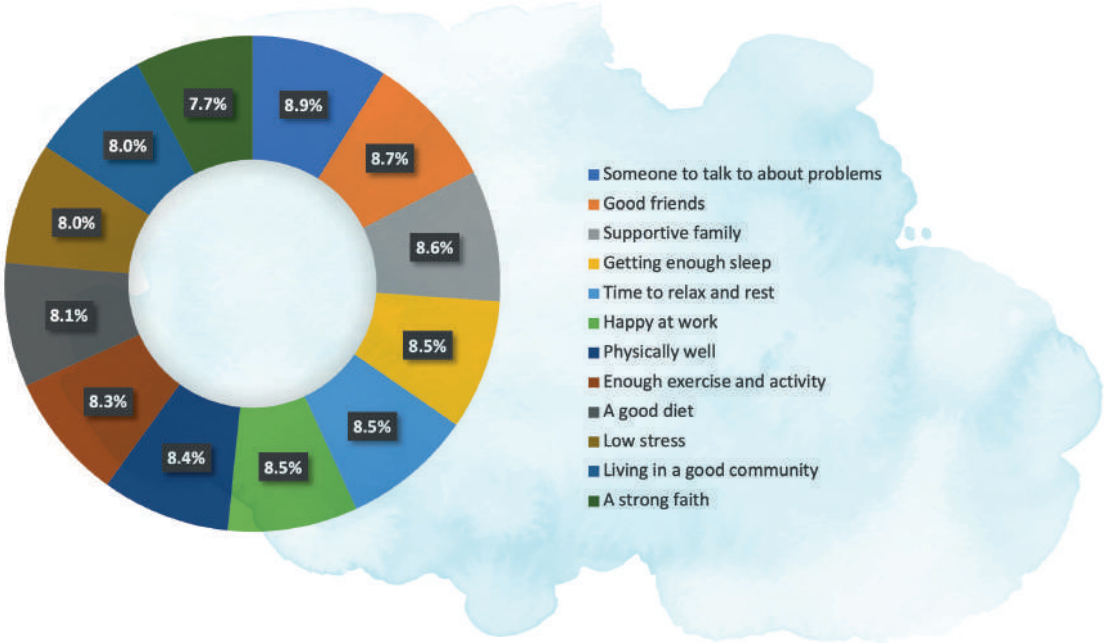
Q16a: If you do volunteer, please tell us what you do



SECTION TWO: YOUR THOUGHTS ON MENTAL HEALTH

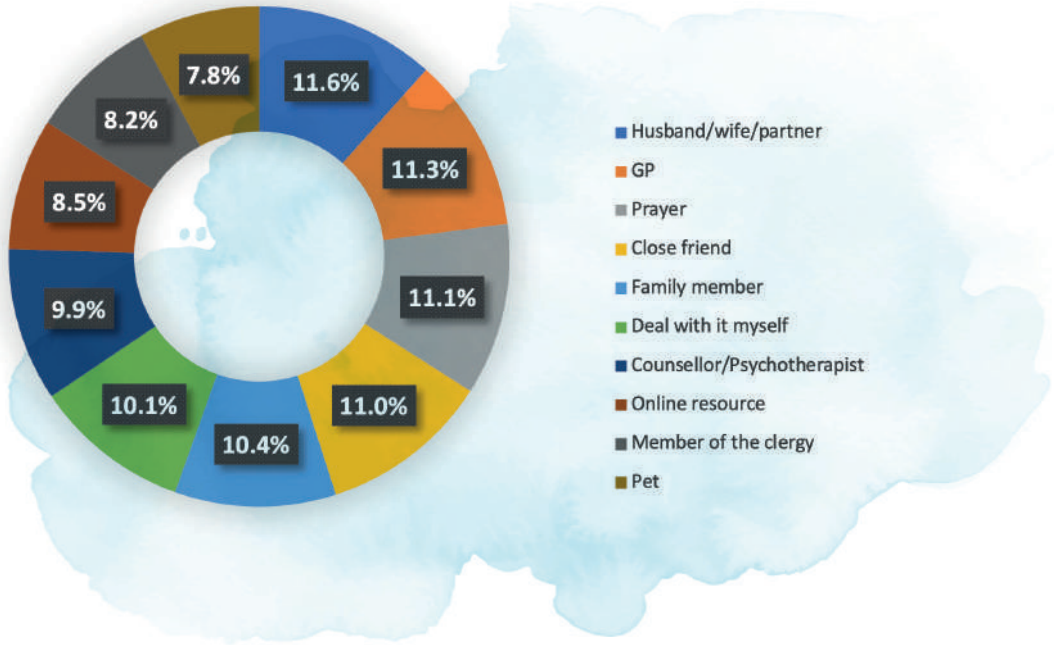
MQ17: How important are the following for good mental health?

Responses to this question were very evenly distributed with only a relatively small difference in the most reported answer, "someone to talk to about problems" (8.9%) from the least reported, "a strong faith" (7.7%).



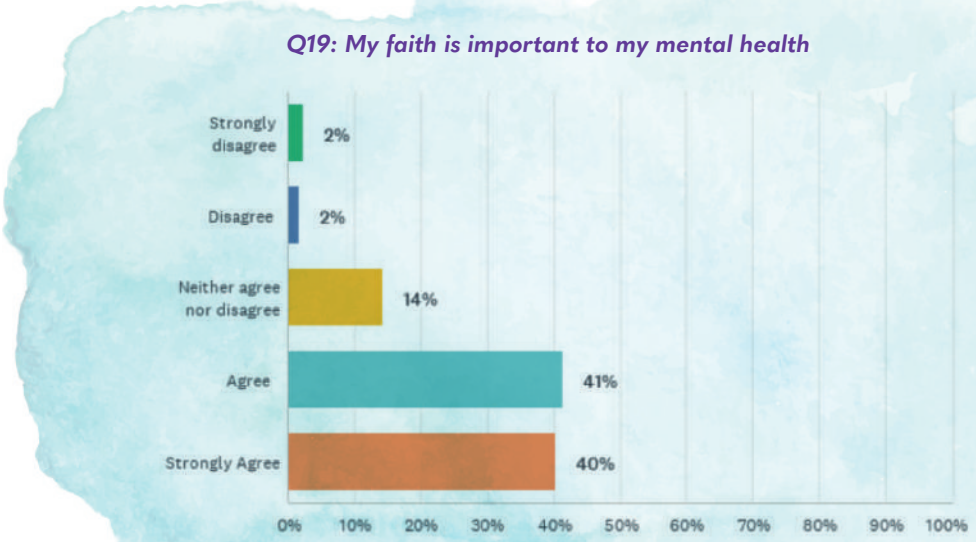
MQ18: If you thought you had a mental health issue, which of these would you be likely to seek support from?

A third of respondents (33%) said they would seek support from their spouse (11.6%), a close friend (11%) or a family member (10.4%). Just over a fifth (21.2%) would go to their GP (11.3%) or a counsellor/ psychotherapist (9.9%). Around a fifth (19.5%) chose prayer (11.3%) or a member of the clergy (8.2%).



MQ19: My faith is important to my mental health

A large majority (81%) either agreed or strongly agreed that their faith was important to their mental health.



MQ20: Which of these organisations/resources have you heard of? (tick as many as you think are relevant).

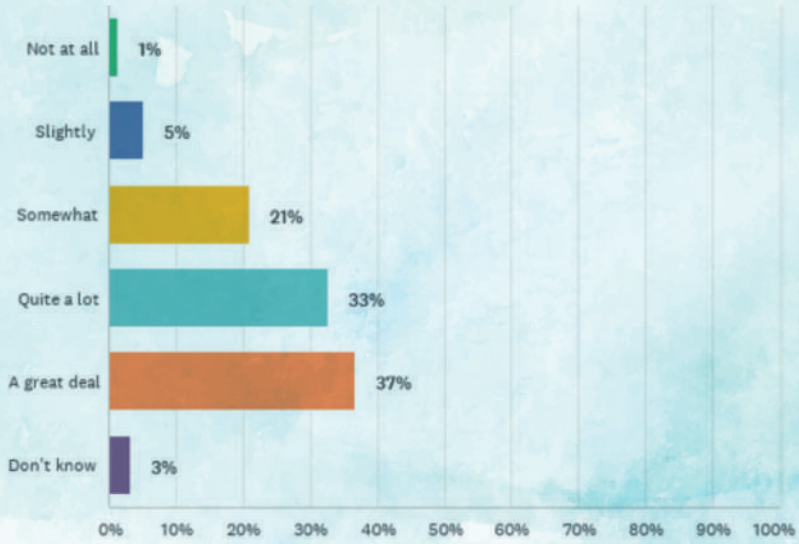
The Samaritans was recognised by almost all respondents (99%) and over three-quarters had heard of Aware (76%). The top nine organisations that respondents had heard of are:

Organisation/Resource	% who knew of the organisation
Samaritans (All Ireland)	99%
Aware (All Ireland)	76%
Jigsaw (ROI)	44%
Mental Health Ireland (ROI)	33%
Lifeline NI (NI)	30%
Yourmentalhealth.ie (ROI)	24%
Action Mental Health (NI)	24%
Mindyourhead.info (NI)	21%
GROW (ROI)	19%

MQ21: How much do you think faith supports good mental health?

69% of respondents thought that faith supports good mental health either a great deal or a lot, with a smaller proportion responding that mental health supports good mental health somewhat (21%). This compares with over 81% of clergy reporting that faith supports good mental health either a great deal or a lot, and compares with the interviews with the House of Bishops, all of whom reported that faith is important for both physical and mental health.

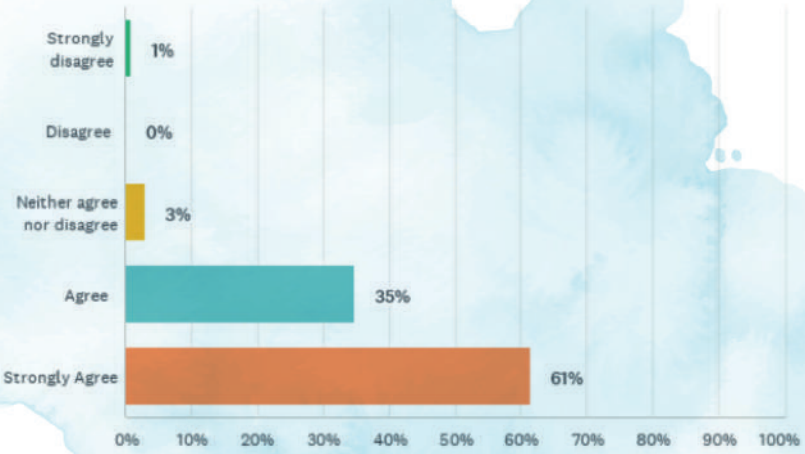
Q21: How much do you think faith supports good mental health?



MQ22: COVID-19 has had a significant impact on some people's mental health.

The survey found that 61% of members strongly agree, and 35% of members agree, that Covid-19 has had a significant impact on some people's mental health. This compares with the findings from the literature (Bentzen, 2020; Lee, 2020) which suggest that Covid-19 has impacted people's mental health in a variety of ways, such as a rise in depression and anxiety, for example.

Q22: COVID-19 has had a significant impact on some people's mental health

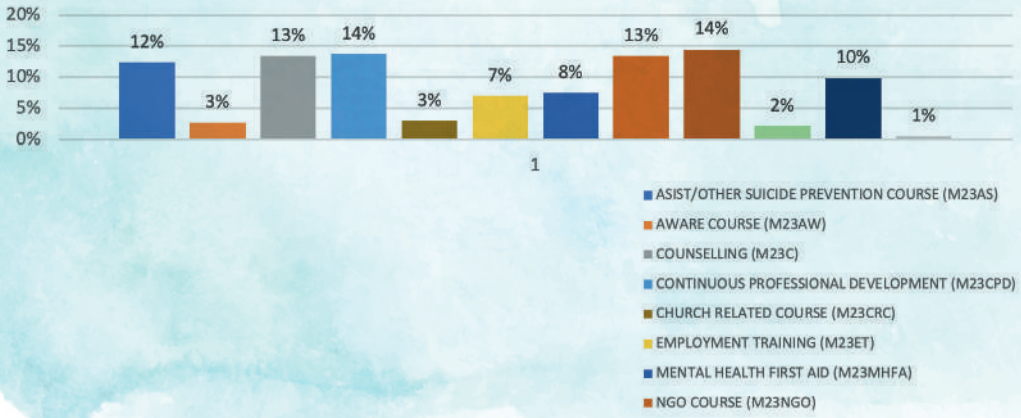


MQ23: Have you ever attended a training course for helping others with a mental health issue?

Three-quarters of respondents had never attended a training course for helping others with a mental health issue. Of the 25% of people who had attended a training course, 14% of people had attended a course with a focus on suicide prevention or depression, with 13% of respondents indicating that they had participated on some training to become a counsellor and/or to maintain their professional status via a mandatory continuous professional development programme.

MQ23a: If Yes, please tell us what training course

Q23: Have you ever attended a training course for helping others with a mental health issue?

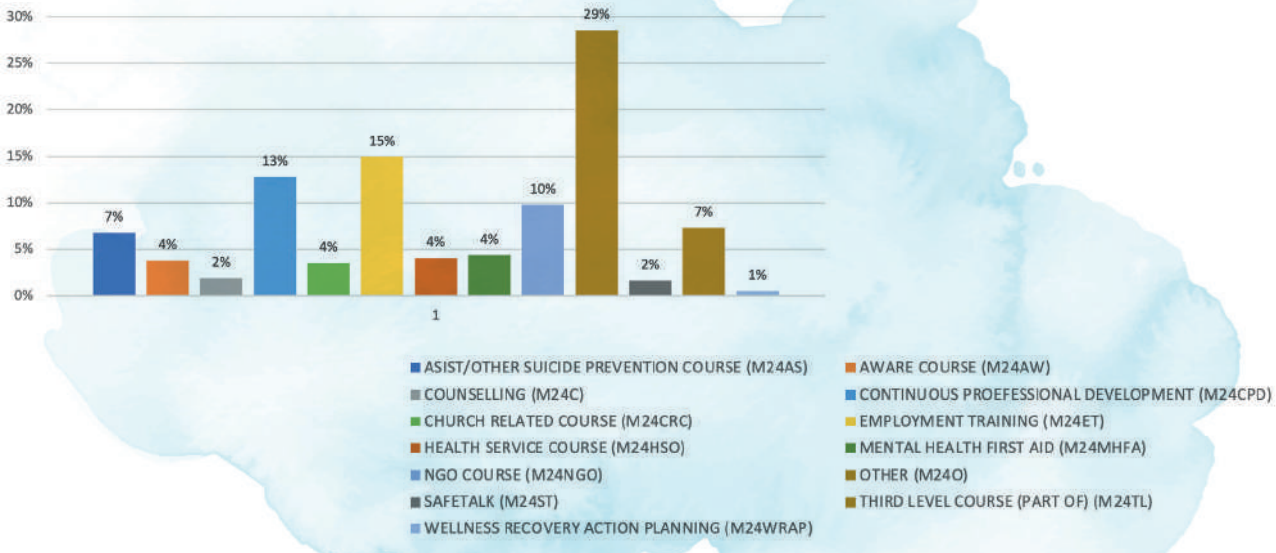


MQ24: Have you ever attended a training course about mental health awareness?

30% of respondents had attended a training course about mental health awareness with 15% of respondents attending training as part of their employment, 13% as part of their continuing professional development and 7% through a third-level course. Beyond this, the range of courses attended by members ranged from mindfulness and stress control, to depression, anxiety and children's mental health.

MQ24a: If Yes, please tell us what training course

Q24: Have you ever attended a training course about mental health awareness?



SECTION THREE: SARAH'S STORY

Sarah's Story, a vignette approach, was used to explore attitudes to mental health in the survey. Vignettes are short stories about a hypothetical person, traditionally used within research on sensitive topics (Gourlay et al, 2014). Sarah's story was created using best practice guidelines in developing a story that respondents reviewed and then were asked questions about.

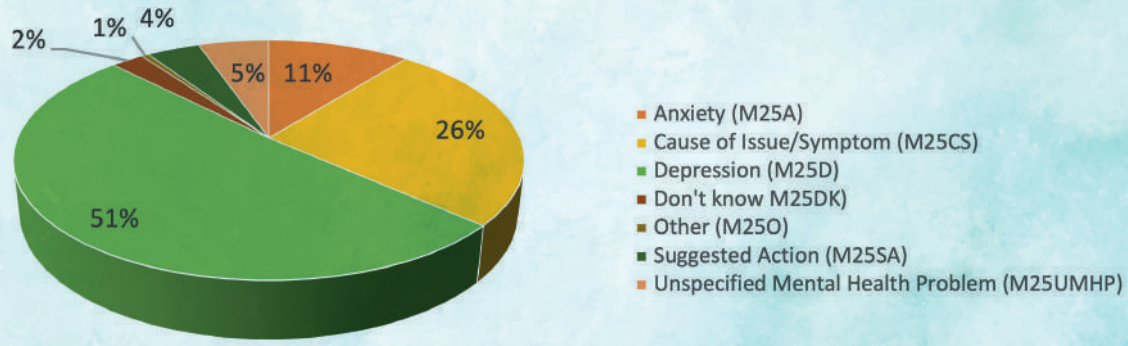
Sarah's Story. We are interested in your thoughts about Sarah's story. Please read her story and answer the following questions.

Sarah, aged 25 and a member of the Church of Ireland, has been feeling unusually unhappy for the last few weeks. She is always tired and has lost her appetite. She has noticeably lost weight as she doesn't feel like eating most of the time. Focusing on her work is a real struggle as she has lost interest in her job which she previously enjoyed, and her performance at work has dropped recently. She is not joining the weekly online church services as often as she used to and her friends in the select vestry are concerned about her. Her other friends and colleagues have also noticed some of the changes and they are worried for her. Sarah is putting off making any decisions and even day to day tasks can seem too much for her, taking a lot of effort to complete. Sarah has stopped going to the gym and walking with her friend and feels guilty about this all the time. Sarah's family is very concerned.

MQ25: What, if anything do you think is Sarah's issue?

Over half of respondents (51%) suggested that Sarah's issue was depression. Some respondents also commented on the possible causes of Sarah's issue, with suggestions ranging from lack of confidence to loneliness, low self-esteem and the impact of Covid-19. Interestingly, this correlates with findings in the literature which note that rates of depression in Ireland are above EU averages for both men and women (Eurostat, 2017).

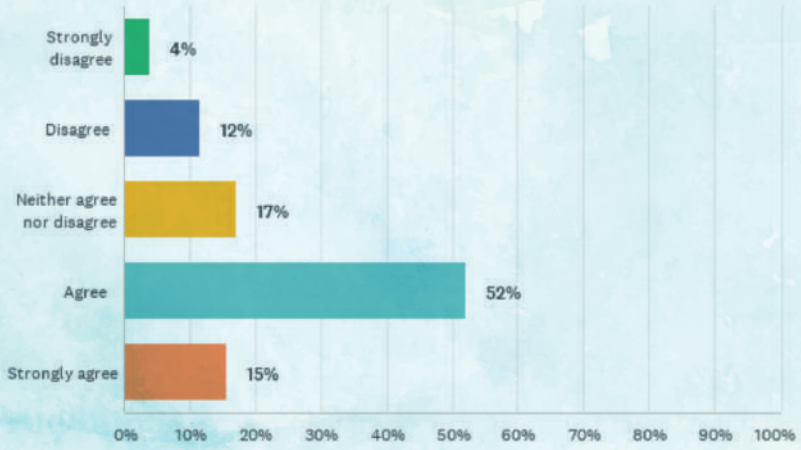
Q25: What, if anything do you think is Sarah's issue?



MQ26: I would know where to get help in my local area if I was having the same experience as Sarah

67% of respondents agreed, or strongly agreed with this statement, suggesting that they would know where to get help in their local area if they were having the same experience as Sarah. A minority, 33%, were not as certain, highlighting the need for more signposting and enhanced conversations around mental health supports. The literature suggested that the Church could play a role in this, following the TEACHER mental health initiative (Grcevich, 2018) which includes providing a welcoming environment, good communication and offering education and support to members.

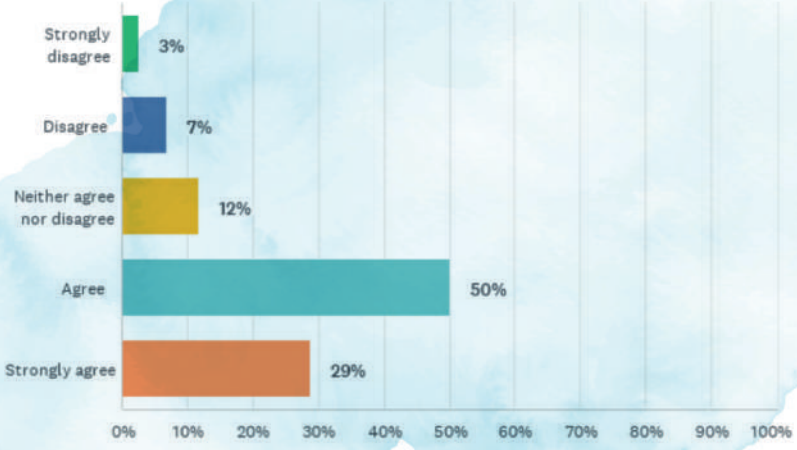
Q26: I would know where to get help in my local area if I was having the same experience as Sarah



MQ27: If I was feeling like Sarah, I would seek help from my GP or a mental health professional

79% of respondents in total either agreed (50%) or strongly agreed (29%), that they would seek help from their GP or mental health professional if they were feeling like Sarah. This finding is important, as advocates for promoting positive mental health would always encourage those experiencing poor mental health to seek medical and/or therapeutic help, as it is shown to increase chances of recovery and improve well-being.

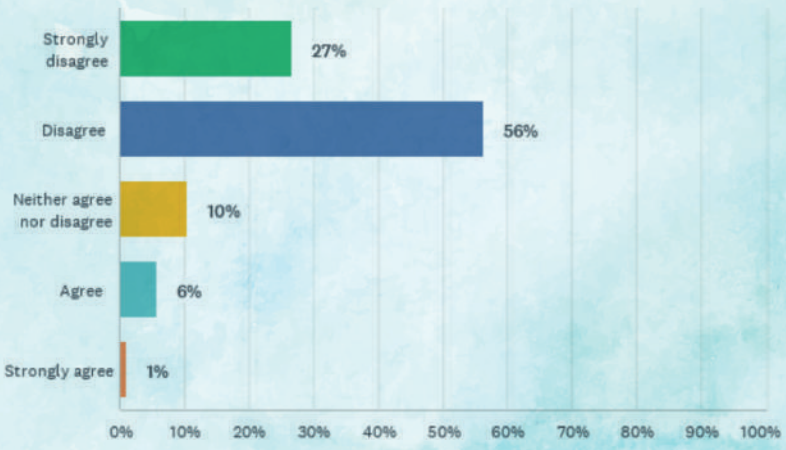
Q27: If I was feeling like Sarah, I would seek help from my GP or a mental health professional



MQ28: I think Sarah is experiencing normal everyday ups and downs

83% of respondents in total either disagreed (56%) or strongly disagreed (27%) that Sarah was experiencing normal every day ups and downs. This suggests that respondents may have a reasonable understanding and awareness of symptoms of poor mental health and corresponds with the literature[15] which suggests that educating faith communities to increase mental health literacy and awareness is increasingly important.

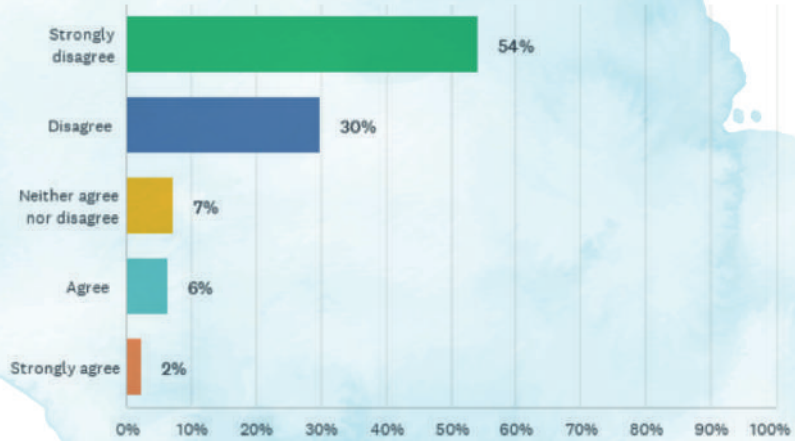
Q28: I think Sarah is experiencing normal everyday ups and downs



MQ29: Seeing a GP or mental health professional for an issue like Sarah's means you are not strong enough to manage your own difficulties

84% of respondents in total disagreed (30%) or strongly disagreed (54%) with the statement. This suggests that respondents understand the importance of seeking help if someone is experiencing a mental health issue, and that looking for help is not perceived as a weakness. It contributes to one of the research findings which is that there is a good understanding of care pathways for mental health problems.

Q29: Seeing a GP or mental health professional for an issue like Sarah's means you are not strong enough to manage your own difficulties

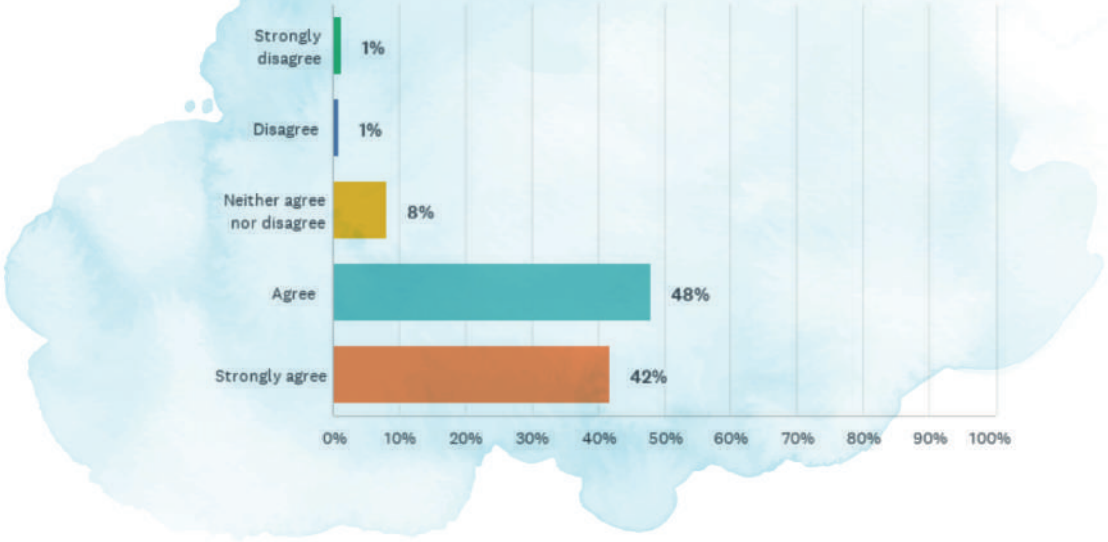


[15] *Meadows Mental Health Policy Institute.*

MQ30: I think treatment provided by a GP or mental health professional would be helpful for Sarah

A high majority of respondents agree (48%) or strongly agree (42%) that they think the treatment provided by a GP or mental health professional would be helpful for Sarah. This finding emphasises the importance of seeking help when feeling unwell.

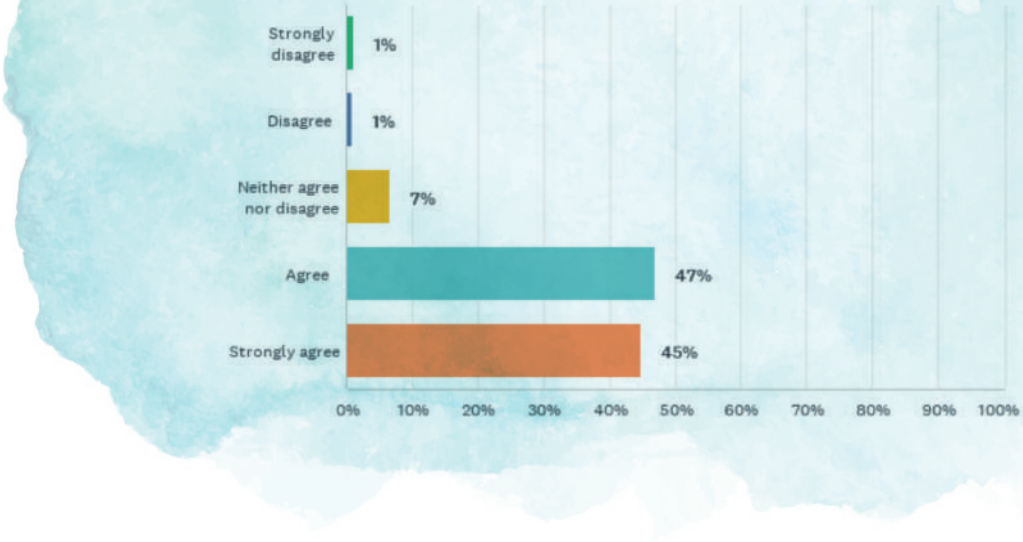
Q30: I think treatment provided by a GP or mental health professional would be helpful for Sarah



MQ31: If I was feeling like Sarah, it would be good to seek help from a GP or mental health professional

An understanding of the importance of seeking help was affirmed with most respondents agreeing (47%) or strongly agreeing (45%) that, if they were feeling like Sarah, it would be good to seek help from a GP or mental health professional.

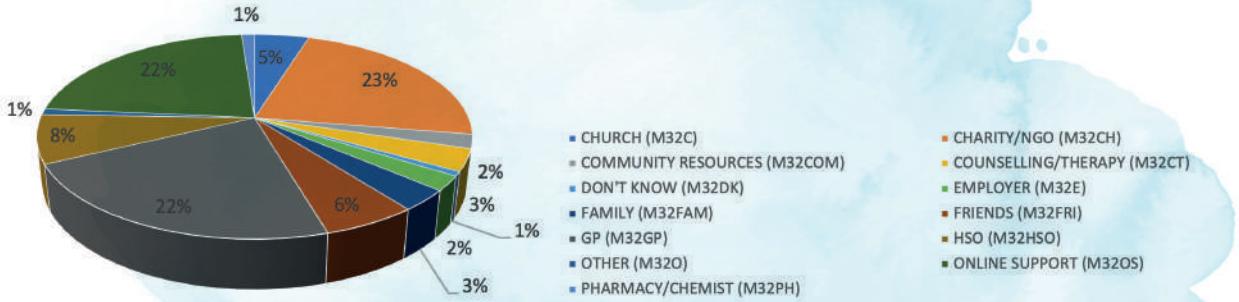
Q31: If I was feeling like Sarah, it would be good to seek help from a GP or mental health professional



MQ32: Where do you think Sarah can find out information about how she is feeling? [Think about and list where you might source information for mental health issues]

As the graph illustrates, respondents suggested 12 different places where Sarah could find information about how she was feeling. Suggestions ranged from charity / non-governmental organisations, to the GP and online supports. A small number suggested friends, Church and family. This suggests that there is a good understanding of the supports in the community available to people experiencing poor mental health.

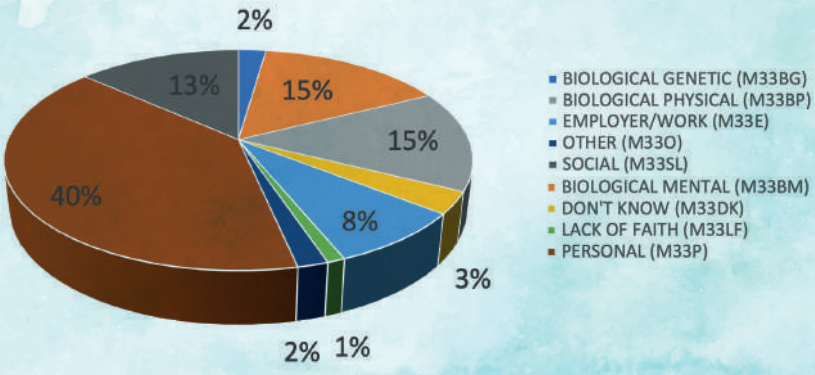
Q32: Where do you think Sarah can find out information about how she is feeling?



MQ33: What, if any, do you think are the causes of how Sarah is feeling? [List any personal, social, or biological causes you can think of]

Just under half of respondents (40%) suggested that personal circumstances may have been the cause of how Sarah is feeling, with a smaller number (15%) suggesting physical or biological factors that are contributing to the way Sarah is feeling. Some comments included that it could be relationship problems, bullying, loneliness or financial difficulties, which provides some insight into the respondents' understanding of what can contribute to poor mental health.

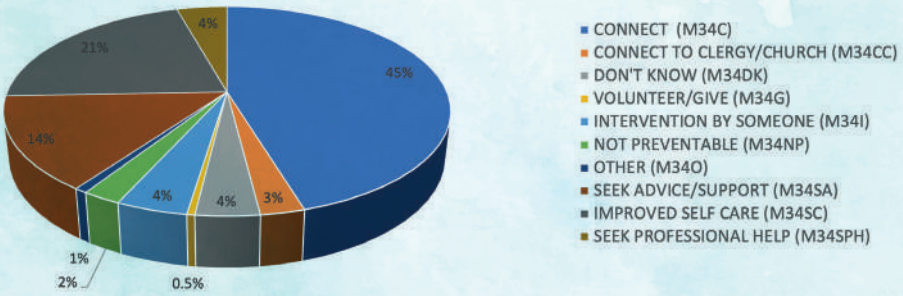
Q33: What, if any, do you think are the causes of how Sarah is feeling?



MQ34: How, if at all, do you think Sarah's issue might have been prevented? [Think about things that Sarah or others can do to stop issue/s like this from happening]

45% of respondents suggested that stronger connections may have prevented Sarah's issue, suggesting she talk to friends and/or family. 21% said that improved self-care may have helped - e.g. diet, exercise, sleep, having a hobby and a daily routine. Seeking professional help was mentioned in 14% of the responses, which primarily consisted of suggesting that Sarah should go to see her GP.

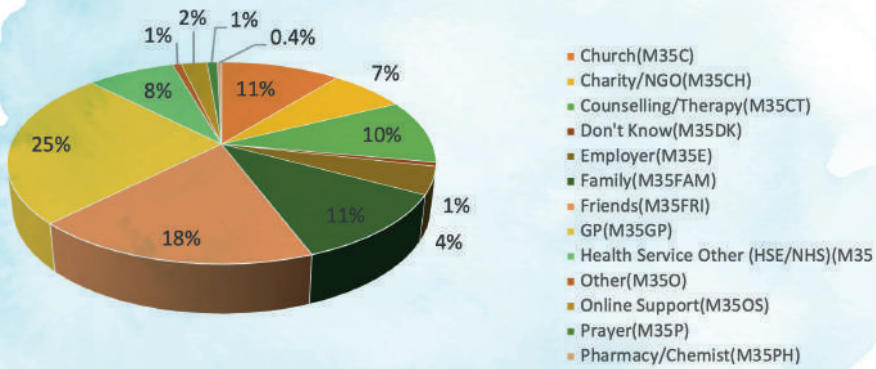
Q34: How, if at all, do you think Sarah's issue might have been prevented?



MQ35: Who do you think Sarah should try and get help from? [Think about any professionals and any non-professionals that you think might be able to help]

43% of respondents suggested that Sarah should try and get help from professionals including her GP, other Healthcare Professionals, or a Counsellor/Therapist. 29% of respondents suggest talking to family or friends and 11% suggested approaching the Church, predominately the rector. Interestingly, only 1% suggested prayer as a source of help, although the overall project findings suggest that both faith and prayer are important for maintaining good mental health, and that prayer is the most important support for clergy if they have a mental health issue.

Q35: Who do you think Sarah should try and get help from?

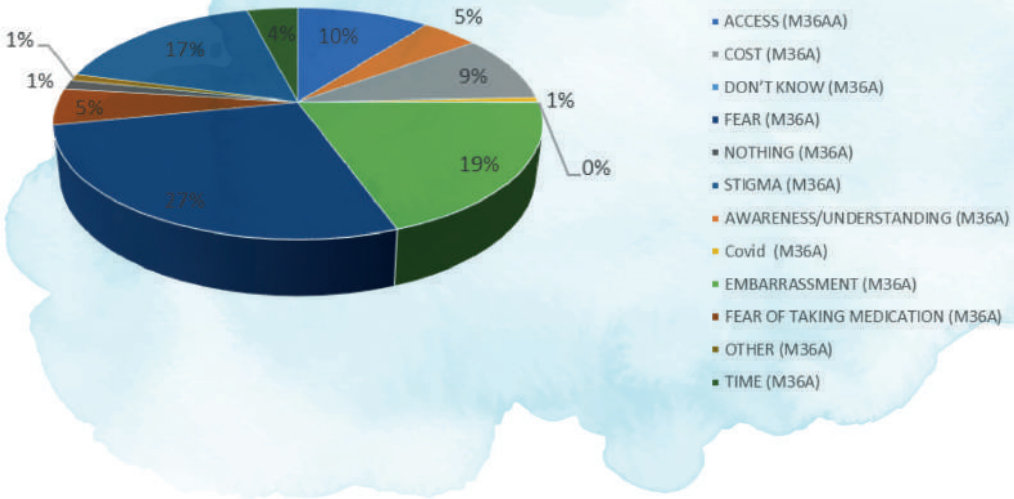


MQ36: What do you think might stop Sarah from seeking help for how she is feeling from the following people?

Healthcare professionals

27% of respondents cited fear as their main reason for not seeking help. Embarrassment (19%) and stigma (17%) were also significant reasons cited as reasons for not seeking help from healthcare professionals.

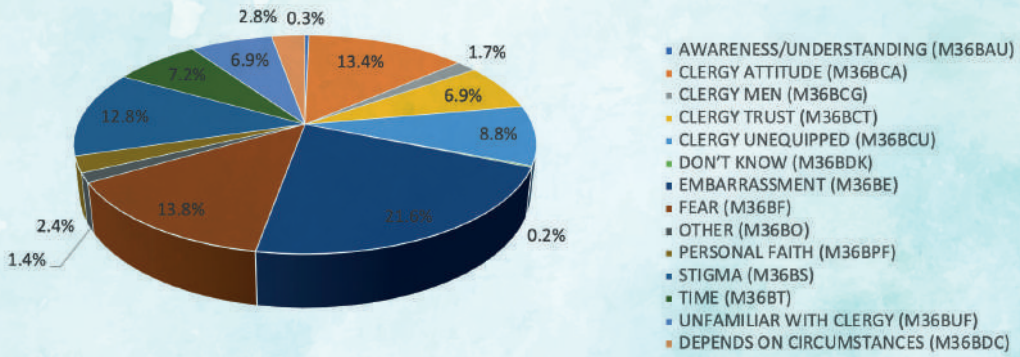
Q36a: What do you think might stop Sarah from seeking help for how she is feeling from the following people?



Member of clergy

Over 21% of respondents cited embarrassment, with a lower proportion (13.8%) suggesting fear or stigma (12.8%). Respondents also suggested they would not seek help from clergy due to the attitude of the clergy (13.4%), that they felt clergy were unequipped to respond adequately (8.8%) or that they didn't trust (6.9%) or know the clergy well enough to make a disclosure (6.9%).

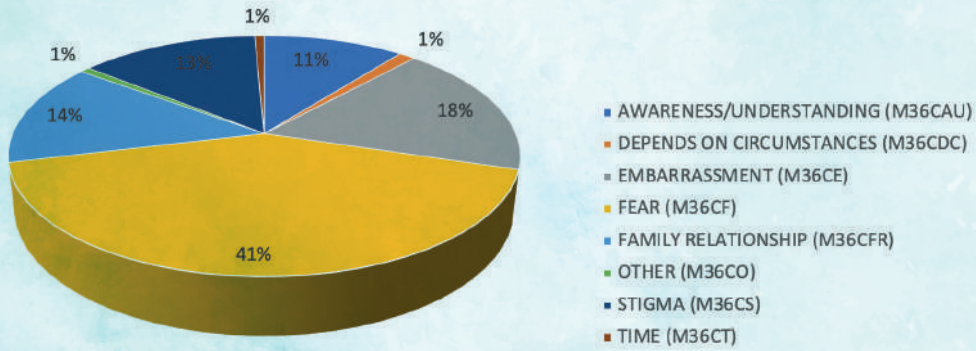
Q36b: What do you think might stop Sarah from seeking help for how she is feeling from the following people: Clergy?



Family

41% of respondents said that fear was the primary reason for not seeking help from family. This included fear of upsetting them, worrying them, bothering them, showing weakness, letting them down. Embarrassment was also a reason given for not talking to family (18%), along with stigma (13%).

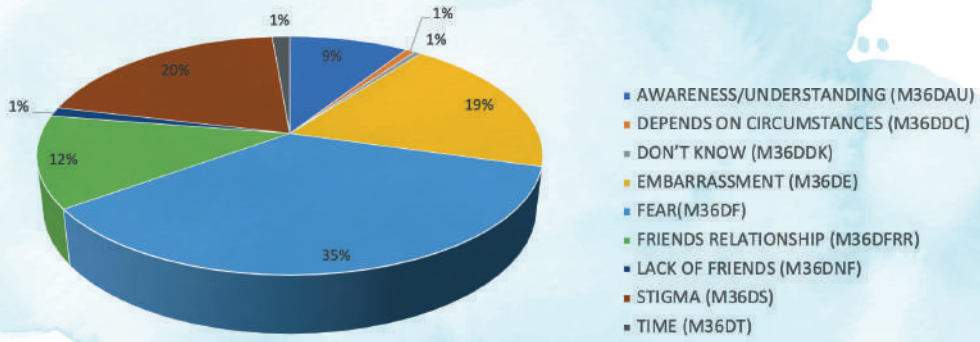
Q36c: What do you think might stop Sarah from seeking help for how she is feeling from the following people: Family?



Friends

35% of respondents suggested that fear was the main reason they would not seek help from friends. 19% of respondents said embarrassment would be the primary reason why they would not talk to friends, with 20% concerned that levels of stigma might be high. This finding may suggest that people are more willing to share their mental health issue with family than friends due to the stigma associated with mental health issues.

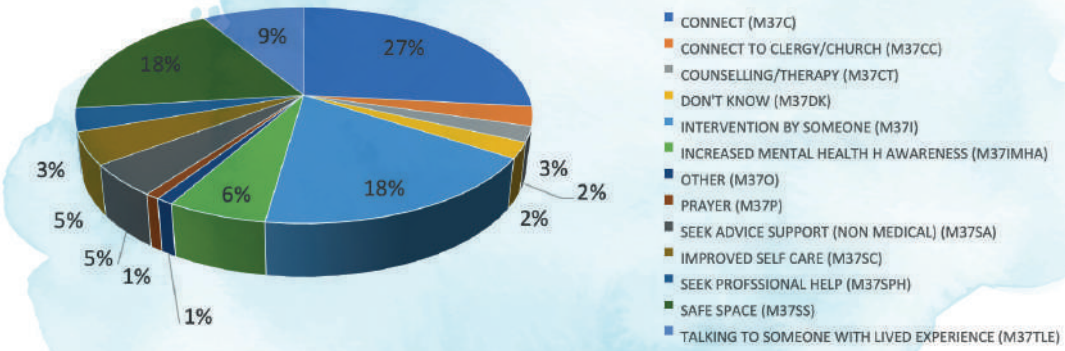
Q36d: What do you think might stop Sarah from seeking help for how she is feeling from the following people: Friends?



MQ37: What do you think might help Sarah to talk about how she is feeling?

27% of people suggested connections, and connecting with people, might help Sarah to talk about how she is feeling. A smaller number suggested a safe space to talk (18%) or an intervention by someone (18%), suggesting that people around Sarah should be proactive and approach Sarah to ask how she is feeling. Interestingly, only 1% of respondents suggested prayer as a way of helping Sarah to talk about how she is feeling.

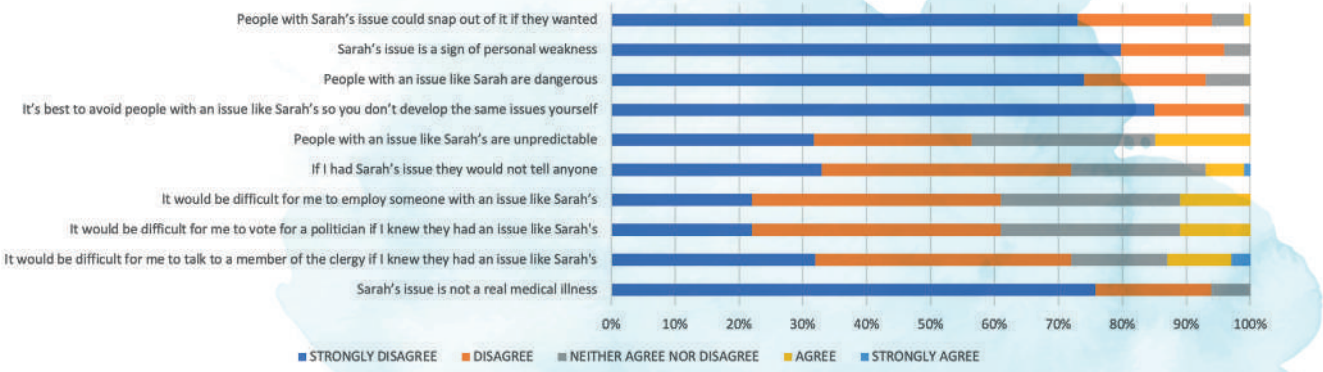
Q37: What do you think might help Sarah to talk about how she is feeling?



MQ38: To what degree do you agree with the following statements?
This question is asking what <u>YOU</u> think about Sarah

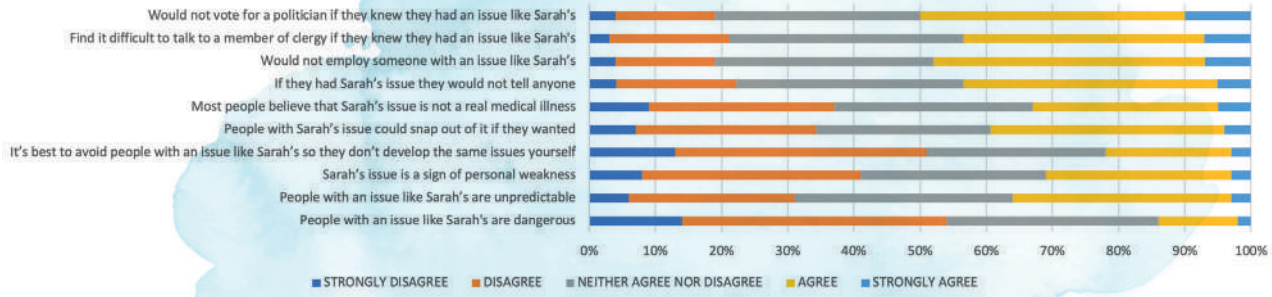
This question gave respondents an opportunity to agree or disagree with 10 statements. As illustrated from the graph, a number of statements received no agreement from respondents. These statements include the following: "Sarah's issue is a sign of personal weakness"; "people like Sarah are dangerous"; "it's best to avoid people with an issue like Sarah so you don't develop the same issues yourself"; and "Sarah's issue is not a real medical illness".

15% of respondents agreed with the statement that people with an issue like Sarah's are unpredictable, with 11% of respondents suggesting it would be difficult to employ someone with an issue like Sarah's and that it would be difficult for them to vote for a politician if they knew that the politician had an issue like Sarah's. 10% of respondents also agreed that they would find it difficult to talk to a member of the clergy if they knew the clergyperson had an issue like Sarah's. These findings contribute to the need to create an open culture around mental health, and start a discussion about how mental health can affect our perceptions of others.



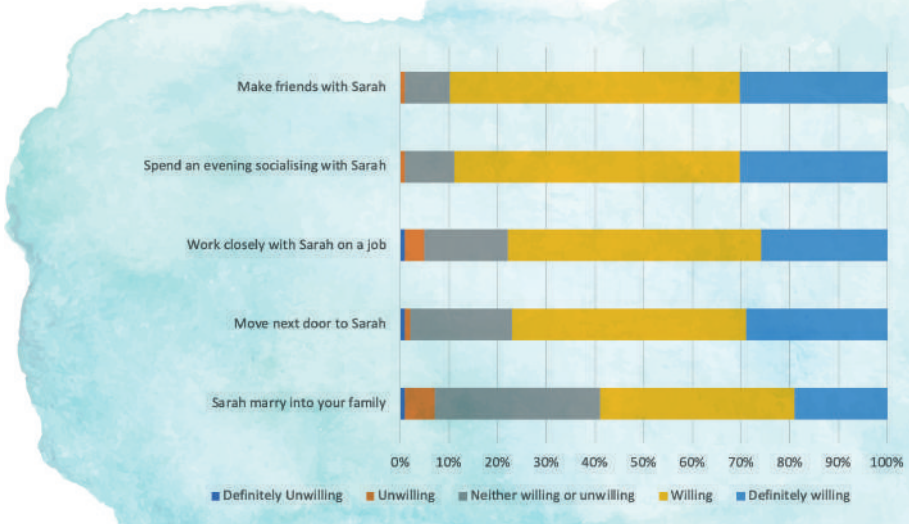
MQ39: To what degree do you agree with the following statements? This question is asking what you think OTHER PEOPLE might think about Sarah

Interestingly, the answers to this question are in some contrast to the answers provided for Q38, now that the question focused on 'other people'. For example, half of respondents agreed (40%) or strongly agreed (10%) that other people would not vote for a politician if they knew they had an issue like Sarah's, whilst, when self-reporting, 11% of respondents suggested this would be a difficulty for them (Q38). 48% of respondents agreed (41%) or strongly agreed (7%) that they would not employ someone like Sarah, compared with 11% of people in Q38. A further contrast is clear when answering the statement 'I would find it difficult to talk to a member of clergy if I knew they had an issue like Sarah's', with 43% of respondents agreeing (36%) or strongly agreeing (7%) with this statement. This compares with 10% respondents in Q38. In terms of making a disclosure, 43% of respondents agreed (38%) or strongly agreed (5%) that 'other people' would not tell anyone if they had Sarah's issue. This provides some insight into levels of stigma with regard to mental health, and can be linked back to earlier findings that suggest that fear and embarrassment would be reasons why a person might not make a mental health disclosure. Finally, 39% of people agreed (35%) or strongly agreed (4%) that others might suggest that people with Sarah's issue could "snap out of it" if they wanted.



MQ40: How willing or unwilling would you be to engage with Sarah in the following situations?

The graph indicates a good willingness of respondents to engage with Sarah in a number of different situations. For example, 89% of respondents were willing (59%) or definitely willing (30%) to make friends with Sarah and spend an evening socialising with Sarah. A slightly smaller number (78%) would be willing (52%) or definitely willing (26%) to work closely with Sarah on a job and move next door to Sarah. Nearly two-thirds of respondents (59%) would be willing or definitely willing for Sarah to marry into their family.



APPENDIX TWO

CLERGY SURVEY QUESTIONS AND RESPONSES

SECTION ONE: ABOUT YOU

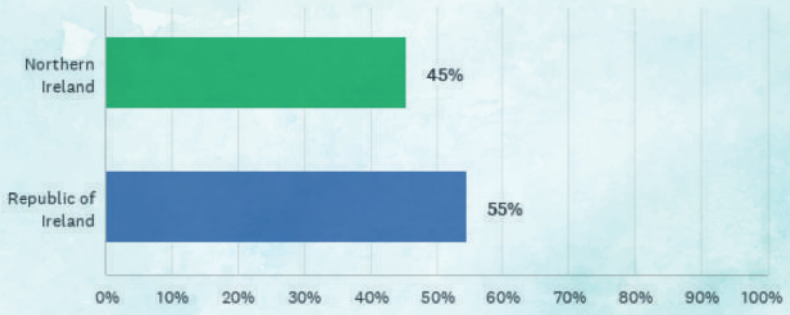
CQ1: Consent. n=292

After data cleansing consented to participate in this study. 3 members of the Clergy did not give consent to participate in the survey.

CQ2: Which jurisdiction do you live in?

Just over half (55%) of respondents are based in the Republic of Ireland, with 45% living in Northern Ireland.

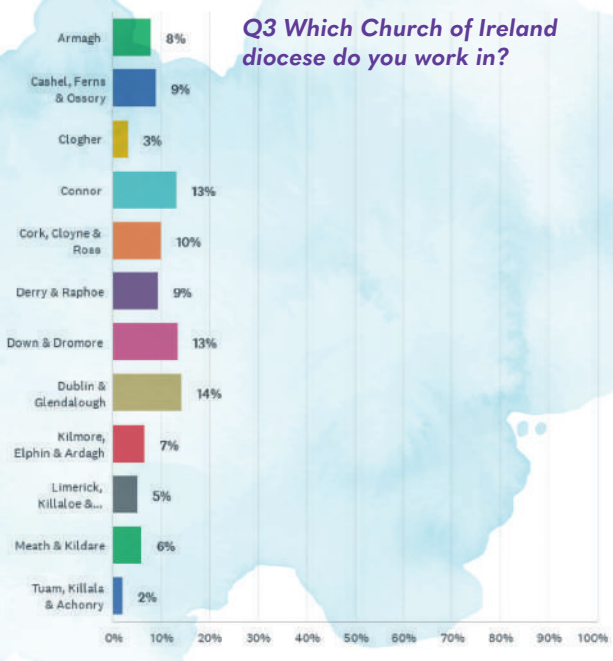
Q2: What do you think might help Sarah to talk about how she is feeling?



CQ3: Which Church of Ireland diocese do you work in?

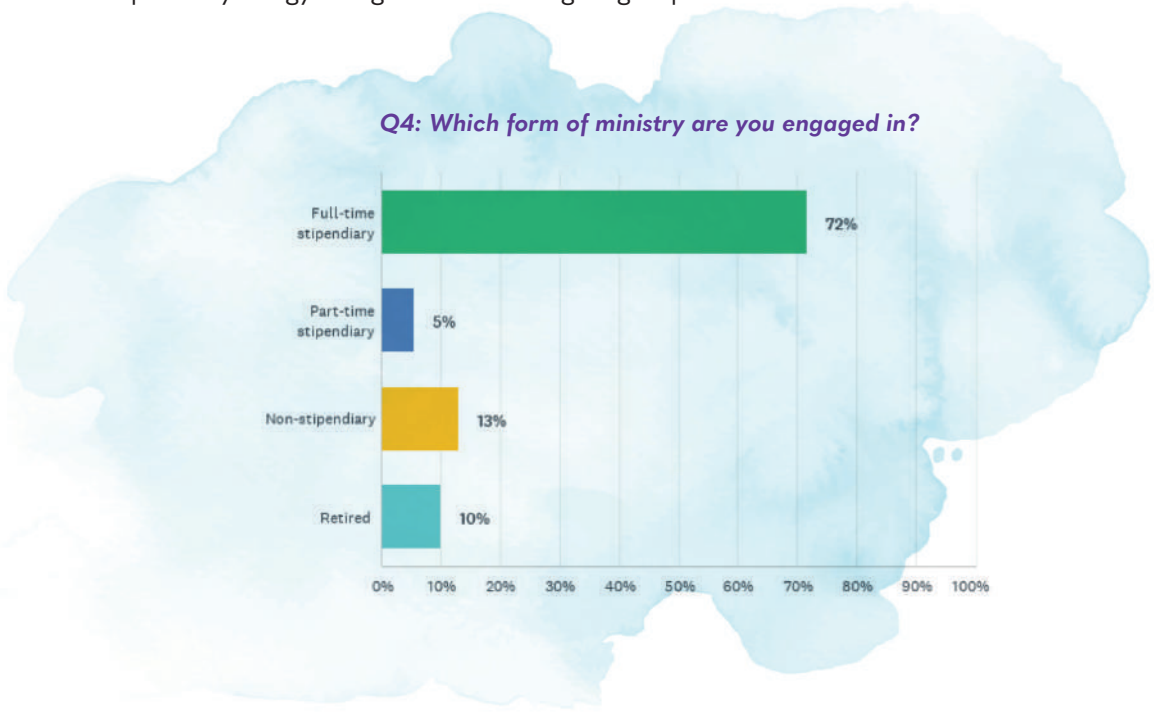
The greatest number of respondents work in the dioceses of Dublin and Glendalough (14%), Down & Dromore (13%), Connor (13%) and Cork, Cloyne & Ross (10%).

Q3 Which Church of Ireland diocese do you work in?



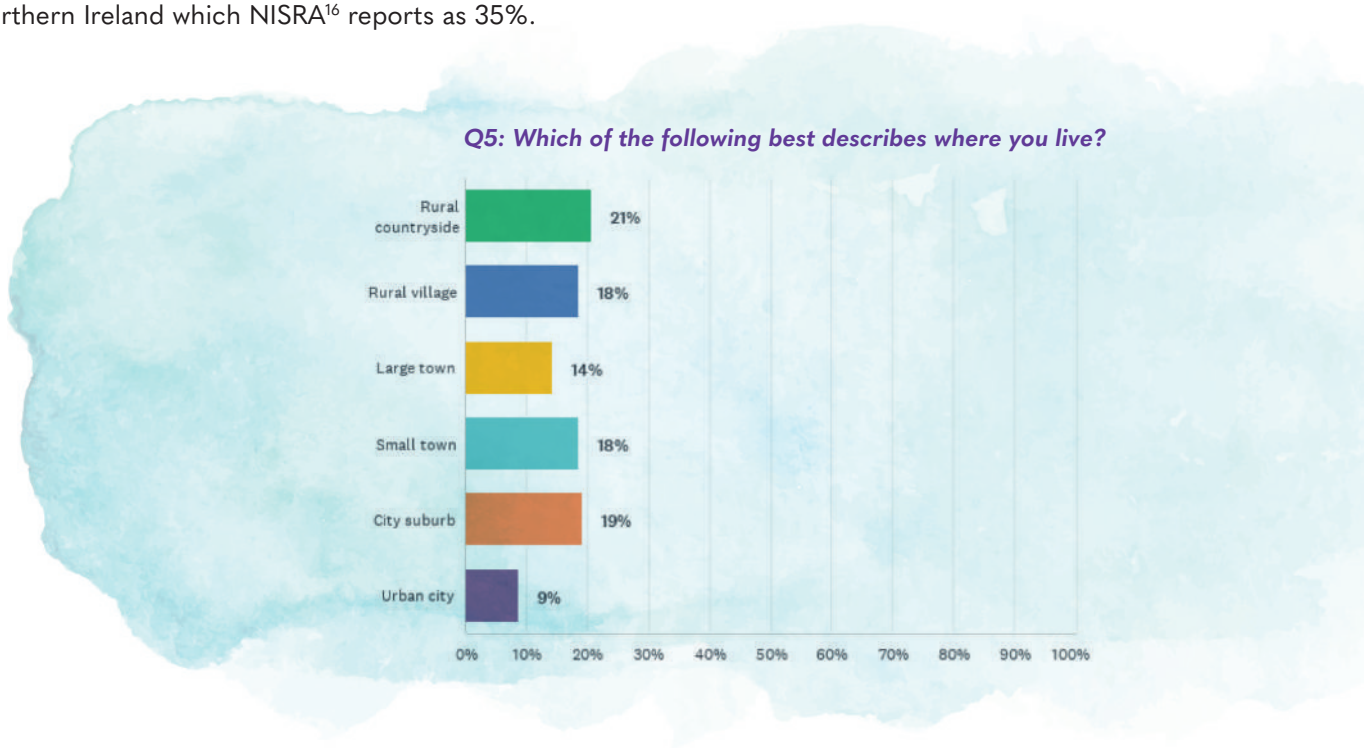
CQ4: Which form of ministry are you engaged in?

Full-time stipendiary ministers represented almost three quarters (72%) of all respondents, with non-stipendiary clergy being the second largest group at 13%.



CQ5: Which of the following best describes where you live?

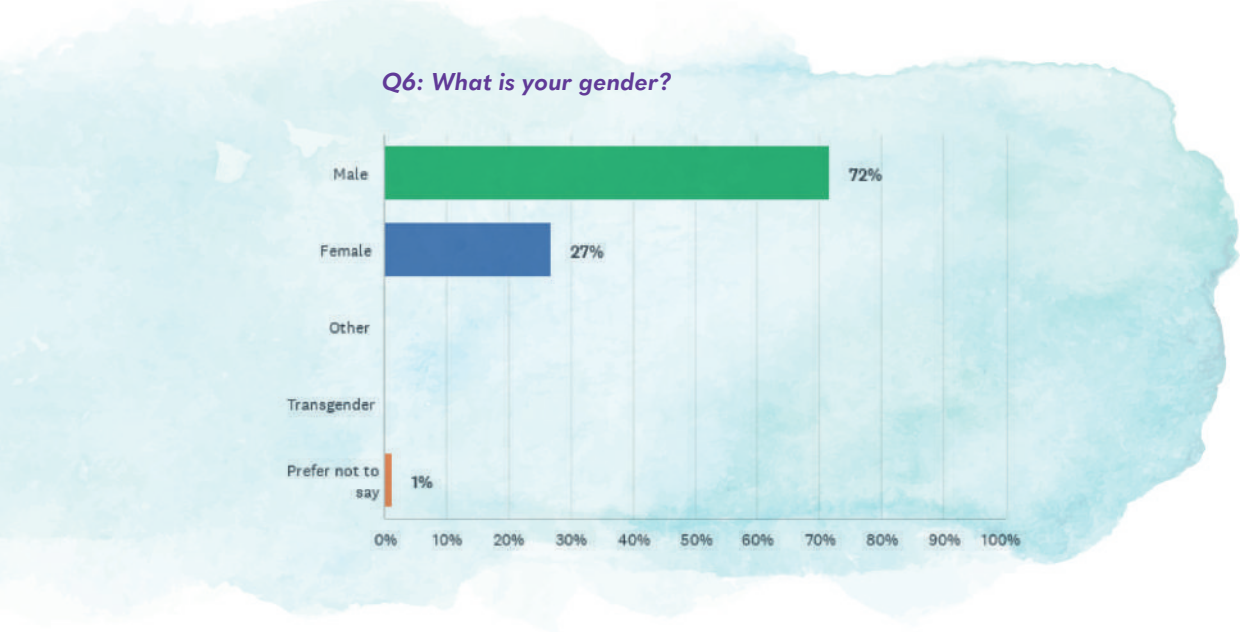
57% of respondents reported living in the rural countryside (21%), a rural village (18%) or a small town (18%). The CSO reports that approximately 31% of the population of the Republic of Ireland live in 'rural' areas, including those living in towns with a population of less than 1,500. This is similar to the figure for Northern Ireland which NISRA[16] reports as 35%.



[16] *https://www.nisra.gov.uk/support/geography/urban-rural-classification*

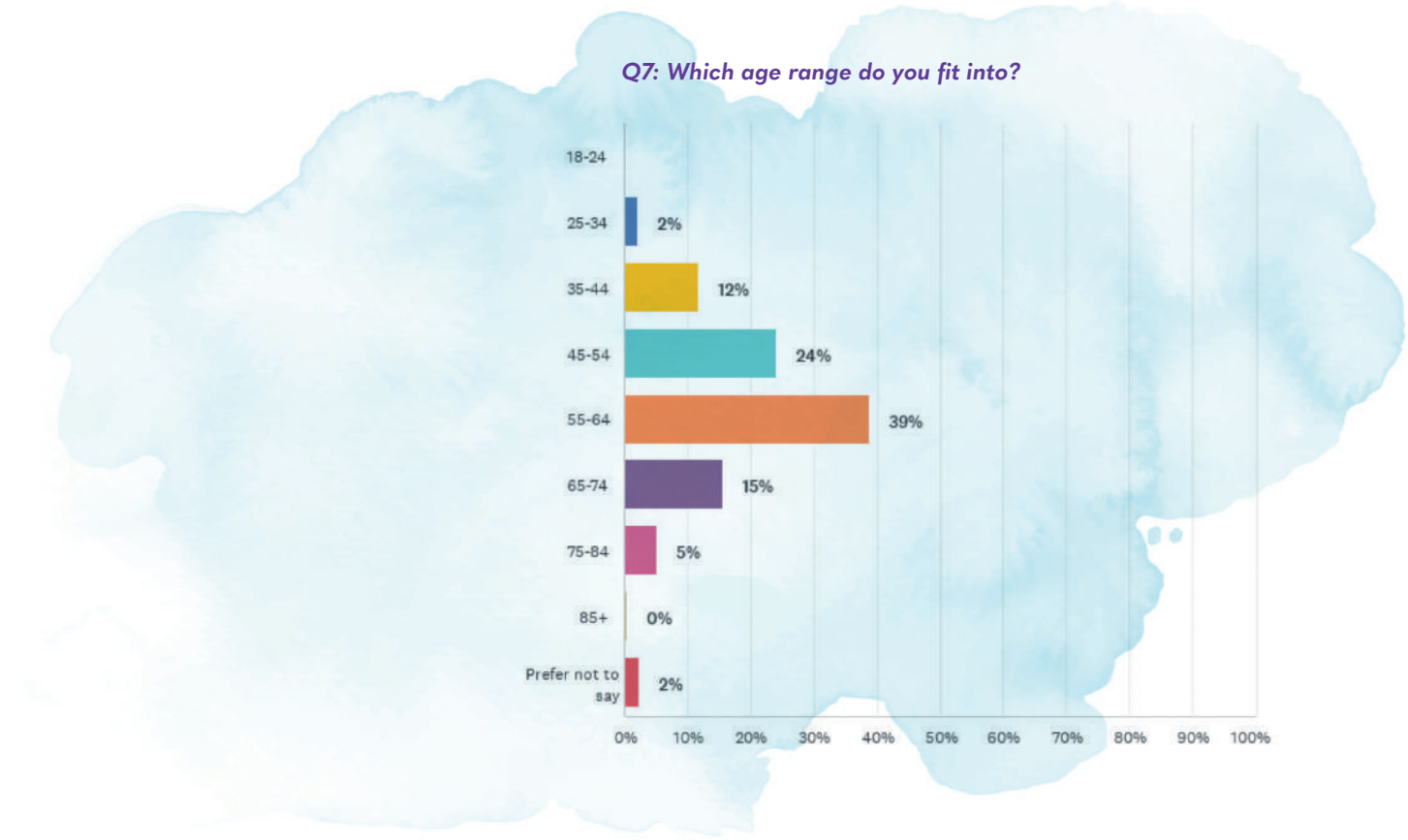
CQ6: What is your gender?

Male respondents (72%) outnumbered females (27%) by almost 3 to 1. This is broadly in line with the overall gender breakdown of active clergy, with 77% being male and 23% female.



CQ7: Which age range do you fit into?

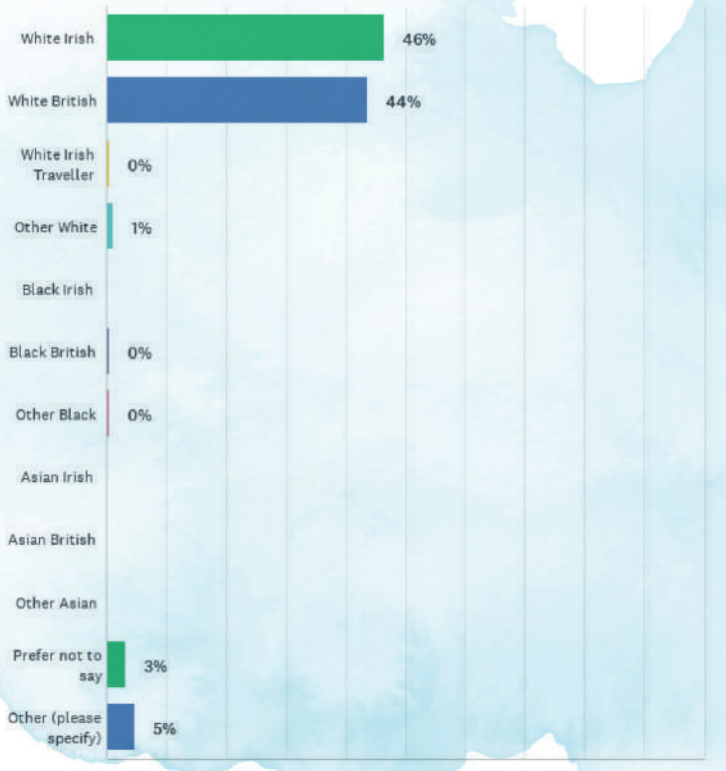
A clear majority of respondents (59%) were 55 years of age or older, with 38% being under 55 years old and 2% preferring not to say.



CQ8: What is your ethnicity?

90% of respondents classified themselves as either White Irish (46%) or White British (44%).

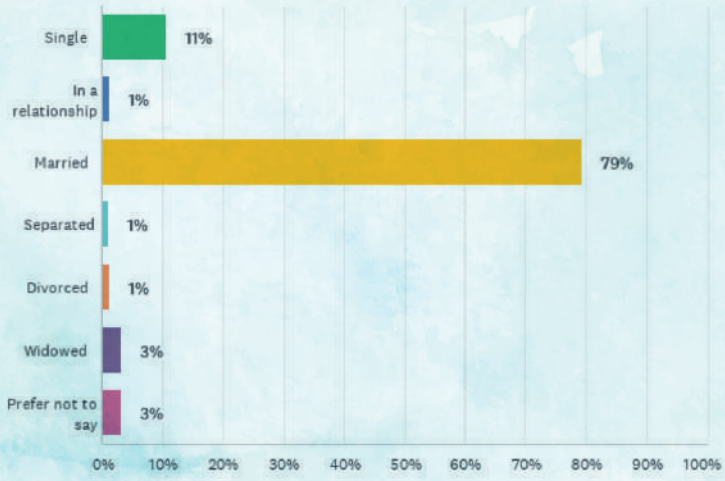
Q8: What is your ethnicity?



CQ9: What is your current relationship status?

Over three-quarters of respondents were married, with 11% reporting their status as single.

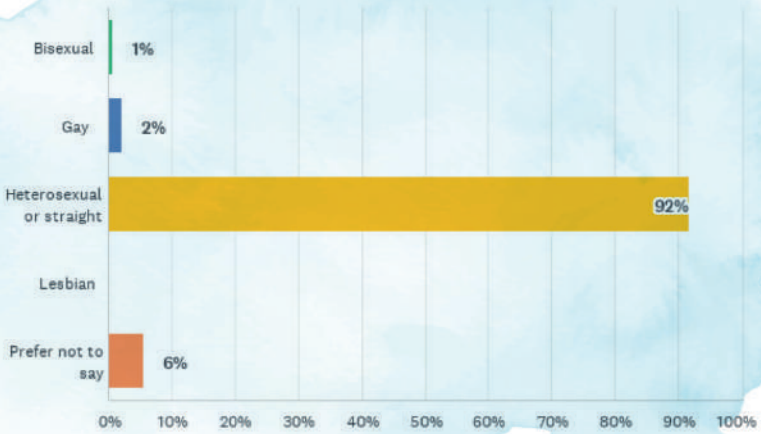
Q9: What is your current relationship status?



CQ10: What is your sexual orientation?

The respondents overwhelmingly identified as heterosexual or straight (92%), with only 2% identifying as gay and 1% as bisexual.

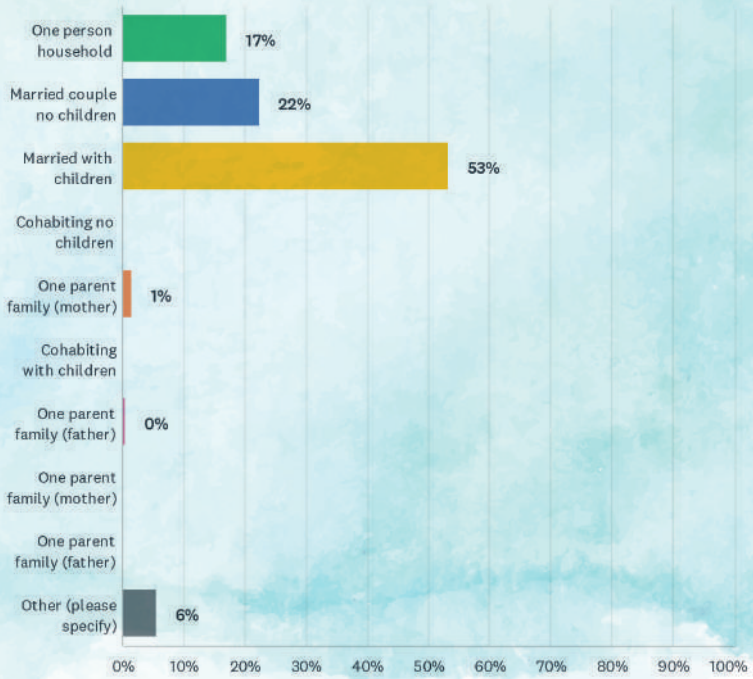
Q10: What is your sexual orientation?



CQ11: Which of the following best describes your household?

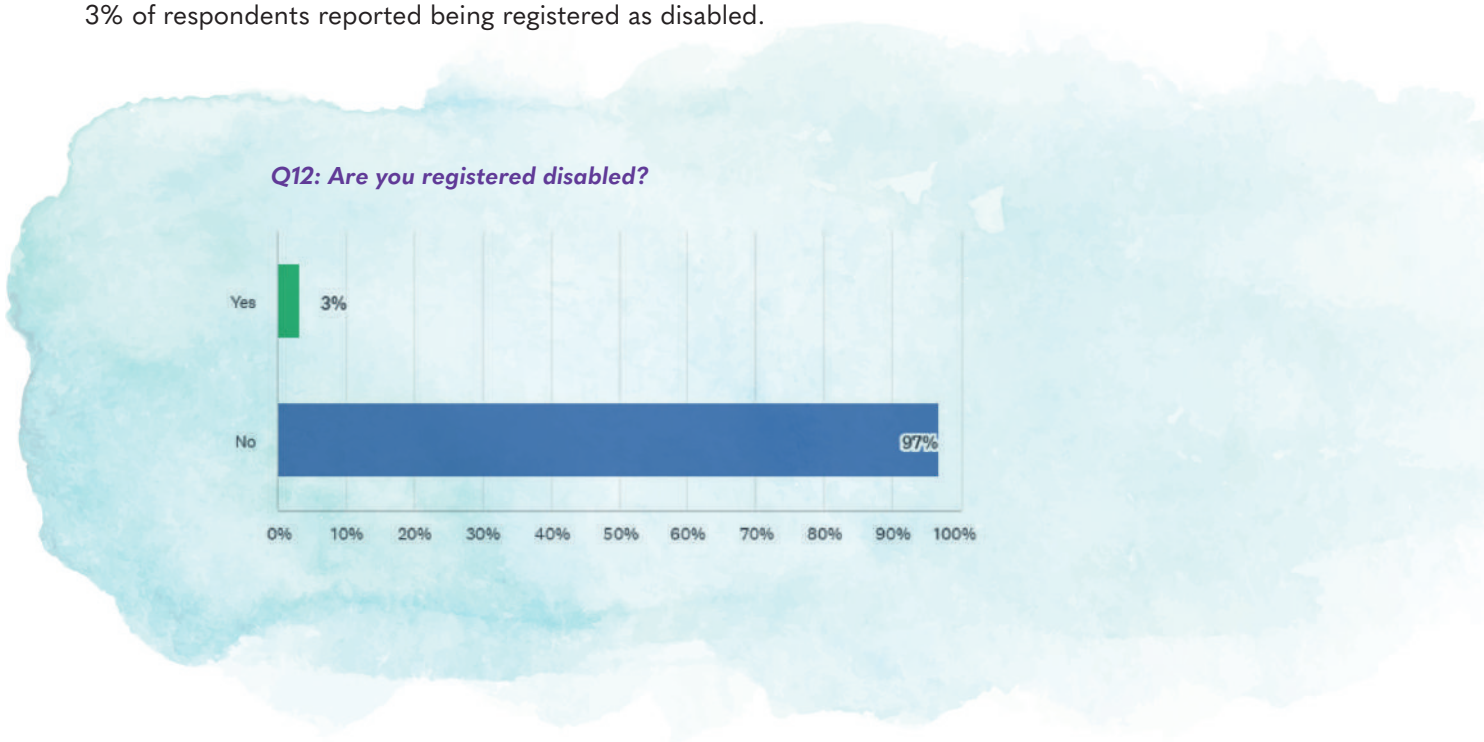
Just over half (53%) of respondents reported being part of a married couple with children, with another 22% being married with no children.

Q11: Which of the following best describes your household?



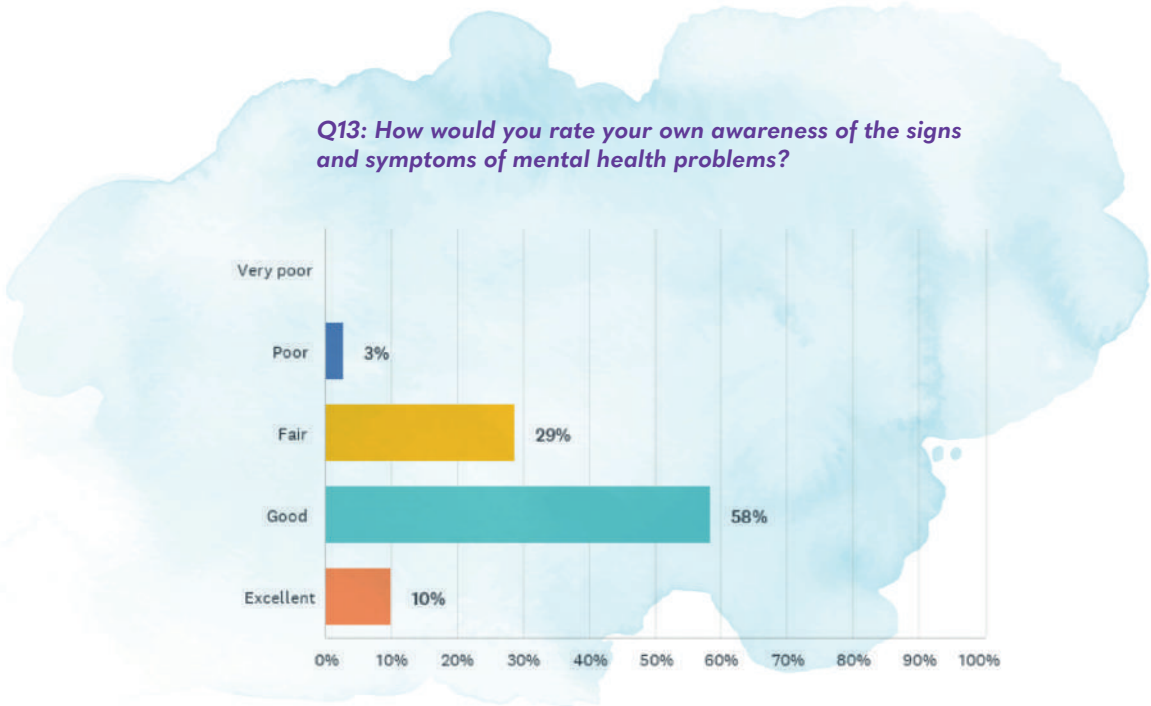
CQ12: Are you registered disabled?

3% of respondents reported being registered as disabled.



CQ13: How would you rate your own awareness of the signs and symptoms of mental health problems?

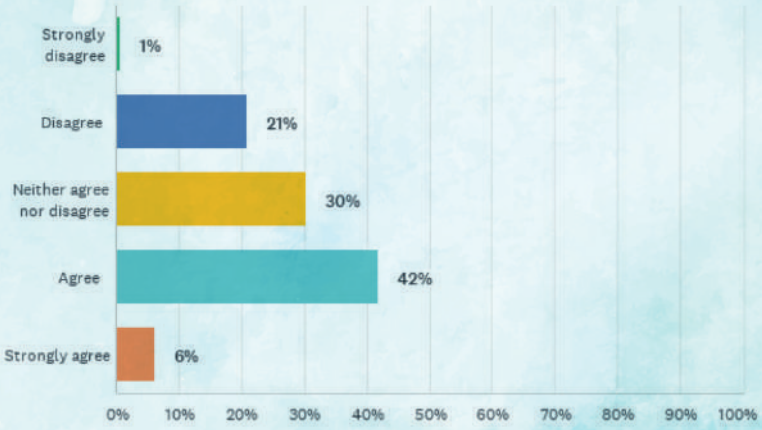
Over two-thirds (68%) of respondents rated the awareness of the signs and symptoms of mental health as either good (58%) or excellent (10%).



CQ14: I have enough knowledge to support a member of my congregation with a mental health issue

Almost half (48%) of respondents either agreed (42%) or strongly agreed (6%) that they had enough knowledge to support a parishioner with a mental health issue. That compares strikingly to the less than a quarter (22%) who disagreed or strongly disagreed.

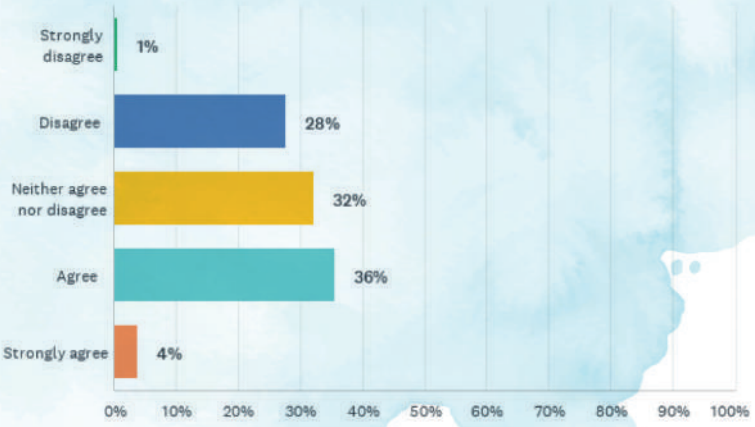
Q14: I have enough knowledge to support a member of my congregation with a mental health issue



CQ15: I have the appropriate skills to support a member of my congregation with a mental health issue

40% of respondents in total either agreed (36%) or strongly agreed (4%) that they had the appropriate skills to support a parishioner with a mental health issue. By contrast, 29% either disagreed (28%) or strongly disagreed (1%).

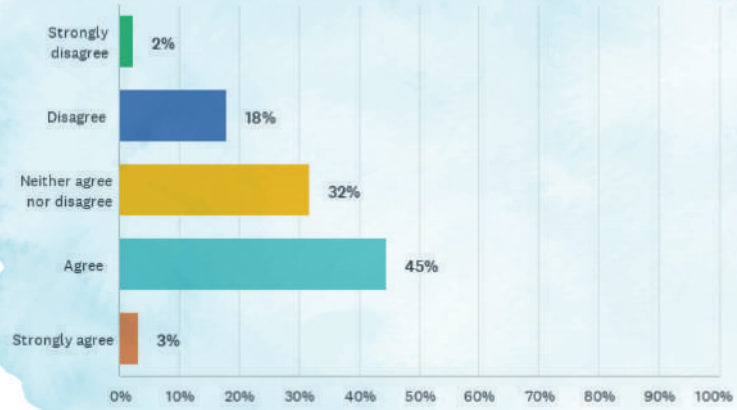
Q15: I have the appropriate skills to support a member of my congregation with a mental health issue



CQ16: I have the confidence to support a member of my congregation with a mental health issue

Just under half of respondents (48%) reported having the confidence to support a parishioner with a mental health issue. This is more than twice the number (20%) who felt they did not have the confidence, with a further 32% neither agreeing nor disagreeing with the statement.

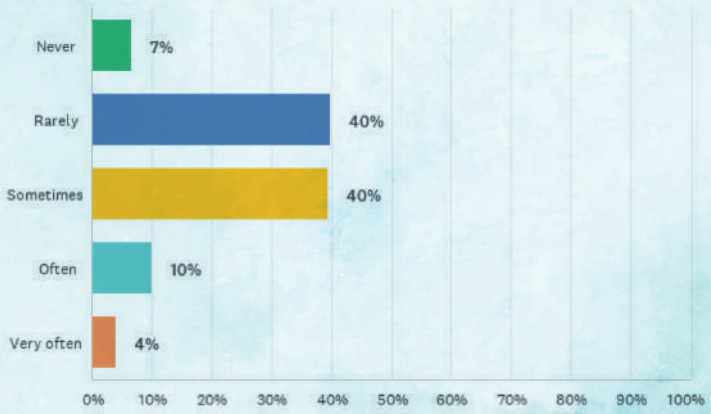
Q16: I have the confidence to support a member of my congregation with a mental health issue



CQ17: How often does a member of your congregation come to you for support, guidance or advice about their own mental health?

Almost half of respondents (47%) stated that members of their congregation approach them about mental health issues either never (7%) or rarely (40%). Only 17% reported being approached often (10%) or very often (4%), with 40% being approached sometimes.

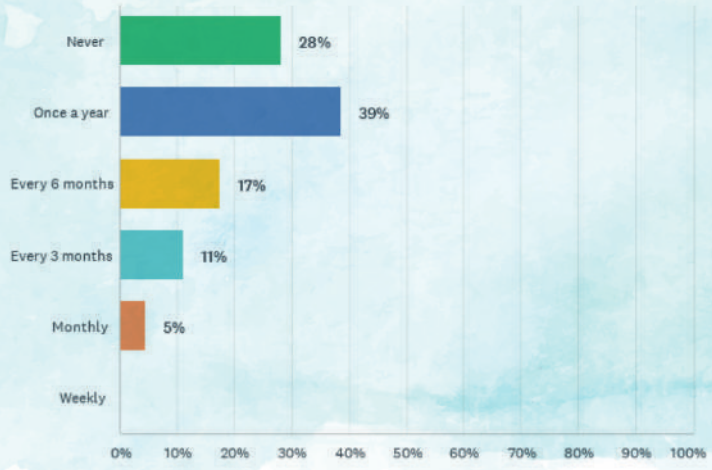
Q17: How often does a member of your congregation come to you for support, guidance or advice about their own mental health?



CQ18: How often would you signpost a member of your congregation to mental health supports or services?

More than two thirds of respondents (67%) signpost mental health supports or services to members of their congregation either once a year (39%) or never (28%). The remaining one third signpost services twice a year (17%), quarterly (11%) or monthly (5%).

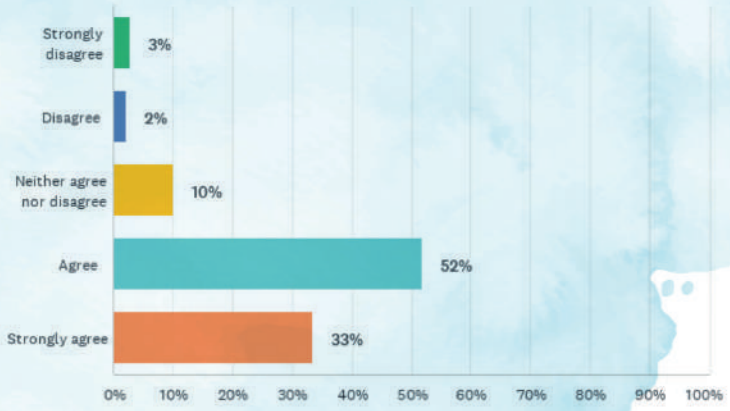
Q18: How often would you signpost a member of your congregation to mental health supports or services?



CQ19: It is the responsibility of the Church to support people with mental health issues

A very significant majority (85%) of clergy either agreed (52%) or strongly agreed (33%) that the Church has a responsibility to support people with mental health issues. Only 5% either disagreed (2%) or strongly disagreed (3%), with the remaining 10% neither agreeing nor disagreeing.

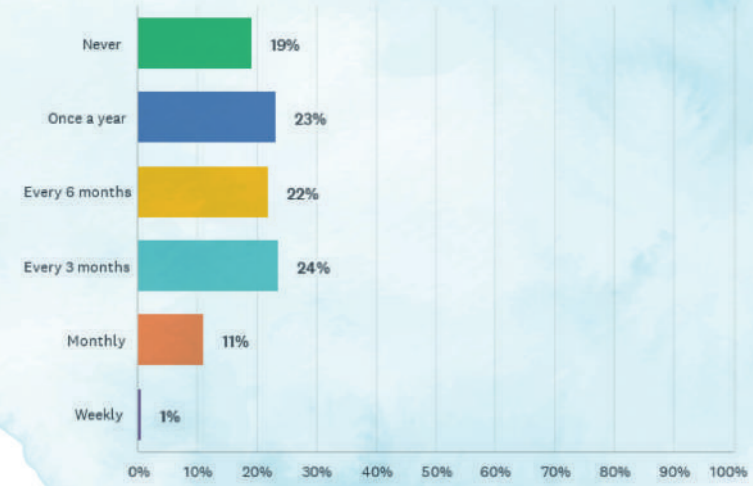
Q19: It is the responsibility of the Church to support people with mental health issues



CQ20: How often do you refer to mental health and mental health issues in your sermons?

Less than half (42%) of respondents reported referring to mental health in their sermons either never (19%) or once a year (23%). The other respondents do so either twice a year (22%), four times a year (24%) or more frequently (12%). By contrast the LifeWay Study (2016)[17] study found that 66% of clergy referred to mental health once a year or less

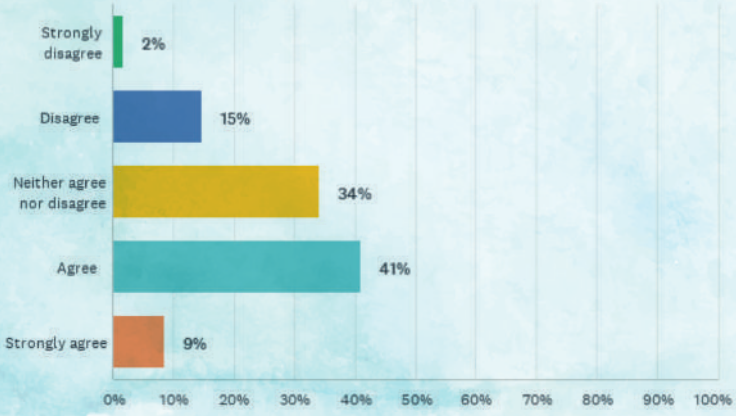
Q20: How often do you refer to mental health and mental health issues in your sermons?



CQ21: Stigma of mental health issues is common in the Church of Ireland *(Stigma is when someone sees a person in a negative way because of their mental health issues).*

Half of our respondents either agreed (41%) or strongly agreed (9%) that stigma of mental health issues is common in the Church. This is almost three times the number (17%) who either disagreed (15%) or strongly disagreed (2%). Just over one third (34%) neither agreed nor disagreed.

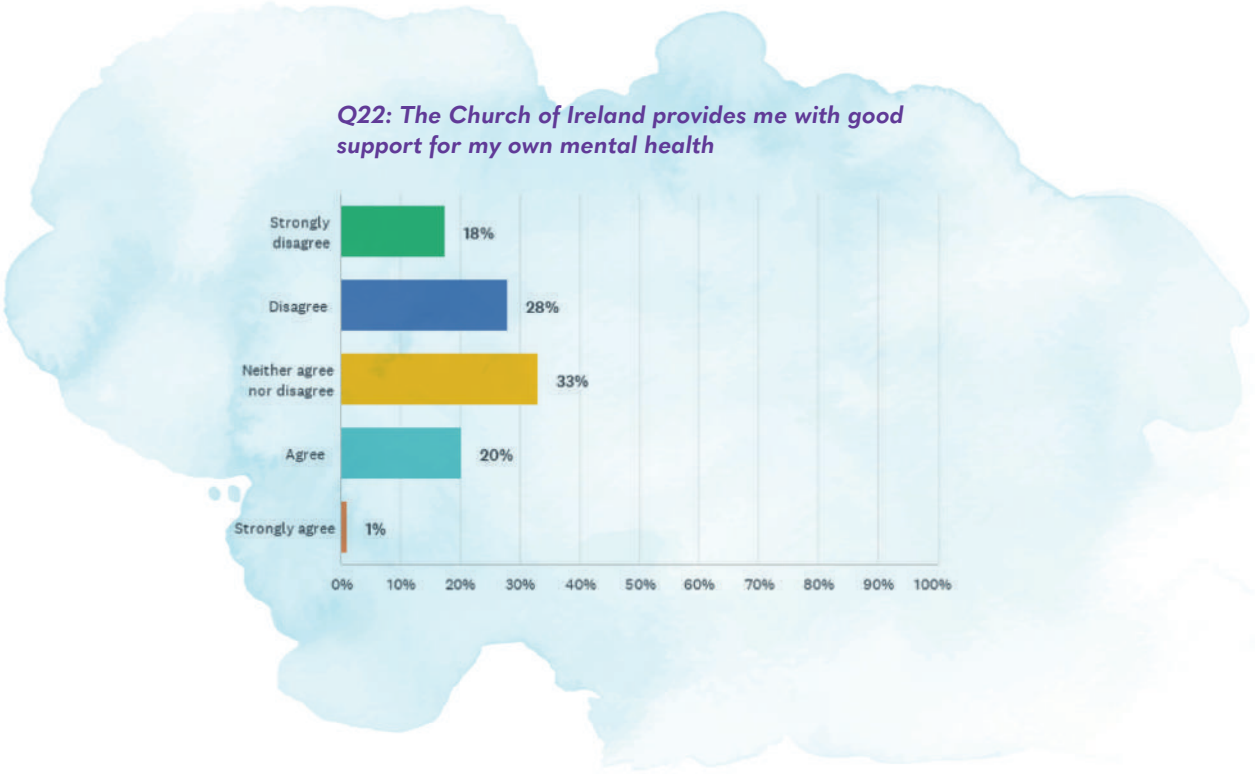
Q21: Stigma of mental health issues is common in the Church of Ireland



[17] *Lifeway (2016). The study of acute mental illness and Christian faith. Lifeway. Nashville*

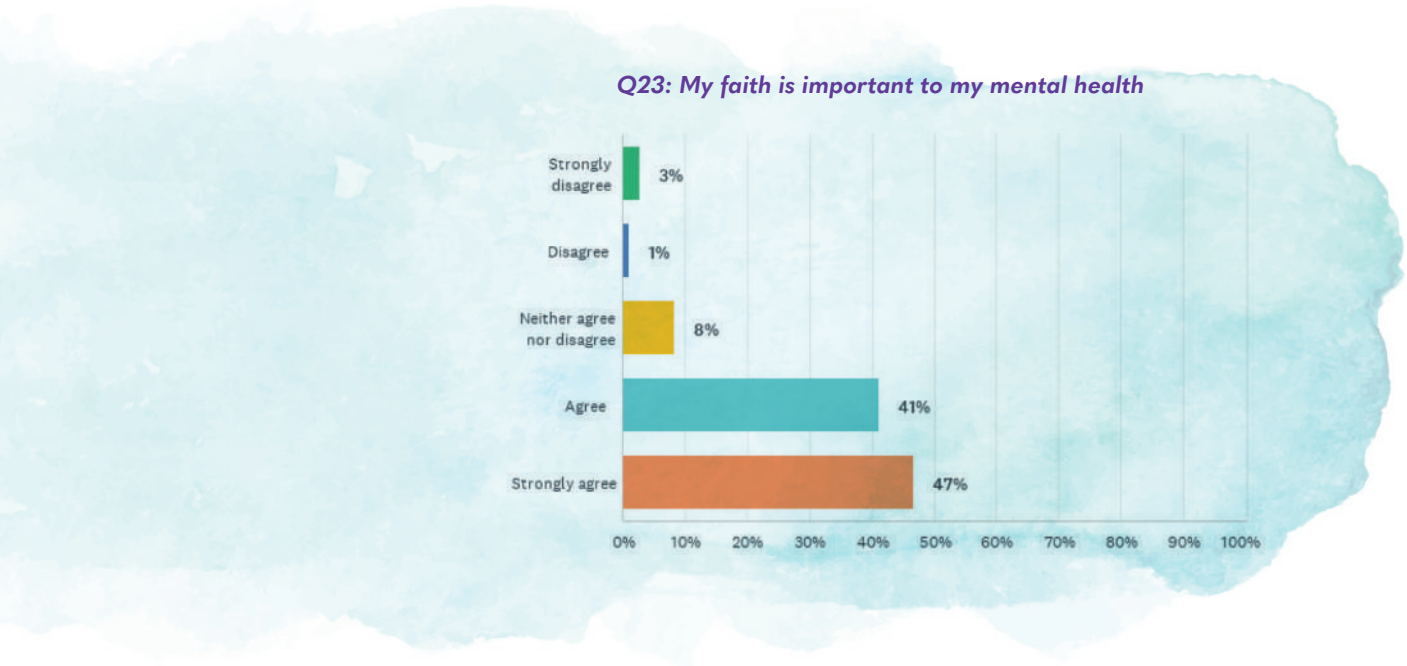
CQ22: The Church of Ireland provides me with good support for my own mental health

Just under half (46%) of clergy either disagreed (28%) or strongly disagreed (18%) that the Church provided them with good support for their own mental health. This was more than twice the number (21%) who either agreed (20%) or strongly agreed (1%). One third (33%) neither agreed nor disagreed.



CQ23: My faith is important to my mental health

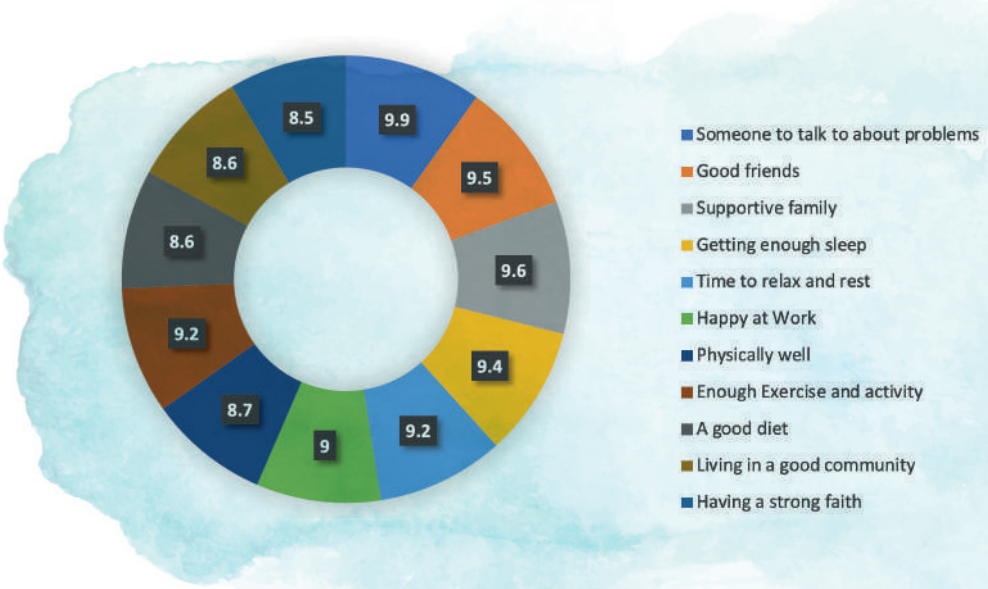
A very large majority (88%) either agreed (41%) or strongly agreed (47%) that their faith was important to their mental health. Only 4% either disagreed (1%) or strongly disagreed (3%) with 8% neither agreeing nor disagreeing.



SECTION TWO: YOUR THOUGHTS ON MENTAL HEALTH

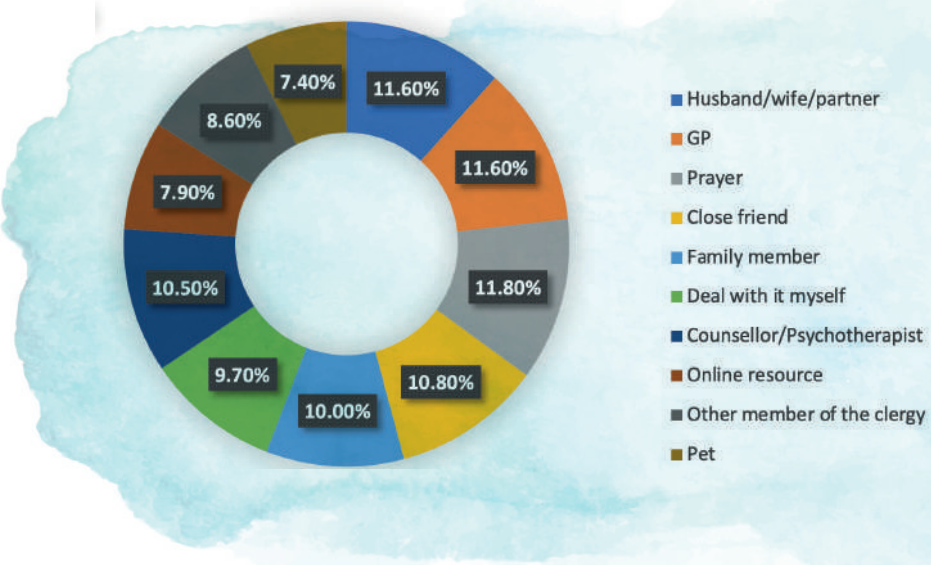
CQ24: How important are the following for good mental health?

Physical factors were cited by almost two thirds (36%) of respondents. These consisted of getting enough sleep (9.4%), being physically well (8.7%), getting enough exercise (9.2%) and having a good diet (8.6%). Personal relationships were chosen by 29%, broken down into someone to talk to (9.9%), good friends (9.5%) and supportive family (9.6%). Having a strong faith was chosen by 8.5% of respondents.



CQ25: If you thought you had a mental health issue, which of these would you be likely to seek support from?

Prayer was selected by 11.8% of respondents, making it the most popular choice for support. However, 32% chose their spouse (11.6%), a close friend (10.8%) or a family member (10%). Almost one quarter (22%) chose a medical professional, either a GP (11.6%) or a counsellor (10.5%).



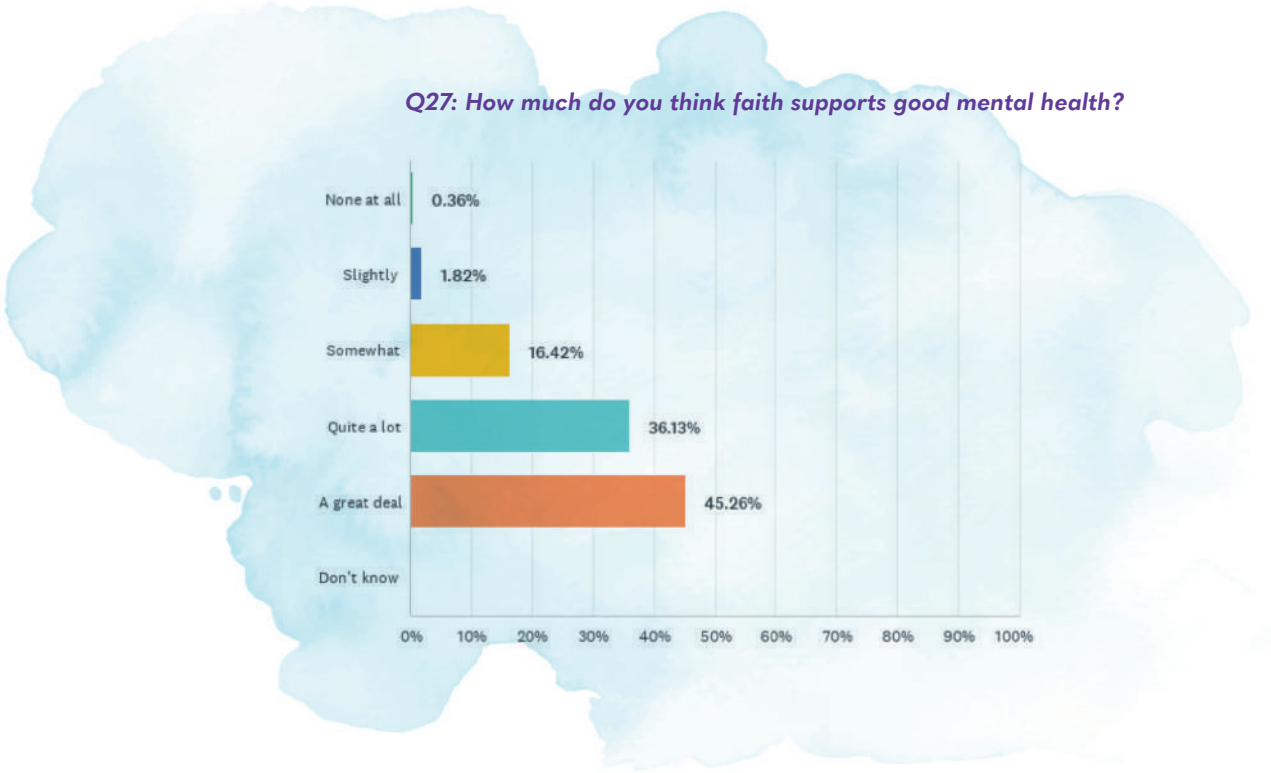
CQ26: Which of these organisations/resources have you heard of?
(tick as many as you think are relevant)

The Samaritans was recognised by almost all respondents (99%). Aware was recognised by 70% making it the only other organisation recognised by more than half the clergy. The top nine organisations recognised are:

Organisation/Resource	% of clergy who knew of the organisation
Samaritans (All Ireland)	99
Aware (All Ireland)	70
Lifeline NI (NI)	40
Jigsaw (ROI)	34
Mental Health Ireland (ROI)	33
Action Mental Health (NI)	33
PIPS (ROI)	24
Yourmentalhealth.ie (ROI)	24
Mindyourhead.info (NI)	21

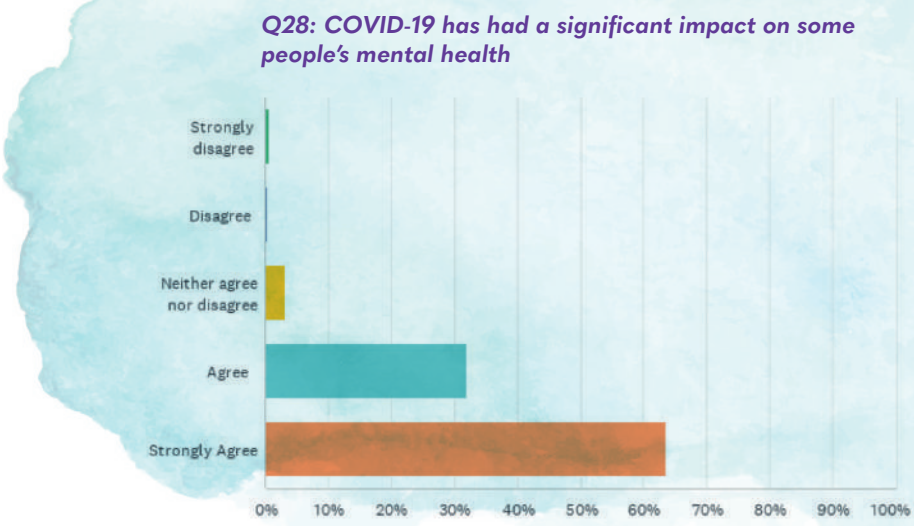
CQ27: How much do you think faith supports good mental health?

Over three quarters of clergy (81%) felt that faith supports mental health either a great deal (45%) or quite a lot (36%). Only 16% of respondents felt faith somewhat supported mental health and another 2% that it did so slightly.



CQ28: COVID-19 has had a significant impact on some people's mental health

Almost all clergy (98%) either agreed (32%) or strongly agreed (63%) that COVID-19 has had an impact on some people's mental health.



CQ29: Have you ever attended a training course for helping others with a mental health issue?

There was quite an even split between respondents who had (43%) and had not (57%) attended such a course. Among those who had attended courses, Church-related courses were attended by 22%, 16% participated in a mental health first aid or psychological first aid course, 15% went to other NGO courses relating to mental health and 14% stated they had attended ASIST or other suicide prevention training courses.

Course	%
ASIST/other suicide prevention courses (C29AS)	14%
AWARE course (C29AW)	3%
Counselling/therapy (C29CT)	2%
Continuous professional development (C29CPD)	2%
Church related course (C29CRC)	22%
Mental health first aid/psychological first aid (C29MHFA)	16%
NGO Course (C29NGO)	15%
Other (C29O)	10%
Safetalk (C29ST)	4%
Third level course (part of) (C29TL)	8%
WRAP (C29WRAP)	2%

CQ30: Have you ever attended a training course about mental health awareness?

Responses were similar to those in the previous question, with 47% having attended training and 53% not. For those who had attended training Church-based training mental health awareness courses were the most popular (29%), 13% stated they had attended ASIST or other suicide prevention training courses. 7% attended a mental health first aid or psychological first aid course, and 8% participated in other NGO courses relating to mental health.

Course	%
ASIST/other suicide prevention courses (C30AS)	13%
AWARE course (C30AW)	3%
Counselling/therapy (C30CT)	3%
Continuous professional development (C30CPD)	5%
Church related course (C30CRC)	29%
Employer (C30E)	2%
Health Service/NHS (C30HSO)	7%
Mental health first aid/psychological first aid (C30MHFA)	7%
NGO Course (C30NGO)	8%
Other (C30O)	8%
Safetalk (C30)	3%
Third level course (part of) (C30TL)	8%
WRAP (C30WRAP)	2%

"THE RESPONSE AND ATTITUDE OF THE CHURCH TO MENTAL HEALTH SUFFERING MAY BE TO PROVIDE A PERSPECTIVE OF HOPE, RELIEF, COPING, OR MEANING IN LIFE."

BRAAM, 2017

"THE LOCAL CHURCH IS A PLACE WHERE PEOPLE CAN CONNECT WITH OTHERS AS WELL AS RECEIVE ASSISTANCE, WARMTH AND KINDNESS PARTICULARLY DURING TIMES OF DISTRESS."

GALLET, 2016

SECTION THREE: SARAH'S STORY

Sarah's Story, a vignette approach, was used to explore attitudes to mental health in the survey. Vignettes are short stories about a hypothetical person, traditionally used within research on sensitive topics. Sarah's story was created using best practice guidelines in developing a story that respondents reviewed then were asked questions about.

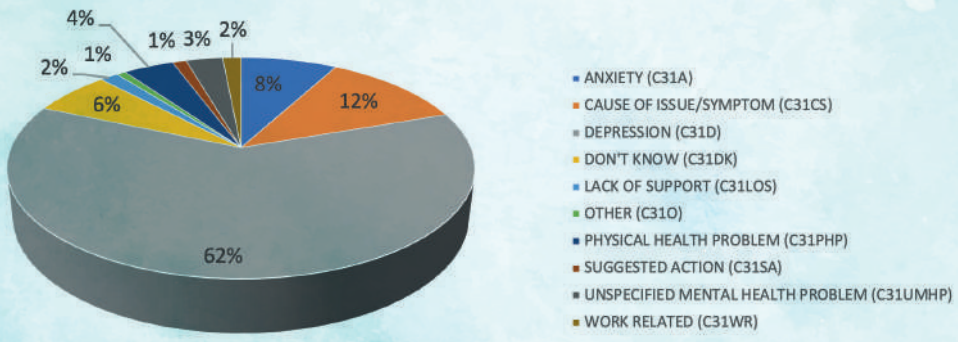
Sarah's Story. We are interested in your thoughts about Sarah's story. Please read her story and answer the following questions.

Sarah, aged 25 and a member of the Church of Ireland, has been feeling unusually unhappy for the last few weeks. She is always tired and has lost her appetite. She has noticeably lost weight as she doesn't feel like eating most of the time. Focusing on her work is a real struggle as she has lost interest in her job which she previously enjoyed, and her performance at work has dropped recently. She is not joining the weekly online church services as often as she used to and her friends in the select vestry are concerned about her. Her other friends and colleagues have also noticed some of the changes and they are worried for her. Sarah is putting off making any decisions and even day to day tasks can seem too much for her, taking a lot of effort to complete. Sarah has stopped going to the gym and walking with her friend and feels guilty about this all the time. Sarah's family is very concerned.

CQ31: What, if anything do you think is Sarah's issue?

Overall there was a clear understanding by the large majority of respondents that Sarah's issue was likely to be depression, with 62% of responses reporting depression. This compares to 51% of members who identified depression as the key issue.

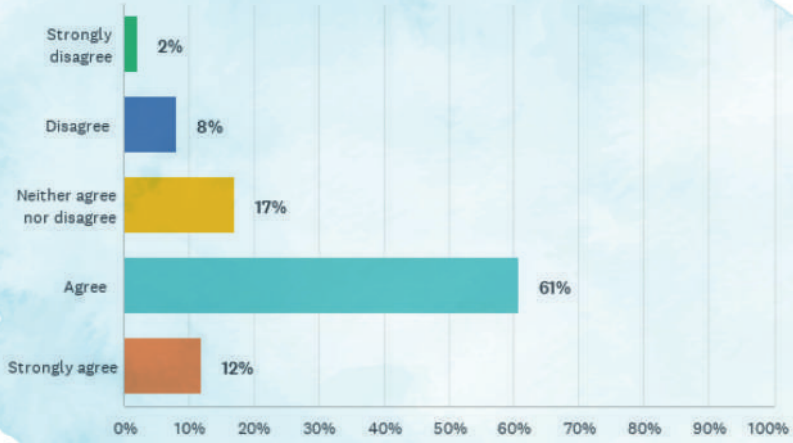
Q31: What, if anything do you think is Sarah's issue?



CQ32: I would know where to get help in my local area if I was having the same experience as Sarah

The vast majority of clergy (73%) stated that they would know where to get help in their local area if they were struggling with the same experience as Sarah (61% agreed, 12% strongly agreed). The literature suggests that the Church could play a role in signposting information following the TEACHER mental health initiative (Grcevich, 2018) which includes providing a welcoming environment, good communication and offering education and support to members.

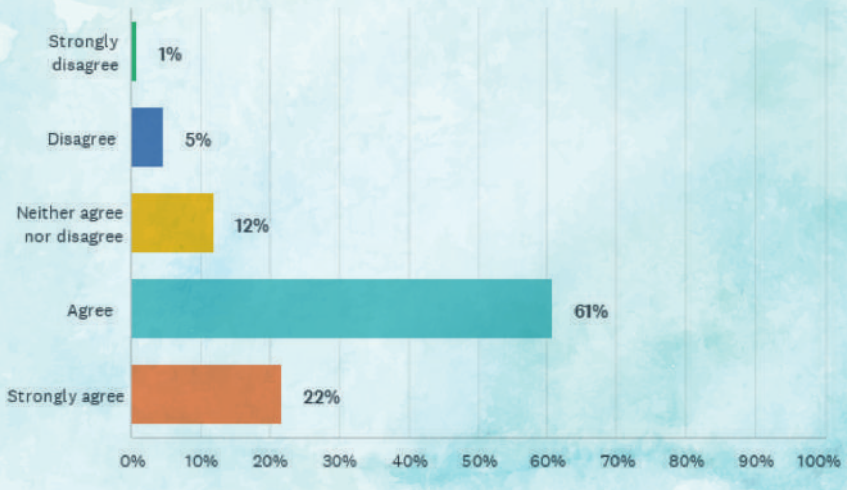
Q32: I would know where to get help in my local area if I was having the same experience as Sarah



CQ33: If I was feeling like Sarah, I would seek help from my GP or a mental health professional

83% of respondents either agreed or strong agreed that they would seek help from their GP or a mental health professional if they were feeling like Sarah. Accessing the correct pathways of support is a crucial part of mental health recovery.

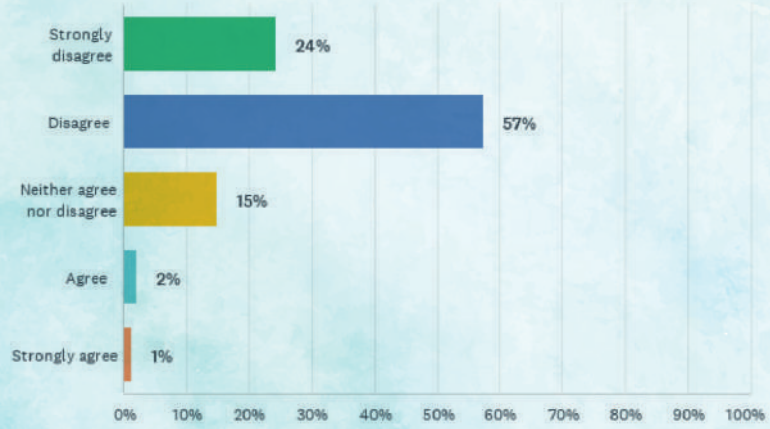
Q33: If I was feeling like Sarah, I would seek help from my GP or a mental health professional



CQ34: I think Sarah is experiencing normal everyday ups and downs

81% of respondents disagreed or strongly disagreed with this statement. This suggests that respondents may have a reasonable understanding and awareness of symptoms of poor mental health and corresponds with the literature[18] which suggests that educating faith communities to increase mental health literacy and awareness is increasingly important.

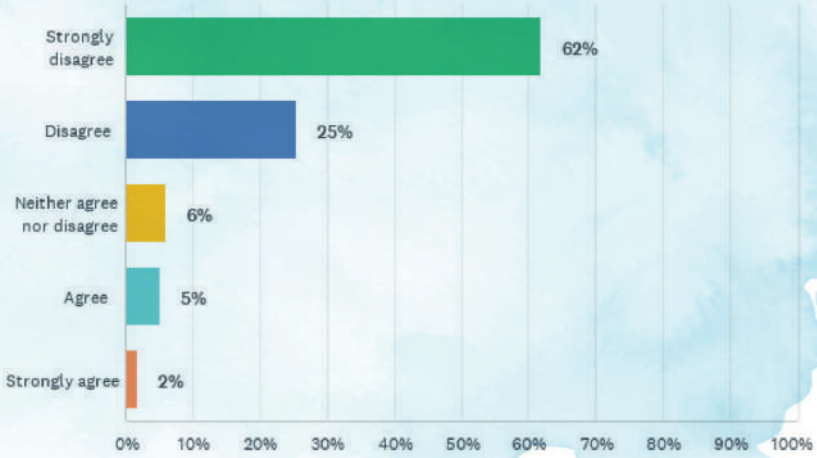
Q34: I think Sarah is experiencing normal everyday ups and downs



CQ35: Seeing a GP or mental health professional for an issue like Sarah's means you are not strong enough to manage your own difficulties

62% of clergy respondents strongly disagreed that seeing a GP or mental health professional for an issue like Sarah's meant that you were not 'strong' enough to manage your own difficulties. A further 25% disagreed (87% in total). Myths about strength and weakness are part of what makes mental health stigma so challenging.

Q35: Seeing a GP or mental health professional for an issue like Sarah's means you are not strong enough to manage your own difficulties

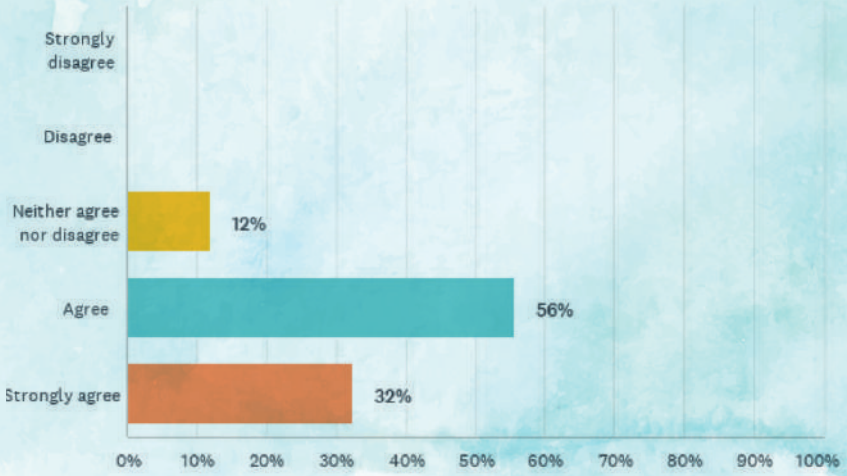


[18] *Meadows Mental Health Policy Initiative*

CQ36: I think treatment provided by a GP or mental health professional would be helpful for Sarah

There was practically unanimous agreement that treatment provided by a GP or mental health professional would be helpful for Sarah with no respondents disagreeing.

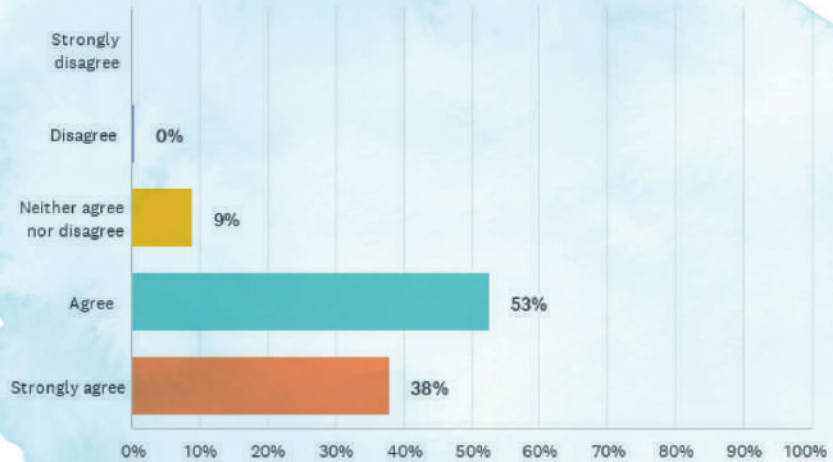
Q36: I think treatment provided by a GP or mental health professional would be helpful for Sarah



CQ37: If I was feeling like Sarah, it would be good to seek help from a GP or mental health professional

Similar to the previous graph, there was almost universal agreement from clergy respondents that it would be good to seek help from a GP or mental health professional if they were feeling like Sarah.

Q37: If I was feeling like Sarah, it would be good to seek help from a GP or mental health professional



CQ38: Where do you think Sarah can find out information about how she is feeling? [Think about and list where you might source information for mental health issues]

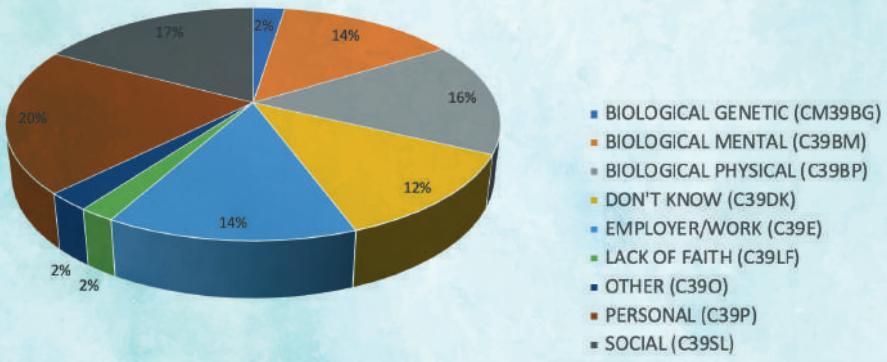
47% of clergy stated that someone like Sarah should seek help primarily from her GP, and 19% suggested she might seek online support or gain information from an online resource. 13% reported that support from the Church and the Church community would be useful. The breakdown of the top five information sources can be seen below.

RESPONSE	%
GP (C38GP)	47%
ONLINE SUPPORT (C38OS)	19%
CHURCH (C38C)	13%
CHARITY/NGO (C38CH)	11%
HEALTH SERVICE OTHER (C38HSO)	5%

CQ39: What, if any, do you think are the causes of how Sarah is feeling? [List any personal, social, or biological causes you can think of]

20% of clergy indicated that the cause of Sarah's issue was personal with a range of possible personal reasons or circumstances given. 17% stated cause might be socially based linked to isolation, lack of connection, loss of connection. 49% of this group linked the lack of connection to lockdown and COVID 19. 16% reported that Sarah's issue might be caused by physical issues such as thyroid problems or underlying physical health conditions.

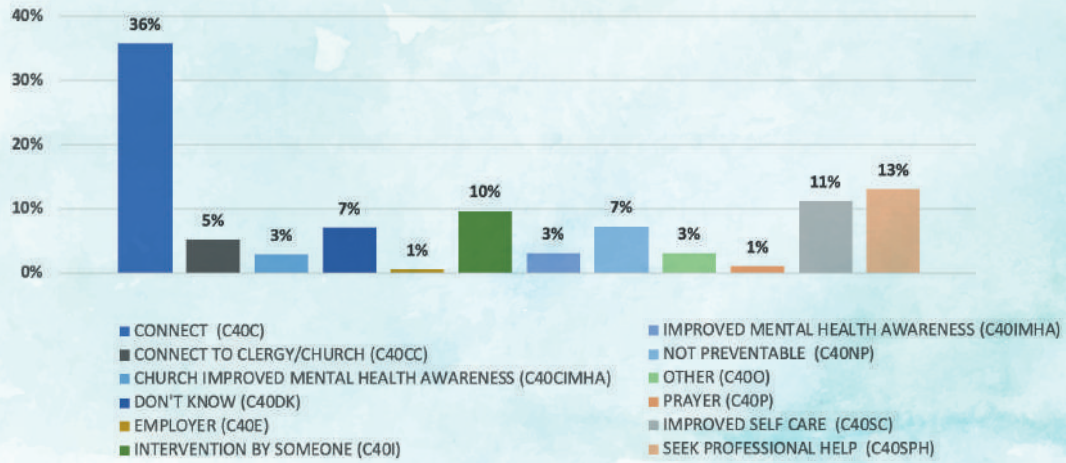
Q39: What, if any, do you think are the causes of how Sarah is feeling?



CQ40: How, if at all, do you think Sarah's issue might have been prevented?
[Think about things that Sarah or others can do to stop issue/s like this from happening]

36% of respondents believe that connecting with people might have prevented Sarah's issue (compared to 45% of members), with 13% saying that Sarah should have sought professional help. 11% felt that improved self-care would have helped (compared to 21% of members), and 10% that someone should have intervened. 5% suggested connecting with a clergy member might have prevented the issue.

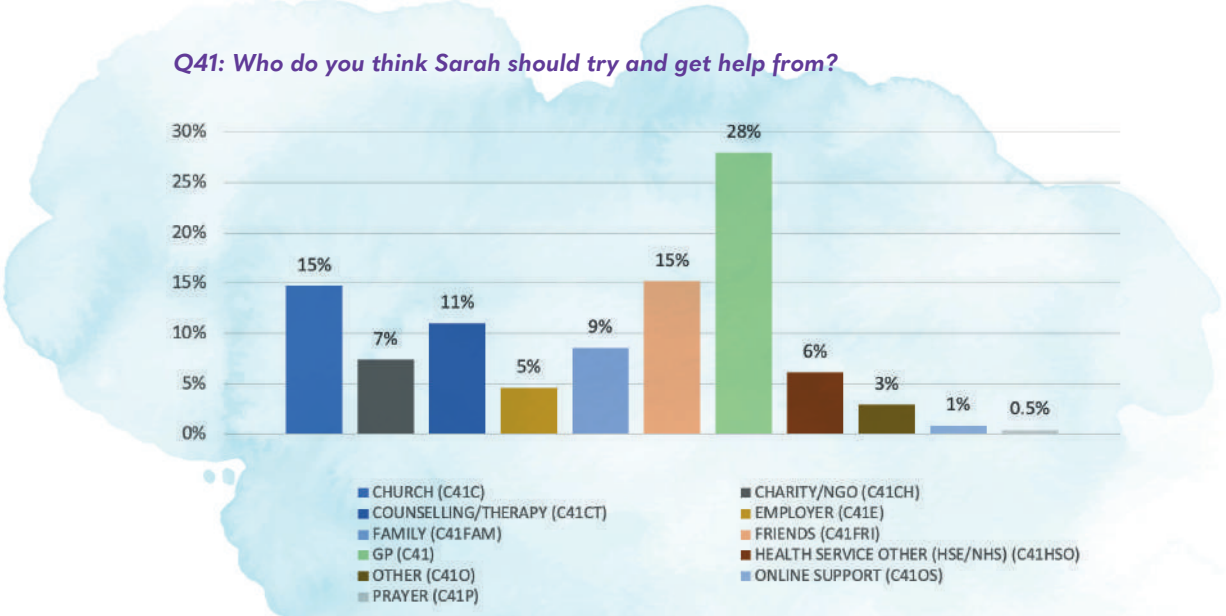
Q40: How, if at all, do you think Sarah's issue might have been prevented?



CQ41: Who do you think Sarah should try and get help from?
[Think about any professionals and any non-professionals that you think might be able to help]

28% of respondents suggested Sarah should try and get help from her GP, with 15% suggesting she should turn to her friends or the Church, and 9% suggesting she should turn to her family. Interestingly, this differs from what members reported, with 43% of members suggesting Sarah should try and get help from her GP.

Q41: Who do you think Sarah should try and get help from?



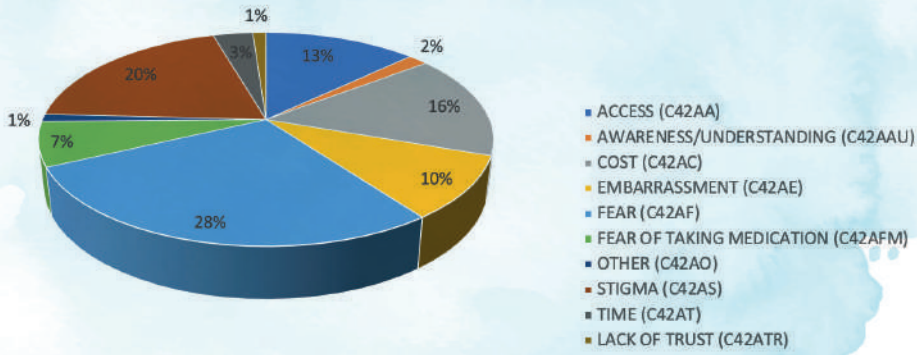
CQ42: What do you think might stop Sarah from seeking help for how she is feeling from the following people?

Overall respondents cited fear and stigma as the main reasons for not seeking help from anyone.

Healthcare professionals

28% cited fear, with stigma mentioned by 20% and cost by 16%. 13% said that access to services/ support as a reason and 10% embarrassment.

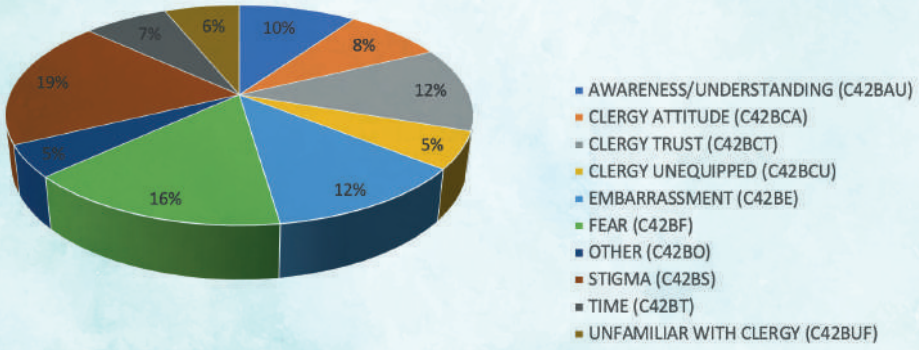
Q42A: What do you think might stop Sarah from seeking help for how she is feeling from healthcare professionals?



Member of clergy

Stigma (19%) was the most cited reason for not approaching a clergy member, followed by fear (16%) and embarrassment (12%).

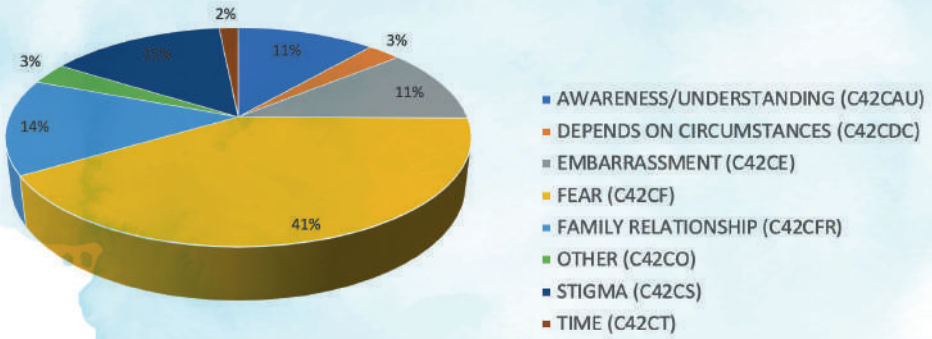
Q42B: What do you think might stop Sarah from seeking help for how she is feeling from the Clergy?



Family

Fear was the predominant reason respondents thought Sarah would not seek help from family (41%), followed by stigma (15%) and then family relationships (14%).

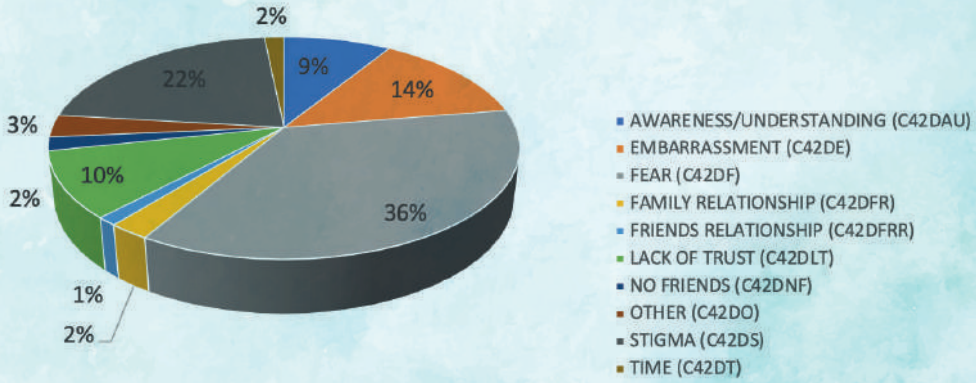
Q42C: What do you think might stop Sarah from seeking help for how she is feeling from her family?



Friends

Fear was the most cited reason for not seeking help from friends (36%), followed by stigma (22%) and embarrassment (14%).

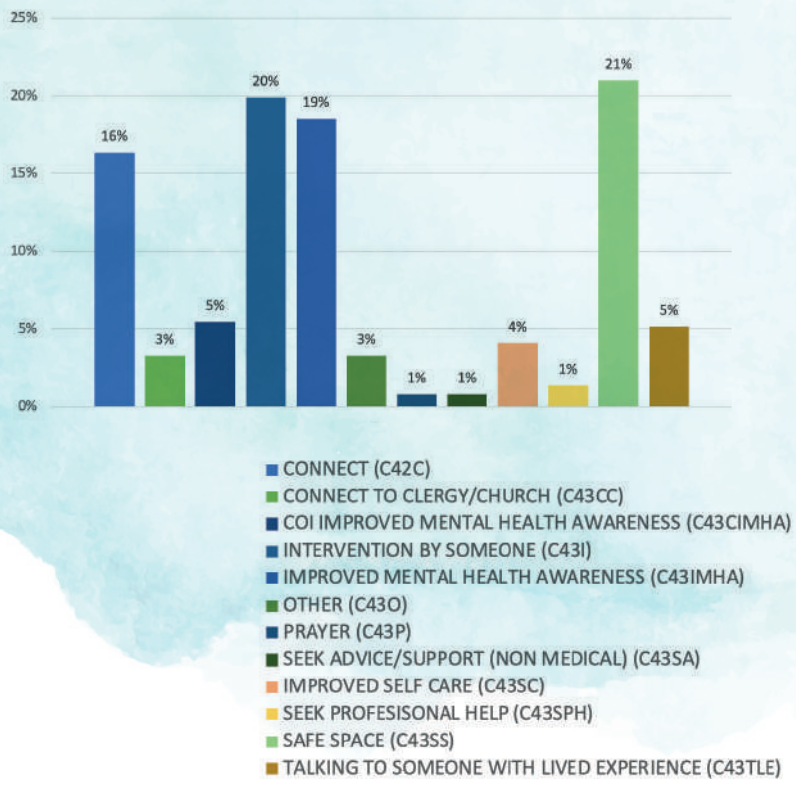
Q42D: What do you think might stop Sarah from seeking help for how she is feeling from her friends?



CQ43: What do you think might help Sarah to talk about how she is feeling?

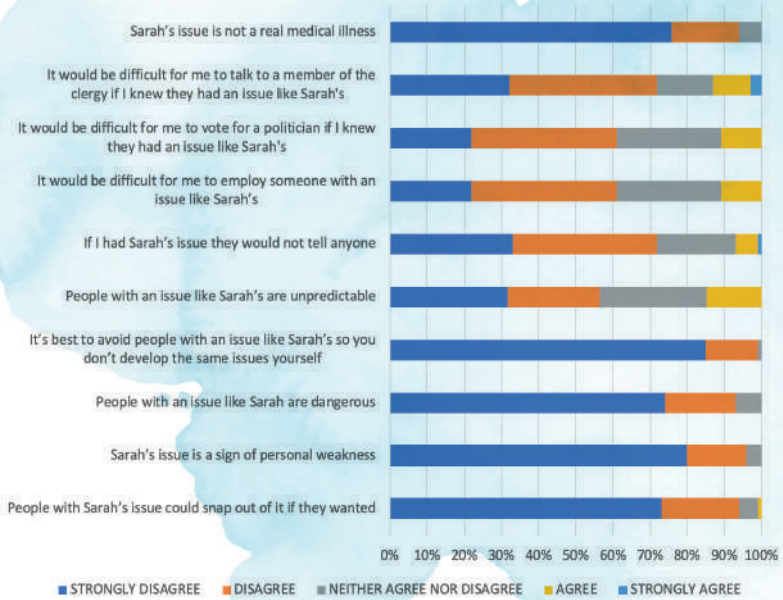
Respondents said providing a safe space for Sarah (21%) would help Sarah to talk, followed by a direct intervention (20%), and improved mental health awareness (19%). Connecting with others was also mentioned by 16% of respondents.

Q43: What do you think might help Sarah to talk about this issue?



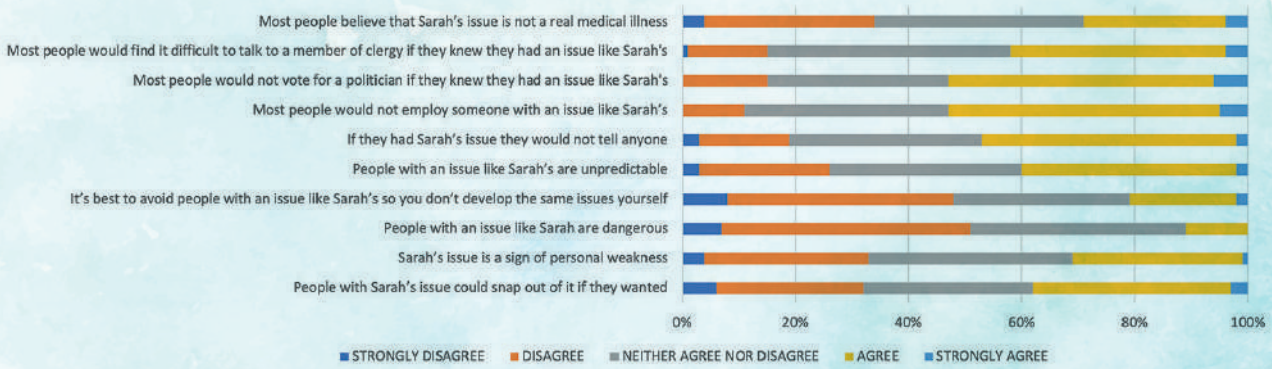
CQ44: To what degree do you agree with the following statements? This question is asking what YOU think about Sarah.

This question gave respondents an opportunity to give their own view i.e. agree or disagree with 10 statements. The vast majority of respondents recognised this was a real medical illness, that there was no need to avoid people suffering in this way, it was not a sign of personal weakness, people couldn't snap out of it if they wanted and they weren't dangerous. There was less certainty about talking to a member of the clergy if the cleric was struggling from mental health issues. Similarly employing, voting for someone or they themselves telling someone else about their own mental health problems. Unpredictability was also seen as a possible issue with 29% of respondents neither agreeing nor disagreeing that people with issues like Sarah's are unpredictable.



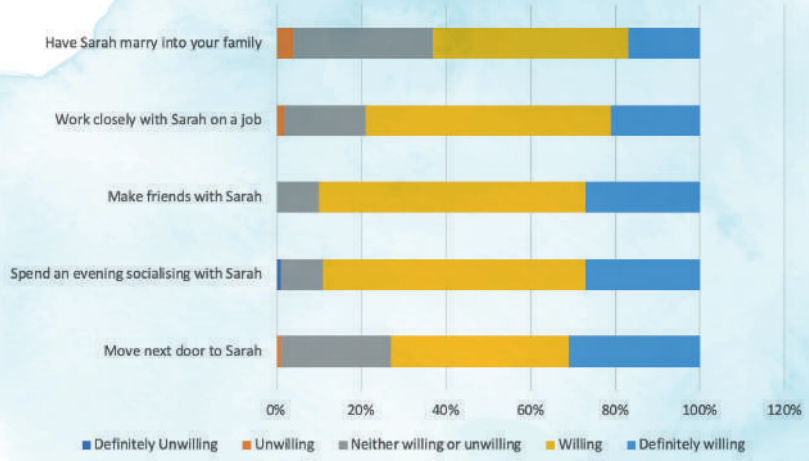
CQ45: To what degree do you agree with the following statements? This question is asking what you think OTHER PEOPLE might think about Sarah

The answers to this same question are in some contrast to the answers provided for the previous question and focus on how they imagine 'other people' would answer the same questions. For example, 93% of clergy said they believed Sarah's issues were a real medical illness. Only 34% however believed that others would view it that way. There was also significantly more 'neither agree nor disagree' answers.



CQ46: How willing or unwilling would you be to engage with Sarah in the following situations?

This question asked respondents how willing they would be to engage with someone struggling with the issues that Sarah has, in a number of different situations. For the majority these issues would not prevent engagement in any context. That said, marriage, close working and living next door with Sarah were seen as potentially more of an issue by respondents with for example 33% being neither willing nor unwilling to have Sarah marry into the family and 26% of respondents being neither willing nor unwilling to move next door to Sarah.



REFERENCES

American Psychiatric Association (2018). *Interventions for first responders show promise.* APA. Washington.

Appleby, L., Kapur, N. & Shaw, J. (2019). *National confidential inquiry into suicide and safety in mental health.* Manchester.

Barns (2020). *The state of the Church.* Barna Group. California.

Beck, U. (2010) *A God of one's own: religion's capacity for peace and potential for violence,* Polity, Cambridge.

Bentzen, J. (2020). *In crisis, we pray: Religiosity and the COVID-19 pandemic.* Dissertation. University of Copenhagen.

Betts, J. & Thompson, J. (2017). *Mental health in Northern Ireland: Research and Information Service Research Paper.* Northern Ireland Assembly. Belfast.

Braam. A.W., Koenig. H.G. (2019). *Religion, spirituality and depression in prospective studies: A systematic review.* J Affect Disord. 1;257:428-438. doi: 10.1016/j.jad.2019.06.063. Epub 2019 Jul 2. PMID: 31326688.

Bryan, K., Haynes, T. & Hartwig, M. (2014). *A rural African American Faith community's solution to depression disparities.* Public Health Nursing; 31 (3). 262-272.

Bunting, B. P., Ferry, F. R., Murphy, S. D., O'Neill, S. M., & Bolton, D. (2013). Trauma associated with civil conflict and posttraumatic stress disorder: evidence from the Northern Ireland study of health and stress. *Journal of Traumatic Stress, 26*(1), 134-141.

Costello, J. & Hays, L. & Gamez, A. (2020). *Using mental health first aid to promote mental health in churches.* Journal of Spirituality in Mental Health. 1-12. 10.1080/19349637.2020.1771234.

Dein, S., Cook, C.C.H. & Koenig, H.G. (2012). *Religion, spirituality, and mental health: Current controversies and future directions, Journal of Nervous and Mental Disease,* 200, 10, pp. 852-855.

Department of Health (2020). *Sharing the vision: A mental health policy for everyone.* Government of Ireland, Dublin.

Eurostat (2017). *Key figures on Europe.* Publications office of the European Union. Luxembourg.

Gallet, W. (2016). *Social connectedness: the role of the local church in building community.* Pointers. 26. 1-4.

Grcevich, S. (2018). *Mental health and the church; A ministry handbook for including families impacted by mental illness.* E.Publications.

Heenan, D., & O'Neill, S. (2019). *Review of Mental Health Policies in Northern Ireland: Making Parity a Reality.* Ulster University.

Henderson, L.K., Craig, J.C., Willis, N.S., Tovey, D. and Webster, A.C. (2010). *How to write a Cochrane systematic review.* Nephrology, 15: 617-624. doi:10.1111/j.1440-1797.2010.01380.x

Holt, C. & McClure, S. (2013). *Perceptions of the religion health connections among African American church lay members.* Qualitative Health Research; 16 (2). 268-281.

Lee, S. A. (2020). *Coronavirus anxiety scale: A brief mental health screener for COVID-19 related anxiety. Death Studies, 44*(7), 393–401. https://doi.org/10.1080/07481187.2020.1748481.

Lifeway (2016). *The study of acute mental illness and Christian faith*. Lifeway. Nashville.

OECD (2018). *Health at a glance: Europe*. State of health in the EU cycle. Paris.

O'Neill, S. & O'Connor, R. (2020). Suicide in Northern Ireland: *Epidemiology, risk factors and prevention*. The Lancet. Psychiatry, 538-546, (7). DOI: 10.1016/S2215-0366(19)30525-5

O'Neill S, Rooney N. (2018). *Mental health in Northern Ireland: an urgent situation*. Lancet Psychiatry (12):965-966. doi: 10.1016/S2215-0366(18)30392-4. Epub 2018 Nov 8. Erratum in: Lancet Psychiatry. 2019 Jan;6(1):e2. PMID: 30415937.

Page M J, McKenzie J E, Bossuyt P M, Boutron I, Hoffmann T C, Mulrow C D et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews BMJ 2021; 372 :n71 doi:10.1136/bmj.n71

Pargament, K. I. (2013). *What Role do Religion and Spirituality Play in Mental Health?* The American Psychological Association. Washington.

Peterson. J., Atwood. J.R., Yates B. (2002). *Key elements for church-based health promotion programs: outcome-based literature review.* Public Health Nurs. Nov-Dec;19(6):401-11. doi: 10.1046/j.1525-1446.2002.19602.x.

Pew Forum on Religion and Public Life (2008). The Pew Research Centre. Washington.

Puttick, R. & Ludlow, J. (2012). *Standards of Evidence for Impact Investing: NESTA Framework*. NESTA. London.

Putnam, R. (2000) *Bowling Alone: The Collapse and Renewal of American Community,* Simon and Schuster, New York.

Reese, B.R. (2019). *Mental health care at Church and beyond.* Equip Press. New York.

Ryan, B. (2018), T*he Church and mental health: theological and practical responses*. Zygon®, 53: 409-426. https://doi.org/10.1111/zygo.12417

Schneider, J. (2006). *Social Capital and Welfare Reform*. New York Chichester, West Sussex: Columbia University Press. https://doi.org/10.7312/schn12650.

Scowcroft, E. (2017). *Suicide statistics report 2017.* London, UK: Samaritans.

Stetzer, E. (2016). *The Christian struggle with mental illness*. Christianity Today.

Williams. D., Gonzalez. H., Neighbors, H., Nesse, R., Abelson, J., Sweetman, J. (2014). *Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites*. Archives of General Psychiatry.64:305–315

World Mental Health Survey (2018). *Harvard World Mental Health Initiative*. Harvard, Massachusetts.

NOTES

The Church of Ireland is working in partnership with existing community and statutory services. Information, support and assistance can be found on the project website.

MindMatters COI

For further information, please contact the project team by:

Email: **mhp@rcbdub.org**
Visiting the MindMattersCOI website: **https://mindmatters.ireland.anglican.org/**
Phone **Rebekah Fozzard, Project Manager,** *at:* **00353 1 4125660**

DESIGN BY
CHRIS CONVILLE