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<th>Promoting mental health and social well-being: Cross border opportunities and challenges</th>
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<td><strong>Author(s)</strong></td>
<td>Barry, Margaret M.; Friel, Sharon; Dempsey, Colette; Avalos, Gloria; Clarke, Patricia</td>
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<tr>
<td><strong>Publication Date</strong></td>
<td>2002-06</td>
</tr>
<tr>
<td><strong>Publisher</strong></td>
<td>Centre For Cross Border Studies</td>
</tr>
<tr>
<td><strong>Link to publisher's version</strong></td>
<td><a href="http://crossborder.ie/publications/ccbs-publications/#2002">http://crossborder.ie/publications/ccbs-publications/#2002</a></td>
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<td><strong>Item record</strong></td>
<td><a href="http://hdl.handle.net/10379/6184">http://hdl.handle.net/10379/6184</a></td>
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Promoting Mental Health and Social Well-being: Cross-Border Opportunities and Challenges

Margaret Barry • Sharon Friel • Colette Dempsey • Gloria Avalos • Patricia Clarke

A Report for the Centre For Cross Border Studies & the Institute of Public Health in Ireland
Promoting Mental Health and Social Well-being: Cross-Border Opportunities and Challenges

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June 2002

The Centre for Cross Border Studies
The Institute of Public Health in Ireland
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The Centre for Cross Border Studies, based in Armagh and Dublin, was set up in September 1999 to research and develop co-operation across the Irish border in education, health, business, public administration, communications, agriculture, the environment and a range of other practical areas. It is a joint initiative by Queen’s University Belfast, Dublin City University and the Workers Educational Association (Northern Ireland), and is financed by the EU Peace Programmes and the Irish Department of Foreign Affairs’ Reconciliation Fund. In 2001 the Centre published research reports on cross-border telecommunications, cross-border health services, all-Ireland co-operation to tackle disadvantage in education, EU cross-border funding before and after the Good Friday Agreement, cross border co-operation in local government and cross-border co-operation between local history societies. In February 2002 it published a research report on the cross-border dimension of the 2001 foot-and-mouth disease crisis.

The Centre has also organized a wide range of North-South and cross-border conferences, seminars and study days in the areas of agriculture, health, education, European co-operation, tourism, ICT, telecoms, citizenship, animal health, currency issues and business research.

The Institute of Public Health in Ireland has been set up to promote North – South co-operation for public health. Established by the Department of Health, Social Services and Public Safety in Northern Ireland and the Department of Health and Children in Ireland, with support from the Royal College of Physicians, the Institute was formally launched in November 1999. Its remit includes research, information, training and policy advice.

The Institute promotes a broad view of public health, recognising the importance of multisectoral working to address the social, environmental and economic determinants of physical and mental health. Health strategies, North and South, indicate a key role for the Institute in tackling health inequalities; strengthening partnerships for health; contributing to public health information and surveillance; developing health impact assessment; strengthening public health capacity and leadership; and networking nationally and internationally.

The Institute has organised conferences, carried out research and developed an all-Ireland leadership programme. Its publications include reports on Partnerships for Health, European Public Health, Health Impact Assessment, the National Anti-Poverty Strategy and Inequalities in Mortality.
We would like to thank all those who contributed to this project and the production of this report, including those project members who completed the telephone interviews and shared with us details of their work.

We particularly wish to thank Dr. Dermot O’Reilly, Queen’s University Belfast, for advice on data sources in Northern Ireland.

We gratefully acknowledge the assistance of the Health Promotion Units at the Departments of Health in the Republic of Ireland, Northern Ireland and Great Britain who shared their expertise and experience with us.

Health Promotion Wales and STAKES, Finland made their work in this area available to us and this was extremely helpful.

A special word of thanks to everybody who took the time to participate in group discussions, and all those who responded to the questionnaire surveys, telephone interviews and who kindly supplied us with relevant reports, surveys and project details.

Thanks also to Dr. Jane Wilde, the Institute of Public Health in Ireland and Ms. Linda Barclay, Health Promotion Agency for Northern Ireland, for their helpful comments on an earlier Interim Report.

Finally, thank you to our colleagues at the Centre for Health Promotion Studies who assisted at various stages, including Ms. Christina Costello, Ms. Janas Harrington and Ms. Mary Byrne.

This project was commissioned by the Centre for Cross Border Studies, Armagh, Northern Ireland. We would like to thank its director, Mr Andy Pollak, for help in editing this report.
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Introductory comments by the Departments of Health

The Department of Health, Social Services and Public Safety (DHSS&PS) and the Department of Health and Children (DOHC) welcome this report, which will assist in raising awareness of current North/South activities. The report identifies gaps in data collection and highlights the potential for future co-operation and development in the field of mental health promotion. The report also identifies a number of key issues for consideration by policy makers, practitioners and researchers. It highlights the need to reduce barriers to create effective models of cross-border collaboration and the need to create appropriate structures which will facilitate dissemination of best practice. The recommendations made are challenging but attainable and if implemented would have significant impact on promoting positive mental health.

The two Departments, together with the Health Promotion Agency for Northern Ireland, have collaborated on specific health promotion initiatives in the last number of years. However it is recognised that a more structured approach to cross-border collaboration is required. Consequently, the three organisations are currently developing a North/South health promotion collaborative programme. Mental health promotion will be an integral component of that programme and this report will be a valuable asset in the development of that aspect of the programme.

DHSS&PS has recently published a new public health strategy, *Investing for Health*, which contains a framework for action to improve health and well-being and reduce health inequalities. Objective 3 in *Investing for Health* is “to promote mental health and emotional well-being at individual and community level”. In addition, the strategy commits DHSS&PS to publish a Mental Health Promotion Strategy and Action Plan during the summer of 2002.

The DOHC has recently published a new health strategy, *Quality and Fairness - a health system for you*. One action planned in Objective 4, which relates to specific quality of life issues, is a new Action Programme for Mental Health which will include a national policy framework. That strategy endorses the aims and objectives set out in the Health Promotion Strategy 2000-2005 which (in relation to mental health) calls for the development of a national positive mental health strategy. The target date for the national framework and strategy is 2003.

Effective collaboration will be required in developing this policy framework. The two Departments concur with the approach advocated in this report in securing the successful transition of policy recommendations into practice.

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Summary

This project reviews current cross-border co-operation in the development of mental health promotion in Northern Ireland and the Republic of Ireland. The project is comprised of two main strands of work:

i) an investigation of cross-border collaborative mental health promotion practices.

ii) an examination of the compatibility and comparability of mental health and related health data sources.

In order to inform the strategic development of collaborative practice, data collection and policy in this growing area, this project entails:

- Systematically documenting the extent and nature of mental health promotion strategies being implemented on a cross-border basis.
- Undertaking an in-depth case study investigation of five selected projects in order to identify key barriers and challenges to conducting cross-border co-operation.
- Examining the comparability and harmonisation of current data sources on population mental health, quality of life and related lifestyle patterns.
- Making recommendations with regard to the necessary research and practice infrastructures for future effective North-South collaboration at a strategic level.

This project was carried out in two phases. Phase 1 of the project involved the collection, collation and analysis of primary and secondary data. Phase 2 focused on the in-depth examination of the policy and practice implications arising from the findings of Phase 1.

Chapter 1 gives the background and rationale to this project and explores the setting for collaboration on an all-island basis. Chapter 2 deals with the project aims and objectives, while Chapter 3 gives detail on the methodologies employed for both phases of the study. Chapter 4 presents the findings from the Phase 1 investigation of cross-border collaborative mental health promotion practices, including details of the five case study profiles. Chapter 5 details the findings from the Phase 2 investigation of collaborative practice and mental health promotion policy on an all-island and international basis. Also presented in this chapter are the findings from the group discussions, roundtable meeting and questionnaire survey. Chapter 6 presents findings from the Phase 1 investigation of the compatibility and comparability of mental health and related data sources. This chapter also presents Phase 2 findings in relation to data and a comparison between both jurisdictions from existing data sets. Chapter 7 is the concluding chapter, which draws together all the findings from the report and makes recommendations for the future development of mental health promotion and social well-being on an all-island basis.
There is increasing recognition, both nationally and internationally, of the need to address mental health as an integral part of improving overall health and well-being. The first ever Surgeon General's Report on Mental Health was published in the United States in 1999, underscoring the fact that 'mental health is fundamental to health' (US Department of Health and Human Services 1999). The World Health Organisation and the World Bank Report (Murray and Lopez 1996) have drawn attention to the rise in mental health problems such as suicide and depression as major public health problems to be addressed in the 21st century. It is predicted that by the year 2020 depression will constitute the second biggest cause of disease burden world-wide. In Northern Ireland, a steadily increasing incidence of depression and suicide has been noted in recent years (Foster et al. 1997). These concerns mirror the findings in the Republic of Ireland where the Report of the National Task Force on Suicide (Department of Health and Children 1998) highlights a significant rise in the male suicide rate over the last 20 years. Suicide is now the leading cause of death among young men (15-24 years) in the Republic of Ireland.

These statistics call for co-ordinated action in developing comprehensive mental health promotion strategies in order to reduce the future incidence of mental health problems. The National Task Force on Suicide (1998) in the Republic of Ireland recommends the use of primary prevention and promotion strategies in order to bring about a reversal of the rising trends in suicide. Programmes targeting greater public awareness and understanding, together with school and community based life-skills programmes, are identified as offering an opportunity of promoting positive mental and social well-being. Similarly, regional and national policy documents in Northern Ireland (e.g. DHSS 1996 and 1997) have called for positive action in this area.

Mental health promotion is concerned with achieving positive mental health and quality of life at a population level. The focus of this interdisciplinary area of practice is on enhancing the strengths and competencies of individuals and communities, thereby promoting positive emotional and mental well-being. Mental health promotion targets the whole population and focuses on the protective factors for enhancing well-being and quality of life, together with early intervention and prevention of mental health problems. The underlying principle of this approach is that mental health is an integral part of overall health and is therefore of relevance to all. Mental health is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth (HEA 1997). The UK Health Education Authority in its Mental Health Promotion Quality Framework (1997) highlights three key influences on mental health:

- Healthy structures such as the economic, social and cultural framework.
- Citizenship, including social support, sense of social integration and inclusion.
- Emotional resilience encompassing self-esteem, coping, life skills and sense of control.
Mental health is therefore a positive concept, which is embedded in the social, economic and cultural life of the community. Positive mental health is important in its own right and is a resource for individuals and nations (Jenkins et al. 2001).

Mental health promotion therefore focuses on improving the social, physical and economic environments that determine the mental health of populations and individuals. An interesting population perspective on promoting positive mental health is outlined in the Australian discussion document *Building Capacity to Promote the Mental Health of Australians* (Health Australia Project 1996). This framework outlines the opportunities for mental health promotion across different population groups from healthy populations to those with mental disorders. The aims and goals of mental health promotion strategies across these diverse groups range from building resilience and promoting health for healthy populations to reducing risk and early identification for high-risk groups, to treatment and optimal care for those with mental disorders. The delivery of such programmes requires the development of health and social policy, which extends beyond the clinical and treatment focus of current mental health service delivery to also encompass promotion and prevention perspectives. In particular, the influence of broader social and economic factors on mental health needs to be addressed. This has special relevance in relation to issues of stress, social isolation of rural areas and the impact of a rapidly changing social, economic and political climate.

Effective policies and strategies at a cross-national, regional and community-wide level are needed to address the broad determinants of mental health and to enhance the well-being and quality of life at a population level. These policies need to be based on sound epidemiological data and effective intervention approaches. While national health surveys of physical health status and its determinants are routinely collected in many developed countries, the situation with regard to mental health is quite different. There is quite limited data on mental health status at a population level or the pattern of differences among different population groups. To determine this information requires the assessment of mental health status and its determinants at a population level.

There is a growing theoretical base and supporting body of evidence informing the development of mental health promotion practice. Over the last twenty years considerable progress has been made in the development of successful evidence-based mental health promotion and prevention programmes (Durlak and Wells 1997; Tilford et al. 1997; Price et al. 1988; Mrazek and Haggerty 1994). Hosman and Jané-Llopis (2000), in a recent report on the evidence of health promotion effectiveness, find ample evidence that mental health promotion programmes not only improve mental health and quality of life but also reduce the risk for mental disorder. This report also attests to the impact of mental health promotion programmes on the reduction of a range of social problems such as delinquency, child abuse, school drop-out, lost days from work and social inequity. There is also a growing body of research which demonstrates the impact
Background and Rationale

of mental health on physical health, thereby highlighting the potential of mental health promotion programmes to contribute to health gain and the wider public health agenda (Frielid 2001). The accumulated findings from systematic reviews and effectiveness studies clearly endorse the value of programmes promoting positive mental health and support initiatives that enhance protective factors with the explicit goal of promoting competence and well-being across multiple domains of functioning (Barry 2001).

At a policy level, a number of key international organisations, such as the World Health Organisation, the World Federation for Mental Health and the World Psychiatric Association, are playing an important role in stimulating collaborative action to promote the value placed on mental health at national and international levels. Jenkins et al. (2001) provide an interesting overview of a variety of recent EU and international initiatives aimed at enhancing the implementation of mental health promotion. At a European level these include: the European Network on Mental Health Policy established in 1995, the Key Concepts for European Mental Health Promotion in 1997, and EC Mental Health Indicators Project in 1999. These initiatives serve to strengthen mental health policy and practice, exchanging experiences and expertise and stimulating joint research and practice developments on a cross-European basis. Particular recognition is given to the added value of concerted strategies between member states in enhancing the value and visibility of mental health in Europe.

Despite the growing recognition of the importance of this area, there is currently no co-ordinated policy guiding the development of mental health promotion in the North or South of Ireland. Likewise, there are quite limited population databases, both North and South, on current mental health status at national or regional levels. In Northern Ireland recent health policy documents have identified mental health as an area for positive action. The Regional Strategy for Health and Social Well-being 1997-2002, Health and Wellbeing: Into the Next Millennium, and the complementary document, Well into 2000, acknowledge the need to address the social, economic and personal determinants of mental health. In 1998 the Department of Health and Social Services in Northern Ireland commissioned the Health Promotion Agency to develop a strategy and action plan for mental health promotion. It is interesting to note that the terms of reference for the Regional Working Group, established for this purpose, explicitly state that:

_The strategy and action plan should address issues which affect mental health; it should have a mental health rather than a mental illness focus and should aim to cover the needs of individuals and communities, not just those with existing mental health problems._
In 1999 the Regional Working Group was designated as the Task Force on Mental Health Promotion with a remit also to address suicide prevention and the mental health needs of young people. As part of this initiative the Northern Ireland Health Promotion Agency has produced a database of current mental health promotion initiatives in Northern Ireland (1999). This database documents a range of existing projects with the aim of promoting positive mental health across Northern Ireland.

*Minding our Health, A Draft Strategy for Promoting Mental and Emotional Health in Northern Ireland* (2000), proposes that improved mental health knowledge, understanding and behaviour can be achieved through co-ordinated action in the following areas:

- Strategic and operational planning to develop and assess the impact of all public and organisational policies with an emphasis on how they can contribute to the mental health and emotional well-being of individuals, communities and the wider population.
- Public and professional information to increase awareness and understanding of positive mental health and emotional health and well-being, and reduce stigmatisation and fear associated with mental health problems.
- Education and training to enable change and development at individual and community level through the provision of information support services and collaborative working.
- Research and analysis to inform, plan and evaluate mental health promotion.

The *Minding our Health* document is pending publication. Current initiatives and policy developments in the Republic of Ireland also reflect an increasing emphasis on this area. The Health Promotion Strategy 2000-2005 (Department of Health and Children 2000) targets positive mental health and is committed to initiating policy, research and practice developments in this area as part of its five year strategy. The strategy sets out the following objectives:

- To initiate research into models of best practice in mental health promotion.
- To initiate research into the development of a national positive mental health strategy.
- To work in partnership to support the implementation of the recommendations of the Report of the National Task Force on Suicide (National Health Promotion Strategy July 2000)

A number of regional strategies and initiatives have also been developed by the health promotion departments in the regional health boards e.g. the North Western Health Board’s ‘Strategy for Mental Health in the North West into the Millennium and Beyond’.

These developments are in line with European wide initiatives which increasingly emphasise the importance of collaborative efforts and the added value of concerted action between countries. The Tampere Conference (October 1999)
underlined the importance of mental health and the need for action in this area on a cross-European level. Member States of the European Union were requested to take action in this field by:

- Promoting mental health and preventing mental illness.
- Encouraging the exchange of best practice and information.
- Promoting joint projects with other Member States.
- Furthering and supporting research into mental health and its promotion.

This was further addressed by the Council Ministers of the European Union, when Council Resolution of 18 November 1999 on the Promotion of Mental Health (2000/C86/01) recognised the need for addressing the promotion of mental health in the increased co-operation with applicant countries and invited the member states to:

- To give due attention to mental health and to strengthen its promotion in their policies.
- To collect good quality data on mental health and actively share it with other Member States and the Commission.
- To develop and implement action to promote mental health and prevent mental illness and promote exchange of good practices and joint projects with other Member States.
- To stimulate and support research on mental health and its promotion, also using the opportunities provided by the Fifth Framework programme of the European Community for research, technological development and demonstration activities (Council of European Union 1999).

The World Health Organisation (2001) stated that the formulation and evaluation of policy require the existence of a well-functioning and co-ordinated information system and that the mental health of communities should be monitored by including mental health indicators in health information and reporting systems. The WHO suggested indices should include both the numbers of individuals with mental disorders and the quality of care, as well as more general measures of the mental health of communities. Using these indicators, research should be carried out on a wide international basis to understand variations across communities and to learn more about the factors that influence the cause, course and outcome of mental disorders (WHO 2001). European initiatives have addressed the need for the collection of good quality data to direct policy and practice in the mental health area. All over Europe there is an increase in mental health problems and disturbances (e.g. depression and substance abuse disorders) and therefore monitoring of the current trends in the mental health of populations is necessary in all EU member states (STAKES 1999).

Mental health is seen as an indivisible part of general health and reflects the equilibrium between the individual and the environment. Mental health is influenced by individual psychological and biological factors, social interactions, societal structures and resources and cultural values. In this context,
mental health is a central part of a process that comprises predisposing, actual precipitating and supporting factors as well as various consequences and outcomes. A mental health indicator therefore is a measure of the state of mental health and indicates a priority or a problem. These may be items in health surveys or statistical data gathered (European Health Monitoring Programme 2001). Monitoring mental health can be defined as systematic, repeated measures of matters related to the mental health of the population. In addition to collecting data, monitoring health implies following up the measures with the purpose to interpret the evolution of mental health situations according to established policies and strategies and to take relevant actions if necessary (European Health Monitoring Programme 2001).

Mental health indicators and a monitoring system are necessary to determine trends and to detect mental health changes resulting from external events, and also to assess the effectiveness of mental health prevention and treatment programmes, thus strengthening arguments for the provision of more resources. There is a need for this kind of evaluation at all levels - local, regional, national and European level (STAKES 1999).

An important task is to collect and analyse epidemiological information to identify the broad psychosocial determinants of mental health problems, as well as to provide qualitative information on the extent and type of problems in the community. The traditional approaches of epidemiology measure health outcomes in terms of pathology. Although psychiatric epidemiology has traditionally also looked at protective factors, there is a need for an epidemiology of health, which estimates health potentials in addition to risk factors. Mental health promotion is a natural domain for the development of indicators for this new epidemiology, since many of the components of health potential are directly or closely associated with mental health. Thus the development of valid and reliable mental health indicators has a clear research implication (STAKES 1999).

The report by STAKES (1999) stated that there exists an evident need to develop a system of population level indicators for mental health, including positive mental health. An effective monitoring system was identified as one needing indicators which are sensitive to change and culture, includes citizens’ and users’ participation, and has relevance for policy and planning. This would include the collection of information on existing mental health indicators and their definitions, as well as the mental health information systems developed in the different EU Member States or by international organisations including WHO and OECD, and analysis of their quality, coverage and validity. This report recommended the:

- Creation of a system of mental health indicators to be used by the Member States and the Commission in which information concerning both adults and children/youth is included.
- Testing the feasibility and usefulness of the indicators and the monitoring system in pilot projects.
• Production of a set of recommendations concerning the methods of data collection.
• Creation of an information exchange network.

A number of recent projects have addressed the monitoring of mental health data on a cross European basis and the harmonisation of data collection methods. The Euro-REVES project, funded by Biomed 1 in 1994, is a European concerted action on harmonisation of health expectancy calculations. Life expectancy has increased in most European countries, but the value of this additional lifespan in terms of mental and physical health is unclear. The project was set up to promote harmonisation of data collection and calculation methods and to examine their policy relevance on a cross national basis (Hibbett et al. 1999). As part of this project a mental health sub-committee examined the current state of harmonisation with regard to mental health indicators in Europe. Although this project focused primarily on mental health expectancies such as indicators of dementia and depression, it emphasised the importance of cross European collaboration and called for comparable data sources and further harmonisation of European mental health surveys.

The Health Monitoring Programme (HMP) was established by the European Commission in 1997 and aims to contribute to the establishment of a Community Health Monitoring System. There are three pillars under which the activities of the HMP are conducted.
• Pillar A concentrates on the establishment of community wide health indicators (indicators project).
• Pillar B focuses on the development of a community-wide network for sharing health data (HIEMS)
• Pillar C is concerned with analyses and reporting of data (health reports).

Within the various pillars, there are a number of initiatives relating to health data harmonisation for monitoring and planning purposes. The Health Monitoring Programme has funded a number of projects to further investigate European data covering many health issues. As cited previously, since 1999 a two-year action project co-ordinated by STAKES, Finland has been dedicated to the establishment of mental health indicators for the European Union. Following a review of existing mental health and well-being indicators and information systems across Europe, the project aims to agree on harmonised mental health indicators which will be recommended to the European Commission for inclusion in the European Community Health Indicator system (Lehtinen & Korkeila 2000). The areas of mental health identified by the Mental Health Indicators group as necessary for an EU mental health monitoring system include: 
• demographics
• social stress
• social interaction
• positive mental health
• the subjective experience of the individual
the need, use and demand for services and
disability, morbidity and mortality.

A practical goal of this initiative is to have from each group the smallest number of indicators necessary to have reliable measures.

More generally in terms of health monitoring, the European Health Risk factor Monitoring programme (EHRM) is at the preliminary stages of compiling a database of cardiovascular health risk factors from all EU countries which carry out a national health survey (Tolonen et al. 2001). The health-related risk factor data are being assessed for compatibility in terms of data collection methods and instruments used. More specifically, the HIS/HES (Health Interview/Health Examination Surveys) project, again under the auspices of the Health Monitoring Programme, is investigating the compatibility and comparability of European data relating to all aspects of physical and mental health (Koponen & Aromma 2000).

More locally, the island of Ireland has seen its population life expectancy increase, but mortality from major chronic conditions continues to be amongst the highest in Europe, identified through data collected routinely by statistical offices in each country (Department of Health and Social Services 1997; Central Statistics Office 1999). While a number of health surveys have been undertaken in both Irish jurisdictions, it is unclear what data exists in relation to mental health and well-being and its level of compatibility and comparability. Over the years there has been an excellent working relationship between the Health Promotion Agency for Northern Ireland, the Health Promotion Unit at the Department of Health & Children and the regional health promotion departments from all health boards in the Republic of Ireland. As health is one of the areas for co-operation identified by the Good Friday Agreement, an opportunity presents itself to develop a strategic approach to health promotion and primary care initiatives on an all island basis. Several joint initiatives have been identified including research, the exchange of information on models of best practice, professional training and public information campaigns. “Strengthening cross border co-operation will ensure that meaningful and sustainable health promotion initiatives are developed on an all island basis” (National Health Promotion Strategy 2000-2005, July 2000 p15).

Within this context and in recognition of the increasing need to address mental health as an integral part of improving overall health and well-being, this project examines the opportunities and challenges for cross-border co-operation in the area of mental health promotion.
Project Aims and Objectives

This report looks specifically at cross-border co-operation in the development of effective mental health promotion policies on a strategic North-South basis. The use of rigorous data sources combined with the identification of collaborative models of good practice will provide a sound empirical base for the development of effective policy and practice on a cross-border basis. This multi-focused data set will provide a valuable resource for the strategic planning of such bodies as the recently established all-island Institute of Public Health in Ireland and respective national and regional health agencies. Recommendations will be made with regard to strategies and structures for the development and delivery of sustainable collaborative programmes aimed at enhancing the mental health and improved quality of life of the wider community. Due to the nature of funding, the project was carried out in two distinct phases, hereafter called Phase 1 and Phase 2.

The aims of the overall project are:

• To document the current extent and nature of mental health promotion strategies being implemented on a cross-border basis.
• Using the case study method, to carry out an in-depth investigation of a selected number of projects in order to identify the key barriers and challenges to conducting cross-border co-operation.
• To identify examples of good practice and examine their policy implications.
• To assess existing data on mental health status, lifestyles, quality of life and inequalities for comparability between the North and South with a view to sharing and harmonising existing data sources.
• To make recommendations on the opportunities for strategic North South co-operation in the development of collaborative mental health promotion policies and practices.

There are two main strands of work within the project:
A: Investigation of cross-border collaborative mental health promotion practices.
B: Compatibility and comparability of mental health and related health data sources.

The key objectives of each strand of Phase 1 are outlined below.

Strand A. Investigation of Cross-Border Collaborative Mental Health Promotion Practices
The objectives for Strand A of the project are:
• To establish an inventory of current levels of co-operation in the promotion of mental health on a North-South basis.
• To categorise the range and extent of collaborative interventions, documenting their focus, funding, co-operative mechanisms and implementation strategies.
• To select from this inventory up to five case studies of collaborative initiatives which can be examined in greater detail concerning the challenges, opportunities and obstacles to co-operation.
Strand B. Compatibility and Comparability of Mental Health and Related Health Data Sources

This section of the study concentrates on compiling an inventory of the current state of mental health data and related determinants in Northern Ireland and the Republic of Ireland. More specifically, the investigation of data will be made to determine compatibility and comparability across the following parameters:

- Measures of population mental health status.
- Socio-demographic and economic parameters.
- Mental health, lifestyle patterns and quality of life.
- Mental health service utilisation - attitudes and patterns.

Having determined and documented the compatibility and comparability of existing data, together with the extent of collaborative practice in Phase 1, there is the opportunity to establish the feasibility of joint analyses and to make recommendations concerning the opportunities for harmonisation and collaboration between partners in the Republic and Northern Ireland.

It is critical that we have more focused study of the issues pertaining to both strand A and B in order that future efforts can benefit from the successes and failures of current initiatives. Phase 2 of this project aims to address these issues in a systematic fashion, providing an opportunity for focused discussion and critical reflections on the issues raised in Phase 1 of the project.

The objectives for Phase 2 of this work are:

- To disseminate the findings from Phase 1 of this project.
- To conduct interviews and group discussions with key players in this area in order to draw out lessons in good practice and insights for future development.
- Based on the review of the above information, to consider the policy implications for the development of mental health promotion policies and practices on a strategic all-island basis.
- Based on the assessment of the mental health population data available, North and South, to make recommendations on indicators necessary and survey designs desirable for comparable, compatible data for population monitoring.
- To make recommendations with regard to the necessary infrastructure for future effective collaboration at a strategic level.
Phase 1: Methodology common to Strands A and B

In order to compile an inventory of the current levels of collaborative mental health promotion practice together with existing mental health and related data sources in the Republic and Northern Ireland, a questionnaire survey was carried out with health agencies, organisations and individuals known to be involved in the area. A cascade approach was used with initial contact persons or organisations being asked to forward copies of the questionnaires to relevant others known to them.

Sample Frame
Since 1992 the Department of Health Promotion of the National University of Ireland, Galway has maintained an up-dated database with names of health-related organisations, both national and international. Accordingly, contact information was extracted from the database concerning all organisations in the Republic of Ireland and Northern Ireland that were known to be involved in the area of health promotion and mental health, and possibly involved in population surveys. A range of organisations and health board departments together with voluntary, community and statutory agencies with a mental health focus throughout Northern Ireland and the Republic of Ireland were identified. There was a particular focus on the border counties in this exercise. The database of mental health promotion initiatives in Northern Ireland was also consulted and listed projects were contacted. The organisations contacted included the following:

- Statutory and voluntary organisations such as the Health Promotion Agency for Northern Ireland, the Health Promotion Unit at the Department of Health and Children, Republic of Ireland, Mental Health Association of Ireland, AWARE, The Samaritans, and Praxis.
- Directors of Public Health and Health Promotion Managers from the four Health and Social Services Boards in Northern Ireland.
- Contact names from the database of mental health promotion initiatives in Northern Ireland (1999) and the Northern Ireland Regional Task Force on Mental and Emotional Health.
- Directors of Public Health, Health Promotion Officers and Programme Managers for Mental Health Services from the eight Regional Health Authorities within the Republic.
- Relevant university departments in relation to national and regional mental health data sources.
- Directors of the funding organisations of the EU Programme for Peace and Reconciliation and Co-operation and Working Together (CAWT) in relation to cross-border funded programmes with a mental health focus.
Methodology

Data Collection
In September 2000 a letter was circulated to the organisations listed above to inform them about the project “Promoting Positive Mental Health: Cross-Border Opportunities and Challenges”. A cascade approach was used to further identify relevant contact persons. From this initial mailing some 153 contacts/organisations were identified.

A second distinct letter was written inviting these organisations to fill in a three page questionnaire concerning their level and type of participation in cross-border work in the mental health field, and to further identify population based mental health surveys.

The detail concerning the methodologies of the two strands of the project will now be described separately.

Phase 1 Strand A: Investigation of Cross-Border Collaborative Mental Health Promotion Practices

Inventory of Existing Co-operative Initiatives
The questionnaire relating to mental health cross-border initiatives was adapted from existing surveys conducted by Health Promotion Wales (1995) and by the Health Promotion Agency for Northern Ireland (1999). Respondents were asked to provide general information about the project including: project partners, details of funding sources, intended duration, intervention approaches, evaluation mechanisms and co-operation structures (see Appendix 1).

Selection of Case Studies
Using the information provided by respondents to the questionnaire survey, five specific projects were selected for case study investigation. This involved examining the process of project development and delivery with a particular focus on the experience of cross-border collaboration. A review was undertaken of all project documentation together with available project reports and evaluation studies.

The five individual projects were not meant to be representative. The criteria employed for their selection were as follows:

- Clear evidence of active cross-border collaboration.
- Clear mental health promotion focus.
- Project evaluation component.
- Project reports and documentation were available.

After the five case studies were selected, a letter was sent to the named project partners. This letter informed the project partners that they had been selected for case study review and that they would be contacted by Dr. Patricia Clarke from the Centre for Cross Border Studies in Armagh to arrange a suitable time for a
Methodology

semi-structured interview. In order to develop a clear picture of the project background, project partners were asked to forward any relevant documentation they had to the Centre for Health Promotion Studies at NUI, Galway. In particular, information concerning the following was gleaned:

• Project focus and rationale.
• Project aims and objectives.
• Project duration and funding.
• Intervention approaches.

Telephone Interviews
In addition to the project documentation review, semi-structured telephone interviews with the key players involved in the project development and delivery were also undertaken. These interviews were carried out in order to develop an understanding and appraisal of the levels and mechanisms of collaboration involved across the various projects.

Each project was asked to nominate up to four project members for interview, preferably two members from the North and two from the South. These included project members involved in varying capacities from project worker to manager. Those nominated and interviewed were not necessarily the named contact persons shown in the description of the case studies.

Following the letter forwarded to the project partners, Dr. Patricia Clarke of the Centre for Cross Border Studies contacted all interviewees by telephone and asked them to participate in a semi-structured interview regarding their respective study.

An interview protocol was drawn up for this purpose with the aim of exploring:

• Cross-border co-operation structures - project management, progress reports, evaluation.
• The nature of cross-border contact involved - frequency, locations, nature and benefits of contact made.
• Perceptions of cross-border working - motivation, expectations, benefits, difficulties and experiences of cross-border working.

A copy of the interview protocol is available in Appendix 2. The interview protocol was either e-mailed or faxed through for review prior to the telephone appointment. Typically the telephone interviews lasted between 20-25 minutes. The interviews were not recorded but verbatim notes were taken throughout each conversation. These notes were entered onto the computer immediately following each interview.

Interviewees were requested to forward any progress or evaluation reports mentioned during their interview to the Centre for Health Promotion Studies, National University of Ireland, Galway.
Methodology

Analysis of Data
The interview transcripts, along with any other project documentation received by Dr. Clarke, were sent to the Centre for Health Promotion Studies for analysis. The first stage of the analysis involved familiarisation with the data collected from the semi-structured interviews and the project documentation. All of the interviews were read through several times in order to get an understanding of the nature of responses in general and also for each individual project. Once this process was completed, the data was entered onto the computer.

Project profiles were drawn up based on the documents reviewed and the combined views gleaned from interviews with the project members. As far as possible the original statements made by interviewees are reported verbatim. Questions and interviewee responses were sorted under the following headings:
1. Background to the Project.
2. Cross-Border Co-operation Structures.

A case study profile of each of the five projects is presented in the next chapter. All case study descriptions were forwarded to the original people interviewed in order to check for accuracy and validity of the profiles prior to inclusion in this report.

Phase 1 Strand B: Compatibility and Comparability of Mental Health and Related Health Data Sources

The aim of this component of the study was to ascertain what population based data relating to mental health existed on the island of Ireland. While nationally representative samples are most useful for population monitoring, it was decided to include all surveys even if regional or locally based. The data must have been collected in the past 10 years on community based samples and not in clinical situations. The focus in this project is on mental health data at a population level, giving special weight to data sources useful for mental health promotion. As a result, studies relating to clinical populations or mental health service statistics have not been included.

The following domains of mental health and well-being were included for collection. While it was desirable to have all domains, surveys were included if one or more of the following were present:
• Measures of population mental health status.
• Socio-demographic and socio-economic factors.
• Lifestyle patterns and quality of life.
• Mental health service utilisation - attitudes and patterns.
Methodology

Methods for Review and Survey Inventory
From the sample frame and data collection procedure described earlier, information was sought concerning any population-based surveys that had been carried out during the previous 10 years which reported on mental health indicators, lifestyle factors, demographic characteristics of respondents, among other variables. Eight new contacts regarding population-based surveys were obtained from the first circulation. The names of these new contact organisations were incorporated into the database and phone calls made in order to inform these organisations about the project and to determine their involvement with population-based surveys. As before, a cascade approach was used, with these new contacts being asked about further possible contact names.

The identified organisations were asked to send copies of their survey instrument, reports, or relevant articles to the Centre for Health Promotion Studies, NUI, Galway. Personal contacts and local knowledge were also used to retrieve information on surveys applicable in this context. In addition to those contacted externally, there were a number of relevant population based surveys carried out in-house through the Centre for Health Promotion Studies, NUI, Galway.

Determining Factors
There are many components within a survey that may limit comparisons being made with other data. Differing study design, target population and the type and level of measures used can prevent collection of comparable information. It was decided to critically review the eligible mental health surveys in both jurisdictions to determine the methods and indicators used in the reporting of surveys. The following details were assessed for each survey.

Survey Population
The target population refers to the population for which information is required. In most surveys a sample of this population is used and should represent the target population. Survey populations are usually of a specified age group in a defined geographical region. The time period over which the survey was carried out was also recorded, as was the frequency which it was carried out, i.e. once off or repeated.

Sample Size and Response Rate
Besides the representation of the target population, the size of the survey sample is important to allow for sampling variation and detection of real effects within samples. The response rate is therefore critical and refers to both the representation and power of a survey.

Sample Framework
The sampling frame is the list of sampling units from which the sample is selected. While the unit of analysis in a survey is normally the individual, it may also be household or community. These registers can vary in their completeness,
Methodology

e.g. people dying or transient populations, and target population representation, 
e.g. under-representation of marginalised groups on electoral registers. The 
sampling frame therefore can effect the generalisability of outcome 
measurement.

Study Design and Methodology
There are a number of different study designs used in population surveillance 
and epidemiology, but most are quantitative in nature. Descriptive designs such 
as cross-sectional surveys simply describe a factor of interest at a particular point 
in time. More analytical designs, e.g. retrospective or prospective, allow a 
thorough testing of hypotheses and ascertainment of the direction of association 
between risk factor and health outcome. The choice of design relates to the aim 
or research question being investigated by the study.

Whether the survey is descriptive or analytical, the data must be collected. Some 
studies use information from previous records, whereas primary data collection is 
normally done using self-administered questionnaires or semi-structured 
interviews. The self-administered questionnaire helps minimise social desirability 
and interviewer bias. The interview technique or administered questionnaire can 
record more detailed information and probe in more depth compared to the self-
administered questionnaire. Both techniques have different types of bias and 
potentially different response rates, hence introducing response bias into results.

Measures
Within a particular concept, outcome measures or question items used can vary 
from survey to survey. In the area of mental health and quality of life, standard 
scales are often used to measure these variables, thus facilitating comparability 
across data. Such scales produce a composite score that is more reflective of the 
concept of interest than single item measures, but perhaps more important is the 
reliability and validity inherent to the development of standardised scales 
(Bowling 1997). The most commonly used scaling method is the Likert scale, 
which normally comprises a series of five or seven opinion statements about an 
issue. Visual analogue scales are similar to Likert measures. They use a line 
defined in length with a descriptive word at each end representing the extremes 
of the concept being measured.

Other indicators relating to the determinants of mental health include socio-
demographic and socio-economic status. Factors such as age, gender, education, 
employment status and marital status are commonly recorded using single item 
questions. Occupation is an important determinant of health but there can be 
difficulties with its classification. Social class is derived using occupation but may 
vary depending on whether the occupation is of the respondent, of the head of 
household from which respondent comes or, if female, of the respondent’s 
partner. The locality of dwelling may also vary from survey to survey depending 
on definition of boundary, e.g. a rural area is defined in the Republic of Ireland 
Census 1996 as a geographical location with population less than 1,500.
Methodology

Lifestyle risk factors relating to mental health and well-being may include cigarette smoking, alcohol consumption, dietary habits, physical activity, illegal substance use and body mass. Each of these indicators can be measured using single item or batteries of questions. The accuracy and precision of the self-reported information is affected by the measure used and the way the question is framed.

Using the above criteria, the collected data sources were reviewed, examining their comparability and compatibility and identifying strengths and weaknesses in terms of harmonisation. The findings from this section are presented in Chapter 6.

Phase 2: Methodology common to Strand A and B

Much of the methodology employed in Phase 2 of the project was common to both strands A and B. The core objectives of dissemination of findings, and development of practice and policy which will facilitate cross border collaboration and harmonisation of mental health surveillance, interweave both strands. Therefore, the majority of methods described below relate to both Strand A: Collaborative Mental Health Promotion Practices, and Strand B: Compatibility and Comparability of Mental Health Data.

Dissemination of Findings from Phase 1

Interim Report
When the interim report was published, copies were sent from the Centre for Cross Border Studies to all who had participated in Phase 1 of the study, including practitioners, voluntary and community groups, researchers and policy makers.

Study Day at the Centre for Cross Border Studies
Accompanying the interim report was an invitation to attend a study day on 6th September 2001 in the Centre for Cross Border Studies in Armagh. The purpose of this day was to disseminate the findings from Phase 1 and to invite reflections on the information presented.

A total of 119 people were invited to attend this study day and 45 people, representing a wide range of interests, including policy makers, health agencies and voluntary and statutory bodies, attended. Presentations based on the findings of Phase 1 were made and these were followed by a group discussion.
Discussion Groups
Immediately following these presentations, four structured discussion groups were convened with the 45 people attending the study day to consider the findings and to draw out the implications for policy and practice development. A facilitator and rapporteur attended each group. The questions addressed by the groups were:
• What are the aims and expected added value of cross-border collaboration?
• How do we evaluate current cross-border collaboration?
• What are the key learning points from current experiences?
• What are the current barriers to effective cross-border collaboration?
• Under what conditions could investment in cross-border collaboration become more effective and efficient?
• How do we further the harmonisation of mental health data collection on the island of Ireland?

After the sessions the four groups reconvened and their rapporteurs presented a report from each group. This session was recorded and rapporteurs’ notes were given to the project research staff. These notes were later subject to content analysis in order to catalogue views on collaboration, lessons in best practice, mechanisms for cross-border co-operation and key areas and opportunities for future development. The policy and practice results are presented in Chapter 5 and the data compatibility and comparability results are presented in Chapter 6. Based on the findings from this study day, a questionnaire was developed to further explore the views of stakeholders and participants around cross-border working (Appendix 3).

Review of Policy Frameworks
A review was then carried out of existing health policy and policy developments internationally including the European Union, England, Scotland and Wales. There was a particular focus on mental health and mental health promotion. A review of the international literature was also carried out looking at examples of collaboration, partnership, and inter-sectoral co-operation in health activity and health promotion and their associated evaluations.

Roundtable Discussion Day
A discussion day was held on the 5th December 2001 at the Department of Health and Children, Dublin. The aims of this discussion were:
• To review current policy developments concerning mental health promotion (strategies and data sources) in the UK, Northern Ireland and the Republic of Ireland.
• To consider the strategic steps required for effective collaboration on the development and implementation of a mental health promotion policy.
• To examine recommendations for harmonisation of mental health data at a pan-European level and their implications for developing comparable and compatible population mental health data on an all-island basis.
Methodology

To identify the structures needed for collaboration on:

a) developing best practice and policy
b) key common mental health indicators.

Fourteen representatives from nine organisations with responsibility for the development of mental health policy and the collection of mental health data in Northern Ireland and the Republic of Ireland were invited to participate in this roundtable discussion. Also invited were those with responsibility for policy and data in the Department of Health in England and a representative from STAKES, Finland, who are co-ordinating the mental health indicators project of the European Health Monitoring Programme.

Five people from four organisations representing both health departments, North and South, and data collection agencies attended the meeting. A further three invitees, representing two organisations which were unable to attend, submitted reports in advance of the meeting. Another organisation sent a report to the project researchers after the meeting. Follow-up interviews were carried out with other key players who were unavailable on the day. The roundtable discussion meeting was recorded and the tapes then transcribed and analysed using content analysis. Reports submitted were incorporated into the results, which are presented in Chapters 5 and 6. A list of all the agencies and organisations who contributed in person, by phone and who submitted reports for this meeting are available in Appendix 4.

Newsletter

A newsletter summarising the findings from Phase 1 of the study was compiled using Microsoft Publisher. This newsletter was circulated to a total of 146 people from the various organisations involved in health policy, health services and health promotion activities in both Northern Ireland and the Republic of Ireland.

Invited Reflections on Phase 1 Findings

Based on the findings of the group discussions at the Armagh study day, a questionnaire, consisting of both open and closed ended questions, was developed to further explore the views of the various individuals and organisations involved in health promotion activities and cross-border projects (Appendix 3). This questionnaire, which was particularly aimed at inviting views from those who were unable to attend the Armagh study day, was sent to 114 of the 146 people/organisations who had also received a copy of the newsletter. Individuals in both Health Departments, in health boards North and South, research bodies, voluntary agencies and statutory agencies received this questionnaire along with a return addressed envelope. Follow up telephone calls were made to remind people to fill in and return the questionnaire. 41 fully completed questionnaires were returned.
Methodology

Data Analysis
Quantitative data were analysed using SPSS (Statistical Package for Social Scientists) version 10. Qualitative data were analysed using content analysis where responses were coded and categorised as themes emerged. All results are presented in Chapters 5 and 6.

Comparisons of existing mental health data
Results from surveys that included the GHQ-12 in the Republic of Ireland, Northern Ireland and other parts of the United Kingdom were gathered and, where possible, comparisons in results made between the countries. Comparisons were also made between existing SF-36 and SF-12 studies. Comparisons were made between the countries on school aged children, as a defined population group, using the HBSC analysis. These findings are presented in Chapter 6.

Standardisation of data
Methods for standardisation of data collection were developed drawing from the experience of existing pan-European and international projects. Data from the roundtable discussions and the European Health Monitoring Project were also employed. Existing projects were reviewed and findings were incorporated.
Questionnaire Survey
From the questionnaire survey some 74 responses were received from the 153 organisations that were contacted. Follow up calls and reminders were issued to non-respondents. Of the 74 responses received, 46 completed questionnaires were received with a further 28 respondents indicating that their project was not cross-border in nature or that they had forwarded the questionnaire onto someone else. Of the returned questionnaires, six were completed by the cross-border partner of the same project, resulting in a total of 40 identified projects. Of these 40 projects, 19 were cross-border projects (see Table 1) and 15 did not have a cross-border element. A further six projects reported cross-border contact of a more informal and less active nature, either through informal contacts with like organisations, volunteers or clients from across the border and/or an expressed interest in developing further cross-border working.

The projects for which information was received were very diverse and targeted many different population groups such as teenagers, prostitutes, those with a diagnosed mental health disorder, the elderly and carers/staff. The focus of the projects was also quite varied, covering areas such as needs assessment, awareness raising, counselling, therapy training, support services and strategy development. Projects dealing with suicide prevention and/or depression featured most, with 23% of the returned questionnaires dealing with these issues. Also featuring were projects with a rehabilitation/vocational training focus (12%). The projects also reflected a variety of levels of collaboration:
(i) policy/strategic - development of shared policy and strategic plans.
(ii) discrete - individually distinct and formally structured projects.
(iii) informal - co-operation of a less discrete nature, not formally structured.

A wide variety of agencies from statutory agencies to voluntary organisations were represented in the returned questionnaires. All of the projects were at varying stages of their project life. While some were just starting, others were mid way and some had finished.
### Table 1: Summary of the 19 Cross-Border Projects with a Mental Health Focus

<table>
<thead>
<tr>
<th>NAME OF PROJECT</th>
<th>Lead Agency NI</th>
<th>Lead Agency ROI</th>
<th>Collaboration</th>
<th>Target Population</th>
<th>Key Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerned About Suicide Leaflet</td>
<td>WHSSB</td>
<td>NWHB</td>
<td>Policy/Strategic</td>
<td>General</td>
<td>Information and awareness around suicide</td>
</tr>
<tr>
<td></td>
<td>Barry McGale</td>
<td>Tom Connell</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>048 71865127</td>
<td>072 52900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SHSSB</td>
<td>NEHB</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Deirdre McNamee</td>
<td>Roisin Lowry</td>
<td>MEH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>028 37520500</td>
<td>041 6850674</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-Border Service for Managing PND</td>
<td>CBCH&amp;SS</td>
<td>NEHB</td>
<td>Policy/Strategic</td>
<td>Expectant mother and mothers with babies &lt;2 years</td>
<td>Information, assessment, screening and counselling</td>
</tr>
<tr>
<td></td>
<td>Roisin Burns</td>
<td>Rosemary O’Callaghan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>048 38831983</td>
<td>042 9385417</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young Men &amp; Positive Mental Health</td>
<td>Western Health and Social Services</td>
<td>North Western Health Board</td>
<td>Policy/Strategic</td>
<td>Young men</td>
<td>Assess attitudes to help-seeking behaviour and develop interventions</td>
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<td></td>
<td>Demot Lynch</td>
<td>Anne Sheridan</td>
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<td></td>
<td>028 82835292</td>
<td>074 23786</td>
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<td>Support Services for Cancer Patients</td>
<td>Ulster Cancer Foundation</td>
<td>Irish Cancer Society</td>
<td>Informal</td>
<td>Cancer patients</td>
<td>Support for cancer patients</td>
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<td></td>
<td>Eileen Creery</td>
<td>Olwyn Ryan</td>
<td></td>
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<td></td>
<td>028 90 926320</td>
<td>01 6681855</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting Positive Mental Health in Rural Communities</td>
<td>RH&amp;SWP</td>
<td>NWHB</td>
<td>Discrete</td>
<td>General</td>
<td>Promote cross-border co-operation concerning the promotion of mental health and well being in rural communities.</td>
</tr>
<tr>
<td></td>
<td>Therese Lowry</td>
<td>Anne Sheridan</td>
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<td>074 23786</td>
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<td>Homefirst</td>
<td>NUI, Galway</td>
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<td></td>
<td>Mary O’Neill</td>
<td>Dr. Margaret Barry</td>
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<td>048 25635575</td>
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<td>Suicide Awareness Strategy</td>
<td>Suicide Awareness Co-ordinators in</td>
<td>Suicide Resource Officers in Republic of</td>
<td>Informal</td>
<td>General</td>
<td>Development of Suicide Strategy</td>
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<td></td>
<td>Northern Ireland</td>
<td>Ireland</td>
<td></td>
<td></td>
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</tbody>
</table>
### Table 1 continued: Summary of the 19 Cross-Border Projects with a Mental Health Focus

<table>
<thead>
<tr>
<th>NAME OF PROJECT</th>
<th>Lead Agency NI</th>
<th>Lead Agency ROI</th>
<th>Collaboration</th>
<th>Target Population</th>
<th>Key Focus</th>
</tr>
</thead>
</table>
| Melvin Project  | Action Mental Health  
John McBride  
028 686 59934  
NWHB  
Eithne O’Sullivan  
072 20400 | NWHB  
Eithne O’Sullivan  
072 20400 | Discrete and Other | Adults, individuals mental health/behavioural problems | Social rehabilitation |
| Cognitive Therapy Training  
and Research Project | Sperrin Lakeland  
HSC Trust  
Dr. Kate Gillespie  
028 82835288 | NWHB  
Pat Benson  
071 42111 | Discrete | Adults with mental health difficulties | Psychotherapy, enhance health and well-being |
| National Schizophrenia  
Northern Ireland and  
Schizophrenia Ireland | National  
Schizophrenia  
Fellowship NI  
Michael Woodhall  
028 90403232 | Schizophrenia  
Ireland  
Orla O’Neill  
01 8601602 | Informal | Those affected by Schizophrenia | Support services, information |
| Young People Alcohol and Drugs | NWHB  
Roisin McBride  
075 21044 | Informal | School children | Drug and alcohol intervention |
| V.O.T.E. | Action Mental Health  
Linda Leonard  
028 9043726 | TIE Project  
Frances Smyth  
091 528122 | Other | Young people aged 16-25 | Vocational training for people with disability, mental illness or complex needs. |
| Shared Frontiers | Sperrin Lakeland  
HSCT  
Seamus Garvey  
028 82835316 | NWHB  
Pat Benson  
071 42111 | Other | Adults with an identified mental health or behavioural problems | Assessment of current needs of those with mental health problems. |
| Promoting Mental Health in the Older Person Conference | SHSSB  
Deirdre McNamee  
028 37520500 | NEHB  
Roisin Lowry  
041 6850674 | Informal | Elderly | Enhance health and well being of the elderly |
## Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

<table>
<thead>
<tr>
<th>NAME OF PROJECT</th>
<th>Lead Agency NI</th>
<th>Lead Agency ROI</th>
<th>Collaboration</th>
<th>Key Focus</th>
<th>Target Population</th>
<th>Project Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARL (XB Activities in Restorative Labour)</td>
<td>Queens University Belfast</td>
<td>Rehab Group Moore Belfast</td>
<td>Discrete</td>
<td>Vocational/rehabilitation training</td>
<td>Disadvantaged</td>
<td>Outcomes of children and young people with a mental health problem</td>
</tr>
<tr>
<td>INSURE</td>
<td>University College Dublin</td>
<td>Queens University Belfast</td>
<td>Discrete</td>
<td>Epidemiological study of suicide and its risk factors</td>
<td>General</td>
<td>Outcomes of children and young people with a mental health problem</td>
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<tr>
<td>Downe Residential/Cheel Training</td>
<td>Dr Kevin Malone 01 8852174</td>
<td>Derg Finn Partnership Peter Byrne 072 69048</td>
<td>Informal</td>
<td>Provide autism specific training for staff</td>
<td>Adults with an identified mental health or behavioural problem</td>
<td>Outcomes of children and young people with a mental health problem</td>
</tr>
<tr>
<td>Cheel Training</td>
<td>Clare O’Mahony 028 90641346</td>
<td>Cheel Training</td>
<td>Informal</td>
<td>Improve QOL (quality of life) of disadvantaged</td>
<td>Disability/Elderly/Caregivers</td>
<td>Outcomes of children and young people with a mental health problem</td>
</tr>
<tr>
<td>Derg Finn Partnership</td>
<td>Head office Paul Anderson 074 32438</td>
<td>Outreach office in NI Claire Keatinge 028 90641346</td>
<td>Informal</td>
<td>Identify health promotion initiatives for older people</td>
<td>Elderly</td>
<td>Outcomes of children and young people with a mental health problem</td>
</tr>
<tr>
<td>Outreach to women in prostitution, health support and counselling</td>
<td>National Council for Aging and Older</td>
<td>Age Concern Claire Keatinge 028 90641346</td>
<td>Informal</td>
<td>Outreach to women in prostitution, health support and counselling</td>
<td>Adults, midlife</td>
<td>Outcomes of children and young people with a mental health problem</td>
</tr>
</tbody>
</table>

### Table 1 continued: Summary of the 19 Cross-Border Projects with a Mental Health Focus
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

All 19 cross-border projects with a mental health promotion focus were categorised in one of six categories as devised by Health Promotion Wales (1995). These categories are as follows:

- **Category 1** - Mental Health Promotion programmes which have been universally applied to everybody within or across particular developmental stages or within a particular setting.
- **Category 2** - Programmes related to infants and pre-school children within high risk groups (e.g. play groups, parenting projects).
- **Category 3** - Programmes related to school aged children or young people within high risk groups (e.g. young carers, special needs).
- **Category 4** - Programmes related to adults or elderly within high risk groups (e.g. post-natal, social support, helplines).
- **Category 5** - Programmes related to individuals or groups with an early or less disabling mental health or behaviour problem (e.g. occupational health, self help).
- **Category 6** - Programmes related to individuals or groups with an identified severe mental health or behavioural problem or a diagnosed mental illness.

All categories with the exception of Category 2 were represented. Summary descriptions of the projects in each of these categories are available from the authors on request.

**Case Studies**
The five case studies are now presented:

**Case Study 1: Concerned About Suicide**

**Target:** General Population

<table>
<thead>
<tr>
<th>Northern Ireland</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Barry McGale</td>
<td>Ms Deirdre McNamee</td>
</tr>
<tr>
<td>Suicide Awareness Co-ordinator</td>
<td>Mental Health Promotion Officer</td>
</tr>
<tr>
<td>Health Promotion Department</td>
<td>Health Promotion Department</td>
</tr>
<tr>
<td>Western Health and Social Services Board</td>
<td>Southern Health and Social Services Board</td>
</tr>
<tr>
<td>Lime Villa</td>
<td>Lisanally House</td>
</tr>
<tr>
<td>12c Gransha Park</td>
<td>87 Lisanally Lane</td>
</tr>
<tr>
<td>Londonderry BT45 6WJ</td>
<td>Armagh BT61 7HW</td>
</tr>
<tr>
<td>(028) 7186 5127</td>
<td>(028) 3752 0500</td>
</tr>
<tr>
<td>bmgalewestcare.n-i.nhs.uk</td>
<td><a href="mailto:hpromotion@adhsst.n-i.nhs.uk">hpromotion@adhsst.n-i.nhs.uk</a></td>
</tr>
</tbody>
</table>
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

<table>
<thead>
<tr>
<th>Republic of Ireland</th>
<th>Ms. Roisin Lowry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Tom Connell</td>
<td>Regional Officer Mental Health Promotion</td>
</tr>
<tr>
<td>Suicide Resource Officer</td>
<td>and Suicide Prevention</td>
</tr>
<tr>
<td>Department of Public Health</td>
<td>Health Promotion Department</td>
</tr>
<tr>
<td>North Western Health Board</td>
<td>North Eastern Health Board</td>
</tr>
<tr>
<td>Bishop’s Street</td>
<td>St. Brigid’s Hospital</td>
</tr>
<tr>
<td>Ballyshannon</td>
<td>Ardee</td>
</tr>
<tr>
<td>Co. Donegal</td>
<td>Co. Louth</td>
</tr>
<tr>
<td>(072) 52900</td>
<td>(041) 685 0674</td>
</tr>
<tr>
<td><a href="mailto:thomas.connell@nwhb.ie">thomas.connell@nwhb.ie</a></td>
<td><a href="mailto:roisin.lowry@nehb.ie">roisin.lowry@nehb.ie</a></td>
</tr>
</tbody>
</table>

Background to the Project

Project Rationale

Suicide rates have increased throughout Europe in the past 15 years (Casey 1997). In both Northern Ireland and the Republic of Ireland, suicide rates have been increasing each year. This increase in suicide has been particularly marked among young men between the ages of 15 and 24. In 1997 869 young people aged between 15 and 24 died by suicide in the U.K. and Ireland. There are two suicides every day, 80% by young men. Suicide is a major cause of death in young people (Concerned About Suicide 2001).

Between 1945 and 1995 the rate of suicide in the Republic of Ireland rose from 2.38 per 100,000 population to 10.69 per 100,000 (Report of the National Task Force on Suicide 1998). In Northern Ireland a steadily rising incidence of depression and suicide has been noted in recent years (Foster et al. 1997) and several regional and national policy documents have emphasised the need for action in this area (DHSS 1996 and 1997; Homefirst Community Trust 1998).

Many young people carry out what are called acts of deliberate self-harm, and while not all of these could be classified as attempting suicide, many of them are. Women aged between 15 and 19 years and men aged between 15 and 34 have the highest rates of self-harm. The rate of attempted suicide by young men and boys aged 15-24 has more than doubled since the mid 1980s. In young women the trend is less marked but there has been a 42% increase in attempts by those of 15-24 years since 1992 (A Cry for Help, The Samaritans 2000). Parents are often concerned or confused about the many changes going on in young people’s lives. They can often be the first to identify that their child has a problem with their emotions or behaviour; however it can be difficult, painful or embarrassing to seek help.
Suicide Resource Officers (ROI) and Suicide Awareness Co-ordinators (NI) are frequently contacted about these concerns and feel there is a need for information that can allay parents’ fears. In response, the Concerned About Suicide leaflet project was proposed to highlight the risk factors around suicide and to suggest what people should do if they are concerned. The leaflet would initially be distributed throughout the CAWT area and if successful could be distributed throughout Ireland, both North and South.

This project was developed based on a model which had been used by the US State of Washington. The idea was to replicate the Washington model in Ireland and produce a relevant information leaflet.

**Project Aim**
The aim of this project was:
- To provide information on suicide awareness to the public.

**Project Objectives**
The objectives set for this project were:
- To create awareness of suicide warning signs.
- To provide information on what to do when concerned.
- To encourage people to seek help.

It was envisaged that as a result of the dissemination of the leaflet the public would:
- Be more aware of suicide prevention messages.
- Be more aware of suicide warning signs.
- Be more comfortable about ‘Asking the suicide question’.
- Be more aware of how to get help.

**Duration**
The leaflet project started at the beginning of 1999 but the group had been meeting prior to this. This project and contact is ongoing.

**Funding**
Funding was sought and received from Co-operation And Working Together (CAWT) and also from the respective boards within the CAWT area.

**Intervention Approaches**
The leaflet was launched in the four CAWT areas in May 2001. It was then launched on an all-Ireland basis in October 2001, for use and distribution by all health boards North and South of the border.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

**Cross-Border Co-operation Structures**

A Steering group was established to manage this project consisting of two Suicide Awareness Co-ordinators (WHSSB), a Mental Health Promotion Officer (SHSSB), and two Suicide Resource Officers (NEHB and NWHB).

Regular reports on the project are not produced; however minutes for each meeting are recorded. These minutes are available. There are two members from the North and two members from the South actively involved in the project delivery.

A formal evaluation is planned at time of writing. However the cross-border working is not being explicitly evaluated. When the evaluation is completed the report will be available. Specific outcomes for cross-border co-operation have been agreed.

**Nature of Cross-Border Contact**

The cross-border partners meet every six to eight weeks at the steering group meetings and also keep in close contact by phone and email. Meetings are held mostly in Monaghan, as it is a central location for all involved.

Contact at this stage of the project is with professionals, but in the initial pilot phase clinical and lay people contributed to the design of the information in the leaflet. With the distribution of the leaflet throughout the CAWT area, contact will be at a community level.

Although the project team was an established group of three years standing, most of the team felt that contact had been made between people who would not otherwise have had this kind of cross-border contact, such as different health promotion teams.

Although not all of the team members on this project had made new contacts, some members made many new contacts. For example, at the Irish Association of Suicidology conference in Ennis (September 2000) delegates were asked to fill in feedback forms on the design of the leaflet. Feedback was received from as far away as Australia.

New links along with established links have been beneficial in other aspects of work. It has been very beneficial in terms of sharing information. The group now actively is looking at starting different projects such as ‘Mental Health Promotion Through Sports’. This has resulted not just from the cross-border contact but from contact with the health promotion teams.

**Perceptions of Cross-Border Working**

Every quarter the Suicide Co-ordinators (NI) and Suicide Resource Officers (ROI) meet to discuss relevant issues. The group felt that they served the same population needs, targeted the same groups of people and provided the same resolutions to meet those needs. It made sense to work together, as the only real differences were small local issues such as health board structures.
All involved in the project felt that their individual expectations of cross-border work were met. This type of work was considered to be very worthwhile. Everybody was keen to work collaboratively and both time and printing costs were saved by the combined effort.

There were many benefits to the cross-border element of this work. Realising that all are dealing and working with the same issues regardless of which health system one works with was considered important. Other benefits mentioned were establishing contacts, sharing information, and collaboration among like-minded people.

No real cultural differences were encountered in this project. Terminology and health board structures may be different but those working in the area were like-minded people with the same objectives. As professionals they were all ‘singing from the same sheet’ and the border was really a non-entity.

The cross-border experience was very positive and beneficial for this group. Within the CAWT area, cross-border is now a way of working - not just an experience, and it was felt that this is very much the way forward. Although cross-border structures may be different, this has helped to bring the boards together, to feed off one another and break down any barriers to mental health promotion together.

All involved felt the cross-border element worked extremely well and all involved were united in working together. Aside from the constraining costs of telecommunications and distance, working on a cross-border basis is not very different from working on a cross-board basis.

For all team members the single greatest difficulty associated with the cross-border element of this project was the geographical spread and the travelling constraints of getting the group together.

When asked what the single greatest success of the cross-border element of this project was, individual team members gave a variety of responses. The successes identified were the establishing of networks, sharing ideas, developing relationships, identifying new projects to work on and realising that all involved are confronting the same issues and that there are no real differences between their jobs, North and South.

When asked what they would like to see the project achieve in terms of its cross-border function, all agreed they would like to see the original aims and objectives of the project met. The network has now been established and it would be important to build on this and develop other proposals. The ultimate aim is to raise awareness around the issue of suicide and to encourage people to seek help before the event.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

In order for the project to achieve what it set out to do in terms of the cross-border function, it is essential that the leaflet becomes an all-Ireland project. Suicide is an all-Ireland issue and not just a border issue. The CAWT process can help to achieve this. Senior level commitment already exists as the relevant health board managers sit on CAWT committees.

The group felt that this project is an excellent opportunity to do a piece of work that will be of great benefit to people on the ground and will hopefully lead to replication in other areas.

This work gives the group and individual team members a profile. It is important to be seen by communities and to get to know your communities.

There is a difference between funding and policy mechanisms on both sides of the border. While the eventual outcomes are the same, the manner in which the logistics of funding and policy are addressed can be different.

Case Study 2: Cross-Border Post-Natal Depression Service

Target Population: Expectant mothers and mothers with babies up to the age of 2.

<table>
<thead>
<tr>
<th>Northern Ireland</th>
<th>Republic of Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Roisin Burns</td>
<td>Ms. Rosemary O’Callaghan</td>
</tr>
<tr>
<td>Director of Elderly and Primary Care</td>
<td>Development Officer for Women’s</td>
</tr>
<tr>
<td>Craigavon &amp; Banbridge Community</td>
<td>Health</td>
</tr>
<tr>
<td>HSS Trust</td>
<td>North Eastern Health Board</td>
</tr>
<tr>
<td>Bannvale House</td>
<td>3 Chapel Street</td>
</tr>
<tr>
<td>10 Moyallen Road</td>
<td>Dundalk</td>
</tr>
<tr>
<td>Gilford</td>
<td>Co. Louth</td>
</tr>
<tr>
<td>Co. Armagh BT63 SJX</td>
<td>(042) 9385417</td>
</tr>
<tr>
<td>(028) 3883 1983</td>
<td></td>
</tr>
</tbody>
</table>

Background to the Project

Project Rationale

The Irish National Health Promotion Strategy (Department of Health and Children 2000) identified women as a target population with special needs. One of the objectives set out to improve the health status of Irish women was the promotion of positive mental health especially at vulnerable times in women’s lives. At particular life stages, such as pregnancy, women have important associations with mental health problems, as acknowledged in Northern Ireland’s Minding Our Health draft strategy document (Health Promotion Agency 2000).
Post-natal depression is a significant public health problem experienced by 10-15% of mothers, which causes considerable distress to mothers, children, families and society. The distress caused by post-natal depression is often misunderstood both by the public and health care professionals alike. It is therefore frequently hidden and suffered alone (O’Callaghan 2000). Although it is a common disorder, only half of those affected seek medical help (Health Promotion Unit 1998). Post-natal depression occurs at a time when contact with health care professionals is at its peak. All interactions with mothers can be used more effectively for primary, secondary and tertiary prevention of post-natal depression (O’Callaghan 2000).

Research suggests that effective interventions can help prevent, detect and reduce the impact of post-natal depression. Prompt interventions may reduce the following adverse effects:

- the unhappiness caused by post-natal depression.
- the adverse effects on the child’s behavioural, emotional and cognitive development.
- possible adverse effects on the parent’s relationship which may lead to family breakdown or divorce (O’Callaghan 2000).

Following research by O’Callaghan (2000) on post-natal depression, a gap in service provision was identified at Louth County Hospital, Dundalk. To address this gap, a post-natal support service was set up to offer information, assessment, screening and counselling to distressed mothers. It was felt that by extending this project to include the post-natal services in Northern Ireland, the service could be improved by the sharing of resources, ideas, information and best practice.

**Project Aims**

The aims of this project are:

- To provide a cross-border multi-disciplinary service to develop greater awareness of post-natal depression.
- For all disciplines to facilitate identification of mothers at risk of post-natal depression.
- To offer increased support, counselling and medical assistance to reduce the impact of depression on the mother, the child and the family.

**Project Objectives**

The objectives set out to achieve these aims are:

- Provision of a cross-border multi-disciplinary service on post-natal depression to reduce the adverse effects on mothers and families.
- Mothers at risk will be identified and offered increased support, counselling and medical assistance to reduce the incidence or impact of post-natal depression.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

**Duration**
The Cross-Border Service for Managing Post-Natal Depression was proposed in July 2000. Health visitors in Northern Ireland had already received awareness training and have been using the Edinburgh Post-Natal Depression Scale (EPDS) for several years. A meeting with health managers from Northern Ireland and the Republic of Ireland took place in September 2000 and the project in its present form was due to run to March 2001. Health professionals from each side of the border have been trained to participate in this work and to help integrate it into normal board practice so the work can continue into the future.

**Funding**
Funding for Phase 1 of this project was sought and received from CAWT (Co-operation and Working Together). Phase 2 will be funded by different budgets within the boards involved.

**Intervention Approaches**
A strategic approach, involving multi-disciplinary training and service provision for health care professionals, was developed. The mother is offered screening, using the EPDS. Outcomes will be monitored and evaluated using the same scale.

An empowering approach is used where information on post-natal depression is distributed to all new mothers in contact with the service. Phone support is offered and, if required, counselling is offered to enable the new mother to develop coping strategies. In Northern Ireland all mothers are offered listening visits if post-natal depression is identified.

Health professionals involved in maternal and child health have been trained within both health board areas to use these approaches and to deliver this service. In this way awareness is created, information is shared, and the service can expand and cascade to community level. The planned outcome of this is the prevention of post-natal depression at primary, secondary and tertiary levels. This service has been advertised locally to GPs and public health nurses.

**Cross-Border Co-operation Structures**
This project was guided and driven by a multi-disciplinary steering group consisting of a psychiatrist (North), GPs (North and South), community managers (North), director of nursing (South), public health physician (South), midwife (South), health visitors (North) and health promotion officers (North and South).

Regular reports on progress are produced and copies of these progress reports are available. There are six members from the North and six members from the South actively involved in both the management of the project and its delivery.

The Edinburgh Post-Natal Depression Scale (EPDS) is being used to screen new mothers and this aspect of the project is evaluated by audit. As this project is being funded by CAWT under their Cross-Border Acute Project (CBAP) banner, a
formal evaluation will be carried out by the University of Ulster. When the evaluation is completed the reports will be available. The element of cross-border working is not currently being explicitly evaluated, but it will be at a later date. As yet no specific outcomes or objectives for cross-border co-operation have been agreed but they are under discussion and will be available when they are established.

**Nature of Cross-Border Contact**
The cross-border partners meet every four to six weeks and these meetings take place at alternate sites North and South. Most of the contact is between health professionals but work is continuing at community level.

All involved in this project felt contact had been made between people who otherwise would not have had this kind of cross-border contact. New contacts had been made by the project partners with other health professionals such as health promotion and public health professionals. All interviewed felt that these links have been beneficial in other aspects of their work. Talking to cross-border partners and health professionals from the various fields gave the opportunity to learn from the experience of others both in terms of best practice and also with regard to mistakes made.

**Perceptions of Cross-Border Working**
To enable the development of the post-natal service set up in Louth General Hospital, and to ensure long term benefits for mothers and their families, funding was sought from CAWT (Co-operation And Working Together). By looking at this service as a cross-border option the project was eligible for CAWT funding. The post-natal services in the North are more advanced and it was felt that a lot of learning and education could be exchanged through this expansion. It is hoped that the work across borders will continue. An enormous amount of enthusiasm has been apparent from both project partners. Initial expectations have been both met and surpassed.

The main benefits of the cross-border element of this project have been meeting new people and developing new relationships. Also mentioned are the benefits of learning from other people’s ideas and their experiences of establishing a similar system elsewhere. Increased understanding, learning and sharing are all important benefits.

The project has led to a greater understanding of cultural differences but mostly of the differences between the two health care systems. In Northern Ireland there is an established referral system. In the Republic of Ireland there is no statutory or voluntary referral system.

**Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices**
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

The experience of working on a cross-border project was seen as very positive, with one project partner stating they would definitely consider a cross-border element if they were to work on a similar initiative in the future. The cross-border element worked well with everyone co-operating with regard to meetings and training sessions.

The main difficulty encountered was the difference between the two health care systems. The Public Health Nurse (ROI) service is a different process to the Midwifery and Health Visiting service (NI).

The cross-border element of this project has been successful in developing a service in both jurisdictions. This service can be built upon and developed to provide a more comprehensive service in the future. The interaction between professionals was inspiring. The enthusiasm displayed by all health care professionals was evident in their willingness to share their ideas and thoughts to develop a model of best practice.

All partners agreed that networks of different disciplines working together on a cross-border basis was the way forward. This would result in ensuring that best practice and quality standards are shared and promoted. In order to achieve this future cross-border, multi-disciplinary work, it is important that the human resources are made available. With ongoing support, enthusiasm and strong leadership this should be possible.

This project received support and encouragement from management in both health boards, North and South. This has been enabling for the project.

**Case Study 3: Promoting Positive Mental Health in Rural Communities**

**Target Population:** General

<table>
<thead>
<tr>
<th>Northern Ireland</th>
<th>Republic of Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Therese Lowry</td>
<td>Ms Anne Sheridan</td>
</tr>
<tr>
<td>Rural Health and Social Wellbeing Project</td>
<td>‘Mind Matters’ Project</td>
</tr>
<tr>
<td>23-25 Broad Street, Magherafelt, Co. Londonderry</td>
<td>Health Promotion Department</td>
</tr>
<tr>
<td>BT45 6EB</td>
<td>North Western Health Board</td>
</tr>
<tr>
<td>(028) 7930 1334</td>
<td>Gate Lodge, General Hospital</td>
</tr>
<tr>
<td></td>
<td>Letterkenny, Co. Donegal</td>
</tr>
<tr>
<td></td>
<td>(074) 23786</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:anne.sheridan@nwhb.ie">anne.sheridan@nwhb.ie</a></td>
</tr>
</tbody>
</table>
Northern Ireland | Republic of Ireland
---|---
Ms Mary O’Neill | Dr. Margaret Barry
Health Promotion Service | Centre for Health Promotion Studies
Homefirst Community Trust | Clinical Science Institute
Spruce House, Cushendall Road | National University of Ireland
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Ballymena | (091) 750463
Co. Antrim | margaret.barry@nuigalway.ie
BT43 6HL | (028) 2563 5575
health.promotion@homefirst.n-i.nhs.uk

Background to the Project

Project Rationale

Promoting Positive Mental Health in Rural Communities is an innovative action research project aiming to develop a model of community mental health promotion for rural areas. The international research literature shows few examples of community-based initiatives to promote positive mental health, and this project strives to enrich this field through the development and documentation of effective practice in the area. This project aims to promote cross-border co-operation concerning the promotion of mental health and well-being in rural communities in Co. Donegal and Co. Derry/Londonderry. The project is based on participation between the local communities, health agencies and university researchers.

The Centre for Health Promotion Studies at the National University of Ireland, Galway had been implementing a health promotion initiative in four rural communities in the Republic of Ireland (Centre for Health Promotion Studies, NUI, Galway 2001). The area selected in Co. Donegal was Raphoe and the ‘Mind Matters’ project was set up in response to an expressed community desire to promote mental health and well-being in the community. In a separate initiative in Draperstown, Co Londonderry, a community development project known as the Rural Community Development and Health Project (RCDHP) was set up as a three-year pilot to explore community development and health approaches in a rural setting.

This later evolved into the Rural Health and Social Wellbeing Project (RHSWP). Both ‘Mind Matters’ and the Rural Health and Social Wellbeing Project were built upon the findings of a needs assessment process conducted at the outset from a representative sample of community members (Barry et al. 1999; Barry et al. 2000).
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

A study was commissioned (McCready 1999), with funding from the EU Programme for Peace and Reconciliation, to assess the feasibility of linking the two parallel projects in a joint cross-border initiative. The two communities have much in common and share a similar community profile. They also have had different experiences and there is much mutual learning to be gained from this.

Project Aims
The aims of the project are:
• To implement and systematically evaluate a model of mental health promotion practice based on community participation principles.
• To establish cross-border co-operation with a view to sharing information, experiences and expertise in promoting health and social well-being in rural settings.

Project Objectives
The objectives of the project are:
• To facilitate community networking, both within communities and on a cross-border basis, in addressing the shared mental health needs of rural communities.
• To develop a partnership model of practice whereby community groups will participate in and influence policy and practice with regard to the delivery of mental health and health promotion services to meet local needs.
• To impact on as wide a number of agencies as possible in order to increase understanding and awareness of the influence of broader social and economic factors on the well-being and quality of life of rural communities.
• Based on the findings from the evaluation, to inform the mainstreaming of community participation models of mental health promotion and their role in re-orienting existing statutory and voluntary health services.
• Through the process of project development and delivery, to build on and support and enhance the existing capacities of community groups to engage with voluntary and statutory agencies in addressing local needs.
• Through the sharing of experiences and expertise of community groups and health workers from both sides of the border, to facilitate understanding, co-operation and networking around issues of mutual concern.

Duration
Joint consultation on this project started in 1997. Funding was secured for this project in September 1999 and the first meeting of the Joint Steering Group took place in October 1999. Phase I of the project ran until June 2001. Funding has recently been secured for a second phase.

Funding
This project is being funded until by the ADM/CPA-administered EU Programme for Peace and Reconciliation with support from the North Western Health Board and Homefirst Community Trust.
Intervention Approaches
A wide range of interventions were implemented during Phase 1 of the project. These interventions have encompassed specific target groups (e.g. farming families, women, men and schools) as well as community-wide events, and have involved participants within, between and across communities. The interventions fall into three broad categories, listed below with examples:

1. Information and general awareness raising activities, e.g. the use of drama, the publication of media articles and information stands at local events and health fairs.
2. Community education workshops, e.g. a ‘Mental Health and Farmers’ seminar for people working with farm families and a women’s health evening.
3. Structured programmes over several weeks, e.g. a mental health life skills module in post-primary schools and a personal development programme for mental health service users.

Cross-Border Co-operation Structures
Five members from each project, including the two project workers, were initially invited to form a new cross-border steering group, together with two university researchers. Project activities are jointly planned at regular meetings of this group and the project workers are responsible for ensuring their implementation.

An interim report on the project has been produced:
- Promoting Positive Mental Health in Rural Communities: Interim Report on Phase 1 of a Cross-Border Community-Based Mental Health Promotion Project for Rural Communities (Byrne and Barry 2001).

Other reports produced are
- Rural Health and Social Wellbeing Project: Report on the Planning and Consultation Stages (Byrne and Barry 2000).
- ‘Mind Matters’: Report on the Planning and Implementation Phase of a Community-Based Mental Health Promotion Project (Byrne and Barry 2000).
- Promoting Positive Mental Health in Rural Communities: Process Report on the Development of a Cross-Border Community-Based Mental Health Promotion Project (Byrne and Barry 2000).

In addition, a number of brief reports have also been produced on each of the intervention elements. These reports are available from the Centre for Health Promotion Studies, National University of Ireland, Galway.

Currently 17 people sit on the joint steering group, 10 from the North and 7 from the South, including paid and voluntary members from the community, the services, and the university. The two project workers are closely involved in all aspects of project delivery. In addition, the majority
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

of project activities are jointly delivered by members of other organisations/agencies and some steering group members, as well as by members of various sub-groups associated with the project (e.g. farmers, services, etc).

A formal evaluation is being carried out by the Centre for Health Promotion Studies, National University of Ireland, Galway. Monitoring reports are completed every three months for the Programme for Peace and Reconciliation. The element of cross-border working is being explicitly evaluated. There is a lot of learning that happens on a cross-border basis, which is not as a result of a direct intervention. This learning is being evaluated. Cross-border objectives have been agreed and are part of the funding requirement. These objectives are listed under the heading ‘Project Objectives’ above.

Nature of Cross-Border Contact
The cross-border partners meet every six to eight weeks and meetings alternate between Raphoe and Draperstown. The cross-border contact involves both health professionals and community members.

The cross-border contact has facilitated the making of new contacts that may not have been made outside the project. All interviewed had personally made new contacts. These new contacts have been proven either directly or indirectly to be beneficial in other aspects of work.

Perceptions of Cross-border Working
Within the group there was some experience of previous cross-border work. Also the demographics of the two areas were very similar. Underneath the different structures there were similar issues. Being involved in a structured project such as this one has given the opportunity to get involved with the local community without the stigma of mental health attached.

For the most part initial expectations have been met. In one case individual expectations were modified to be more realistic with regard to the project and this was positive. This project has been a great forum to find out best practice. One respondent cautioned on the need to avoid competition and making comparisons between communities, as this may not be constructive for the project.

The project has many benefits including making new contacts and the sharing of experience and ideas. Co-operation and the networks provided by cross-border working were also beneficial.

Initially when the groups met it was found that there were no real differences between the groups in terms of religious background, agricultural background, age etc. and they both started to build a relationship of trust. Both communities now have a greater understanding of each other and are developing a greater understanding of the political and cultural differences.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

It took time to build trust and initially there were feelings of competition, but that is seen as part of the learning. Overall it has been a good and positive experience. The group has worked cohesively and there has been a sense of value and importance to the work. The cross-border element has worked well and it has improved over time. However it was felt that part of the success was due to both sides simply getting to know each other. It was felt it would be a shame not to continue with the project as a difference can be made.

Distance was mentioned most frequently as the greatest difficulty. Difficulties with distance included the time spent travelling from one community to the other. This was time taken away from one’s own community but did not facilitate getting to know those in the other community. Funding was also mentioned as a difficulty but it was acknowledged that is relevant to any project whether it is cross-border or not. Uncertainty about future funding makes it difficult to plan ahead.

This project has had a number of successes according to the interviewees. The most common theme was that the project had developed an awareness and understanding of the differences between the two communities. With time both communities realised also that they shared the same issues and problems. It was also a good opportunity to reach those who are difficult to reach regarding mental health promotion, i.e. rural communities.

All involved felt they would like to see the project and learning continue with communities taking ownership of this work. As everything to date has been documented, the success factors could be used to inform future work elsewhere. Time and money are key to making the current project continue. It will take time for the project interventions to become established in the community. Money is crucial for the project to continue. A project worker is invaluable for improving the cohesiveness of the group. It is important that there is willingness on both sides to continue.

It takes time to build trust across borders, which is why it is important that this project is maintained. To overcome the taboos about mental health we need sustained, ongoing action. This cross-border work challenges the barriers. Cross-border working provides the bridge which helps to narrow the gap between the formal treatment and the natural discussion. Cross-border is a relatively new model and it will be interesting to see the results. While the evaluation takes extra time, it justifies its value. Also it allows people in the treatment field to see another side of working. Health is a generic issue and this could be a very successful project. Given time it could be a model of best practice.
Case Study 4: Support Services for Breast, Laryngeal, Lymphoma, Ovarian, Prostate Cancer and Young People with Cancer and their families.

Target Population: Cancer patients

<table>
<thead>
<tr>
<th>Northern Ireland</th>
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<tr>
<td>Ms. Eileen Creery Ulster Cancer Foundation 40/42 Eglantine Avenue Belfast BT9 6DX (028) 9038 6320 <a href="mailto:eileencreery@btconnect.com">eileencreery@btconnect.com</a></td>
<td>Ms. Olwyn Ryan Irish Cancer Society 5 Northumberland Road Dublin 4 (01) 668 1855 <a href="mailto:oryan@irishcancer.ie">oryan@irishcancer.ie</a></td>
</tr>
</tbody>
</table>

Background to the Project

Project Rationale

Cancer is the second leading cause of death in the island of Ireland (Department of Health and Children 1999). Cassileth et al. (1984) as cited in Boer et al. (1999) notes that with regard to psychosocial problems cancer is a disease which, more than most other diseases, disorders the psychic balance from the beginning of the disease. The patient can be overwhelmed by feelings of despair, panic and other emotions and in other instances experience severe feelings of depression and apathy. Boer et al. (1999) also cite other authors who have documented that feelings of uncertainty are common among cancer patients, for example about the results of treatments and about expectations for the future.

The Irish Cancer Society, founded in 1963, is the national charity in the Republic of Ireland dedicated to preventing cancer, saving lives from cancer and improving the quality of life of those living with cancer through patient care, research and education (Irish Cancer Society 2001).

The Ulster Cancer Foundation in Northern Ireland was founded in 1969. Its Mission Statement is:

The Ulster Cancer Foundation exists to help patients and their families cope with cancer. It is also working for new and better treatments for cancer as well as helping people to reduce their risk of ever developing the disease.

A priority has been to help all those living with cancer in the community by the provision of support services for cancer patients and their families across the province. These include services such as a freephone helpline, nurse counsellors, the Belfast City Hospital Cancer Centre, Belvoir Park Hospital and four cancer units throughout the province. The Foundation’s counsellors and befrienders have helped many in coping with a diagnosis of cancer in the family (Ulster Cancer Foundation 2001).
Informal contact was first established between the Ulster Cancer Foundation and the Irish Cancer Society about 18 years ago. During the 1980s the groups received funding from Co-operation North (now Co-operation Ireland) and at this time meetings were more formal and structured. However since this funding has declined meetings have been less frequent and are informal.

Support services for breast, laryngeal, lymphoma, ovarian, prostate cancer, and young people with cancer were developed 10 years ago in the Ulster Cancer Foundation. The cross-border element developed approximately eight years ago. This is an informal arrangement with recovering cancer patients in the Republic of Ireland travelling to Northern Ireland to avail of the support services offered by the Ulster Cancer Foundation.

The project provides support groups for cancer patients and their families. All of the support groups are patient-focused. All patients are asked what it is they want from the meetings. Topics for the support group meetings range from aromatherapy to medical speakers.

Also provided are:
- A professional fitting service for mastectomy patients.
- A volunteer befriending service.
- A freephone helpline.
- Professional counselling.

**Project Aim**

The aim of this project is:
- To provide on-going support for cancer patients and their families.

**Cross-Border Arrangements**

At the moment there is no formal arrangement between the Ulster Cancer Foundation and the Irish Cancer Society; rather what appears to have developed is that patients from the Republic in need of cancer support services have found that there is no such service and then contact the service in Northern Ireland.

**Funding**

Both the Ulster Cancer Society and the Irish Cancer Society are charities and are funded by donations from the public. The cost of travelling from the Republic of Ireland to Northern Ireland may be prohibitive for some patients in need of support, so the possibility of having this funded by a transportation company is currently under investigation.

**Intervention Approaches**

All interventions are patient-focused and services are patient-led. At the beginning of each year, every patient on the Ulster Cancer Foundation database is contacted and asked if they wish to remain on the database for support services.
The Foundation has a range of support groups that meet in various centres throughout Northern Ireland. These groups meet regularly and are facilitated by Ulster Cancer Foundation Nurses.

There is a free telephone and call-in service. Accurate and easily understood information is available on all aspects of cancer. This service is provided by specially trained nurses with experience in cancer care. It is confidential and available for patients, relatives and anyone concerned about cancer, including health professionals.

An attractive range of bras and swimwear is available at Ulster Cancer Foundation’s headquarters at Eglantine Avenue in Belfast and in a regional office at 14-16 The Diamond in Londonderry. The Ulster Cancer Foundation and the regional officer also stock a wide range of attractive head coverings for patients experiencing hair loss due to chemotherapy. This service is also used by patients living in border counties in the Republic of Ireland.

The Foundation provides a professional counselling service and psychosocial support service for cancer patients and their families. Counselling and volunteer befriending would all be carried out as required and requested.

**Structures**

This project (NI only) is co-ordinated by Eileen Creery. There are no formal cross-border structures.

Regular reports are produced. Most of these are support group evaluations. There are approximately 87 reports in all. Copies of all reports are available. Where necessary names and addresses of participants are omitted to protect confidentiality. There are two members from Northern Ireland actively involved in the project’s management and 10 members actively involved in project delivery.

Each support group meeting is evaluated separately. The group facilitator records a list of names and addresses of people who attend, how well the guest speaker was accepted (in terms of suitability, interest etc.) and feedback from the participants. An evaluation of the services offered by the Ulster Cancer Foundation has been completed and this report is available. The cross-border element of working together is not being explicitly evaluated and no specific outcomes/objectives for cross-border co-operation have been agreed.

**Nature of Cross-Border Contact**

At the professional level the Irish Cancer Society and Ulster Cancer Foundation meet informally twice a year at conferences and meetings. At the community level (in Northern Ireland) the breast and laryngeal, lymphoma, prostate and young people with cancer support groups meet quarterly. The ovarian support groups meet more regularly i.e. monthly excluding July and August.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

All the support group meetings take place in various hospitals, leisure centres and health clinics in Northern Ireland. All the support group contact is at a patient level.

This cross-border work developed because people from the South would ring the cancer support services in the North. They might ring about advice on mastectomy bras and other pieces of equipment and would hear about the support group meetings. There are no similar support groups in the Republic of Ireland so they want to attend those in Northern Ireland. This is particularly true of the border counties, and of breast cancer patients and laryngeal cancer patients.

Perceptions of Cross-Border Working

Prior to the informal arrangement between the Irish Cancer Society and the Ulster Cancer Foundation, cross-border contact would not have been made between people. New contacts have been made both professionally on a cross-border basis and at community level through the support groups. These new links are beneficial in other aspects of work. Existing contacts have been strengthened and there is a sense of enjoyment in being able to facilitate and support people from anywhere who all have the same needs.

No expectations had been set for this project. The service is seen more as an information source and it is up to the individuals to use the information that is made available to them. The main benefit of this service is that it is a patient-focused service and there are few patient-focused services available. The project has not led to a greater understanding of cultural differences between service users. The cross-border nature of this project is described as a positive experience, which is working well at the moment, although there is plenty of scope for expansion.

The single greatest difficulty of this project is getting access to patients’ names and addresses in the Republic of Ireland. Meeting with breast cancer nurses from the Republic of Ireland would help in co-ordinating project services.

The single greatest success of this project is offering support to patients who are in need of it and do not have the service in their own jurisdiction. In terms of its cross-border function the project could become more active and have more participants. In order to see the project become more active the Ulster Cancer Foundation should work more formally and closer with the Irish Cancer Society.
Case Study 5: Young Men and Positive Mental Health

Target Population: Young men

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<thead>
<tr>
<th>Northern Ireland</th>
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<tr>
<td>Mr. Dermot Lynch</td>
<td>Anne Sheridan</td>
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<tr>
<td>Suicide Awareness Co-ordinator</td>
<td>Health Promotion Service</td>
</tr>
<tr>
<td>Western Health and Social Services Board</td>
<td>North Western Health Board</td>
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<tr>
<td>Tyrone and Fermanagh Hospital</td>
<td>Gate Lodge</td>
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<tr>
<td>Omagh</td>
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<td>Co. Tyrone</td>
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<td></td>
<td><a href="mailto:anne.sheridan@nwhb.ie">anne.sheridan@nwhb.ie</a></td>
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</table>

Background to the Project

Project Rationale

Suicide rates have been increasing every year in both Northern Ireland and the Republic of Ireland. Swanick (1997), cited in Brady (2000), refers to the growing concern about the rising rate of suicide among young men. This increase in suicide has been particularly marked among young men between the ages of 15 and 24. In 1997 869 young people aged between 15 and 24 died by suicide in the U.K. and Ireland (The Samaritans 1998).

Several studies point to the role of mental health professionals in helping to reduce the suicide rate. Brady in her 2000 report cites some of these studies and makes particular note of the role of GPs and nurses in the community setting.

The Young Men and Positive Mental Health Project (YM&PMH) arose from concerns regarding the rising rate of suicide among young men. The project is an action research project aiming to assess and address mental health needs and identify attitudes that stand in the way of people seeking help. The target group were men aged between 15 and 30 years living the Finn Derg Valley area, a rural cross-border area covering parts of counties Donegal and Tyrone (Brady 2000).

Project Aims

The project aimed to:

- Promote positive mental health among young men aged 15-30 years.
- Reduce the suicide rate among this group.
- Raise local awareness regarding the emotional needs of men and other related issues.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

Project Objectives
The objectives set to meet these aims were:
• To assess the current situation regarding local men’s mental health needs.
• To design interventions based on the findings of research conducted locally, as well as elsewhere, which would provide young men with alternative ways of coping with problems.
• To feed back research findings to the local community, and work to raise men’s mental health as an issue of priority.

Duration
The project was carried out over two years starting in May 1998. The first year was dedicated to research looking at local attitudes towards men and a focus group study with men giving their own views (Brady 1999). The second year was dedicated to implementing and evaluating interventions based on year one research (Brady 2000). The final report was launched in Stranorlar, Co. Donegal, in November 2000. Following this, funding was made available for a six-month follow-up on the recommendations in the Donegal region.

Funding
The Young Men and Positive Mental Health project was funded through the Mental Health Association of Ireland for two years by the EU Programme for Peace and Reconciliation and through CAWT.

Intervention Approaches
Difficulties have been encountered in engaging young men in health promotion work. It was decided, based on year one research findings, that the best way around this problem would be to provide training for those in the study already working with young men (Brady 2000). Work was focused on three main areas:
• Schools
Four schools within the study area (two in Tyrone and two in Donegal) took part in a pilot mental health module. This module was based on five key areas taken from the research: mental health, positive coping, relationships, help seeking and services, and gender and youth. Training was given to all teachers and youth workers involved in the delivery of this module. The module was run over 10 weeks in the schools.
• Local community
The key findings of year one research were fed back to the community with information evenings in Donegal and Tyrone. Specifically targeted were those who are involved with young men on a regular basis and they were invited to attend training in the form of ‘Youth and Gender’ Workshops. In all 34 people received this training including Samaritan volunteers, FAS supervisors, sports coaches, teachers, health and religious workers.
• Services
Two types of training were piloted with staff from the mental health services:
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

The ‘Youth and Gender’ one-day training workshop was attended by nursing staff from a local psychiatric day hospital facility. Local youth workers also attended. It aimed to raise awareness of issues relating to the mental health of young people, particularly young men, as well as teaching new methods for engaging patients in group work.

A one-day workshop on ‘Suicide Risk Assessment’ was attended by 15 community-based nursing and counselling staff. Due to the increasing rate of suicide among young men, this was felt to be a valuable intervention and was organised by the project using trainers from WHSSB (Brady 2000).

Cross-Border Co-operation Structures
The project was managed on a day to day basis by Health Promotion Services, NWHB, but in terms of overall direction was managed by the steering group. The steering group was multi-disciplinary and drew members from Northern Ireland and the Republic of Ireland. Areas represented in the membership included health promotion, suicide awareness, psychiatry, voluntary sector, youth and community sector, teachers, and both Mental Health Associations.

Regular reports on the project are available and they are:
- Update report, October 1998
- Update report, April 1999
- Year 1 Research Report, October 1999
- Update Report, January 2000
- Final Project Report, October 2000
- Summary Final Report, October 2000

There are 12 members, six from the North and six from the South, actively involved in the management of the project. The numbers involved in the delivery vary depending on the intervention.

A formal evaluation of the project was not required by the funding organisation. Evaluations of the various project interventions did take place in the course of the project. The cross-border element of this project is not being explicitly evaluated. Specific outcomes/objectives for cross-border co-operation have not been agreed. The final report (Brady 2000) does not distinguish between the two border regions as the border did not really have an impact on attitudes - there was no great difference between the two areas.

Nature of Cross-Border Contact
For the duration of the project the cross-border partners met approximately twice a year. The project worker met with the cross-border partners every two months. All the meetings between the cross-border partners took place in Ballybofey, Co. Donegal.
There was no formal community cross-border contact. Contact was at professional and voluntary level and included teachers being jointly trained and a variety of professionals attending awareness seminars and workshops. Contact has been made with people who otherwise would not have had this kind of cross-border contact such as teachers, youth workers and mental health professionals. These contacts have resulted in professional relationships which continued after the life of the project. All interviewed had made new contacts, particularly in health promotion and the voluntary sector. These new links have been beneficial in other aspects of work and one respondent has continued to work in the area of young men and mental health.

Perceptions of Cross-Border Working
The idea for taking a cross-border geographical area and focusing a project on men’s mental health took root in 1997. The Finn Derg valley was identified because suicide of young men was an issue in both areas and they had similar mental health and social needs. It made sense to study these, share knowledge and pool resources. Co-operation and Working Together (CAWT) funding made this possible.

Initial expectations have been met by all involved. This type of co-working was considered to have been informative because of the exchange and sharing of ideas. There was a suggestion that these exchanges should be ongoing formally and informally.

The project had many benefits including the exchange of ideas on effective practice, learning from each other and sharing resources. It has resulted in the establishing of multidisciplinary networks and training on a cross-border basis. The project was found to lead to greater understanding of cultural differences and also a greater understanding of cultural similarities. Differences in each system were realised, understood and addressed, whereas there were no great differences in attitudes on both sides.

Different people had different experiences of the cross-border nature of the project. As the work was initially perceived as coming out of the Republic of Ireland, extra steps and effort had to be made to change that perception. Sitting around the table with colleagues from across the border was described as interesting and informative. Membership of the steering group was described as a very positive experience where one felt valued, and this was strongly recommended.

The cross-border element improved as more contacts were made at grassroots level. Although the project always had the support of the health boards, improved contact at grassroots level gave the project more access to communities on the ground. Although this particular project is now finished, one of its lessons was that every speciality and discipline should have links with their partners in the other jurisdiction.
No preparatory work was done before the project started and this was the single greatest difficulty associated with the cross-border element of this project. Because of this, cross-border partners had some difficulties with shared ownership and contact, with some members trying to take ownership to the exclusion of others. Defining the nature of true cross-border work and agreeing expectations on this from the outset should help avoid this in future cases.

The single greatest success associated with this project was highlighting the mental health needs of young men aged 15-30. The schools initiative and the suicide risk assessment training for health professionals were also considered to be very successful. Networking at community level was important. It is hard to gain access to communities on the ground but this project enabled this to happen.

In terms of the cross-border function of the project, it would be important for the recommendations of the study to be implemented. Further reconciliation work and improving cross-border relations around mental health issues would be hoped for. In order to make this happen focus is needed on improving cross-border relations around mental health. A clearly agreed dynamic aim for the cross-border element would be important. Finally, funding is necessary to foster this progress.

The most important part of this project was the involvement of young men talking about their mental health. This was done by working on a cross-border basis; however working in this way neither enhances nor detracts from the issue of mental health.

**Case Study Profiles**

The case study profiles focus specifically on experiences of cross-border working, exploring current levels and mechanisms of collaboration together with identification of key barriers and challenges. The project profiles were drawn up based on information gleaned from the project documents received and the views of project members recorded during the telephone interviews. A general overview of the five projects is provided together with a summary of the issues raised by project members in the course of the interviews concerning cross-border working. Descriptions of each of the individual case study profiles are also presented in this chapter.

**Overview of Case Studies**

The five case studies profiled in this report show that mental health promotion is a diverse and dynamic field involving a range of professionals, community groups and agencies. Mental health promotion is increasingly recognised on the agendas of a range of statutory and voluntary organisations and agencies, North and South. The case studies demonstrate a creative interplay of top-down and
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

bottom-up initiatives ranging from professionals working with women at risk of post-natal depression, people with a diagnosis of cancer, members of the general public, to participative projects with rural community groups and young men. The focus of the interventions span activities from the local community level to regional initiatives to those targeting an all-Ireland audience. Likewise, the interventions provided range from awareness raising, support groups, specialised training, programme development to direct service provision. The projects are at different stages of development from having recently commenced to ongoing and completed programmes. All are located in Northern Ireland and the border counties and involve a range of health boards, trusts, voluntary agencies and community groups to varying degrees.

Background to the Projects
The projects range in focus from multi-disciplinary training/service provision and resource development on a cross-border basis to the development of innovative strategies for addressing the shared mental health needs of young men, rural communities and the general public in the border region. Three of the five projects described are focused primarily at developing collaborative links at the professional level. Of the remaining two projects, one includes a specific community-based partnership approach and the other, concerned with support services for people with cancer, is very much a patient-centred initiative.

Funding
Four of the five case studies are discrete and structured projects, which are in receipt of dedicated funding from either the EU Programme for Peace and Reconciliation or CAWT. These projects also reported support from regional health boards, trusts and voluntary organisations. The support service for cancer patients is an example of a project established on an informal basis, with no current explicit funding for the cross-border work. However the initial co-operation between the cancer foundations North and South was initiated through funding from Co-operation North some 18 years earlier.

Many of the project members interviewed commented that the presence of CAWT and Peace and Reconciliation monies made cross-border co-operation possible and allowed these initiatives to get off the ground. However they also pointed to the difficulties of short-term funding and the uncertainties surrounding continuity and sustainability.

Evaluation
The structured projects have explicit aims and objectives and include monitoring and evaluation methods to varying degrees of sophistication. In three of the projects the evaluation involves liaison with outside university researchers. Progress reports are produced by these projects on a regular basis and this may well reflect the requirements of the funding agencies. However it is interesting to note that only one project reports explicit evaluation of the objectives for
cross-border co-operation, with one other project reporting that these are currently under consideration. In the case of remaining projects, the evaluation of the mechanism and process of cross-border working would appear to be largely implicit, with no explicit objectives being set for establishing evidence of effective cross-border collaborative working.

**Co-operation Structures**
The predominant co-operative structure employed appears to be that of a joint steering group composed of representatives from North and South. These groups typically include multi-disciplinary professional groups, together with community representatives in the case of the Promoting Positive Mental Health in Rural Communities project. In the case of the cancer project, this is an informal arrangement, which is co-ordinated by the Care Services Co-ordinator based in Northern Ireland.

The nature of cross-border contact appears to be mainly through the mechanism of the steering groups. Meetings are generally held at 4-8 week intervals, with projects alternating the location of the meetings between North and South. Contact is primarily at a multi-disciplinary professional level across the statutory and voluntary agencies on a North-South basis. However many of the project interventions involve joint training and workshops for health workers, teachers and community members from both sides of the border. Almost all project activities involve a good deal of inter-agency and cross-sectoral collaboration both within and across regional structures.

**Perceptions of Cross-Border Working**
Project members who participated in the interview process were questioned concerning their initial motivation for involvement in cross-border collaborative work. The responses include: identifying a gap in service provision; extending an existing established service across the border; developing novel interventions, resources and materials to address common mental health needs in the border region. Eligibility for CAWT and Peace and Reconciliation funding prompted organisations to apply for ring fenced funding to develop these initiatives on a cross-border basis.

**Perceived Benefits**
The reported experience of cross-border working is very positive and overall it is viewed as a worthwhile and beneficial experience.
Findings from the Investigation of Cross-Border Collaborative Mental Health Promotion Practices

The perceived benefits of cross-border working include the following:

• Exchange of ideas and effective practices including sharing resources in terms of expertise, time and costs. Clearly project members perceive many benefits to cross-border working as the following comments illustrate:

  *The project had many benefits including the exchange of ideas and effective practice, learning from each other and sharing resources... and... the establishing of multidisciplinary networks and training on a cross-border basis.*

  *Increased understanding, learning and sharing are all important benefits.*

  *The interaction between professionals was inspiring. The enthusiasm displayed by all health care professionals was evident in their willingness to share ideas and thoughts and to develop a model of best practice.*

• Establishing relationships and networks across disciplines, professionals, communities, service users and organisations on a cross-border basis. The benefits of working with like-minded people were underscored with an awareness that even though health workers may be working across different health systems, they are addressing the same issues.

  *Within the CAWT area cross-border working is now a way of working, not just an experience...it is very much the way forward.*

  *...realising that all involved are confronting the same issues and that there are no real differences between their jobs, North and South.*

The cross-border projects are seen as strengthening existing relationships and leading to new ones being established. Most project members report high levels of enthusiasm and good co-operation among the participating organisations and individual workers.

  *The group has worked cohesively and there has been a sense of value and importance to the work.*

• All were of the opinion that there was scope for expansion and many saw the opportunity for developing new proposals and projects based on their experiences to date in the current projects.

  *The network has now been established and it would be important to build on this and develop other proposals.*

Cross-border collaboration is clearly perceived as an opportunity for developing and promoting best practice on an all-island basis.
Reported Barriers and Difficulties
Project members were questioned concerning difficulties or barriers experienced in relation to successful collaborative work. A wide range of views were expressed, even between members of the same project. However, a number of interesting issues were raised in the course of the interviews. These include the following:

- Issues of shared ownership were raised, particularly where partners from one side of the border may have developed the original idea for the project. The importance of having some initial preparatory work to agree on the expectations of cross-border working from the outset was highlighted. It was also felt that this would aid in defining the nature of true cross-border work.

- Building up of trust between the partner groups was highlighted as being critically important, and the need for a recognition that this was a slow process that takes time. Feelings of rivalry and competition between the cross-border partners were also expressed, particularly at the early stages of project development.

- Constraints in terms of resources were also mentioned as difficulties, including distance/geographical spread and the time taken in getting all partners together at regular intervals.

- Funding was also mentioned as a difficulty, particularly in relation to uncertainty about future funding and how this negatively affects planning. There was a general appreciation that cross-border working takes time and that, given the complexity of the mental health area, sustained ongoing action is needed. Continuity of funding is perceived as being critical to this endeavour.

- The need for better co-ordination across the two jurisdictions was also commented on, particularly with regard to differences in the structure and working practices of the two health care systems North and South.

It is clear from the case study profiles that there is a general awareness among project members that many organisations North and South are serving the same population needs and targeting the same groups of people. As commented by one of the people interviewed, within the CAWT area cross-border co-operation is now a way of working, not just a once-off experience, and is regarded as being very much the way forward. Working on a cross-border basis is viewed by some project members as not being any different from working on a cross-board or cross-sectoral basis, as the same issues of partnership and collaboration are involved. The view was expressed that all involved in the area of mental health promotion are confronting the same issues North and South, and that it makes sense to pool resources, expertise and experience in order to promote best practice in the area.
Project members emphasised the importance of building on the work achieved to date. Generally there was a perception that good working relationships and networks are being established and these could now serve as a useful base on which to develop best practice.

As one person put it:

_every speciality and discipline should have links with their partners in the other jurisdiction._

Building on existing networks would facilitate different disciplines working together in order to develop best practice. There is a recognised need for more formal and co-ordinated links at organisational level across the different sectors in order to increase the opportunity for sharing knowledge, experiences and expertise. It was perceived that improving cross-border relations on mental health issues requires more focused efforts in terms of providing support, enthusiasm and strong leadership.
This chapter outlines the findings from the Phase 2 investigation into collaborative practice and policy. The findings from the study day in Armagh are presented first. Arising from the study day in Armagh a questionnaire was developed to further explore participants’ views on cross-border collaboration, and the results from this survey are then presented. Next we present the findings from the roundtable discussion in Dublin. Finally, this chapter explores the literature available on policy and collaborative practice on an all-island and international level.

Armagh Study Day

The purpose of the study day was to disseminate the findings from Phase 1 and to invite reflections on the information presented. 45 people representing a range of interests, including policy makers, health agencies and voluntary and statutory bodies, attended. At the meeting a number of questions were explored with regard to mental health promotion practice and policy. These questions and the findings from the discussion are now presented:

- What are the aims and expected added value of cross border collaboration in the mental health promotion area?

Some participants felt the aim of this type of collaboration should be to meet the needs identified on the whole island, and to improve the mental health and well-being of the population together with promoting positive mental health in the key target groups.

With regard to the added value of cross-border collaboration, the main points raised were:

- Exchange of ideas and gaining from the experience of others.
- Building relationships and networks.
- Developing and generating new ideas and proposals.
- Financial resources which are available for cross-border work.
- Sharing of best practice.
- Highlights differences in structures e.g. voluntary, informal, statutory.
- Pooling resources.
- Linking with people who have already invented the wheel.
- Value to clients.

One group felt that it might be of more value if projects were perceived as ‘on the island of Ireland’ rather than from different sides of the border. Once the networks are enabled to grow, border perceptions will diminish.

One group drew attention to certain conditions, beyond mental health promotion, that should be met if there is to be a persistent value to cross-border collaboration. These are:

- An agreed emergent strategy for collaboration led by a government level steering group with access to sustainable funding.
• Time and effort must be put into the various projects, networking with each other, forming partnerships, trusting relationships and a common basic understanding of each health system.
• Terms of reference must be drawn so that projects not only have aims and objectives for collaboration on the health promotion aspect, but also on the nature of the collaboration.

In addition the following must be kept in mind:
• Who are the key stakeholders and how do we evaluate and demonstrate the effectiveness and value of projects?
• Who are the service users and how do we meet the need identified on the island to improve the health and well-being of the population?
• **What are the key learning points from current experiences?**

The responses to this question are presented in the following themes:

**Evaluation and learning**
It was felt that there is a need to evaluate not only the projects but the partnership also. In addition, if there is evidence for something: do it. Where there is no evidence: research it.

Some participants felt that there is learning needed around what makes a true partnership. Though borders exist everywhere, for example between health boards, by focusing on the partnership the border will not matter. In addition, there are cultural, economic and social differences between the North and South of Ireland and the terminology used in the two jurisdictions can be different. Cross-border working highlights these differences and this is important. The relationship between steering groups and the people on the ground is an area in need of development.

**Sustainability**
It is important to maintain networks once projects have officially ended. If projects are to become sustainable, they must be incorporated into the mainstream of care provision. If people don’t understand the benefits, then the project may only exist while the funding is there to support it.

**Service users**
Cross-border working benefits the clients but we need to include the service users as part of the planning process. The policy makers are operating at one level but the conceptual level needs attention.

**Funding**
Available funding acts as a stimulus but sometimes it can be difficult to find specific funding for cross-border mental health promotion. There was a feeling that money is provided for mental illness rather than mental health promotion. In addition, focus on mainstreaming a project is needed rather than funding for time-limited projects.
Collaborative Practice and Policy

Practice
This work allows people to focus more specifically on mental health as a pure concept. Cross-border work is a wonderful learning opportunity with beneficial parallel developments. Mental health promotion needs to establish a network of interested parties.

Three things are needed to develop understanding of mental health promotion on a cross-border basis:
1. Supportive training.
2. Research and policy infrastructures.
3. Sustainability of initiatives at a service level.

• What are the current barriers to effective cross border collaboration?

The following themes emerged in response to this question:

Organisations and partnerships
Projects can be above and beyond the core business of the organisations supporting them. It takes time to build trust and there is more work needed around partnership. Collaboration is not at the higher levels of government in that it is not ingrained in collaborative health policy.

The question ‘Who takes the lead and who controls?’ was raised. In any partnership there is a need to draw funding, so someone needs to be the lead partner. Furthermore, there is not always equity of resources and this may bring about animosity or negativity from one or both sets of partners.

Evidence and information
Many groups felt that there is not a standard approach or view on health promotion with regard to where it begins or ends, nor are there standardised data collection methods. Furthermore, we do not know what works and what does not work. There does not appear to be a central agency/point/database for identifying what collaborative projects are out there. While the impetus of cross-border working is relatively new, it is already becoming fragmented. While a number of cross-border bodies which work on promoting cross-border health now exist, the responsibilities of each unit are unclear and we need to pull this together on a cross-border basis. Many felt that there is a lack of information for potential partners with regard to resources and sustainability, and this can be coupled with the fear of the unknown and questions such as ‘If you get in, can you get out?’

Practical Barriers
A number of practical barriers to cross-border working were identified within the groups. These were:
• The use of the term ‘cross-border’ can act as an impediment to progress as it highlights differences and segregation by
the border. The language used needs to reflect co-operative working and the sharing of common issues such as a shared focus on health.

- Geographical barriers. It is typical to have two bases for cross-border projects: one in the North and one in the South.
- Political and legal barriers resulting from two different jurisdictions.
- Different currencies.
- Different structures between the North and South with regard to professional training.
- Time barriers and constraints. Projects are often extra to an already heavy workload. Working at partnership also takes time. Geographical distance also means that travelling for meetings takes a lot of time. Also it takes time to see the actual benefits of a project.
- Cultural differences between both jurisdictions.
- Political extremists and organised crime may be a barrier in communities.

Other barriers mentioned were the lack of accountability built into projects. As this is not done at the moment, it makes the project more difficult to control. As projects take off and this type of working becomes more effective, it will not be unusual to work on a cross-border basis. An example of this was the Folic Acid campaign which was run on a North-South basis. This was very successful and people look at this as a model for how to run their own projects. However there is a lack of evaluation and this is a problem.

Barriers need to be identified or recognised before a project commences. We should realise that cross-border working is not the answer to all ills. One group felt that ‘barriers can be used as opportunities.’

- How do we evaluate this collaboration?

Responses to this question were categorised as follows:

**Need for evaluation**
Most respondents felt that evaluation was an area that is in need of greater attention and many acknowledged there were difficulties in currently evaluating this collaboration. One of the reasons put forward by the groups for this difficulty is that there is no agreement on or standardisation of the type of evidence to be gained, and this makes evaluation difficult.

**Evaluation of partnership/collaborative practice**
It was felt that the partnership/relationships needed to be evaluated along with the outcomes. Currently there is a lack of evaluation of the process of working together. Something needs to be done to formalise North-South co-operation at the organisational level. One group suggested a template should be developed for best practice in working together which draws on current experience. Thus a standardised approach could be developed with broader parameters than mental health promotion.
Collaborative Practice and Policy

There is a value in developing relationships and building in evaluation from the beginning. The policies and procedures of individual organisations are important, and if they can be married to, or influence, government policy this would be important. One group suggested that all project evaluations could be amalgamated and a meta-analysis carried out. It was felt that it was important to ensure a linkage between the terms of reference, objectives, outcomes and evaluation.

- **Under what conditions could investment in cross border collaboration become more effective and efficient?**

Government and organisational policy

In order for cross-border collaboration to become more effective and efficient, one group clearly felt that there needs to be a demonstrable policy commitment at government level and not just a response due to the political climate. This sentiment was echoed by one of the other groups which was of the view that the value of cross-border work needs to be promoted from the top. A suggestion was made that there should be a steering group at Department of Health level, with representation from both sides of the border, who would set the agenda, ensure sustainability and comparability of data collection and evaluation.

Another group pointed out that although cross-border working is currently prolific in the border regions, most of this work is undertaken by voluntary and community groups rather than statutory bodies. It was suggested that we need to identify and standardise what works and then incorporate this into joint health policy. Collaboration should be part of the core business of health organisations. One group suggested that the National Health Census (in the South) could be automatically collaborative and carried out in partnership.

Identified needs and access to information

Most of the groups felt that project work should be based on identified needs. One group suggested that there might be a need for a cross-border body or organisation to assist in the identification of needs. It was also suggested that a central resource to access collaborative project information, to avoid duplication and emulate good practice would be most useful. Similarly, another group suggested the development of a central register of cross-border projects where the details of work going on are available on an Internet site for all interested parties. Information was seen as being very important but it is essential that those involved in cross-border work know how to access this information.

Evaluation

Evaluation figured strongly in most of the group discussions, with many reiterating the need for more evaluation of work done, evidence-based practice, report dissemination and publication. Evaluation is also needed to ensure that the objectives of cross-border working are clear. Tied to this is the need for clearer aims and
objectives with regard to cross-border working. It was also mentioned that people should be trained properly and given the necessary human resources.

Other
Other points raised were that interested parties throughout the island should be enabled to collaborate on projects and not just communities close to the border. This type of working should be less funding driven and more aimed at promoting the value of joint working. It takes time to communicate and build up networks and this must be acknowledged.

The benefits to the communities in both jurisdictions demand that we should promote mental health for its own sake on a cross-border basis. There is a need to identify and standardise what works and then incorporate it into joint health policy.

Invited Reflections on Phase 1 Findings
Following the study day discussion groups, questionnaires were sent with a copy of the newsletter to all who had been invited to the study day. A number of closed and open-ended questions were asked to further explore perceptions of cross-border working. The results of this exercise are now presented. The questions were based on the findings from the group discussions and were circulated to a wider group, many of whom were involved in Phase 1 but did not attend the study day in Armagh.

A total of 41 questionnaires were returned. Responses from Northern Ireland accounted for 61% (n=25) and responses from the Republic of Ireland accounted for 39% (n=16) of the returned sample.

From the total respondents, 90% (n=36) were either currently involved in cross-border working or had been involved in the past. 33% (n=12) mentioned CAWT as their conduit for involvement in cross-border working. The type of activities mentioned were varied and ranged from once off projects to a wide range of health promotion and public health initiatives.

Organisations with a mental health promotion focus accounted for 79.5% (n=31) of the respondents. However only 29.4% (n=10) of those actually had a policy document or strategic document outlining strategic goals for mental health promotion.

The study day in Armagh was attended by 41.5% (n=17) of the respondents. 52.5% (n=21) of the respondents made comments on the interim (Phase 1) report. It was generally felt that the report was very informative and that there were considerable advantages to pooling experiences and examples of good practice. One commentator felt that there should have been some acknowledgement of the effects of the 'Troubles' on mental health.
Respondents were asked what they felt were the key learning points from the projects described in the Phase 1 report. 26 respondents answered this question. Over half felt that one of the key learning points was the exchange of ideas and good practice. Many felt that there was a greater need for planning and co-ordination at the organisational level and that attention needed to be given to the mechanisms of cross-border working such as relationships, time, funding and evaluation. A few respondents said that this project indicated that mental health promotion activities are now being focused upon to a greater extent.

Respondents were also asked what they felt were the most important aims of cross-border collaboration. Respondents felt that the sharing of ideas, expertise, resources and best practice was very important. Also many felt that this type of working helped to avoid duplication, improved the service to clients and resulted in an optimum use of resources.

Respondents were asked to give their opinion on the benefits of cross-border working by indicating how much they agreed with each item where 1=strongly agree, 2=agree, 3=uncertain, 4=disagree, and 5=strongly disagree. Responses were collapsed into agree, uncertain or disagree. The results are presented in Table 2 below:

**Table 2: Benefits of Cross-border Working**

<table>
<thead>
<tr>
<th>Benefits of Cross-border Working</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchange of ideas and experiences</td>
<td>100 (n=41)</td>
<td>0 (n=0)</td>
<td>0 (n=0)</td>
</tr>
<tr>
<td>Broadening of networks</td>
<td>100 (n=41)</td>
<td>0 (n=0)</td>
<td>0</td>
</tr>
<tr>
<td>Stimulate new thinking</td>
<td>94.9 (n=37)</td>
<td>0 (n=0)</td>
<td>5.1 (n=2)</td>
</tr>
<tr>
<td>Greater understanding of differences in structures North and South</td>
<td>85 (n=34)</td>
<td>2.5 (n=1)</td>
<td>12.5 (n=5)</td>
</tr>
<tr>
<td>Greater understanding of differences in cultures North and South</td>
<td>77.5 (n=31)</td>
<td>2.5 (n=1)</td>
<td>20 (n=8)</td>
</tr>
<tr>
<td>Sharing of resources</td>
<td>66.8 (n=26)</td>
<td>5.0 (n=2)</td>
<td>28.2 (n=11)</td>
</tr>
<tr>
<td>Access to additional funding</td>
<td>78.0 (n=32)</td>
<td>2.5 (n=1)</td>
<td>19.5 (n=8)</td>
</tr>
<tr>
<td>Identifying best practice</td>
<td>87.8 (n=36)</td>
<td>2.4 (n=1)</td>
<td>9.8 (n=4)</td>
</tr>
</tbody>
</table>

From Table 2 we see that the most popular benefits to cross border working were the exchange of ideas and experiences and the broadening of networks. All the benefits mentioned were given the support of the majority of the respondents with the least popular being sharing of resources, with 66.8% (n=26) agreeing that this was of benefit.
Respondents were also asked about the barriers to cross-border working. Again they were given a number of items and responses were collapsed into agree, disagree or uncertain. The results can be seen in Table 3:

**Table 3: Barriers to Cross-border Working**

<table>
<thead>
<tr>
<th>Barriers to Cross-border Working</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource constraints (geographical spread, distance, time etc)</td>
<td>81.6%</td>
<td>13.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>(n=31)</td>
<td>(n=5)</td>
<td>(n=2)</td>
<td></td>
</tr>
<tr>
<td>Issues of shared ownership</td>
<td>62.2%</td>
<td>18.9%</td>
<td>18.9%</td>
</tr>
<tr>
<td>(n=23)</td>
<td>(n=7)</td>
<td>(n=4)</td>
<td></td>
</tr>
<tr>
<td>Differences in the structure and working practices of the two health systems</td>
<td>76.9%</td>
<td>12.8%</td>
<td>10.3%</td>
</tr>
<tr>
<td>(n=30)</td>
<td>(n=5)</td>
<td>(n=4)</td>
<td></td>
</tr>
<tr>
<td>Building of trust between cross-border partners</td>
<td>62.8%</td>
<td>20.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>(n=22)</td>
<td>(n=7)</td>
<td>(n=6)</td>
<td></td>
</tr>
<tr>
<td>Uncertainty of funding</td>
<td>79.5%</td>
<td>2.6%</td>
<td>17.9%</td>
</tr>
<tr>
<td>(n=31)</td>
<td>(n=1)</td>
<td>(n=7)</td>
<td></td>
</tr>
<tr>
<td>Different currencies</td>
<td>33.3%</td>
<td>56.4%</td>
<td>10.3%</td>
</tr>
<tr>
<td>(n=13)</td>
<td>(n=22)</td>
<td>(n=4)</td>
<td></td>
</tr>
<tr>
<td>Political and legal barriers</td>
<td>63.2%</td>
<td>18.4%</td>
<td>18.4%</td>
</tr>
<tr>
<td>(n=24)</td>
<td>(n=7)</td>
<td>(n=7)</td>
<td></td>
</tr>
</tbody>
</table>

There was a little less consensus between the respondents with regard to the barriers to cross-border working. The barriers agreed with by the majority of the respondents were resource constraints (81.6%), uncertainty about funding (79.5%) and differences in the structure and working practices of the two health systems (76.9%). Only 33.3% (n=13) agreed that the different currencies in the two jurisdictions could be seen as a barrier. Issues of shared ownership (18.9%), political and legal barriers (18.4%) and uncertainty of funding (17.9%) had the highest level of ‘uncertain’ responses.

Respondents were asked to rate on a scale of 1 to 10, where 0=of no importance and 10=of great importance, the importance of evaluating the effectiveness of the collaborative aspect of cross-border working. The mean result was 8.69 (sd=1.52), indicating that respondents felt that evaluation was very important.

Respondents were then asked what would help their organisation to evaluate the effectiveness of the collaborative aspect of cross-border working. The supports most commonly cited were time, training, and a clear agreed definition of the aims and objectives of the collaborative aspect. Also mentioned was access to existing models and information, including access to database and population studies. Funding was also mentioned by many respondents as being a support that would help the organisation evaluate this type of work.
Respondents were asked to rate the importance of a common mental health data set between Northern Ireland and the Republic of Ireland, where 0=of no importance and 10=of great importance. The mean rating was 8.28 (sd=1.80), indicating a high level of support for this common data set.

Respondents were asked how this common data set could be used by their organisation. Many respondents felt that such a data set could be used for the purpose of informing the policy makers. Other uses included identifying the health needs in the population, both North and South. Once needs are identified, then programmes can be planned strategically and services developed to meet the health needs of the populations. Trends could also be monitored and comparative analysis could be carried out between the two jurisdictions.

Survey participants were also asked what steps are needed to promote best practice in mental health promotion on an all-island basis. They were given a number of items and responses were collapsed for analysis. The results are in Table 4 as follows:

**Table 4: What steps are needed to promote best practice in mental health promotion on an all-island basis?**

<table>
<thead>
<tr>
<th>What steps are needed to promote best practice?</th>
<th>% Agree</th>
<th>% Disagree</th>
<th>% Uncertain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic political commitment</td>
<td>89.4</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td></td>
<td>(n=34)</td>
<td>(n=2)</td>
<td>(n=2)</td>
</tr>
<tr>
<td>Supportive policy infrastructure to guide developments</td>
<td>90.2</td>
<td>7.4</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>(n=37)</td>
<td>(n=3)</td>
<td>(n=1)</td>
</tr>
<tr>
<td>Developing collaborative relationships at an organisational level</td>
<td>97.4</td>
<td>0</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>(n=38)</td>
<td></td>
<td>(n=1)</td>
</tr>
<tr>
<td>Support and training for those undertaking cross border work on the ground</td>
<td>86.8</td>
<td>0</td>
<td>13.2</td>
</tr>
<tr>
<td></td>
<td>(n=33)</td>
<td></td>
<td>(n=5)</td>
</tr>
<tr>
<td>Forum for knowledge dissemination and sharing of learning experiences</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(n=39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good research infrastructure on which to base project planning and development (population mental health data)</td>
<td>97.4</td>
<td>0</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>(n=38)</td>
<td></td>
<td>(n=1)</td>
</tr>
<tr>
<td>Identifying and evaluating the key objectives of cross-border working</td>
<td>87.2</td>
<td>0</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td>(n=34)</td>
<td></td>
<td>(n=5)</td>
</tr>
</tbody>
</table>

There was a general consensus between all respondents on the steps needed to promote best practice in mental health promotion. A forum for knowledge dissemination and sharing of learning experiences received the most support, with 100% (n=39) respondents agreeing with this step. Closely following this at 97.4% (n=38) was both a good research infrastructure on which to base project planning and development (population mental health data) and developing...
collaborative relationships at an organisational level. The next most popular step was a supportive policy infrastructure to guide developments, with 90.2% (n=37) respondents agreeing with this step.

When asked what would be the critical success factors for developing and implementing an all-island policy for mental health promotion, the most common response was a strategic commitment. This commitment should come not only from service managers but also from Departments of Health: there needs to be the political will at governmental level. Resources, time, training and funding and a clear vision of what was needed, along with the determination of need, were also mentioned.

Similar responses were received when respondents were asked about the main obstacles to developing this policy. Obstacles include the lack of political will, lack of support from managers, time, training and funding. Other responses included issues of shared ownership, differences between the two health systems and lack of information and evaluation. A few respondents mentioned the low priority or undervaluing of mental health within health in general, and the dominance of psychiatry and suicidology in the mental health area.

In order to address this and make cross-border work effective and efficient, respondents felt that strategic planning, political commitment, training, provision of resources, clear and common aims and an understanding of the differences that exist between the two jurisdictions were needed. Co-operation and good communication along with relationships built on mutual trust and needs-based programmes were also mentioned.

General feelings about cross-border work were that it is a very useful and important type of working, which has many benefits. While barriers have been identified, there is much potential for future development. In the words of one respondent: “We should promote a culture where assessment of the cross-border option for devising a needs solution comes as naturally as looking at an adjoining sector, county or region within our respective jurisdictions”.

Roundtable Discussion
The roundtable discussion held in the Department of Health and Children, Dublin, on 5th December 2001 was attended by key policy makers in both Northern Ireland and the Republic of Ireland. The aims of this discussion in relation to practice and policy were:
1. To review current policy developments concerning mental health promotion (strategies and data sources) in the UK, Northern Ireland and the Republic of Ireland.
2. To consider the strategic steps required for effective collaboration on the development and implementation of a mental health promotion policy.
Collaborative Practice and Policy

A summary of the key findings concerning cross-border collaborative practice and policy in both jurisdictions is now presented.

Policy

Health Promotion Unit, Department of Health and Children, Dublin
The Health Promotion Strategy (Department of Health and Children 2000) has a strategic aim in relation to mental health, with greater focus on promoting positive mental health and efforts to reduce the percentage of the population experiencing poor mental health. There is a commitment in the Health Promotion Strategy to initiate the development of a national mental health promotion strategy. However there is no agreed timescale on this.

The new recently published health strategy document, Quality and Fairness: A Health System for You (2001), also has a focus on mental health which is seen as being a critical element of achieving better health for everyone. This strategy specifically recommends programmes to promote positive attitudes to mental health and the need for suicide prevention programmes. This adds a new impetus to what is already included in the Health Promotion Strategy.

Performance indicators on mental health are being developed with the health promotion managers in the health boards and these should be available in 2002. There will be indicators specifically for mental health promotion and this will bring a greater focus on mental health promotion work.

Health Promotion Agency and Department of Health, Social Services and Public Safety, Belfast
A draft mental health promotion strategy called Minding Our Health was submitted to the Department of Health in 1998. A wide range of voluntary and community groups and statutory organisations were consulted on this document. Feedback was incorporated into the discussions and a working group has been established to draft the strategy/action plan for promoting mental health.

The aims of the strategy are to:
- improve people’s mental and emotional well-being, in particular that of people at risk or vulnerable, and people with identified mental health problems, their carers and families.
- prevent or reduce incidence and impact of mental and emotional distress, anxiety, illness and suicide.
- raise awareness of the determinants of mental and emotional health at public, professional and policy making levels and reduce discrimination against people with mental health problems.
- ensure that all those with a contribution to make are knowledgeable, skilled and aware of effective practice in mental and emotional health promotion.
These aims will be realised through a comprehensive partnership approach between the statutory, voluntary and community sectors. This report is pending publication.

Mental Health Promotion falls under the overall Public Health Strategy *Investing for Health*. The draft of that document, which includes suicide prevention, will soon be available. This work has incorporated some material, information and discussion from the South, so there are some similarities in terms of the approaches adopted.

**Mental Health Promotion Initiatives**

*Health Promotion Unit, Department of Health and Children, Dublin*

The Health Promotion Unit in Dublin has supported a broad range of mental health initiatives, undertaken both by the statutory and voluntary sectors. These include the MHAI Mental Health Matters in schools, anti-bullying initiatives, stress management courses for teachers in partnership with the health boards, suicide awareness materials and a helpline for older people in the community.

*Health Promotion Agency NI, Belfast*

A database of mental health promotion initiatives has also been collated. There are between 1,000 and 2,000 people involved in mental health promotion initiatives at some level in Northern Ireland.

**Evaluation of Practice**

*Health Promotion Unit, Dublin*

While there is a lot of good work going on, it is unclear as to how much of it is actually evaluated. From Phase 1 of this report we see that while many cross-border projects are funded, there is little evaluation of the collaborative practice, the added value, and whether the mechanisms for collaboration currently being used are in fact the most efficient or the best.

*Health Promotion Agency NI, Belfast*

There have been substantial changes in the different health promotion arrangements in England, Wales, etc. with regard to evaluation of practice. The Health Development Agency (HDA) is formally charged with collecting evidence on effectiveness and it is looking across all health promotion practice.

In Northern Ireland there appears to be little evaluative work going on in terms of either process, outcomes or collaborative needs. A group in the Department of Health, Social Services and Public Safety has recently been charged with looking at needs and effectiveness of public health approaches in Northern Ireland linked to the Investing in Health Strategy.
Cross-Border Collaboration

*Health Promotion Unit, Department of Health and Children, Dublin*

Discussions have taken place between the Health Promotion Agency NI, the Department of Health, Social Services and Public Safety and the Health Promotion Unit, Department of Health and Children with regard to co-operation between the two jurisdictions on health promotion. The purpose of these discussions is to move current co-operation on from an ad hoc arrangement towards something more formal and structured which would have an agreed budget and a strategic plan. A number of joint projects have already taken place, but one of the areas where both agencies do want to work together on is research and training.

Discussions between the two agencies are becoming more formalised and are being reported back to the North/South Ministerial Council in its health format. Co-operation on health promotion is on the agenda of the ministerial meetings. Over the past eight to nine years co-operation at the level of exchange of information and experiences has taken place. There are plans now to agree strategically what is needed to support co-operation with some joint funding and a formal structure agreed by the Ministers of Health. Cross-border work needs to have the impetus of high level political support and both Ministers are very committed.

*Health Research Board, Dublin*

Through its granting system the Health Research Board has a cross-border interest and there is limited funding available for cross-border research. The funding mechanisms are based on peer-reviewed proposals.

*Health Promotion Agency, Belfast*

Research in health promotion has not been included in the R&D strategy to any great extent and there is a need to visit that under the new Public Health Strategy. It is nevertheless hoped that all cross-border health promotion could be linked in some way.

On the European front the Health Promotion Agency is linked as a collaborating centre to the World Health Organisation and there are moves within the WHO European Centre to collect health-based information, although mental health has not been specifically mentioned.

Cross Border Working and Collaborative Practice Mechanisms

The Case for Collaboration and Joint Working

Collaborative work, partnerships and strategic alliances are becoming increasingly important in the field of health promotion. According to Sindall (1997), we are coming to the best of times in that something approaching an organisational ‘zeitgeist’ has become apparent in recent years. Networks, processes and strategic alliances are now the defining characteristics of modern
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organisational relations. The Australian Institute of Management (1994), cited in Sindall, defines a strategic alliance as “a long term partnership involving two or more organisations formed to benefit from the synergy of working together in an environment of trust, sharing information and resources to achieve a common objective”.

In its Health for All Policy Framework for the 21st century (1999), the World Health Organisation highlights the need for multi-sectoral collaboration to tackle the physical, economic, social and cultural determinants of health. Furthermore this documents states that multi-sectoral action should provide a more effective, efficient and sustainable way to improve health. There is great potential in partnerships that enable different people and organisations to support each other by leveraging, combining, and capitalising on their complementary strengths and capabilities (Lasker et al. 2001).

International collaboration should be initiated, according to Hosman (2000), for the following reasons:

• Scarcity of resources and lack of influence
• Breadth and complexity of the field. We need consensus on evidence-based principles, and we need more in-depth knowledge about a large number of evidence-based programmes and policies and insight into their cost-effectiveness, especially cross-cultural applicability, efficacy, and effectiveness. The only feasible answer is for better and more co-ordinated collaboration across countries and regions.
• Collaboration between research centres located across different countries and regions can produce innovations and integration in theory resulting from the cross-fertilisation of different theoretical paradigms and scientific traditions.
• Growing insight into the inter-relatedness of different health and social problems.

In the United States foundations and government agencies have invested hundreds of millions of dollars to promote collaboration around health issues. Although many of these partnerships and collaborations may differ in form, in the particular goals they are trying to achieve, and in whom they bring together, they all share a common impetus: an appreciation that, in today’s environment, most objectives related to health cannot be achieved by any single person, organisation, or sector working alone (Lasker et al 2001).

STAKES in Finland and the World Health Organisation have also drawn attention to and highlighted the importance of increased collaboration between countries (STAKES 1999; STAKES 2001; WHO 2001). Collaboration is now also a feature of the proposed European Union Public Health Strategy.

Although health problems may be affected by cultural factors, the similarities of health problems across geopolitical boundaries are much more important than their differences. In order to make significant progress in addressing health
problems of all kinds in the coming decades, it is necessary to break down the barriers to effective international collaboration in developing, disseminating, and implementing science and evidence based prevention and health promotion programmes, strategies, and policies (Hosman 2000).

A system of open co-ordination, in which there are formally established means to learn from the experience of others while taking account of national circumstances, provides an opportunity to promote best practice, increasing exchange of information on what works and what does not, and in what circumstances (Mossialos et al. 2001). In many cases it will be possible to develop shared approaches to common problems, but this process must respect historical, political and cultural diversity and not force the harmonisation of processes that, while pursuing the same goal, are organised in ways that are incompatible with each other.

In both Northern Ireland and the Republic of Ireland multi-sectoral collaboration is recognised in the respective health strategies. Strengthening partnerships has been identified as a strategic objective by the Institute of Public Health in Ireland (1999).

**Effectiveness of Collaboration**

Alliances or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-governmental agencies, do work, according to Gillies (1998). They work in tackling the broader determinants of health and well-being in populations in a sustainable manner, as well as in promoting individual health-related behavioural change.

Collaboration can be seen as a ‘good thing’, but there are calls emphasising the need for evidence of its effectiveness (El Ansari et al. 2001). However effectiveness is a value-laden concept and may be seen as much about perceived cost benefits as objective indicators (Costongs and Springett 1997). In addition, this type of evaluation depends on who is defining the criteria of effectiveness (Costongs and Springett 1997) and the differing interpretations that have been placed on evaluation (El Ansari et al. 2001). The challenge to provide evidence of the effectiveness of health promotion activities in pre-determined outcomes should not be underestimated. It is a challenge to assemble evidence in ways that are relevant to the complexities of contemporary health promotion, and to avoid the possibility that this may lead action down a narrow, reductionist route (Nutbeam 1999). Hosman (2000) highlights the need to turn our scientific expertise to studying the factors that facilitate or impede effective collaboration. If collaboration is to be successful in making a difference in the lives of people, then increasing the precision and context of appraising its effectiveness will reduce the nature of inconclusive evidence and is likely to improve the practice of partnerships, coalitions and joint working in health and social care (El Ansari et al. 2001).
Barriers to Collaboration
While the evidence suggests the effectiveness of collaboration, barriers to this type of working have also been identified in the international literature. However, once identified, barriers are not seen as being insurmountable and a variety of publications have drawn attention to the barriers that can arise. If potential barriers are anticipated from the outset, structures can be put in place to deal with them.

Hosman (2000) has referred to some of the barriers that can arise in international collaboration:
• Differences in the meaning and use of relevant concepts between countries and regions.
• Health promotion programmes are written in the languages of the different countries.
• Many organisations and networks are not even aware of the existence of other groups mandated to achieve the same goals and objectives. Unless we can create mechanisms by which such duplication is limited, we can expect an increasing number of cases in which the proverbial wheel is independently invented time and again in different countries and regions.

Barriers can also occur in collaboration or partnerships on a national or micro level. The lesson from the experience in South Africa (El Ansari and Phillips 2001) suggests that wide representation, commitment and a sense of ownership, sound leadership skills, regular and effective communication, reliable member expertise and capabilities, and attention to power issues are crucial elements in the partnership equation.

Costongs and Springett (1997) state that there is clearly a need, particularly in more hostile environments, to pay close attention to the micro-dynamics of inter-organisational relations and joint working. Careful attention to the most basic process issues, including the quality of chairing and facilitation skills and the design of meetings, is essential. These approaches have the potential to make or break a partnership or coalition when the parties involved are under pressure or are themselves going through difficult periods of change.

O’Neil, cited in Sindall (1997), says there needs to be greater sensitivity to the politics of intersectoral action. This includes a heightened awareness and understanding of the fact that both individual and organisational actors bring their own (self) interests and agendas to any collaborative venture. Such a perspective should enable all parties concerned to make a more realistic assessment of what can and cannot be achieved in the light of power relations, resource constraints and environmental demands.

A number of researchers (Lasker 2001) note that partnerships can also generate a good deal of frustration. Because collaboration requires relationships, procedures, and structures that are quite different from the ways many people and
Dynamics and Mechanisms of Collaboration
A first condition for effective collaboration is to reflect on the principal reasons why collaboration is needed, and what kind of added value could be expected from such efforts. Insight into the different goals of international collaboration could help us to assess and improve the quality of current activities (Hosman 2000)

Lasker (2001) highlights that although there has been a lot of research which looks at the various aspects of partnerships and the outcomes related to their effectiveness, the frameworks developed thus far do not identify the mechanism that enables partnership to accomplish more than individuals and organisations on their own. There is a need to conceptualise and measure the proximal outcome of partnership functioning that captures the mechanism making collaboration especially effective.

A number of collaborative and partnership projects have taken place in the Republic of Ireland, Northern Ireland and in other parts of Europe. From Phase 1 of this project we have seen that on the island of Ireland many projects came together on a cross-border basis for a variety of different reasons.

There are many examples of evaluation in health promotion and practice but there are fewer examples of evaluation of the collaboration or partnership aspect. This appears to be particularly true with regard to mental health promotion. However we are now faced with the opportunity to address this. Mental health promotion is now being recognised as an area where more collaboration and joint research is needed. This is clear from the work of STAKES, which is supported by the European Commission, and the work of the World Health Organisation, which has devoted its 2001 report to mental health.

Examples of Collaborative Work
Examples of collaborative initiatives have been identified in the health literature. While they are not mental health promotion initiatives, nevertheless the findings and results concerning collaboration can be applied to the mental health promotion area. We will first look at a number of initiatives and programmes on the island of Ireland and then look at some projects outside Ireland.

The C-BAP Project
The C-BAP (Cross-Border Acute Project) developed when the Craigavon Area Hospital Trust (CAHT) in Northern Ireland and the North Eastern Health Board (NEHB) in the Republic of Ireland recognised that not only would provision of a shared dermatology service facilitate the development of a mutual benefit, but through the medium of reciprocal exchanges and joint project activity, opportunities
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for reconciliation and greater understanding within and between the cross-border communities would be created. This project was evaluated by a team from the University of Ulster (Hayes et al. 2000).

Many benefits to this project were documented. Through cross-border working nurses acquired new skills and forged new relationships with colleagues. In addition nurses developed a new sense of energy to their work. Nurses placed great value on the benefits gained and felt that this contact heightened an awareness of similarity rather than differences across the border.

Patients surveyed believed firstly that cross-border co-operation in health was possible and in addition it was of benefit to them. Patients surveyed viewed health concerns as an excellent medium for breaking down barriers and felt that collaboration would result in a reduction in waiting lists and an improvement in both the standards and quality of health provision. The readiness of the patients to engage in cross-border co-operation in health issues was seen as an acknowledgement that health concerns do not recognise political boundaries.

A strategy was developed and implemented for C-BAP: this proved to be a positive experience that promoted learning and action while at the same time encouraging enthusiasm, solidarity and support between like-minded people. Funding that was made available for the project allowed innovation, experimentation and the dissemination of good practice. The project thus helped to reduce the impact of political frameworks on the provision of health care.

There were also apparent barriers to the project. There appeared to be a lack of clarity about the aims and purpose of this work, resulting in a shift away from the original objectives with the cross-border dimension becoming a peripheral aspect of the initiative. In addition, there were deficiencies in the quality and quantity of contact as no joint training took place, and personnel from both jurisdictions appeared to be reluctant to travel across the border for meetings. Shortcomings existed in terms of communication and information mechanisms.

It was felt that for effective cross-border co-operation to occur closer liaison between all project staff is required. Active involvement by all members would suggest commitment at a high level. In conclusion, the C-BAP by its very existence showed how understanding and vision are broadened through joint activities.

Cross-border Co-operation in Health Services
This study was carried out by Jamison et al. (2001) for the Centre for Cross Border Studies. The study focused on initiatives with the greatest potential for future development in health services across the Irish border. The study found that although differences exist between the two health systems, they have common core principles, face common health and service problems, and there are similar approaches to tackling issues.
It was felt that at both an overall strategic and an individual project level, greater clarity is needed about the objectives of improving cross-border co-operation and the obstacles that stand in the way of achieving that improvement. Obstacles have the potential to greatly inhibit the scope of cross-border working, suggesting that concerted efforts are required to identify and dismantle such potential barriers, where this is feasible and appropriate.

It was also recommended that much greater collaboration should take place on the island in relation to evaluation and research, particularly on projects comparing the effectiveness of the two health care systems. In addition, there should be much greater co-operation in the field of public health, particularly in joint health promotion campaigns.

Co-operation and Working Together (CAWT)
Co-operation and Working Together (CAWT) came about in 1992, when the North Eastern and North Western Health Boards in the Republic of Ireland and the Southern and Western Health and Social Service Boards in Northern Ireland entered into a formal agreement known as the Ballyconnell Agreement to co-operate in improving the health and social well-being of their resident populations. Official endorsement for the CAWT process has been given at a national level by both Ministers for Health and Departments of Health in Northern Ireland and the Republic of Ireland (CAWT 1999).

Within the CAWT structure there are 10 different sub-groups, one of which has a health promotion function and another a mental health function (Robinson & McReynolds 2001). The CAWT sub-group on mental health was established in September 2001 and works under the same terms of reference as CAWT. It is made up of representatives from 11 organisations including boards and trusts from the Republic and Northern Ireland. These include the North Western Health Board and the North Eastern Health Board in the Republic of Ireland, and the Southern Health and Social Services Board, the Western Health and Social Services Board and nine health trusts in Northern Ireland.

The group has set up a ‘meet and greet’ facility where members visit each other’s services and exchange information and experiences. Mental health promotion has been identified as an area to be taken forward by the group.

Through CAWT a number of different projects, training events, conferences and information exchanges have taken place. CAWT's Strategic Plan 2001-2004 stresses the importance of CAWT working collaboratively with governmental North-South bodies like the Special EU Programmes Body and the Food Safety Promotion Board. It also highlights the importance of linking with organisations such as the all-island Institute of Public Health in Ireland (Robinson & McReynolds 2001).
An independent evaluation of the CAWT organisation has been carried out (Clarke & Jamison 2001). This evaluation found that the work of CAWT was mostly project-focused, very diverse and heavily dependent on EU grant funding. The majority of projects focused on training and education. However the few projects that involved patients on a cross-border basis did show clear benefits to the clients.

It was found that CAWT provides a focus for cross-border working among senior management and that a rich network of contacts has been established across the border region. These new relationships have resulted in professionals becoming more comfortable with the concept of cross-border working and as a result there is an increased awareness and enthusiasm about its future potential.

**EU Programme for Peace and Reconciliation**

The EU Programme for Peace and Reconciliation was launched in Ireland in 1995 in response to the combined military ceasefires throughout Northern Ireland and the Republic during the previous year. The Programme consisted of seven sub programmes with sub programme 3 concentrating on cross border co-operation. There was a specific aim included to promote cross border reconciliation and development. Intermediary Funding Bodies, including the Northern Ireland Voluntary Trust (NIVT), Co-operation Ireland, Area Development Management Ltd and the Combat Poverty Agency (ADM/CPA) were responsible for a significant part of its implementation (Northern Ireland Voluntary Trust et al. 1999).

In 1999 these agencies commissioned an evaluation of the impact of cross-border work, and specifically considered the following:

- An assessment of the impact of the cross-border projects themselves.
- Consideration of the operational and strategic barriers to cross-border development.
- Identification of opportunities for the future of cross-border development.
- Highlighting good practice in cross-border co-operation.

This evaluation found that there were many positive impacts to cross-border working, which included a high level of interest at a grassroots level in forming cross-border/cross-community networks resulting in 834 groups receiving funding for cross-border/community links. Promoter groups often made links in more than one area. While the majority of project links were formed within Northern Ireland and six Southern Border Counties, the ability of groups to form networks throughout Ireland and at a wider, international level, demonstrated the potential for future cross-border work in transcending problems associated with distance. Of those groups who were involved in cross-border work, 95% said that they would be definitely interested in further work of this kind.

Some of the barriers identified in this evaluation include a lack of human resources/time to effectively implement projects. Cross-border projects are often additional to an organisation’s existing (core) work load and frequently the most
able people, who already lead the existing workload, are expected to shoulder the additional responsibilities of the cross-border project. The project management skills required to implement cross-border projects may not be available from the experience/skills base of the promotional organisations.

Strategic barriers identified include the lack of a co-ordinated plan for cross-border work, which should include a sub-regional focus and a multi-sectoral approach. This plan should be underpinned by a relevant policy framework and a single control mechanism for the plan's development budget. While there are examples of co-operation between the voluntary and statutory sectors, the level of co-operation and understanding of each other's activities/objectives is still not sufficient to build lasting partnerships which can address issues on a cross-border basis.

This evaluation goes beyond the Peace and Reconciliation Programme and makes recommendations for the future of cross-border work on the island. It takes account of the uncertain political situation as well as potential roles for emerging and evolving cross-border structures. The strategic recommendations are:

- Influence policy which will be supportive of cross-border work.
- The development of a co-ordinated plan for cross-border work.
- The development of sub-regional plans.
- The promotion of greater cross-border networking.
- The provision of funding for cross-border co-operation on an all-island basis.
- Maintain the role of non-governmental bodies in the facilitation of cross-border work and disbursement of enabling resources.
- Build on cross-border work supported by Measures 3.1 and 3.4.
- Maintain the East-West dimension of cross-border work.
- Raise understanding of the roles/remit of all organisations involved in cross-border work.

*Lessons from International Findings*

International collaboration has occurred in both mental health and in other health promotion activities. In 1999 the World Psychiatric Association launched ‘Open the Doors’, which was the first-ever global programme against the stigma and discrimination associated with schizophrenia (Sartorius 1997, cited in WHO 2001). The goals of this programme were to increase awareness and knowledge about the nature of schizophrenia and treatment options; to improve public attitudes to people who have or have had schizophrenia and their families; and to generate action to eliminate stigma, discrimination and prejudice. The World Psychiatric Association has produced a step-by-step guide to developing an anti-stigma programme, including reports on the experience of countries that have undertaken the programme and information from around the world on other anti-stigma efforts. The results of programmes from different countries are added to the global database so that future efforts benefit from previous experience.
Other organisations have been working for the purpose of promoting best practice and co-operation on a cross-border or international basis. Examples of such international collaboration are the European Network on Health Promotion Policy and the International Collaborating Network of Community Mental Health Leading Experiences.

Effectiveness and evidence-based practice are two important areas within health promotion and this is also recognised internationally. The International Union of Health Promotion and Education has developed standards for levels of evidence in health promotion effectiveness. The Campbell Collaboration has been formed with a membership drawn from 15 countries. Their mission is to provide high quality, sound evidence for policymakers, practitioners and the public to make well-informed decisions about public policy (Davies and Boruch 2001).

Some collaborative health projects have evaluated the collaborative aspects of their work - such as the Liverpool City Health Plan, which is part of the WHO Healthy Cities Project. The effectiveness of joint working while developing this plan was examined by Costongs and Springett (1997). Many benefits and a few difficulties around joint working were highlighted in this project. Boundaries between organisations were ‘softened’ because of the joint working process. There was greater understanding and appreciation of what other people and organisations do, which created a force to carry something through. In addition, because the City Health Plan was developed together, it was open to discussion and therefore was more accountable and more likely to be jointly owned. Time was the constraint most frequently reported by project members. Achieving consensus was a time consuming activity, and the time needed for joint working was often in addition to people’s other responsibilities. In addition, participants had different ideas about the best way to work, and they had their own agendas and interests which made it difficult to compromise and to focus on a clear strategy. The key informants uniformly agreed that, even with its faults, joint working had been effective in developing the City Health Plan, but more attention needed to be paid to the process of people working together.

Other work which has looked at the collaborative/partnership aspect was carried out by El Ansari et al (2001) in South Africa. A cluster evaluation of these partnerships demonstrated that, in addition to motivating all stakeholders to forge closer working relationships, it is necessary for partnerships to pay close attention to a variety of structural and operational dimensions, the lack of which can prove to be major constraints to effective partnership functioning.

In the United Kingdom Health Action Zones (HAZ) were set up to encourage innovative methods of improving people’s health in some of the most deprived areas of England. Part of that process involved breaking down the traditional barriers preventing different agencies from working together. Partnership working was acknowledged by all HAZs to be essential in achieving HAZ
objectives, both in terms of providing mechanisms for joint decision making and also for delivering programmes on the ground. The Department of Health is currently carrying out a national evaluation of HAZs.

Frameworks for Collaboration
As we are becoming increasingly aware of the role of partnership, collaboration and joint working in health promotion, frameworks are being developed for the purpose of facilitating this type of working.

The Institute of Public Health in Ireland has identified strengthening partnerships for health as one of its strategic objectives. Based on a workshop bringing together people from different disciplines, sectors and parts of Ireland, North and South, a Framework for Partnership was developed (Boydell 2001). In the US Lasker et al (2001) have also developed a framework for collaboration.

The Institute for Public Health in Ireland’s Partnership Framework document (2001) states that when beginning the journey, it is critical that all existing and potential members share the vision and purpose. It is this commonality that brings members together to focus on achieving a mission. Building relationships is fundamental to the success of collaboration. Effective collaborations are characterised by building and sustaining ‘win-win-win’ relationships - the kind of relationships where expectations are clear and understood by all members of the collaboration and by those who are working with the collaboration. Defining relationships assists in identifying tasks, roles and responsibilities, work plans and ultimately reaching desired outcomes.

Description of the IPHI Framework
Six contextual factors have been identified as important for the partnership:
1. Connectedness or social cohesion.
2. History of working together.
3. Political climate.
5. Resources.
6. Catalysts or drivers.

All elements of the IPHI framework are grounded in valuing and respecting diversity. Differences of opinion are likely to emerge in a partnership. This should not be seen as a problem, but as healthy and predictable. The challenge is to use difference constructively as an opportunity to increase understanding and produce a meaningful, well thought through vision about purpose.
The core foundation represents the common ground for the partnership: a shared purpose and strategy. Building the foundation will be the first task of a newly formed partnership. It includes the development of the following:

- Vision
- Mission
- Principles
- Values
- Measuring impact
- Infrastructure
- Contribution

Process factors are internal and relate to the specific skills and dynamics of the partnership, which are needed to build effective working relationships and capability. Partnership requires effective leadership. Partnership efforts depend on clear and open communication. Norms of language should be established which agree language usage acceptable to all members, especially with regard to terminology and jargon. Team building is a process which requires its own pace.

Obtaining and utilising information is essential for partnerships. Reviewing examples of other successful models of partnership will help in adapting or customising a partnership model. Data must be collected which establishes benchmarks for future impact and outcomes analysis.

Evaluation efforts are essential to monitor progress related to a partnership’s goals and objectives and to make modifications as necessary. Outcomes represent the desired ‘conditional’ changes. While a vision articulates a picture of the future that the partnership seeks to create, the outcomes address specific ‘conditions to be achieved’.

In order for partnerships to be sustainable, it is essential that systems are put in place to provide sustained membership, resources and effort. Formal operational agreements may be necessary. In addition, respect for diversity lays the groundwork for a dynamic partnership (Boydell 2001).

Lasker et al. (2001) highlight that the mechanism that gives collaboration its unique advantage is synergy. A framework for operationalising and assessing partnership synergy, and for identifying its likely determinants, can be used to address critical policy, evaluation and management issues related to collaboration.

Sindall (1997) says that health services and health promotion agencies can themselves become exemplars of the new ways of working and organising that organisational learning theories suggest. To make real progress in inter-sectoral collaboration, we need to be developing not only the capacity for joint working, but also our ability to read, interpret and ultimately to shape the context in which collaboration occurs.
Policy Developments

Promotion of Mental Health

Due to its many dimensions, the promotion of mental health is the area most prone to fragmentation within health promotion. Therefore special emphasis must be given to co-operation and activities aimed at promoting mental health and these should be supported and augmented by linking them when possible with other EU action (STAKES 1999). The ways in which experts define both mental health and mental health promotion vary widely. Greater agreement is necessary to reach better understanding of the existing values and paradigms, and to make effective co-operation and evaluation possible.

The idea of the relevance of mental health promotion in all sectors of the society needs to be firmly rooted in contemporary thinking and made widely known at individual, community, national and international levels. A common language for exchanging information must be found and developed (STAKES 2001).

Well-planned public awareness and education campaigns can reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closest to each other. In addition, a wide range of strategies are available to improve mental health and prevent mental disorders (World Health Organisaiton 2001).

The need for co-operation

STAKES (1999) recommends the creation of an information exchange capacity/network to gather and disseminate information on matters relevant to mental health taking place in the European Union institutions.

Co-operation is also recognised by the World Health Organisation (2001), which states that alliances between public health agencies and research institutions in different countries will facilitate the generation of knowledge which will help in a better understanding of the epidemiology of mental disorders, and the efficacy, effectiveness and cost-effectiveness of treatments, services and policies. In addition, research should be carried out on a wide international basis to understand variations across communities (WHO 2001).

Research and Development

One of the key areas identified for enhancing promotion of mental health is research and development. Co-operation between member states could give the most added value in the European Union. There is a need for integration of activities in relation to the promotion of mental health (STAKES, 1999).

Studies concerning the effectiveness of promoting mental health have been extensively reviewed (IUHPE 2000). The conclusion from these reviews is that there exists clear evidence
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on the effectiveness of several mental health promotion programmes. In addition initiatives have developed to stimulate the sharing of models of good practice across countries and regions.

Sharing inventive and effective practices and programme-related knowledge across borders will accelerate further development of high-quality health promotion (STAKES 2001). According to the World Health Organisation (2001), the burden of mental and behavioural disorders will only be reduced if effective interventions are developed and disseminated.

The World Health Organisation (2001) also recommends that the mental health of communities should be monitored by including mental health indicators in health information and reporting systems. Monitoring is necessary to assess the effectiveness of mental health prevention and treatment programmes, and it also strengthens arguments for the provision of more resources. New indicators for the mental health of communities are necessary.

Need for Policy Development

Mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. The formulation of policy must be based upon up-to-date and reliable information concerning the community, mental health indicators, effective treatments, prevention and promotion strategies and mental health resources (World Health Organisation 2001).

Health strategies and policies of different countries are beginning to show a greater awareness of mental health issues. At the European level key interest lies in the ability to compare the policies of different countries which may differ substantially. This task requires a standardised and comprehensive system of describing and evaluating the impacts of the policies (STAKES 1999).

The proposal for a programme of Community action in the field of public health (2001-2006) as cited in STAKES report (2001), recommends that each member state of the European Union should draw up a strategic mental health policy that is well integrated with its overall health policies at national, regional and local levels. While each member state has its own special needs, problems, resource constraints and challenges, all share some common areas that need to be addressed by national policy if effective use is to be made of the resources available to improve mental health (STAKES 2001). The following key points were highlighted with regard to the development and implementation of mental health policy across Europe:

- There is no health without mental health! Mental health must be regarded as an indivisible part of public health.
• Mental health problems cause a heavy and increasing burden that contributes to high costs to our societies, long-lasting disability, increased mortality and enormous human suffering. Moreover some mental health problems, such as depression, are becoming increasingly common.
• Effective evidence-based measures are available to promote mental health as well as to prevent and treat mental health problems.
• Each member state should develop its own mental health strategy as an integral part of a comprehensive public health policy taking into account the social and cultural circumstances. Mental health should be considered in all policies across all levels and sectors.
• Substantial added value is to be gained in the field of promotion of mental health by tightening co-operation between member states and applicant countries, as well as with the rest of Europe and within a more global context.

The STAKES report points to the fact that an efficient collaborative structure for the various organisations and networks active in the field is still lacking and highlights that transnational collaboration can help achieve mutual benefits between participants.

The World Health Organisation has stated that governments are the ultimate stewards of mental health, and need to assume the responsibility for ensuring that these complex activities are carried out. One critical role in stewardship is to develop and implement policy. This means identifying the major issues and objectives, defining the respective roles of the public and private sectors in financing and provision, and identifying the policy instruments and organisational arrangements required in the public and possibly the private sectors to meet mental health objectives. It also means prompting action for capacity building and organisational development, and providing guidance for prioritising expenditure, thus linking analysis of problems to decisions about resource allocation (World Health Organisation 2001).

It is of the utmost importance that mental health and its promotion should be integrated closely with all public health strategies. The value of mental health needs to be recognised throughout the European Union - across all levels and all sectors of society - and the EU should use all available means to facilitate international co-operation and alliances between member states (STAKES 2001).

Mental Health Policies in Europe
In 1997 11 out of 15 member states surveyed said they had a written mental health policy statement or relevant documents setting out the government’s overall mental health strategy with a timetable for implementation (STAKES 1999). Included are the UK and Ireland.
At the national level, the lack of policy frameworks emphasising the importance of mental health poses a major barrier. The awareness of governments and policy makers concerning mental health issues must be raised (STAKES 1999).

**European Policy**
In May 2000 the European Commission adopted a Communication on the Health Strategy of the European Community (COM (2000) 285 final). In addition a proposal for adopting a programme of Community action in the field of public health was also adopted.

This new health strategy and the public health action programme will bring about a substantial reform of European health policy. The action programme provides for a more horizontal approach to improving the health of EU citizens, and explicitly commits to consultation with a wide range of stakeholders in the health community. This broad strategy on health combines action in the field of public health with measures to ensure consistency with other EU policy areas.

Article 152 of the Treaty on European Union states that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. The need for a broad strategy does not only arise from the legal requirement to integrate health into all EU policies contained in article 152, but also responds to the fact that the health of EU citizens is directly or indirectly affected by a number of EU policies.

A Communication on the Development of Public Health Policy (contained within the Health Strategy Communication) outlines a possible new Community public health policy based upon three strands of action which include tackling health determinants through health promotion and disease prevention.

**Policy Documents in Neighbouring Countries**

**England**
The policy document *Saving Lives: Our Healthier Nation* (1999) recognises that mental health problems are common and many people experience anxiety or depression at some point in their lives. Poor mental health is a risk factor for many physical health problems. This document sets out a specific target to reduce the death rate from suicide and undetermined injury by at least a fifth by 2010, saving up to 4,000 lives in total.

Also included is a commitment to a new mental health strategy for which the UK government has developed a National Service Framework for Mental Health (1999). Included in this framework is a standard for mental health promotion. For the first time, health and social services have been given a clear remit to promote mental health. By March 2002 health authorities, in partnership with social services, must develop a range of strategies to meet the National Service Framework’s performance targets. Within the Department of Health, the mental
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Health policy branch was reorganised in 2000 into a series of project teams which reflect broadly the standards set out in the National Service Framework (Berry 2001).

To support local services in developing strategies for mental health promotion, the Department of Health commissioned Mentality to produce a framework document entitled *Making it Happen* which was published in 2001. This framework is illustrated by examples of good practice, and offers practical advice on how to develop and implement an effective mental health promotion strategy.

The National Institute for Mental Health England (NIMHE) has been formed and will play a key role in leading the policy implementation and service development agenda across mental health (Berry 2001).

*Scotland*

Key health priorities for Scotland include addressing mental illness. Mental health problems are one of the commonest causes of ill health in Scotland. In terms of mortality, suicide is an important cause of premature death, especially among young men (*Health in Scotland* 2000). The Framework for Mental Health Services in Scotland (1997) stated that a comprehensive local mental health service should "promote mental health and engage actively in health promotion, including action to de-stigmatise mental health".

The Health Education Board for Scotland (HEBS) recognises that an important part of people’s life circumstances is the extent to which there are health educational and wider health promoting influences wherever people live, learn, work, spend leisure times and seek help.

As mental health was identified as a national priority by the Scottish Department of Health, the HEBS agency developed a specific mental health promotion strategic statement. The HEBS has outlined three clear areas by which this can be achieved:

- Promotion of life skills and coping skills among the general population
- Work relating to the prevention of mental health problems
- A focus on changing public attitudes to mental health problems.

This can be facilitated through the development of alliances and networks to regard mental health as an issue which concerns everyone. As yet there is no formal mental health promotion strategy in Scotland, but there are plans to develop one by the newly-formed National Advisory Group.
Collaborative Practice and Policy

Wales
In 1997 15 health gain targets were set for Wales which included a specific target for health promotion. Since then the National Assembly has published *Promoting Health and Well-being: Implementing the National Health Promotion Strategy* and is in the process of implementing its proposed programme of action (Department of Health 2002).

The Welsh Strategy document *Improving Health in Wales* (2001) also has an aim to promote the health and well being of everyone living in Wales and provide effective and efficient services.

In addition two strategy documents have been published: *Everybody’s Business* (National Assembly for Wales 2001) which is concerned with child and adolescent mental health services, and *Equity, Empowerment, Effectiveness, Efficiency* (National Assembly for Wales 2001) which is concerned with adult mental health services. Both documents highlight mental health promotion as being necessary for maintaining good mental health, and the development of the skills and resources necessary to enable people to live with mental illness. In addition, health promotion has a key role to play in programmes to improve mental health and to reduce the incidence of mental illness in society.

These documents also state that evidence based practice within the field of mental health promotion must be developed, and this knowledge and the associated skills must be cultivated and disseminated through inter-disciplinary training and education.

*Everybody’s Business* (2001) describes good joint working as the ‘holy grail’ of all attempts to improve delivery of health, education and social services. Collaboration needs to be driven from the top of each agency and reflected in good working relationships on the ground. Joint training is a potent force in fostering inclusive attitudes to inter-agency and professional-carer co-operation.

Regional Policy Documents
The national strategy documents in both Northern Ireland and in the Republic of Ireland have already been mentioned. However within all the health boards and the N. Ireland health trusts there are health promotion departments. Some departments have appointed an officer specifically for mental health promotion. In some cases individual boards or organisations have developed a mental health strategy for their region. An example of this is the North Western Health Board. The overall objective of its strategy document *Into the Millennium and Beyond* (2000) is to ensure the promotion of positive mental health for the community in general and the development of services to treat and rehabilitate those with mental illness.
The Western Health Board has developed a health promotion strategy (Western Health Board 1999). Although this does not contain a specific aim for mental health promotion, Goal 1 aims to affirm and support healthy lifestyle choices (physical, mental, emotional, social and spiritual health). Evans & Jones (2001) state that within the Western Health Board there is now an increasing recognition among service providers that mental health can be actively promoted in the same way as physical health. In order to address this issue, it has been acknowledged that there is a need to develop a plan for mental health promotion. Mental health promotion initiatives have also been undertaken in the North Eastern and Midland health board regions.
PHASE 1

In the first phase of this project a total of 25 organisations or individual persons responded with information about their involvement in mental health research in the form of reports, articles and questionnaires or interview schedules used in the data collection process. Following analysis of the 25 responses obtained, it was subsequently noted that nine of these reports did not have information related to a definable population-based survey. These nine responses would be more accurately characterised as organisational annual reports, strategy documents or clinical surveys rather than population-based survey reports. A further two surveys, while population based, related to attitudes towards mental health and well-being and were not considered directly relevant for mental health monitoring purposes.

Details were received of 14 surveys which did meet the inclusion criteria for this study. Table 5 lists the authors and study names and Table 6 describes the associated survey design, methodology, target population, sample size and year the survey work was undertaken. Ten surveys were carried out in the Republic of Ireland, three in Northern Ireland and one was performed in both jurisdictions plus the USA.

All the surveys were cross-sectional in design and had been carried out in the previous four years, with the exception of the Living in Ireland Survey of 1994 which was a panel survey, and the cross-national survey which was circa 1995. The target population for the majority of the surveys in each area was adults, defined as 18 years and over in the Republic of Ireland and 16 years and over in the North. The Health Behaviours in School Children survey was the only survey relating to younger people and was performed in both the North and South of Ireland using a self-administered questionnaire completed in a classroom setting. The smallest sample size from all the studies was 131 and the largest 16,600. A variety of sample frameworks were used across the various surveys.

Of the adult surveys, in the Republic of Ireland there were five national, two regional and two local, and two regional in the North. Three of the national surveys in the Republic of Ireland related to the general population. The sample for both components of the National Health and Lifestyle Survey (SLÁN) was selected from a nationally representative population framework, the electoral register. While the sample for the main component was randomly selected and nationally representative across various socio-demographic and economic groupings, a smaller sub-sample was used in the examination component and resulted in a quota based sample. The main component of SLÁN used a postal self-administered questionnaire, while in the examination component the participant attended a clinic and was given the questionnaire to complete during the examination process. The Living in Ireland Survey is part of the ongoing European Household Panel Survey, a Europe-wide harmonised approach.
primarily carried out for socio-economic monitoring purposes. The Irish survey, however, includes additional modules designed to allow wider assessment of households and individuals. Interviewer administered questionnaires were completed by individuals randomly selected from the electoral register.

The Northern Ireland Survey of Health and Social Wellbeing is similar to SLÁN in that it was the survey of health and behaviour risk factors among the general population in Northern Ireland. Over 3,000 households were selected from the Valuation and Land Agency list of private addresses in Northern Ireland. Each member of the household over the age of 16 years was asked to complete a questionnaire, administered by a fieldworker.

While two other surveys in the Republic of Ireland were nationally representative, they related to specific population groupings - General Health Care of the Prisoner Population and Prevalence of Depression in Third Level Students. Both surveys used self-administered questionnaires completed in their respective settings. Similarly, the Survey of Health in the Northern Ireland Civil Service is specific only to the civil servant population and used postal self-administered questionnaires. The Cross-National Survey of mothers aged 55 years and over used nationally representative samples in both Northern Ireland and the Republic of Ireland. Interviews were conducted in the home with the women, and following the interview, a self-administered questionnaire was completed.

The other adult surveys were either regionally based or relating to sectors of the local population. In the Republic of Ireland, rural populations were targeted in the Mental illness in an elderly rural population in Ireland: a prevalence study. The elderly were specifically surveyed in the regional Health and Social Services for Older People. The two other non-nationally representative surveys focussed on homeless men in Dublin and mental health specifically in the Western Health Board area. There were no local surveys identified in Northern Ireland.

Two population-based surveys were identified which are currently in progress. The INSURE (Ireland North-South Urban Rural Epidemiological) survey is a prospective investigation into age and demographic risk factors for suicidal behaviour (McClelland and Malone). The Health Status Health Gain Unit, NUI Galway is beginning a prospective investigation into health and inequalities using three age cohorts across various life stages in the western and eastern populations of the Republic of Ireland (Lifeways Cohort study). Mental health is an integral component of this study with self-reported measures and biological markers being used for assessment purposes.

A summary of the mental health indicators and the measures used, socio-demographic and economic indicators, related lifestyle behaviours and mental health problems are shown for each survey in Table 7. In total, 14 different mental health indicators were identified from the various surveys, with 12 different types of measurement scales used.
Self-rated General Health
Most commonly used general health measures related to self-rated general health, with nine surveys (six in Republic and three in Northern Ireland) recording this information using some level of Likert type scale. *The Northern Ireland Survey of Health and Social Wellbeing* used the following question within the SF-36 scale:

In general would you say your health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The *National Health and Lifestyle Survey* and the *Living in Ireland Survey* in the Republic of Ireland asked this question in exactly the same way, although not as part of the SF-36. Each of the remaining adult surveys used the same measure for general health and the children’s HBSC survey used a similar three-point scale.

General Health Status and Quality of Life
Health status was also commonly recorded with seven surveys doing so (five in the Republic and two in Northern Ireland). Two different generic health status measures were used for this purpose, the EuroQoL-5D and the SF-36. The EuroQoL-5D is a generic multi-dimensional health profile, which includes five domains; mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Overall perceived health status is also recorded on a visual analogue scale of 1-100 (EuroQoL group 1990). The Short Form-36 (SF-36) health survey scale comprises 36 items which measure the following eight dimensions: physical functioning, role limitations (physical), role limitations (social), social functioning, mental health, energy/vitality, pain and general health perception. This widely used scale has been found to have good psychometric properties (Ware et al. 1993).

Four studies in the Republic measured quality of life using a combination of the WHOQoL-BREF, single item Likert scale and the SEIQoL scale. There were no such measures in any of the Northern Ireland surveys. The recently developed UK WHOQoL-BREF instrument (WHOQoL Group 1998) is an abbreviated version of the WHOQoL-100 quality of life assessment. There are 26 individual items in the WHOQoL-BREF that represent four domains related to quality of life: physical health, psychological, social relationships and environment. The psychological dimension covers a number of mental health related items. The single Likert scale used was the following and was taken from the WHOQoL-BREF.
How would you rate your quality of life:

<table>
<thead>
<tr>
<th>Very poor</th>
<th>Poor</th>
<th>Neither poor nor good</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

The Schedule for Evaluation of Individual Quality of Life (SEIQoL) is an Irish developed scale which measures general quality of life from the perspective of the individual respondent (Browne et al. 1997). The individual names five areas most important to their quality of life, describes current functioning in each of the areas and outlines the relative weighting or importance they give to each area in their judgement of quality of life.

**Psychological distress**
Psychological distress was measured by seven surveys (four in Republic and two in North) each using the GHQ-12. The GHQ-12, a widely applied instrument to indicate psychological distress, is the short form of the General Health Questionnaire (GHQ) designed by Goldberg (1978) as a self-administered instrument for use in community settings. The cross national survey also measured psychological well-being using the Questionnaire on Resources and Stress (QRS-F) and life satisfaction using the Philadelphia Geriatric Centre Morale Scale. Many of the other mental health indicators were recorded by single surveys only.

**Mental and Physical Health Problems**
Each national survey recorded information relating to self-reported mental and physical health morbidity and health service utilisation. As was also the case in the regional or specific population surveys, reported diagnosis of depression and anxiety were the most commonly noted mental health problems. Those needing mental health services were identified in the Health and Social Services for Older People survey using the Hospital Anxiety and Depression Scales (HADS). Among the depression scales used in individual surveys were the Zung Self-Rating Depression Scale (Zung 1965) and the Centre for Epidemiologic Studies Depression Scale (CES-D) (Radloff 1977). Physical morbidity was mainly recorded using the long term limiting illness indicator.

**Social Support and Stress Measures**
The Northern Ireland Survey of Health and Social Wellbeing survey used the same perceived social support seven item scale as that in the Health Survey for England 1994. However, there was no such comparable measure in the National Health and Lifestyle Survey in the Republic of Ireland. Respondents were asked about their perceived level of stress in the past year in the Northern Ireland national survey but not in the Republic’s.
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources

Socio-demographics
In almost all surveys, the only common socio-demographic indicators were age and gender. In the adult national surveys, North and South, detailed information was recorded on education. Given the strong predictive power of education as an indicator for inequalities in health, the ability to classify data into primary, secondary and third level education as a single measure of inequalities is an invaluable measure in any population health monitoring system. The more complex measure of social class was also recorded in the national surveys. Each survey recorded the occupation of the respondent, which was then classified into one of six social classes based on job title and employment status. Other indicators of social inequality such as home tenure and marital status were recorded in the national and some regional surveys.

Lifestyle Behaviours
Lifestyle factors were recorded in six surveys in the Republic and all three Northern surveys. Most commonly recorded were prevalence, frequency and quantity of consumption of both tobacco and alcohol - however, the measures used for each of these were not directly comparable. Dietary habits were also measured but in a non-standard way. Three questions relating to frequency of consumption of foods high in fat, sugar and fruit and vegetables were asked in the Northern Ireland Survey of Health and Social Wellbeing, whereas a 148 item semi-quantitative food frequency was used in the National Health and Lifestyle Survey in the Republic. Participation in physical activity was only recorded at a national level in the Southern survey. Many of the other smaller regional and local surveys measured this parameter but employing different measures.

Young People
The socio-demographic, economic and lifestyle variables recorded in the children’s survey, HBSC, were the same due to observation of an internationally devised protocol. There were three mental health and well-being measures common in both the Northern and Southern arms of the HBSC survey. General health and satisfaction with health were measured using a 3 and 5 point Likert scale respectively. The Rosenberg Self-Esteem Scale was used to measure self-esteem among the young people.
### Table 5: Mental health population surveys in the Republic of Ireland and Northern Ireland

<table>
<thead>
<tr>
<th>NORTHERN IRELAND</th>
<th>STUDY NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Department of Health and Social Services, Northern Ireland</td>
<td>The First Northern Ireland Survey of Health and Social Well-being 1997</td>
</tr>
<tr>
<td>2 Civil Service, Northern Ireland</td>
<td>Survey of Health in the Northern Ireland Civil Service</td>
</tr>
<tr>
<td>3 Health Promotion Agency, Northern Ireland</td>
<td>The Health Behaviour of School-Aged Children in Northern Ireland (HBSC) 1997/98</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPUBLIC OF IRELAND</th>
<th>STUDY NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Department of Health Promotion, NUI, Galway, Republic of Ireland</td>
<td>Survey of Lifestyle Attitudes and Nutrition (SLÁN)</td>
</tr>
<tr>
<td>5 Department of Health Promotion, NUI, Galway, Republic of Ireland</td>
<td>Examination component of SLÁN</td>
</tr>
<tr>
<td>6 Economic and Social Research Institute, Dublin, Republic of Ireland</td>
<td>Living in Ireland Survey</td>
</tr>
<tr>
<td>7 Department of Health Promotion, NUI, Galway, Republic of Ireland</td>
<td>General Health Care Study of the Prisoner Population</td>
</tr>
<tr>
<td>8 Depression Research unit, St. Patrick's Hospital, Dublin and AWARE, Republic of Ireland</td>
<td>Prevalence Of Depression In Third Level Students: A National Survey</td>
</tr>
<tr>
<td>10 Health Promotion Department, Western Health Board, Republic of Ireland</td>
<td>Western Health Board, Mental Health Survey, 2000</td>
</tr>
<tr>
<td>11 Royal College of Surgeons in Ireland and Department of Public Health, Eastern Health Board, Republic of Ireland</td>
<td>Health Status And Health Care Access Of Homeless Men In South Inner City Dublin Hostels</td>
</tr>
<tr>
<td>12 Health Services Research Centre, Royal College of Surgeons in Ireland, Republic of Ireland</td>
<td>Health and Social Services for Older People</td>
</tr>
<tr>
<td>13 Department of Health Promotion, NUI, Galway, Republic of Ireland</td>
<td>Health Behaviour of School-Aged Children (HBSC) 1998</td>
</tr>
</tbody>
</table>
### Table 6: Mental health population surveys - Methodological details

<table>
<thead>
<tr>
<th>STUDY NAME</th>
<th>STUDY DESIGN</th>
<th>Methodology</th>
<th>Area Covered</th>
<th>Sample Size</th>
<th>Age Range (years)</th>
<th>Date of Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTHERN IRELAND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 The First Northern Ireland Survey of Health and Social Well-Being 1997</td>
<td>Cross-sectional</td>
<td>Administered questionnaire</td>
<td>Regional</td>
<td>7,000</td>
<td>≥ 16</td>
<td>1997</td>
</tr>
<tr>
<td>2 Survey of Health in the Northern Ireland Civil Service</td>
<td>Cross-sectional</td>
<td>Self-administered postal questionnaire</td>
<td>Regional</td>
<td>16,600</td>
<td>16-70</td>
<td>2000</td>
</tr>
<tr>
<td>REPUBLIC OF IRELAND</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Survey of Lifestyle Attitudes and Nutrition (SLÁN)</td>
<td>Cross-sectional</td>
<td>Self-administered postal questionnaire</td>
<td>National</td>
<td>6,539</td>
<td>≥ 18</td>
<td>1998</td>
</tr>
<tr>
<td>5 Examination component of SLÁN</td>
<td>Cross-sectional</td>
<td>Self-administered questionnaire</td>
<td>National</td>
<td>565</td>
<td>≥ 18</td>
<td>1998</td>
</tr>
<tr>
<td>6 Living in Ireland Survey</td>
<td>Panel survey</td>
<td>Administered questionnaire</td>
<td>National</td>
<td>9,905</td>
<td>≥ 17</td>
<td>1994 /1997</td>
</tr>
<tr>
<td>7 General Health Care Study of the Prisoner Population</td>
<td>Cross-sectional</td>
<td>Self-administered questionnaire</td>
<td>National</td>
<td>777</td>
<td>≥ 15</td>
<td>2000</td>
</tr>
<tr>
<td>8 Prevalence Of Depression In Third Level Students: A National Survey</td>
<td>Cross-sectional</td>
<td>Self-administered questionnaire</td>
<td>National</td>
<td>1,531</td>
<td>≥ 17</td>
<td></td>
</tr>
<tr>
<td>9 Mental Illness In An Elderly Rural Population In Ireland: A Prevalence Study</td>
<td>Cross-sectional</td>
<td>Semi-structured interview</td>
<td>Local</td>
<td>650</td>
<td>≥ 65</td>
<td>Circa 1997</td>
</tr>
<tr>
<td>10 Western Health Board, Mental Health Survey, 2000</td>
<td>Cross-sectional</td>
<td>Administered questionnaire</td>
<td>Regional</td>
<td>700</td>
<td>≥ 18</td>
<td>2000</td>
</tr>
<tr>
<td>11 Health Status And Health Care Access Of Homeless Men In South Inner City Dublin Hostels</td>
<td>Cross-sectional</td>
<td>Semi-structured interview</td>
<td>Local</td>
<td>171</td>
<td>≥ 18</td>
<td>1999</td>
</tr>
<tr>
<td>12 Health and Social Services for Older People</td>
<td>Cross-sectional</td>
<td>Semi-structured interview</td>
<td>Regional</td>
<td>937</td>
<td>≥ 65</td>
<td>2000</td>
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<tr>
<td>14 Cross-national comparisons of ageing mothers of adults with intellectual disabilities (USA, Northern Ireland and Republic of Ireland)</td>
<td>Cross-sectional</td>
<td>Semi-structured interview and self-administered questionnaire</td>
<td>National (NI 151) (RI 131)</td>
<td>744</td>
<td>≥ 55</td>
<td>Circa 1995</td>
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</table>
### Table 7: NORTHERN IRELAND

<table>
<thead>
<tr>
<th>Survey No.</th>
<th>Mental Health Indicators</th>
<th>Measures</th>
<th>Demographics</th>
<th>Socio-economic</th>
<th>Lifestyle</th>
<th>Mental and Physical Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Health</td>
<td>5 point Likert</td>
<td>Age</td>
<td>Employment Status</td>
<td>Smoking</td>
<td>Long term limiting illness</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>Social Support Scale</td>
<td>Gender</td>
<td>Occupation</td>
<td>Alcohol</td>
<td>Stress</td>
</tr>
<tr>
<td></td>
<td>Well-Being</td>
<td>SF-36</td>
<td>Education</td>
<td>Social Class</td>
<td>Diet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychological Distress</td>
<td>GHQ-12</td>
<td>Marital status</td>
<td>Income</td>
<td>Body Mass</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tenure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>General Health</td>
<td>5 point Likert</td>
<td>Age</td>
<td>Employment Status</td>
<td>Smoking</td>
<td>Diagnosed with anxiety</td>
</tr>
<tr>
<td></td>
<td>Psychological Distress</td>
<td>GHQ-12</td>
<td>Gender</td>
<td>occupation</td>
<td>Alcohol</td>
<td>Diagnosed with depression</td>
</tr>
<tr>
<td></td>
<td>Stress</td>
<td>Series of 5 point Likert scales</td>
<td>Marital status</td>
<td>Social Class</td>
<td>Diet</td>
<td>Diagnosed with other mental illness</td>
</tr>
<tr>
<td>3</td>
<td>General Health</td>
<td>3 point Likert</td>
<td>Age</td>
<td>Employment Status</td>
<td>Smoking</td>
<td>Bullying</td>
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<td></td>
<td>Satisfaction With Life</td>
<td>5 point Likert</td>
<td>Gender</td>
<td>(parents)</td>
<td>Alcohol</td>
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<td>Self Esteem</td>
<td>Rosenberg Self-Esteem Scale</td>
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<td>Diet</td>
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<td></td>
<td>Loneliness</td>
<td>4 point Likert</td>
<td>Tenure</td>
<td></td>
<td>Exercise</td>
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<tr>
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<td></td>
<td></td>
<td>Locality</td>
<td></td>
<td>Illegal substances</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Body Mass</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Accidents</td>
<td></td>
</tr>
<tr>
<td>Survey No.</td>
<td>Mental Health Indicators</td>
<td>Measures</td>
<td>Demographics</td>
<td>Socio-economic</td>
<td>Lifestyle</td>
<td>Mental and Physical Morbidity</td>
</tr>
<tr>
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</tr>
<tr>
<td>4</td>
<td>General Health Quality of Life Satisfaction with Health Health Status</td>
<td>5 point Likert 5 point Likert 5 point Likert EuroQoL-EQ-5D</td>
<td>Age Gender Education Marital status Home Tenure Locality Number in Household</td>
<td>Occupation Employment Status Social Class Medical Card Status</td>
<td>Smoking Alcohol Diet Exercise Body Mass Illegal Substances Accidents</td>
<td>Diagnosed with depression Diagnosed with anxiety Attend mental health services Long term limiting illness</td>
</tr>
<tr>
<td>5</td>
<td>General Health Quality of Life Quality of Life Satisfaction with Health Depression Psychological Distress Health Status</td>
<td>5 point Likert WHOQoL-BREF 5 point Likert 5 point Likert CES-D GHQ-12 EuroQoL-EQ-5D</td>
<td>Age Gender Education Marital status Home Tenure Locality Number in Household</td>
<td>Employment Status Occupation Social Class Medical Card Status</td>
<td>Smoking Alcohol Diet Exercise Body Mass Illegal Substances Accidents</td>
<td>Diagnosed with depression Diagnosed with anxiety Attend mental health services Long term limiting illness</td>
</tr>
<tr>
<td>6</td>
<td>General Health Satisfaction with Life Psychological Distress</td>
<td>5 point Likert Series of 6 point Likert scales GHQ-12</td>
<td>Age Gender Education Marital Status Tenure</td>
<td>Employment Status Occupation Income Medical Card Status</td>
<td>Smoking Body Mass</td>
<td>Long term limiting illness Self-reported mental health problems</td>
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### Table 7 Continued: REPUBLIC OF IRELAND

<table>
<thead>
<tr>
<th>Survey No.</th>
<th>Mental Health Indicators</th>
<th>Measures</th>
<th>Demographics</th>
<th>Socio-economic</th>
<th>Lifestyle</th>
<th>Mental and Physical Morbidity</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>General Health Quality of Life Quality of Life Satisfaction with health Psychological Distress Health Status</td>
<td>5 point Likert 5 point Likert WHOQol-BREF 5 point Likert GHQ-12 EuroQol-EQ-5D</td>
<td>Age Gender Education Marital status Locality Tenure No. in Household</td>
<td>Employment Status Occupation Social Class Medical Card Status</td>
<td>Smoking Alcohol Diet Exercise Illegal Substances Accidents</td>
<td>Diagnosed with depression Diagnosed with anxiety Hospital inpatient for depression Hospital inpatient for anxiety</td>
</tr>
<tr>
<td>8</td>
<td>Depression History of Depression</td>
<td>Zung Scale</td>
<td>Age Gender Household Composition</td>
<td></td>
<td></td>
<td>Treatment sought for depression Attitudes to treatment in GP</td>
</tr>
<tr>
<td>9</td>
<td>Anxiety Depression</td>
<td>GMS-AGECAT</td>
<td>Age Gender</td>
<td></td>
<td></td>
<td>Medication used</td>
</tr>
<tr>
<td>10</td>
<td>Mental Well-being Satisfaction with Life Mental Health</td>
<td>Series of 4 point Likert scales Series of 5 point Likert scales 5 point Likert</td>
<td>Education</td>
<td></td>
<td></td>
<td>Prevalence of mental health service use</td>
</tr>
<tr>
<td>11</td>
<td>General Health Quality of Life Social Support Health Status Psychological Distress</td>
<td>5 point Likert SEIQoL MOS scale SF-36 GHQ-12</td>
<td>Age Education Marital Status Parenthood Nationality</td>
<td>Medical Card Status</td>
<td>Smoking Alcohol Consumption Alcohol Dependence Exercise Illegal Substances</td>
<td>Diagnosed depression Diagnosed anxiety Treated for depression Treated for anxiety Prevalence of mental health service use</td>
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<td>12</td>
<td>Anxiety/Depression</td>
<td>HADS</td>
<td>Age Gender Locality</td>
<td>Occupation</td>
<td></td>
<td>Prevalence of mental health service use Long term limiting illness</td>
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Table 7 Continued: REPUBLIC OF IRELAND AND CROSS NATIONAL

<table>
<thead>
<tr>
<th>Survey No.</th>
<th>Mental Health Indicators</th>
<th>Measures</th>
<th>Demographics</th>
<th>Socio-economic</th>
<th>Lifestyle</th>
<th>Mental and Physical Morbidity</th>
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</thead>
<tbody>
<tr>
<td>13</td>
<td>General Health Satisfaction With Life Self Esteem Loneliness</td>
<td>3 point Likert 5 point Likert Rosenberg Self-Esteem Scale 4 point Likert</td>
<td>Age Gender Education Tenure Locality</td>
<td>Employment Status (parents)</td>
<td>Smoking Alcohol Diet Exercise Body Mass Illegal Substances</td>
<td>Bullying</td>
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<tr>
<td>14</td>
<td>General Health Social Well-being Psychological Well-being Functional Reliance Social Reliance</td>
<td>5 point Likert Convoy Model of social support QRS-F Philadelphia Geriatric Centre Morale Scale Barthel Index 5 single items</td>
<td>Age Gender Education Marital status</td>
<td>Employment Status Income</td>
<td></td>
<td>Stress Long term limiting illness</td>
</tr>
</tbody>
</table>

EuroQoL-EQ-5D: The EuroQoL Quality of Life Scale (The EuroQoL Group 1990)
WHOQoL BREF: World Health Organisation Quality of Life Scale (The WHOQoL Group 1993)
CES-D: The Centre for Epidemiologic Studies Depression Scale (National Institute of Mental Health, USA 1972, Radloff 1977)
GHQ-12: General Health Questionnaire (Goldberg 1978)
Zung Scale: Zung's Self-rating Depression Scale (Zung 1965)
GMS-AGECAT: Geriatric Mental State Automated Geriatric Examination for Computer Assisted Taxonomy (Copeland et al. 1986)
SF-36: Short Form-36 Health Survey Questionnaire (Ware et al. 1993)
SEIcoL: Quality of Life (Browne et al. 1997)
MOS Scale: The Medical Outcomes Study Social Support Survey (Sherbourne and Stewart 1991)
HADS: Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983)
Rosenberg Self-Esteem Scale: (Rosenberg 1965)
QRS-F: Questionnaire on Resources and Stress (QRS-F, Freidrich et al. 1983)
Philadelphia Geriatric Centre Morale Scale: (Lawton 1975)
PHASE 2

Based on the compilation of mental health data sources on the island of Ireland, Phase 2 of the project was concerned with making recommendations on mental health indicators that would aid in the harmonisation of mental health population surveillance in both Northern Ireland and the Republic of Ireland. The most commonly used measures of mental health identified in Phase 1 are summarised below.

**Measures of Mental Health**

**General Health Questionnaire**
The General Health Questionnaire (GHQ) is the most widely used population measure of psychological disturbance in the United Kingdom (O’Reilly & Browne 2001). The GHQ-12 is the shortest version available with half the items indicating health and the other half illness. It may be used either to obtain a dimensional measure of psychological distress or to express the probability that a respondent might be found to have a psychiatric illness at second stage interview. The GHQ-12 may be used to assess changes in psychological distress with time by repeated re-testing (Goldberg & Williams 1988).

The GHQ was designed for use in general population surveys, in primary medical care settings or among general medical outpatients. The questions ask whether the respondent has recently experienced a particular symptom (like abnormal feelings or thoughts) or type of behaviour. Emphasis is on changes in condition, not on the absolute level of the problems, so items compare the present state to the person’s normal situation with responses from “less than usual” to “much more than usual”. The GHQ is normally completed by the patient/respondent (McDowell and Newell 1987).

A low score represents low probability of psychological morbidity whereas a high score indicates probable psychological disturbance (O’Reilly & Browne, 2001). Two methods of scoring the GHQ-12 can be used: the Likert method (scores vary from 0 to 36 with a higher score indicating greater distress) or choosing a cut-off score that dichotomises the population into “cases” exhibiting psychological distress in need of help and “normals” (Goldberg 1972).

A study by Sturgis et al. (2001), which reviewed health measures, stated that GHQ-12 reliability has been less frequently examined than validity but results have generally been satisfactory. The problem of test-retest reliability is problematic though because the dysfunctions captured by the GHQ-12 are supposed, by definition, to be transitory. The GHQ is actually an instrument designed to identify persons in the community who appear to suffer from significant mental health problems (mainly anxiety and depression) but it does not provide a general or overall health profile score (Sturgis et al. 2001).
Short Form 36 (SF-36)
The SF-36 is a generic measure of health, which includes a reliable short measure on mental health both from the illness and well-being aspect. Within the instrument there are eight multi-item dimensions of health: physical functioning (10 items), social functioning (2 items), role limitations due to physical problems (4 items), role limitations due to emotional problems (3 items), mental health (5 items), energy/vitality (4 items), pain (2 items) and general health perception (5 items). The SF-36 is a cost effective way to measure both health and mental health simultaneously and has repeatedly been shown to be a valid and reliable instrument for measuring general health in a wide variety of settings from assessing the outcomes of clinical interventions to measuring population health (O’Reilly & Browne 2001).

The SF-36 appears to be aimed at the most useful level of generality for a policy relevant profile according to Sturgis et al (2001). It was found to be superior to the EuroQol system both in terms of health domain coverage and in terms of sensitivity. The SF-36 appears not to suffer from ‘ceiling’ or ‘floor’ effects, but calibrates the whole range from excellent to very poor health. Sturgis et al’s analysis found that the extra sensitivity of the SF-36 is genuine, marking real variations in health. The SF-36 has been listed by the European Community Health Indicator project (ECHI) as a measure of Quality of Life. Use of one instrument would thus provide synergy between various interests (European Health Monitoring Project 2001).

WHOQoL-BREF
The WHOQoL-BREF is an abbreviated version of the WHOQoL-BREF-100 quality of life assessment. There are 26 individual items in the WHOQoL-BREF that are representative of four domains related to quality of life: physical health, psychological, social relationships and environment. The four domain scores of the WHOQoL-BREF were found to correlate highly with the WHOQoL-BREF-100 domain scores (the WHOQoL-BREF Group 1998). This parent instrument is the result of much international collaboration to develop a multidimensional, multilingual, reliable, valid and responsive assessment of quality of life, and is currently available in 40 languages worldwide (the WHOQoL-BREF Group 1994a, b, 1995, 1998). A total quality of life score is obtained by summing up the individual scores on each item and domain scores are scaled in a positive direction (i.e. higher scores denote a higher quality of life with the highest possible score in each domain being 100). As reported by the WHOQoL-BREF Group (1998) domain scores produced by the WHOQoL-BREF have been shown to correlate at 0.9 with the WHOQoL-BREF-100 domain scores, which in turn has demonstrated criterion validity. The WHOQoL-BREF domain scores have also been shown to display good discriminant validity, content validity and test-retest reliability (The WHOQoL-BREF Group 1998).
EURO-Qol EQ-5d

The EuroQol EQ-5D instrument is a measure of health status/health-related quality of life (EUROQoL Group 1990). The descriptive component of the instrument aims to capture physical, mental and social functioning, summarising health using five dimensions; mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Within each dimension there are three levels indicating whether the respondent has no problem, a moderate problem or an extreme problem with that parameter. A visual analogue scale (VAS) represented by a thermometer is also incorporated on which respondents rate their overall health state on a range from 0 (worst health) to 100 (best health). Sturgis et al. (2001) report that this system has not been shown to have the required levels of concept coverage and sensitivity, being subject to strong ‘ceiling’ effects (inability to detect differences between persons with better levels of health).

CES-D

The Centre for Epidemiologic Studies Depression Scale, CES-D, is a 20 item, self report depression scale used to identify depression in the general population (Radloff 1977). It has an emphasis on affective components such as depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite and sleep disorders. Scores of 16 or more are commonly taken as indicative of depression and referred to as ‘cases’.

Comparisons of Results from Population Surveys

Very few of the above mentioned measures were used in all surveys identified in Ireland, resulting in little comparable data with which to assess mental health status. Information on psychological distress, however, was available using data collected from the GHQ-12, the SF-36 and the SF-12.

The Northern Ireland Health and Well-being Survey (1997) used the GHQ-12 with half the sample and the SF-36 with the other half. A secondary analysis of the data, undertaken by O’Reilly and Browne (2001), compared the Northern Ireland GHQ-12 scores with those from the Health Survey for Scotland (1995) and the Health Survey for England (1995). For the purposes of this project an additional comparison was made with the GHQ-12 scores from the two Republic of Ireland National Surveys, SLÁN 1998 and Living in Ireland 1997.

It should be noted that there are methodological differences between the various surveys for which the GHQ-12 results are reported. The SLÁN survey (1999) was cross-sectional and used a self-administered questionnaire aimed at adults aged 18 and over. However it should be noted that the GHQ-12 was administered only to the sub-sample who participated in the clinical examination and is therefore not nationally representative. In Northern Ireland, the Health and Social Well-being Survey is also cross-sectional but the questionnaire is administered by an interviewer and with a target population aged 16 years and over. The Living in Ireland survey is an interviewer administered panel survey of people aged 17
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years and over. The Health Surveys for England and Scotland are both cross sectional using interviewer administered questionnaires among people aged 16 years and over. On the GHQ-12 scores, two cut-off values, 3 and 4, were used to dichotomise the respondents’ scores. The percentage respondents above the two cut-off values of the GHQ-12 are presented in the following Table 8 (adapted from O’Reilly 2001). Both cut off scores are presented.

Table 8: Percentage respondents (aged 16-64 years) above the GHQ-12 cut-off in the Republic of Ireland, Northern Ireland, England and Scotland

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GHQ ≥3</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>GHQ ≥4</td>
<td>10.4</td>
<td>15.8</td>
<td>17.3</td>
<td>18.9</td>
<td>23.6</td>
</tr>
</tbody>
</table>

These results show that using both cut off scores Northern Ireland exhibited the highest levels of psychological morbidity of all countries. The lowest level of psychological morbidity, either using a cut-off of 3 or 4, was observed in the Republic of Ireland, the lowest being among respondents to the Living in Ireland Survey (1997). There is little difference in the psychological morbidity rates between Scotland and England. However respondents in Northern Ireland exhibited a substantially higher psychological morbidity than their counterparts in England and Scotland.

Regarding quality of life measures, O’Reilly and Browne (2001) compared SF-36 scores between Northern Ireland and England. This comparison found that even with its slightly younger population, Northern Ireland has a lower mean score (worse health) on all dimensions of the SF-36. For many of the dimensions of the SF-36 the difference in mean scores between Northern Ireland and England improved with increasing age. One exception to this was the mental health dimension which in Northern Ireland gradually disimproved with age. In England levels of mental health were well maintained across the age range.

A study by Layte & Jenkinson (2001) reported on the construction of the Physical and Mental Summary Scores derived from the SF-12 for a representative sample from the Republic of Ireland and then compared the results to a normative sample from England. Compared to their English counterparts, the respondents in the Republic of Ireland were found to have significantly higher average physical and mental health status. This difference persisted across the distribution. With regard to mental health this difference was particularly marked, with the
Irish sample average over five units higher than the English sample average. When analysed by sex, the health advantage of the population of the Republic of Ireland persisted, though the difference between Irish and English men was not significant. With regard to all age groups the population of the Republic of Ireland had a significant health advantage over their English counterparts in terms of mental health scores.

However a direct comparison is difficult as it should be noted that the two different modes of collection of the two surveys could have influenced these results. The majority of the Irish interviews were by telephone and the SF-12 (subset of questions from the SF-36) was used. In the English study the SF-36 was used and data was collected by mail questionnaire (Layte & Jenkinson 2001).

**HBSC**

The Health Behaviour in School-Aged Children (HBSC) study was carried out in 28 countries including England, Northern Ireland and the Republic of Ireland. The HBSC study is a unique cross-national research study conducted in collaboration with the WHO Regional Office for Europe. This project aims to gain new insight into and increase understanding of health behaviour, lifestyles and their context in young people. The HBSC study aims to inform and influence health promotion and health education policy, programmes and practice aimed at school aged children at the national and international levels (World Health Organisation 2000). The study involves extensive quantitative data collection from a representative sample of 11-15 year olds every three to four years. The last survey was carried out in 1997/1998 (Health Promotion Agency 2001).

The survey is conducted in the school setting and involves children completing a questionnaire that was designed by international HBSC members and the HBSC international research protocol. The data can be used in two main ways: to study trends over time both within and between countries; and to enable the analysis of inter-relationships between health behaviour and health, and the factors that may affect them. The core questions, which must be used in each country, are of particular use for monitoring, and the focus questions provide the opportunity to explore certain issues in greater depth. On the national level, it is of critical importance that each country draws its sample in a way that meets its needs for valid comparisons over time and within and across regions. In an international research project investigating comparisons across countries, each participant should draw the sample in a similar fashion (World Health Organisation 2000).

Assessment of how students feel in general - whether they feel low (have negative affect) or lonely - although not a direct measure of health, was included as indicator of mental health (HBSC 2000). The following comparisons between school aged children in England, Northern Ireland and the Republic of Ireland were made using HBSC data.
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How the students feel in general was assessed by asking: ‘In general, how do you feel about your life at present?’ The majority of students reported feeling very happy or quite happy. 92.3% of students in England, 90% of students in Northern Ireland and 89.2% of students in the Republic of Ireland reported feeling happy.

Students were also asked if they ever felt lonely. 12.3% of students in Northern Ireland, 11.8% of students in the Republic of Ireland and 10.6% of students in England reported that they felt lonely rather often or very often.

Students were also asked if they had used medication for nervousness in the previous month. 5.3% of students in Northern Ireland, 4.5% of students in the Republic of Ireland and 3.6% of students in England reported that they had used medication in the month prior to the survey for nervousness.

The usefulness of the HBSC study is that it allows for direct comparisons across countries. Valid cross-country comparisons are particularly important in emphasising commonalities across countries, as well as differences between them (WHO 2001).

Consultation on Data Harmonisation

The findings from the study day in Armagh with regard to data harmonisation are presented first. The study day was attended by 45 people, representing a wide range of interests including policy makers, health agencies, research bodies, voluntary organisations and statutory bodies.

Armagh Study Day Discussion Groups

At the study day in Armagh, a question was asked with regard to data harmonisation on an all-island basis. The findings from the discussion are now presented:

Discussion groups were asked: ‘How do we further the harmonisation of mental health data collection on the island of Ireland?’

There was a general view that the harmonisation of data sources was desirable. Key issues highlighted included the following:

In order to achieve harmonisation, it was felt that cross-border collaboration needs to become part of the core business of health organisations. Furthermore we need to look at where health promotion fits into overall health policy. We also need to agree on what constitutes evidence. Another group suggested we might have more discussion with professionals and research bodies to agree standards and the selection of specific measures for national surveys.
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East-West and North-South
There was also an awareness of East-West comparability versus North-South comparability issues. Northern Ireland will not be able to change and become comparable with the Republic of Ireland if it means they will no longer be able to compare with the UK. One group said that the data discussion needs to be opened up. While the populations may be quite similar North and South, there may in fact be very different experiences of using the different systems North and South. We should also be looking at the use of health services and the standard of services, North and South.

Various points were raised and the following suggestions offered for standardising the collection of mental health data:
- Standardise health measurement scales.
- Agree a core data set that must be common to all measures of health within projects and/or as national surveys.
- Develop comparable tools and link them into how all health organisations are administered.
- Commission studies with an emphasis on using scales that would be common to both sides of the border.
- Develop a uniform template.
- Use a common EU data set onto which individual countries can add their own specific data requirements.
- Have those working at a European level lobby for such harmonisation.

Roundtable discussion
Following the study day in Armagh, a roundtable meeting was held in the Department of Health, Dublin, with a number of the key stakeholders from Northern Ireland and the Republic of Ireland, including statistical agencies and both Health Promotion Agencies. Reports were submitted to the meeting by the DHSSPS in Belfast and the European Health Monitoring Programme. The aims of the meeting in relation to mental health population surveillance were:
- Examine recommendations for harmonisation of mental health data at a pan-European level and their implications for developing comparable and compatible population mental health data on an all-island basis.
- Identify the structures needed for collaboration on key common mental health indicators.

Each attendee reported on potentially relevant mental health data available through their organisation and any existing or pending strategic plan for mental health monitoring.

Data Collection and Surveys
Health Promotion Unit, Department of Health and Children, Dublin
Preparations are currently underway for SLÁN 2, the National Health and Lifestyle Survey in the Republic of Ireland. At the planning level, discussions may be broadened to include Northern Ireland so that comparable data would be
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources

available at a strategic level. Representation on the steering committee from the Northern Ireland Health and Well-being Survey would be important in this regard. The Health Promotion Unit recognizes the logic of all-island health and lifestyle surveillance, noting that there will be some areas where there are differences but the general view is to co-ordinate as much as possible of this kind of work, particularly data gathering and training.

Health Research Board, Dublin
Data collected in the mental health area by the Health Research Board is basic epidemiological information on all admissions and discharges to psychiatric hospitals. In addition, there are case registers established in three counties since 1984 that follow longitudinally in a defined geographical area all interactions with the psychiatric services, be they community or in-patient services.

At the structural level, there are exchange visits between the HRB and the Department of Health, Social Services and Public Safety’s Information and Analysis Unit in Northern Ireland. The ESRI was also involved in some of these meetings. These visits were very useful and highlighted the differences in the basic epidemiological data that is being collected North and South. The Health Research Board has had collaboration with the Information and Analysis Unit in Belfast. There is also interest in carrying out a psychiatric morbidity study throughout the island and discussions have taken place with colleagues in Northern Ireland.

Economic and Social Research Institute, Dublin
As discussed earlier in this report, the Living in Ireland Survey focuses mainly on socio-economic issues but also includes a number of health related questions. In this survey several health indicators are used, and are supplemented with questions about chronic physical and mental health problems, which are International Classification of Diseases (ICD) coded. Information using the GHQ-12 is gathered every year and since 1994 the ESRI has also included a question on ‘sense of mastery’. In 1999 the ESRI carried out the Health Consumer Survey (N =2,600) and used the SF-12 as part of that.

Initially the Living in Ireland survey was part of the European Community Household Panel Survey (ECHPS) collated by Eurostat. To date a standardised, harmonised sampling and data collection method has been used throughout Europe, but the survey stops in 2001 and there will be no Living in Ireland Survey in 2002. The new EU SILC (Statistics on Income and Living Conditions) will be taken over by the Central Statistics Office. The questions have not yet been finalised and it is unclear as to whether it will contain any related to health, including the GHQ-12 or SF-36.

Centre for Health Promotion Studies, NUI Galway
SLÁN2 is commissioned by the Department’s Health Promotion Unit and co-ordinated by the Centre for Health Promotion Studies, NUI, Galway. The measures are not yet finalized, but
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources

will endeavour to take on board the STAKES recommendations in order to have data harmonised with the European Health Monitoring Project and comparable with Northern Ireland.

Health Promotion Agency, Belfast
There is support for the view that data collection should be comparable. This has been discussed with the Health Promotion Unit (HPU) in Dublin and the Health Promotion Agency (HPA) in Belfast. In the initial draft mental health promotion documents produced by the Health Promotion Agency for Northern Ireland there was a recommendation that there should be data collection and information systems established to complement the work on mental health promotion. In the meantime there is a data source in Northern Ireland that can be used to inform the policy document and will be complemented by discussions with the HPU in Dublin about cross border initiatives.

There was a general welcome for the proposal to include Northern Ireland in the SLÁN 2 survey, as health promotion is highlighted as an area for co-operation in the Good Friday Agreement. However the ringfencing of budgets for this collaboration has not been finalised to date. If the EU Mental Health Monitoring report informs SLÁN 2 it would be very useful in order to ensure compatible data North and South from a European perspective.

The second Health and Social Well-being Survey has just been completed in Northern Ireland. In terms of mental health data, in the first survey half the sample were administered by the GHQ-12 and the other half received the SF-36. This round includes only the GHQ-12. The Health Behaviour in School Children (HBSC) survey was also carried out in 1998 and a secondary analysis on this data, published in 2001, was carried out looking specifically at mental health issues for young people. This was published in 2001. The HBSC may not be carried out again in Northern Ireland because a new survey called the Young Persons’ Behaviour and Attitudes survey has been introduced. This survey, which looks at 11-16 year olds, may be better suited to questions of local relevance. However it does not contain core questions which may be compared with other countries as is the case with the HBSC protocol.

Department of Health, Social Services and Public Safety, Belfast
One of the main sources of data on mental illness and learning disability is the Mental Health Inpatients System (MHIS), which is an individualised patient database of all persons admitted to mental illness or learning disability hospitals in Northern Ireland. However as the MHIS relates only to persons admitted as inpatients to mental illness/learning disability hospitals, it gives no indication of the prevalence or incidence of mental illness/learning disability in the population at large.
The annual psychiatric census collects individual details of all patients in psychiatric or learning disability hospitals with a continuous unbroken inpatient spell lasting one year or more on the census date, and those patients who are detained in hospital on that date regardless of their length of stay. The Mental Illness/Learning Disability Census is also conducted each year. This collects aggregated data on numbers of patients resident in each mental illness or learning disability hospital or on home leave on the census date.

Mental Health Indicator Recommendations from the European Health Monitoring Programme

Each EU Member State signed up through its Ministry for Health to comply with the population health surveillance recommendations arising from the EU Health Monitoring Programme due to report at the end of 2002. The recommended mental health indicators for Europe have been developed through a two year project which commenced in 1999, co-ordinated by the STAKES organisation in Finland (European Health Monitoring Programme 2001). The final report is pending publication. This project aimed to collect information on existing information systems and indicators and to agree on harmonised definitions of mental health indicators, which would then be incorporated into a comprehensive European health monitoring system. The project conceived the concept of mental health as having two dimensions:

Positive mental health
Positive mental health is seen as a value and a resource in itself. Individuals who display positive affect and positive personality traits usually have high levels of self-esteem, sense of mastery, sense of coherence (life experienced as meaningful and manageable) and self-efficacy. Positive mental health can also be conceptualised as the ability to cope with adversity, and avoid breakdown or diverse health problems when confronted with adverse experiences.

Negative mental health
Negative mental health is concerned with mental disorders, symptoms and problems. Mental disorders are defined in the current diagnostic classifications by the existence of specific clusters of symptoms. Mental symptoms and problems also exist without the criteria for clinical disorders being met. These sub-clinical conditions, as well as general psychological distress, are often a consequence of persistent or temporary adversities. They can be a marked burden and often lead to consultations in primary health care.

Psychological distress is a non-specific syndrome that covers constructs like anxiety, depression, cognitive problems, irritability, anger, obsession-compulsion etc. Depression and anxiety are usually recognised as core distress syndromes that have psychological and somatic components.
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The EU Mental Health Monitoring Group agreed that the state of mental health, including various levels of ill-health, health and well-being, is the most important domain to be covered by the set of indicators. Within the Health Monitoring Programme there are a number of health indicators which relate to mental health, the main categories being health status, demographics and socio-economic factors, determinants of health and health systems.

Health status
The principal indicators relating to mental health fall under the health status category of indicator. Selected indicators have been chosen because of their direct relation to monitoring (e.g. their share of the total burden of ill-health) or because of their reference to known risk factors or to identified activities in prevention and health care e.g. avoidable mortality (STAKES 2001). The concept of mental health can be divided into diverse measurable dimensions. Negative mental health can be measured on the levels of specific psychiatric disorders. Psychological distress, usually measured by various symptom checklist scales, comprises a cluster of diverse constructs like anxiety and depression. Thirdly there are important links between general quality of life (QoL) and mental health.

There are three sub-domains within the health status domain:
- Cause specific mortality
- Morbidity, disease specific
- Morbidity, generic

Cause specific mortality figures are routinely collected and collated by national statistical offices and it is therefore not crucial that they be collected within health surveys per se. Alcohol and smoking related deaths are considered pertinent to mental health and recommended for inclusion in a monitoring system.

Indicators of Disease Specific Morbidity as recommended by the Mental Health Indicators Group are shown in Table 9, which has been adapted from the European Health Monitoring Report (2001). The references for each measure are numbered in the table and detailed at the end of the table. All indicators should be used as independent and links to other variables should be scrutinised (other measures of mental health, somatic illness, protective factors as well as risk factors).
### Table 9: EU Recommended Indicators of Disease Specific Morbidity

<table>
<thead>
<tr>
<th>Indicator/Measure</th>
<th>Definitions and Guidelines for use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>An episode of depression for at least two weeks. The measure provides a 12-month prevalence figure of MD using a specific algorithm to define caseness. Diagnostic requirement: positive response to stem questions + at least 3 additional symptoms (Yes responses) Refs: 1, 2</td>
</tr>
<tr>
<td>CIDI-SF episode of major depression</td>
<td></td>
</tr>
<tr>
<td>Generalised anxiety disorder (GAD)</td>
<td>A disorder with pervasive anxiety lasting for at least 6 months. The measure provides a 12-month prevalence figure of GAD using a specific algorithm to define caseness. Diagnostic requirement: the period of anxiousness lasted 6 months or more, the qualifiers of criteria A and B were met, and the subject endorse at least three symptoms in B12 series. Ref: 1</td>
</tr>
<tr>
<td>CIDI-SF generalised anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>Suicide Attempts:</td>
<td>Survey item from CICI: ‘You attempted suicide’ (during the last 12 months) Express as a population based rate: lifetime suicide attempts Ref: 3</td>
</tr>
<tr>
<td>Single item on lifetime suicide attempts</td>
<td></td>
</tr>
<tr>
<td>Alcohol dependence: Cage questions</td>
<td>Estimate of excessive alcohol use as inquired in the CAGE measure. Cut.point to be used (most commonly used in studies): 2 or more sensitivity and specificity to detect lifetime DSM-III-R alcohol dependence (cutpoint 2 or more): 78% and 76.1% respectively Sensitivity and specificity to detect current DSM-III-R alcohol dependence (cutpoint 2 or more): 100% and 61% respectively Ref: 4, 5, 6, &amp; 7</td>
</tr>
<tr>
<td>Cage questions</td>
<td></td>
</tr>
</tbody>
</table>

**References**

Suggested Generic Morbidity indicators include the use of self-perceived health and prevalence of long standing illness with both measures having significant links to mental health. Additional composite indicators of generic morbidity suggested by the EU HMP are presented in the following Table 10 which has been adapted from the European Health Monitoring Report (2001). References for each measure are numbered in the table and detailed at the end of the table. All indicators should be used as independent and links to other variables should be scrutinised (other measures of mental health, somatic illness, protective factors as well as risk factors).

**Table 10: EU Recommended Indicators of Generic Morbidity**

<table>
<thead>
<tr>
<th>Indicator/Measure</th>
<th>Guidelines for use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychological Distress</strong></td>
<td>Psychological distress is a non-specific dimension of psychopathology, and indicates something is wrong but does not yield diagnostic assessment; comprised usually of anxiety and depression related distress states. A specific formula is used to calculate the score. European population means: 71-81.5 Cutpoint for population norm: 76 and cutpoint to predict disorder: 56 Ref: 8, 9, 10 &amp; 11</td>
</tr>
<tr>
<td>MHI-5 from SF-36</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological Well-being:</strong></td>
<td>Relates to the experience of positive mental health. 10 a) A specific formula is used to calculate the score. Population Norm: 1)52.2; 2)60.9 (SD:22.4); 3)71.1 (SE:0,2) Cutpoint for population norm: 70 Cutpoint for disorder: 62 10 b) Single item on happiness Ref: 8, 11</td>
</tr>
<tr>
<td>a) Energy, vitality from SF-36</td>
<td></td>
</tr>
<tr>
<td>b) Single item on happiness</td>
<td></td>
</tr>
<tr>
<td><strong>Impairment:</strong></td>
<td>Impairment due to mental health problems: signifies a lowered level of ability to function than usual. A specific formula is used to calculate the score. Population Norm: 1)65.8; 2)81.3(SD: 40.7); 3)89.3(SE: 02) Cutpoint for population norm: 89 Cutpoint for disorder: 80 Ref 8, 11. 11b) Lost workdays may be used as an outcome variable for mental health. Ref: 11, 12</td>
</tr>
<tr>
<td>Role limitation due to emotional problems from SF-36</td>
<td></td>
</tr>
<tr>
<td><strong>Sense of Mastery:</strong></td>
<td>Sense of mastery is a form of perceived personal control. Personal control refers to a sense of control over the events in one’s life. Cutpoint: &lt;20 points signifies low mastery (the 7-item version) Ref: 13, 14</td>
</tr>
<tr>
<td>Sense of Mastery 7-item version</td>
<td></td>
</tr>
</tbody>
</table>
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources

Table 10 continued: EU Recommended Indicators of Generic Morbidity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimism</td>
<td>Optimism has been characterised in general as a stable feature of personality and a prospective predictor of adaptation to stressful encounters. Norms for college students: 14.33 (SD=4.28) (LOT-R) Bypass patients 15.16 (SD04.05) (LOT-R) Mean of LOT-R score in a sample of 25,000 Finns:16.42 (SD=3.86) Cutpoint for optimism (&gt;defined as ‘optimist’): 20 Ref 15</td>
</tr>
<tr>
<td>Social Support</td>
<td>Social support is defined as availability of people whom the individual trusts and who make one feel cared for and valued as a person. Total score is calculated by summarising the scores for each item. The total score is used as categorical variable by using the following code: Poor social support 3-9 Moderate social support 10-12 Strong social support 13-14 Ref 16</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>Social isolation signifies lack of confidants and close relationships. Classification into ‘not isolated’ and ‘social isolated’ groups. Positive response to one or more questions leads to classification of being socially isolated Ref 2</td>
</tr>
<tr>
<td>Life events</td>
<td>Life events can be defined as major occurrences in one’s life that require psychological adjustment to some degree. Cutpoint: 2 events within half a year Ref 17</td>
</tr>
</tbody>
</table>

References:
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources


Demographics and socio-economic factors
Several demographic variables have been shown to correlate with mental ill-health. Among the most crucial are gender, age, marital status, education, ethnicity or race, place of domicile, and urbanicity. The existing information indicates strongly that demographic and social stress factors are of use in estimating mental health risks and possible needs for intervention at population level.

Determinants of health
Many variables affect mental health status. This category comprises all factors which determine health outside the health systems. Included are personal and biological factors such as sense of mastery and optimism, low levels of which have been linked to mental and general ill health; and health behaviours or lifestyle factors which have been clearly associated with, or causally linked to, specific diseases and health problems. Intermediary to actual behaviour, attitudes towards health are important in developing policies. Living and working conditions including stress and social support are important. The link between stress and ill-health has led researchers to focus on the situation of stress. Social support is seen as a protective factor against illnesses when faced with various forms of stress. Evidence shows that social support, especially perceived social support, correlates strongly with measures on mental health, particularly when the individual experiences stress. Social and cultural environment variables such as employment status, social networks and schooling levels have a clear-cut relation with health.

Health systems
There are various components of the health system which impact on mental health, and are therefore useful for mental health monitoring purposes. This domain includes indicators on the health services system as well as on prevention and promotion. Prevention, health protection and health promotion have been included as a sub-domain to stress its importance from a public health point of view. Generally speaking this section should include measures for the existence and extent of disease or risk factor specific prevention programmes and for the frequency and effectiveness of their uptake.
Findings from the Compatibility and Comparability of Mental Health and Related Health Data Sources

Also included as a sub-domain are health care resources such as psychiatric beds, psychiatrists and professionals other than physicians in mental health care. The health care utilisation sub-domain includes discharges due to mental disorders and long stay patients. Disability pensions and money spent on disability due to mental disorder would be included in the social services and welfare domain. The sub-domain of expenditure includes measures such as total national expenditure and proportionate national expenditure on psychiatric services. Health care quality indicators should contain indicators that give information on the performance and/or quality of the medical care system.
Conclusions and Recommendations

Given the breadth and complexity of the field of mental health promotion, covering a wide range of topics, settings, populations and strategies, there is a need for innovative and effective strategies and policies to address these issues comprehensively. As may be seen from the selected projects profiled in this report, the areas covered span support for people with cancer, postnatal depression, public awareness of suicide, mental health of young men and rural communities. The search for more effective and efficient strategies to work collaboratively across the Irish border on the development, implementation, evaluation and dissemination of mental health promotion programmes and strategies is a key challenge for the next decade.

Based on the examination of the information gathered in the course of this project, a number of issues are highlighted for further consideration and key recommendations are made.

**Added Value of Collaboration**

A first condition of effective cross-border collaboration is to reflect on the reasons why collaboration is needed and what kind of added value could be expected from such efforts. Insight into the different goals of cross-border collaboration could help to assess and improve the quality of current activities. As pointed out by Hosman (2000) in relation to international collaborative efforts:

*In order to make significant progress in addressing health problems of all kinds in the coming decades, significant progress must be made in breaking down the barriers to effective international collaboration and in developing, disseminating, and implementing science- and evidence-based prevention and health promotion programs, strategies and policies.*

In view of the insufficient resources for research and the development of effective policies and programmes in the mental health promotion area, it makes sense to pool knowledge, expertise and resources. There are a wide range of mental health issues for which promotion and preventive efforts are needed. In order to tackle these issues comprehensively, the development and implementation of integrated strategies are needed rather than isolated and once off developments. The findings from this report suggest that for successful cross-border collaboration in this area there needs to be support at a high political level. Co-operation on health promotion is on the agenda of the North/South Ministerial Council and over the past number of years co-operation at the level of exchange of information and experiences has taken place. It is now timely to give greater visibility to mental health promotion on this agenda and to agree strategically on priority areas and the types of support needed for co-operation in terms of formal structures and dedicated funding.

**Building on Lessons Learnt**

In order to facilitate cross-fertilisation and the dissemination of knowledge and expertise, it is critical to build on the experiences and lessons learnt to date. From the overview of current work, it appears that there may be a number of
projects/practitioners engaged in similar type initiatives who may be unaware of each other’s existence. These groups may be encountering similar difficulties in establishing collaborative mechanisms and may also have developed innovative solutions. It is important that there is an opportunity to build on these experiences so that learning can be maximised.

In addition, project findings need to be disseminated at regional and national levels in order to provide an opportunity to inform policy and practice. Currently there is no formal mechanism or forum for dissemination and sharing of experiences in order to inform more effective co-operative working mechanisms. There is now an opportunity for cross-fertilisation between projects especially when it comes to effective cross-border working. This would provide a unique opportunity to study the role of factors such as different community structures, health services, attitudes and values, differences in legislation and policies on the promotion of positive mental health.

Enhancing Cross-Border Collaboration
At present there is little support and training available to new projects embarking on cross-border working for the first time. Project members pointed to the need for preparatory work for successful cross-border work. This would include support regarding agreeing expectations for cross-border working and establishing effective co-operative mechanisms, training in undertaking reconciliation work and developing effective collaborative practices. Support in these areas would facilitate the development of practical guidelines for enhancing effective cross-border working.

Consideration needs to be given as to what mechanisms and networks are essential for sustaining progress in effective collaboration in this new and fast growing area. In order to maximise effective cross-border working, sustainable cross-border relationships are needed at an organisational level in order to support functional ties and networking extending beyond the scope of individual projects. Creating appropriate mechanisms and structures that will facilitate effective transfer of knowledge and dissemination of best practice is essential for progressing effective collaboration on an ongoing basis.

Evaluation of Cross-Border Working
It would appear that specific evaluation of cross-border co-operation is very limited. As a result we have little empirical evidence of whether the mechanisms used at present are the most effective or whether indeed the objectives of cross-border co-operation are being achieved. Guidelines for effective cross-border working would greatly assist individual projects in their efforts. Criteria for monitoring and evaluating cross-border collaboration are needed in order to track progress and to maximise learning for the planning and development of future efforts. Researchers have a useful role to play in working with communities and service providers around these issues.
Data Harmonisation
In terms of mental health population data and its comparability and compatibility, there were only four surveys identified in the past 10 years which collected information at a national (South) and regional (North) level in the two Irish jurisdictions. Very few surveys performed in this way in both jurisdictions used the same methodological approach or included directly comparable measures of mental health and its determinants. There was a mix of positive and negative mental health measurement, some surveys combining both and others focusing mainly on one aspect. Most focus was in relation to self-reported general health and health status but others also included measures of depression, anxiety and psychological distress. The most commonly used scales were the GHQ-12 and SF-36. While the use of single item Likert scales is useful for ease of completion, and in the case of self-reported general health correlates well with more composite measures of mental health and quality of life, the reliability and validity of the concept being measured is not assured. Use of standardised scales to measure mental health and general well-being such as the GHQ-12 or SF-36, or the quality of life measures such as the WHOQoL-BREF or EUROQoL-5D, capture more powerfully the essence of these domains and help to ensure their valid and reliable measurement.

In Northern Ireland there was the Northern Ireland Survey of Health and Social Wellbeing and in the Republic both components of the National Health and Lifestyle survey (SLÁN) plus the Living in Ireland Survey. Each survey included the same Likert scale measuring self-rated general health, which is very useful for comparison purposes. However a single measure such as this does not alone encompass the spectrum necessary for population mental health monitoring. While the GHQ-12 was utilised in each survey, only half of the sample in the North completed this while the other half completed the SF-36. In the South the smaller examination sample in SLÁN did complete a number of mental health instruments including the GHQ-12. However since this component of the survey resulted in a quota based sample, the generalisability of the results to the national population is not possible. The Living in Ireland survey in the Republic was a nationally representative survey which included the GHQ-12 and therefore supplies a very useful indicator of the level of psychological distress amongst adults in the Republic of Ireland. It remains, however, that there is no normative data relating to the GHQ-12 in both jurisdictions.

All surveys, whether national, regional or local, were cross-sectional and used mainly some form of questionnaire. There were methodological differences in terms of administration of the questionnaires: in the Republic of Ireland some were self-completed and returned by post, others were self-administered but completed within a confined setting. In the North the Northern Ireland Survey of Health and Social Wellbeing questionnaire was administered by a fieldworker.
Co-ordinated Approach in Health Monitoring

Following the compilation of population based surveys in the Northern and Southern jurisdictions of Ireland, and following discussion with the relevant stakeholders, it is clear that no co-ordinated approach to population mental health monitoring exists on the island of Ireland. The inconsistency in methodologies, target populations and measures used limits to a large extent comparability of the surveys identified, thus reinforcing the need for harmonisation. There is, however, a certain level of compatibility given the use of valid scales in the measurement of self-reported general health, psychological distress, quality of life and health status. Phase 2 of this project compared the measure common in both Northern Ireland and the Republic of Ireland (i.e. the GHQ-12) with UK countries. It appears that the Republic of Ireland has lower levels of psychological distress compared to its UK counterparts and that people in Northern Ireland fare worst of all. Allowance must be made, however, for the variation in survey population and survey design.

A common information system would be most beneficial on the island for both mental and physical health purposes. A co-ordinated and standardised approach which embraces the social, environmental and cultural differences is needed which would allow both regional and national information to be extracted. Particularly given the move within Europe for harmonisation of data systems, both Northern Ireland and the Republic of Ireland will be obliged in some way to follow this direction in order to facilitate necessary comparisons with neighbouring countries. There is certainly willingness for collaboration on mental health measurement on the island and this has to some extent taken place through statutory agencies. It remains, however, that a strategic approach between the two jurisdictions, driven by policy, is needed.

One of the main recommendations from the report of the EU Health Monitoring Programme project on mental health indicators is that the SF-36 be used for monitoring various domains of mental health. The STAKES working group did consider the GHQ, but decided not to adopt this measure because it was originally designed to measure psychiatric disorders among patients of general practitioners. Furthermore the GHQ is known to be defective in identifying chronic distress due to the structure of the alternative answers to the items (STAKES report). Results from a study of the SF-36 carried out by Ware et al. (1998) suggests that the translation process in each country was successful in achieving conceptual equivalence and not merely literal equivalence. With few exceptions, each SF-36 scale appears to have a comparable interpretation as a measure of physical and/or mental health in each country. Thus there is a solid basis for establishing interpretation guidelines on the basis of the proportions of physical and mental health variance that are accounted for in each scale in each country. Furthermore results observed in this study suggest that the same advantages can be achieved in the countries studied here and with comparability sufficient to warrant their use in multinational comparisons. Simple single item measures of self-rated health and presence of long term illness are also recommended as generic morbidity measures.
Conclusions and Recommendations

The planned recommendations for mental health indicators from the EU Health Monitoring Programme will be timely for the next phase of data collection in the national health survey SLÁN in the Republic of Ireland, which is due to collect the second sweep of data in spring 2002. This presents a unique opportunity for harmonisation of mental health data sources, which will allow for necessary comparisons between countries on a cross-European basis and also facilitate population monitoring and identification of particular interest within countries.

Recommendations

Within the context of recent European developments and based on the findings from this project, the following recommendations are highlighted for action:

Policy and Structures

• A Mental Health Promotion Strategy is needed in the Republic of Ireland to raise the profile of positive mental health and to give a guiding framework for the development and implementation of action plans at national and regional levels. Substantial work has already been carried out in Northern Ireland, with a new strategy pending publication. Likewise, work is currently underway in Britain on the development of policies in England, Scotland and Wales. There is an excellent opportunity for a similar process to be undertaken in the Republic of Ireland with the aim of developing a strategic national mental health promotion policy. The experiences in Northern Ireland and Great Britain, together with guidelines and resources from EU and international initiatives, should prove helpful in the development of this process.

• Steering mechanisms are required to support and guide the development of a co-ordinated plan for the promotion of mental health on an all-island basis. This entails providing the necessary legislation and reform of structures to support and facilitate effective cross-border working on the ground. Collaborative administrative models need to be explored which can build on the positive work already underway and help to overcome the structural barriers identified by respondents in this report. An efficient collaborative structure and supportive mechanisms are needed to facilitate the work of the various organisations and agencies active in the field. High level political support and commitment is required to ensure that a strategic action plan is put in place to support and co-ordinate these developments.

• Funding structures are needed that will recognise and support the necessary collaboration between organisations and sectors on an all-island basis and encourage mutual support between organisations performing similar tasks. It is critically important that dedicated and sufficient resources be
Conclusions and Recommendations

provided with regard to actions on the promotion of mental health on an all-island, inter-agency basis.

• The establishment of an all-island Mental Health Promotion Steering Group is recommended in order to take forward the development of mental health promotion in a co-ordinated fashion and to avoid unnecessary duplication of effort. The proposed grouping could include key players in the areas of policy, research and practice in the Republic and Northern Ireland. A network could also be established to liaise with key players in England, Scotland and Wales in order to promote shared learning and to stimulate joint research and development activities on a strategic North-South and East-West basis. Given the breadth and complexity of the area, mental health promotion requires new ways of thinking and innovative approaches. As suggested by STAKES (1998), bringing together key players could in itself be a tool for improved and shared understanding in the field.

• The integration of mental health promotion across a range of health services from primary care through to mental health and social services is an important element of policy development in both jurisdictions. Mental health promotion is relevant across the entire spectrum of mental health interventions. Effective mental health promotion strategies will need to engage with a broad range of services and community development initiatives spanning the range from early intervention and treatment services through to after care and rehabilitation. Mental health promotion brings a particular focus on improving quality of life, creating supportive community structures, countering discrimination and stigma, and enhancing protective factors for mental health. Ongoing intersectoral and intrasectoral partnerships and liaison among primary care, mental health, public health, community, prison, family, social and welfare services and other relevant statutory and voluntary agencies is therefore critically important in this endeavour.

• The promotion of population level mental health depends on much more than health policies alone. In keeping with the basic principles of health promotion, a multi-sectoral, integrated approach is needed in both jurisdictions that will ensure mental health promotion is embedded firmly in policy across a range of sectors such as employment, education, housing, environment and equality. These efforts need to be co-ordinated across the various sectors and the impact of all public and social policies on population mental health needs to be assessed. The extension of Health Impact Assessment to also include mental health needs to be considered and actively developed.

Collaboration and Dissemination

• Collaboration and consultation with consumers, community groups, service users, voluntary organisations and professional associations is vitally important for successful programme planning and delivery. Active engagement with these different sectors is needed to promote greater understanding of the concept of
positive mental health and its importance for overall good health and quality of life. To increase the visibility of mental health promotion at a societal level, a public awareness strategy is needed in order to counter the stigma attached to mental ill-health and to promote greater public and professional understanding of the importance of promoting positive mental health in its own right as a resource for everyday life.

- The creation of an all-island information exchange capacity and a forum for dissemination needs to be developed to support co-operative working in this area. Newsletters, web sites and joint conferences could be used as a means of sharing expertise and experiences. A live database of mental health promotion activities, similar to that already produced in Northern Ireland, would also be most useful in this respect. An opportunity is presented for co-operation on a North-South and East-West basis in the production and maintenance of this facility. Likewise, a facility for disseminating training and resource materials that support good practice is recommended.

Skills and Training
- The development and sustainability of mental health promotion is dependent on the development of skills to support the implementation of policy initiatives on the ground and to ensure the development of best practice. Mental health promotion requires high level liaison and communication skills to engage and facilitate the participation of diverse sectors. Continuing education and training is required to disseminate knowledge related to mental health and effective intervention programmes, to provide professional training and consultation, and to enhance quality of practice.

Of particular importance here is the development of collaborative models of practice based on working in partnership with a range of agencies and sectors on a strategic cross-border basis. Guidelines for effective cross-border working need to be developed. A template for best practice in collaborative working is needed which draws on available international evidence and builds on experiences to date in terms of the need for planning, setting clear aims and objectives, putting in place co-operative mechanisms, acknowledging barriers, building trust, setting up the required support mechanisms and evaluating the process of co-operative practice. A cross-border and all-island pooling of resources for training and skill development is needed in order to produce the high level expertise and resources required.

Evaluation
- The future development of mental health promotion on the island of Ireland needs to be based on a sound knowledge and evidence base. This demands that appropriate evaluation frameworks and research methods are applied which are capable of capturing the complexity, diversity and creativity of contemporary practice. There is a growing international
Conclusions and Recommendations

evidence base on the effectiveness of mental health promotion activities. This evidence needs to be made accessible to practitioners and policy makers in order to inform best practice and policy.

With regard to cross-border collaborative practice, to some extent the evidence lags behind the practice. Detailed information on implementation and collaborative forms of practice is critical if programme evaluators and implementers are to maximise learning on programme delivery through effective cross-border working. Evaluation needs to be incorporated into programme activity from the outset. This needs to include not only evaluation of programme inputs, impact and outcomes, but also more detailed focus on documenting the process of implementation and styles of working. Improving the capacity of evaluators and practitioners to gather evidence on the process of co-operative working is needed in order to inform the knowledge base in this area. Pluralistic methods of evaluation are recommended in order to capture the complexities and dynamics of co-operative working from the perspectives of the different stakeholders. The building up of case studies in good cross-border collaborative practice on the ground is identified as an area for further development.

Data Collaboration
• With regard to data collaboration, there is a need for greater co-ordination at a policy level to ensure that core sets of data are recorded North and South in order to avoid overlap and ensure a certain level of compatibility. Comparable data is required in order to inform ongoing programme planning and policy development. A joint North-South advisory group to examine existing data sources and to plan and co-ordinate future studies in this area should be established.

• The collection of data on population level mental health status needs to be harmonised, both in terms of the measures employed and methods of administration. The key recommendations from the STAKES report (2001b), as outlined in Chapter 6, need to be implemented, thereby ensuring compatibility, not only on an all-island basis, but also with UK and European counterparts. In particular, the recommendations regarding the collection of data on positive indicators of mental health need to be considered.

• Both existing and future data sources on population mental health should be effectively disseminated in an accessible format in order to guide mental health promotion policy, planning and practice at all levels.

Final Conclusions

Effective collaboration and a sound knowledge and evidence base are essential elements for the development of a comprehensive mental health promotion strategy. To reduce barriers and create effective cross-border collaboration in this
area, we need to develop insights into the dynamics and models for collaboration and their outcomes. This will entail more systematic and critical study of the factors that facilitate or impede effective collaboration. The present study provides an overview of current cross-border co-operation in the development of collaborative practices and data sources in the mental health promotion area. Clearly, given the lower than desired response rate to the initial questionnaire survey, the study does not claim to have carried out an exhaustive inventory of current initiatives. Likewise, the findings from the case studies and interviews are not being presented as representative but rather as illustrative of current perceptions of people actively working on cross-border projects in this area.

Notwithstanding this, the report does highlight a number of key issues for consideration: the development of policy and a co-ordinated plan of action on an all-island basis; setting up a more functional and supportive system of collaborative relationships on a North-South and East-West basis; collaboration and dissemination of information and knowledge to increase the visibility and relevance of positive mental health across all sectors of society; the recognition of training needs and skills development; explicit identification of the main objectives of cross-border working and a facility for monitoring and evaluating these in the course of project development. The establishment of a network of key players in this area together with the setting up of steering mechanisms would greatly facilitate the process of developing effective best practice and policy.

The existing mental health data sources in both Irish jurisdictions have been determined and documented in this report. Having established the strengths and weaknesses of existing data, current opportunities for collaboration between partners north and south of the border and with colleagues in the UK and Europe are highlighted. The specific requirements for further co-operation and harmonisation of data sets need to be addressed. Based on the compatibility study, recommendations are made concerning the requirement for standardisation of measurement and methodologies and the inclusion of positive mental health indicators.

Ultimately, by determining the mental health status and needs of the population in the two Irish jurisdictions, appropriate planning and targeting of mental health promotion strategies can be directed through specific policy development. This includes the need for policies which address the broad determinants of mental health on a cross-sectoral basis. The mental health impacts of social and economic policies at the population level needs to be considered if the wider public health potential of mental health promotion is to be realised. Bringing together key players from policy, practice and research in the area of mental health promotion on the island of Ireland will provide a unique opportunity for collective reflection on these issues, and on the insights and lessons learnt to date regarding effective cross-border working. This is a critical first step in moving towards the establishment of successful and sustainable collaborative initiatives in the future.
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References


This questionnaire aims to collect information on projects and interventions that are intended to promote positive mental health and which include a cross-border dimension. Please copy this questionnaire and complete for each separate project.

<table>
<thead>
<tr>
<th>What is the title of the project?</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

Name of contact person in the organisation? (Northern Ireland and Republic of Ireland)

<table>
<thead>
<tr>
<th>N.Ireland</th>
</tr>
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<tbody>
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E-mail address Republic

<table>
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<tr>
<th>E-mail address Northern Ireland</th>
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Telephone Number Northern Ireland

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<tr>
<th>Telephone Number Republic</th>
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At what level of collaboration is the project involved?

<table>
<thead>
<tr>
<th>Policy/strategic level</th>
<th>Informal collaboration</th>
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<td>[ ]</td>
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<table>
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<tr>
<th>Discrete project</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Please specify:
Please provide a brief description of the project.

What are the Objectives of the project?

Which of the following categories apply to your project? (Please tick)

**Population:**
- Mental Health Promotion universally applied
- High risk groups
- Individuals or groups with an early or less disabling mental health or behaviour problem
- Individuals or groups with an identified severe mental health or behavioural problem or diagnosed mental illness, or their carers.

**Lifestage:**
- Infants
- Pre-school children
- School aged children
- Adults
- Mid-life
- Old-age
- Setting:
- Home
- School
- Workplace
- Community
- Media
- Health Services
- Please specify

Other: ____________________________________________________________
Please describe the outcome(s) that were originally planned for this project?

To date, what have been the outcomes or achievements of the project?

What is the level of participation in this project, i.e. number of participants?

What is the period of implementation of the initiative/project, e.g. January 1999 - December 2001?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>If the project has been completed, has a report been written?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was a formal evaluation conducted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, is the report available?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What was the main source of funding?

Please add any further comments you would like to at this time or enclose any further details.
Promoting Positive Mental Health: Cross-Border Opportunities and Challenges

Date:

Project Title: ____________________________________________________________

Name of Organisation: ____________________________________________________

Name of contact person in the organisation: _________________________________

Job Title: ________________________________________________________________

Telephone number: _______________________________________________________

Background to the Project:

1. When was the project established? ______________________________________

2. Expected duration of the project? _________________________________________

3. How did the cross-border project come about? *(Who/what instigated the cross-border work?)*

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

Project Management

4. How is the project funded? *(please list funding agencies)* ______________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

©Centre for Health Promotion Studies, NUI Galway 2001
5. How is the project managed?

6. Are regular reports on progress produced?  Yes [ ]  No [ ]
   (Please list reports)

7. Are copies of these available?  Yes [ ]  No [ ]

8. Is a formal evaluation of the project being conducted?  Yes [ ]  No [ ]
   (please give details)

9. If so, is the report available?  Yes [ ]  No [ ]

10. Is the element of cross-border working being explicitly evaluated?  Yes [ ]  No [ ]

11. If so, have specific outcomes/objectives for cross-border co-operation been agreed?  Yes [ ]  No [ ]

12. Are these available?  Yes [ ]  No [ ]

13. How many members are actively involved in management of the project

   North: 

   South: 

Promoting Positive Mental Health:
Cross-Border Opportunities and Challenges
14. How many members are actively involved in project delivery?
   North: ________________________________
   South: ________________________________

Nature of Cross-Border Contact

15. How often do the cross-border partners meet? ________________________________

16. Where do the meetings take place? ________________________________

17. Is the contact mainly between health professionals or is it at community or grassroots level?

18. Has contact been made between people who otherwise would not have this kind of cross-border contact? ________________________________

19. Have you personally made new contacts? ________________________________
20. Have these links been beneficial to other aspects of your work? ________________

21. Why did you decide to become involved in cross-border work? (what were your initial motivations?) ________________

22. Have your initial expectations been met? ________________

23. What do you consider to be the main benefits of the cross-border element of your work? ________________

24. Has the project lead to greater understanding of cultural differences? ________________
25. Please rank order the following benefits of the cross-border work in order of importance:
   a. Exchange of ideas and experiences
   b. Broadening of networks
   c. Stimulate new thinking
   d. Generate greater understanding about differences in structures North and South
   e. Generate greater understanding about differences in culture North and South
   f. Sharing of resources
   g. Access to additional funding

**Perceptions of the Cross-Border Working**

26. How would you describe your experience of the cross-border nature of your project?

27. How well do you feel the cross-border element is working at the moment?

28. What do you think is the single greatest difficulty associated with the cross-border element of this project?
29. What do you think is the single greatest success associated with the cross-border element of this project?

30. What would you like to see the project achieve in terms of its cross-border function?  
   *(if project is completed - what would you like to have seen?)*

31. What in your view would be important in making this happen?

32. Are there any other observations, thoughts or feelings about the project itself that you would like to add?
Promoting Positive Mental Health and Social Well-being: Cross-Border Opportunities and Challenges

1. 
   a) Name: ____________________________________________
   b) Organisation: ______________________________________
   c) Current Role: _______________________________________

2. Are you/your organisation currently involved in cross-border work?
   Yes ☐ No ☐
   If yes, please give details: ________________________________
   ______________________________________________________
   ______________________________________________________

3. Does your organisation have a mental health promotion focus?
   Yes ☐ No ☐
   If yes, please specify: __________________________________
   ______________________________________________________
   ______________________________________________________

4. Does your organisation have a policy document or strategy, which outlines strategic goals for Mental Health Promotion?
   Yes ☐ No ☐

   If yes, would you please send us a copy of the document.

5. Did you attend the study day on 6th September in the Centre for Cross Border Studies, Armagh?
   Yes ☐ No ☐

6. Are there any observations you would like to make on the report ‘Promoting Mental Health and Social Well-being: Cross-Border Opportunities and Challenges’?
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

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7. What would you consider to be the key learning points from the projects described in the report?
   a) 
   b) 
   c) 

8. What do you consider to be the most important aims of cross-border collaboration?
   a) 
   b) 
   c) 

9. We would like to know your opinion on the following benefits of cross-border working. Please answer ALL the questions by circling the number that best reflects how you feel about each statement:

<table>
<thead>
<tr>
<th>Benefits of Cross-border work</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Exchange of ideas and experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Broadening of networks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Stimulate new thinking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Generate greater understanding of differences in structures North and South</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Generate greater understanding of differences in culture North and South</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Sharing of resources</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Access to additional funding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Identifying best practice</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. Other (please specify in space below)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other: ___________________________
10. We would like to know your opinion on the following barriers to cross-border working. Please answer ALL the questions by circling the number that best reflects how you feel about each statement:

<table>
<thead>
<tr>
<th>Barriers of Cross-border work</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Resource constraints (geographical spread, distance, time)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Issues of shared ownership for partners both sides of the border</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Differences in the structure and working practices of two health systems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Building of trust between cross border partners is a slow process</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Uncertainty about funding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Different currencies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Political and legal barriers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Other (please specify in space below)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other: ____________________________________________________________________________________________

11. Please rate on the following scale (where 0=of no importance and 10=of great importance) the importance of evaluating the effectiveness of the collaborative aspect of cross-border working:

\[
-0-1-2-3-4-5-6-7-8-9-10
\]

12. What kind of support would help your organisation to evaluate the effectiveness of the collaborative aspect of cross border working? ____________________________________________________________________________________________

13. Please rate on the following scale (where 0=of no importance and 10=of great importance) the importance of a common mental health data set between Northern Ireland and the Republic of Ireland:

\[
-0-1-2-3-4-5-6-7-8-9-10
\]

14. In what way, if any, would your organisation use the information that would be available from this common mental health data set?

______________________________________________________________________________________________

______________________________________________________________________________________________
15. What steps are needed in order to promote best practice in Mental Health Promotion on an All-Island basis? Please answer ALL the questions by circling the number that best reflects how you feel about each statement:

<table>
<thead>
<tr>
<th>What steps are needed to promote best practice in Mental Health Promotion on an All-Island basis?</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Strategic political commitment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Supportive policy infrastructure to guide developments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Developing collaborative relationships at an organisational level</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Support and training for those undertaking cross border work on the ground</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. A forum for knowledge dissemination and sharing of learning experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. A good research infrastructure on which to base project planning and development (Population mental health data)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. A facility for identifying and evaluating the key objectives of cross-border working</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Other (please specify in space below)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other: ________________________________________________________________

16. What, in your opinion, are the critical success factors for developing and implementing an All-Island policy for Mental Health Promotion? ______________________________________________________
____________________________________________________________________
____________________________________________________________________

17. What, in your opinion, are the main obstacles in developing and implementing a national policy for Mental Health Promotion? ______________________________________________________
____________________________________________________________________
____________________________________________________________________

18. What conditions are necessary to make cross-border work more effective and more efficient?
   a) ________________________________________________________________

Promoting Positive Mental Health and Social Well-being: Cross-Border Opportunities and Challenges

b) __________________________________________________________________________

c) __________________________________________________________________________

19. Are there any other observations, thoughts or feelings about the report that you would like to add? __________________________________________________________________________

c) __________________________________________________________________________

20. Are there any other observations, thoughts or feelings about cross-border work that you would like to add? __________________________________________________________________________
Organisations which contributed to the Roundtable Discussion on 5 December 2001

- Health Promotion Agency, Belfast
- Health Promotion Unit, Department of Health and Children, Dublin
- Health Research Board, Dublin
- Economic and Social Research Institute, Dublin
- Department of Health, Social Services and Public Safety, Belfast
- Department of Health, London
- Department of Epidemiology and Public Health, Queens University Belfast
- STAKES, Finland
The Centre for Cross Border Studies, based in Armagh and Dublin, was set up in September 1999 to research and develop co-operation across the Irish border in education, health, business, public administration, communications, agriculture, the environment and a range of other practical areas. It is a joint initiative by Queen's University Belfast, Dublin City University and the Workers Educational Association (Northern Ireland), and is financed by the EU Peace and Reconciliation Programmes and the Irish Department of Foreign Affairs’ Reconciliation Fund. In 2001 the Centre published reports on cross-border telecommunications, cross-border health services, all-Ireland co-operation to tackle disadvantage in education, EU cross-border funding before and after the Good Friday Agreement, cross-border co-operation in local government and cross-border co-operation between local history societies. In February 2002 it published a report on the cross-border dimension of the 2001 foot-and-mouth disease crisis.

Other Reports from the Centre


