

# **The Rural Mental Health Project**



## **Final Evaluation Report of the Rural Mental Health Project (Phase 2)**

**Centre for Health Promotion Studies,  
NUI, Galway**

Colette Reynolds

Mary Byrne

Dr. Margaret Barry



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## SUMMARY

The Rural Mental Health Project is a cross-border community project concerned with promoting positive mental health and well-being in rural communities. This initiative brings together two rural community projects, the Mind Matters project in Raphoe, Co. Donegal and the Rural Health and Social Wellbeing Project in Draperstown, Co Londonderry/Derry, in developing a community model of mental health promotion employing cross-border and cross-sectoral strategies. This project, which is funded under the EU Peace and Reconciliation Programme (Peace 2) and part-financed by the UK and Irish governments, has just completed the final Phase 2 of its programme of work.

This report documents the process, impact and outcome evaluation of this community-based initiative and focuses on the progress made since January 2002. Building on what was achieved during Phase 1, Phase 2 extended the project within each of the two local communities and consolidated a working mechanism for cross-border collaboration across the respective community groups, voluntary and statutory agencies. Based on the research evaluation, this report outlines the planning, development and implementation of the programme interventions and examines their impacts and outcomes. In addition, the progress of the project in terms of cross community networking, inter-agency collaboration, cross-border co-operation and furthering peace and reconciliation is documented. Progress towards achieving the key project aims and objectives are assessed, highlighting the impact of what has been achieved and the challenges and opportunities for the future development and sustainability of project activities.

A summary of key Phase 2 activities include the following:

- Re-launch of project with a re-structuring of project management functions and re-establishment of the Cross-Border Joint Steering Committee.
- Continued development of a partnership model involving networking, co-operation and collaboration with cross-community and cross-border groups and agencies.
- Consultation and planning with key groups and organisations to develop and implement project activities.
- Delivery of two structured programmes promoting positive mental health:
  1. The development, implementation and evaluation of the Mind Out programme for promoting the positive mental health of 15-18 year olds in the post-primary

school setting. The Mind Out programme was delivered in five schools in Phase 2, involving 28 teachers and 728 pupils. The delivery of the programme, which adapted materials from an Australian programme, was supported by the development of a structured manual, training support for teachers and the training of local trainers in order to extend delivery of the programme to other schools in the region. Following an extensive evaluation with 1,850 students, this programme was found to have significant positive effects and is now being mainstreamed in schools in the Republic and Northern Ireland

2. Introduction of the Winning New Jobs programme involving over 20 cross-border training and employment agencies, 31 trainers, and 218 participants. This international model programme was successfully adapted and implemented on a cross-border basis and was found to produce positive effects for both unemployed people and mental health service users in terms of re-employment and mental health outcomes. The training materials were adapted to local needs and local trainers are trained in order to ensure the consolidation and sustainability of the programme after the lifetime of this project. This programmes is now embedded within the training and employment agencies in the regions and is set to be rolled out on a larger scale.
- Both the Cross Border Women’s Forum and the Farmers’ Forum were established during Phase 2 and provided a platform for dialogue and networking, laying a good foundation for both of these initiatives to develop further their cross-border co-operation.
  - Delivery of single events and workshops including a men’s holistic health programme, cross-border women’s networking events, school mental health open days, information sessions and seminars for farming families.
  - General media for raising awareness in local communities including the development and distribution of project leaflets and the “Healthy Times” newsletter.
  - A repeat community survey was undertaken in 2003 to ascertain the impact of the project on local community perceptions and attitudes. The findings suggest that the project has had positive effects on community awareness and attitudes at the wider community level. These include increased awareness regarding depression and suicide and improved attitudes to help-seeking.

- Dissemination of project learning and activities to policy-makers, practitioners and researchers through
  1. Representation by Steering Group members on key policy and practice committees.
  2. Presentation of project activities and research findings at regional, national and international conferences.
  3. Inclusion of project reports in regional, national and international publications including the recent World Health Organisation's 2004 Mental Health Promotion: Case Studies from Countries report.
- Hosting of the Partnerships, Equity And Community Empowerment (P.E.A.C.E) Conference to showcase the achievements of the Cross-border Rural Mental Health Project in October, 2004.

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## **CHAPTER 1**

## **INTRODUCTION**

### **1.1 BACKGROUND**

The Rural Mental Health Project is an action research project which aims to promote positive mental health, mutual understanding and reconciliation within cross-community and cross-border rural communities using a community-based approach. This project, which commenced in 1999, is funded under the EU Peace and Reconciliation Programme (Peace 2) and part-financed by the UK and Irish Governments. The project addresses the negative impact of the conflict on the well being of rural communities in the border region, particularly with regard to social and community stressors that affect mental health.

This initiative brings together two rural communities, Raphoe in Co. Donegal and Draperstown in Co. Londonderry/Derry, and seeks to develop a community model of mental health promotion employing cross-border and cross-sectoral strategies. Grounded in an extensive needs assessment and piloting of interventions in Phase 1, the new Phase 2 (January 2002 through June 2004) takes the opportunities arising from peace to consolidate and extend the learning and develop a transferable community model of working. Building on the achievements of Phase 1, the project develops targeted programmes for youth, unemployed people, farmers, women and community groups which are delivered on a cross-border and cross-sectoral basis.

The project adopts a community participation approach and seeks to build community capacity where networks have been weak against a background of peripherality and disadvantage. The community model of working promotes new ways of understanding, supporting and working in partnership with a range of local organisations and agencies and building on resources within the communities. In particular, the Rural Mental Health Project has developed in collaboration with the local communities, health authorities, trusts, education, farming, rural organisations, training and employment agencies and community groups. The key focus of Phase 2 was to consolidate this model of community working together with tried and tested strategies for mental health promotion which can be sustained and expanded beyond the lifetime of the project.

This report reflects on the process surrounding each area of development and the progress achieved in the second phase of the project, from January 2002 through June 2004.

## **1.2 AIMS AND OBJECTIVES**

The aims of Phase 2 of the project were to

- To address the legacy of conflict by tackling the neglected area of mental health in rural communities
- To facilitate community networking, both within and between cross-border communities, 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 findings from the evaluation, to inform the main-streaming 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, support and enhance the existing capacities of community groups in engaging with voluntary and statutory agencies in addressing local needs
- Through the sharing of experiences and expertise of community groups and health worker from both sides of the border, to facilitate understanding, co-operation and networking around issues of mutual understanding and reconciliation.

The project objectives included the following:

- To actively engage people on a cross community, cross-border basis in addressing the impact of the conflict on mental health needs of rural communities, in particular increasing rates of suicide and depression
- To increase understanding of mental health issues at a local community level and to enhance the potential of community groups in influencing the re-orientation of services to meet local needs

- To bring together the expertise of community organisations, health professionals, and researchers from both sides of the border in developing community-based programmes to address the shared mental health needs of rural communities that have been neglected over the last 30 years
- To develop an effective model of mental health promotion practice for rural communities based on community participation principles including new ways of understanding, supporting, and working in partnership with a range of local organisations and building on resources within communities
- To implement and systematically evaluate the process, impact and outcome of participatory community models of mental health promotion practice
- To inform policy and practice at a wider national and international level concerning models of best practice in addressing rural suicide and depression
- To leave in place tried and tested strategies that will ensure the sustainability of community-based programmes for enhancing mental health and improved quality of life and mutual understanding of rural communities.

### **1.3 RATIONALE**

#### **1.3.1 Addressing the Legacy of Conflict: *The mental health needs of rural communities.***

This project focused on disadvantaged rural communities where the impact of the conflict has resulted in persistent levels of health and social problems. Of particular concern were the increasing rates of suicide and depression in both the Republic and Northern Ireland.

Also of concern were issues of stigma surrounding mental health problems, access to services and the broader determinants of mental health such as unemployment, social isolation and economic pressures on farmers, all occurring against a backdrop of rapid social, economic and political change in the border communities. Effective strategies and models of working were used to address the broad determinants of mental health and to enhance well-being and quality of life at a community level.

There is increasing recognition, both nationally and internationally, of the need to address mental health in order to improve overall health and well-being. A landmark World Bank report published in 1996 indicated that mental health issues, such as suicide and depression, are major public health concerns to be addressed in the twenty-first century (Murray & Lopez

1996). In 1999, the first ever US Surgeon General's Report on Mental Health stressed the fact that 'mental health is fundamental to health' (US Department of Health and Human Services 1999). Indeed, it is estimated by the year 2020, depression will become the second leading cause for disease burden (Murray & Lopez 1996).

In recent years, researchers in Northern Ireland have noted a steadily rising incidence of depression and suicide (Foster et al. 1997). Indeed, the Health and Social Wellbeing survey (DHSS 2001) found that people in Northern Ireland are at greater risk of mental ill health than people in England or Scotland. Several regional and national policy documents have emphasised the need for action in this area (e.g. DHSS 1996 & 1997; Homefirst Community Trust 1998). Their concerns mirror findings in the Republic from the recent Report of the National Task Force on Suicide in Ireland (Department of Health, 1998) which points to a significant rise in the male suicide rate over the last 20 years, particularly among the 15-24 age group. Suicide is now the leading cause of death among young men in Ireland. As found in other countries, farmers rank among the occupational groups with high rates of suicide in Ireland (Nic Daeid, 1997).

Mental health is a positive sense of well-being and an underlying belief in our own and others' dignity and worth. Mental health promotion is concerned with achieving positive mental health and quality of life at a population level, focusing on enhancing the strengths and competencies of individuals, groups and communities. Mental health promotion focuses on protective factors for enhancing well-being such as self-efficacy and building supportive relationships. The UK Health Education Authority (now the Health Development Agency) in its Mental Health Promotion Quality Framework (1997) highlighted three key influences on mental health:

- 1) Healthy structures: economic, social and cultural framework
- 2) Citizenship: social support, sense of social integration and inclusion
- 3) Emotional resilience: self-esteem, coping, life skills and sense of control.

The World Health Organisation (WHO) identified the promotion of mental health as an international priority under the Mental Health Global Action Programme (WHO 2002). In the Republic of Ireland, the Health Promotion Strategy 2000-2005 (Department of Health and Children, 2000) is committed to targeting positive mental health. The National Task Force on Suicide recommends the use of primary prevention and promotion strategies in order to reduce the future incidence of mental health problems and bring about a reversal of the rising trends in

suicide. Programmes targeting greater public awareness and understanding, together with school- and community-based lifeskills programmes, offer an opportunity of promoting positive mental and social well-being.

The Northern Ireland mental health promotion strategy published in January 2003 entitled “Promotion Mental Health: Strategy & Action Plan 2003 – 2008” (DHSS, 2003), backs a broad conception of mental health promotion, beyond simply prevention. The strategy looks to the relationships between mental health and physical health; emotional health; behavioural problems; domestic violence and child abuse; substance abuse; living and working conditions such as homelessness or poor housing, poverty and unemployment; and risk-taking behaviour such as smoking. The strategy has four aims:

1. Improve people’s mental and emotional wellbeing, especially those at risk and people with identified mental health problems, their carers and families
2. Prevent / reduce the incidence and impact of mental distress, mental illness and suicide
3. Raise awareness of the determinants of mental health at public and policy making levels, and reduce prejudice against people with mental health problems
4. Ensure that all those involved in mental health promotion and treatment are informed, skilled and aware of effective practices.

The strategy also sets a target to reduce the percentage of people with a potential psychiatric disorder, as measured by the GHQ-12 score, from a baseline of 21% in 2001 to 19.5% by 2008.

There are few examples of community-based approaches to mental health promotion. This rural mental health project strives to enrich the field through the development and evaluation of a community model of practice. An extensive process of community consultation was engaged at each stage of the project including feedback of research findings and active participation in planning, implementation and evaluation. Phase 1 included the Peace & Reconciliation funded Feasibility Study by McCready (1999); an extensive needs assessment survey and focus groups in both communities (Barry et al., 1999; 2000); and the establishment of a detailed system of monitoring and evaluation (Byrne and Barry, 2001). Phase 2 of the project has focused on developing and sustaining a cross-border community model of mental health promotion for rural areas.

### **1.3.2 Improving Cross-Border Co-operation: *Taking opportunities arising from peace***

There is great potential for enriched learning through shared information and experience; this, however, has often been lost in Ireland as cross-border co-operation has been prevented by the conflict in Northern Ireland. Fear and suspicion have forced communities with similar problems to develop solutions in isolation from each other. The advent of the Peace Process and the Good Friday Agreement has provided a mandate and support for cross-border co-operation; health is one of the areas for co-operation identified by the Good Friday Agreement. This project takes the opportunity to strengthen cross-border co-operation in developing meaningful and sustainable mental health promotion initiatives for rural communities

According to McCready (1999), some of the benefits of cross-border work are as follows:

- promotion of contact, discussion and respect for diversity between different traditions and cultures
- opportunity to build a strong community infrastructure against a background of peripherality in places where previously networks have been weak
- exchange of ideas and experience to stimulate new thinking and thus enrich projects and joint activities
- enhancement of the process of community development, building confidence and giving communities a stronger voice in decision making processes.

The theme of cross-border work is therefore central to this project and there is a clear focus in Phase 2 on the development of cross-border partnerships and collaboration in the delivery of programmes. The primary aims of this project as a whole were to address the legacy of conflict through rural mental health promotion; to establish cross-border co-operation with a view to facilitating understanding and sharing of information, experiences and expertise; and to identify mechanisms to ensure sustainability. It is hoped that the expansion of a common, community-led mental health promotion strategy for the areas of Draperstown and Raphoe through the Rural Mental Health Project was one route towards accruing these benefits.

### **1.3.3 Paving the Way to Reconciliation**

Within Phase 2, particular efforts were made to engage difficult to reach groups including young men, members of the Protestant community, and marginalised women across all interventions. This project brought together community members, health professionals, and other community workers in promoting contact and discussion around shared mental health

needs in rural communities. A diverse range of people from both sides of the border worked together sharing resources and expertise around planning and organising a number of cross-border project activities. These included:

- Co-operation between various community groups in planning community events, workshops and training courses, and highlighting issues of social inclusion
- Farming groups and organisations from both sides of the border establishing co-operative efforts in addressing mental health issues for the farming community North and South
- Teachers and community workers from both communities coming together in planning the delivery of the MindOut schools mental health programme
- Collaboration between a range of health workers and training and employment agencies to deliver the Winning New Jobs Programme, aimed at providing job-seeking skills and preventing depression among the unemployed
- Secondary school students from the North and South meeting together to exchange their experiences and establish contact in a positive environment which enhances their understanding of each others' social and cultural contexts.

Through the sharing of experiences and expertise of community groups and health workers from both sides of the border, the project sought to facilitate understanding, co-operation and networking around issues of mutual concern

#### **1.4 FOCUS OF PHASE TWO**

During Phase 2 of the project, various interventions were developed in co-operation with specific population groups in the community.

- Post-primary school youth (15-18 years)
- Young men (18 – 25 years)
- Women
- Unemployed
- Families in the farming industry

Each group was engaged in the planning and organisation of the intervention programmes in order to embed initiatives within the local community and structures and enable local

ownership. Sustainable links were established with services in order to highlight gaps, improve communication, and ensure continued support at a local level.

Besides programmes and events for individual target groups, interventions were also planned to impact on the general community by raising awareness, disseminating information, and reducing stigma associated with mental ill-health.

### **1.5 PRINCIPLES UNDERPINNING THE PROJECT**

This project entailed a community-based approach in recognition of the fact that community members are best placed to identify their own needs. Mental health is an integral part of community life, embedded in the social, economic and cultural environments in which people live their lives. As any numbers of factors have the potential to influence mental health, communities can be mobilised to tackle these factors in an appropriate and effective way. The intention of the project was to move beyond prevention strategies targeting only those at high risk and to develop community-wide programmes, accessible to and encompassing all community members. Critical principles that played a key role in the development of the Rural Mental included: consultation, participation, partnership and sustainability.

The planning and consultation process of the project was developed using Bracht et al.'s Five-Stage Community Organization Model (1999) as outlined by Byrne and Barry (2001) which draws on earlier models of community organization practice that have been successfully applied to community public health strategies across the globe since the 1970s. The application of such a model to the area of rural mental health promotion is, however, original and has not been previously reported in the literature.

### **Figure 1.1: Model of Community Organisation (Bracht et al, 1999)**

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1. Community Analysis and Assessment
    - Define the community
    - Collect data
    - Assess community capacity, barriers and readiness for change
    - Synthesise data and set priorities
  2. Design and Initiation
    - Establish a core planning group and select a local organiser or co-ordinator
    - Choose an organisational structure
    - Identify and recruit organisation members
    - Define organisation's mission and goals
    - Clarify roles and responsibilities of citizen members, staff and volunteers
    - Provide training and recognition
  3. Implementation
    - Determine priority intervention activities
    - Develop a sequential work plan
    - Generate broad citizen participation
    - Plan media interventions
    - Obtain resource support
    - Provide a system for intervention monitoring and feedback
  4. Program Maintenance and Consolidation
    - Integrate intervention activities into community networks
    - Establish a positive organisational climate
    - Establish an ongoing recruitment plan
    - Acknowledge the work of volunteers
  5. Dissemination and Reassessment
    - Update the community analysis
    - Assess the effectiveness of intervention programmes
    - Summarise results and chart future directions
- 

Phase 1 was concerned primarily with the planning and piloting of interventions, moving the project from inception to Implementation, Stage 3 of Bracht's model. Phase 2 concentrated on programme maintenance, and consolidation, building on work to date in ensuring the integration of project activities into community networks and the enhancement of community capacities. A key issue at the start of Phase 2 was the last step of the Implementation stage of the Bracht's model: Providing a system for intervention monitoring and feedback.

## **1.6 EVALUATION FRAMEWORK: A SYSTEM FOR INTERVENTION MONITORING AND FEEDBACK**

Given the innovative nature of this cross-border community-based project, a strong research base was critical to evaluate the process of implementation and collaboration together with assessing the project's overall impact and outcome. An extensive process of community consultation was engaged in at each stage of the project's development, including feedback of research findings and active participation by members of the local communities in programme planning and implementation. The use of action research was an integral to the planning and design of this project across the four years, involving a continuous cycle of reflection and monitoring of project activity in order to inform project planning and development on an ongoing basis.

In order to inform the project's development, and ensure the objectives were being met, a system of process, impact and outcome evaluation was put in place. The research model adopted in this project was based on a chain-of-events research paradigm as adapted from the work of Scheirer et al. (1995) who implemented this form of evaluation with large community health promotion programmes in the United States (see Figure 1 below). This form of action-oriented research attempts to relate intended programme outcomes to the realities of programme implementation. This model has a number of key elements

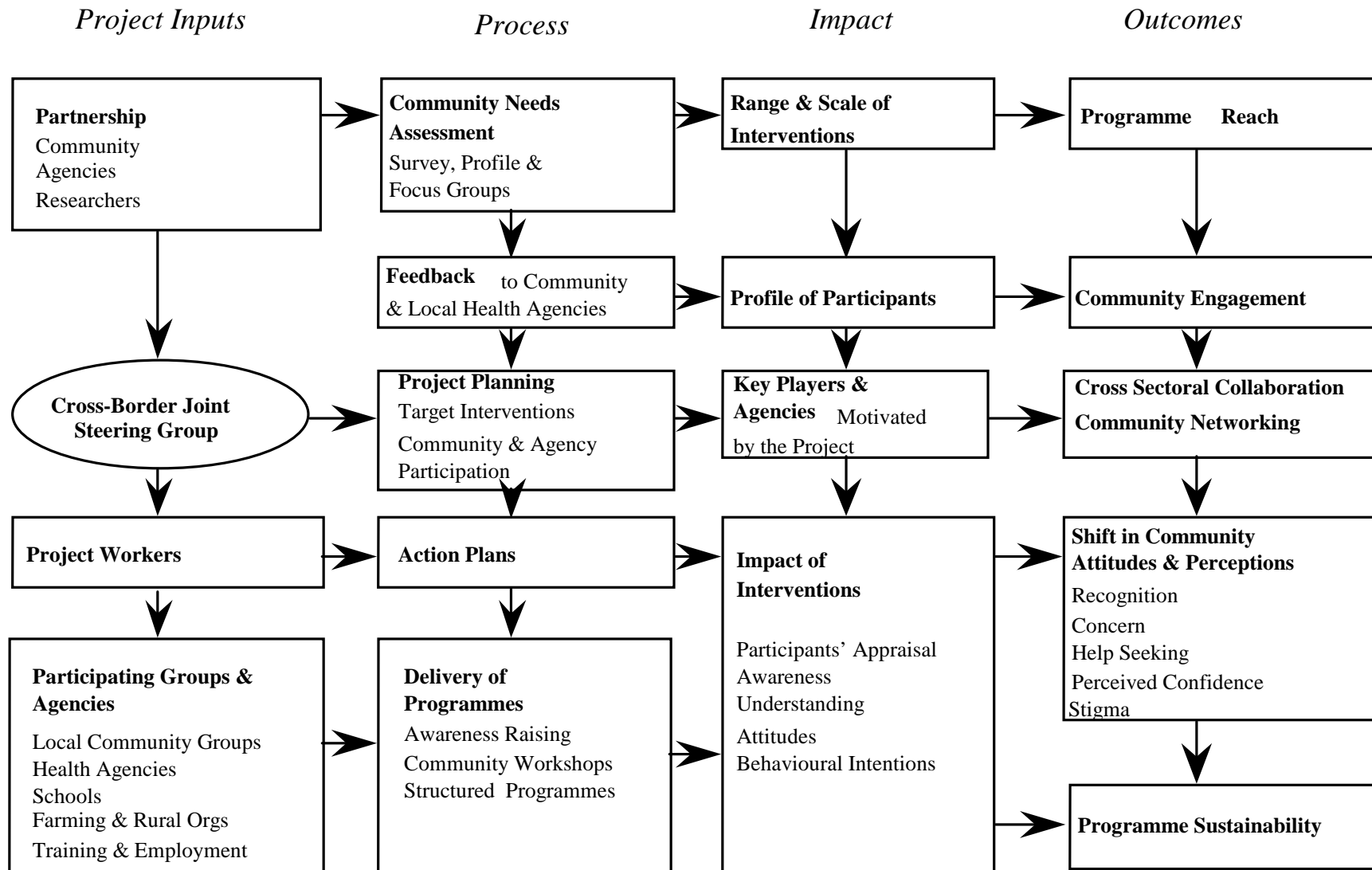
Project inputs

Process evaluation

Impact evaluation

Outcome evaluation

**Figure 1: Project Evaluation Model**



### **1.6.1 Project Inputs**

Project inputs reflected the partnership model of working between the local communities, health agencies and the university researchers on the development and delivery of the overall project. A key organisational structure for the partnership model was the Cross-Border Joint Steering Group, which was comprised of representatives from the local Steering Groups and Project Advisory groups. The Cross-Border Joint Steering Group planned and monitored the delivery of the project and had an overseeing role in terms of its progress and further development. The two Project Managers, one in each community, were also key partners; they had responsibility for implementing the project in the local communities in collaboration with the relevant community groups, health agencies, schools, farming groups and local organisations. The Project Managers represented the face of the project on the ground and as such undertook extensive liaison and networking on a cross-border basis with the various sectors in the local communities. Finally, participating groups and agencies involved in programme planning and deliver were key partners; these included:

- Local community action and development groups, youth groups, women's groups, sports clubs, etc
- Farming and rural organisations
- Statutory agencies including health promotion, primary care, social welfare and mental health services
- Voluntary agencies including the Mental Health Association of Ireland, the Samaritans, and GROW
- Government agencies including the Department of Health, the Department of Agriculture (RoI) and the Department of Agriculture and Rural Development (NI)
- Local schools, training and employment agencies

### **1.6.2 Process of Implementation**

As per the Model in Figure 2, the process of implementation was guided by a 5-step process beginning with a community analysis. The analysis explored mental health perceptions and understandings of the local community, collecting baseline data and assessing the capacity and support for the project. The primary tool used for this was an in-depth community needs assessment survey (Barry *et al*, 2000), together with interviews

with key players in the communities. The needs assessment provided the building block on which the project was developed. Second level consultation, in the form of focus groups with young people and women in the area, was undertaken in order to prioritise the menu of interventions.

Based on the consultations and the needs assessment, the specific project objectives were determined as being to:

- Increase public awareness of depression and suicide
- Reduce social stigma attached to mental ill-health
- Improve attitudes, skills and practices of problem recognition, identification of sources of help and use of services
- Actively engage the local community in addressing these issues
- Re-orient existing services to be more responsive to the needs of local communities

Following on these objectives, three main types of interventions were planned:

- Information and general awareness-raising activities
- Community education workshops
- Structured positive mental health promotion programmes

### **1.6.3 Process Evaluation**

Process evaluation takes on a particularly important role in the context of community programmes; such programmes typically constitute multi-faceted interventions implemented in complex settings with diverse target populations.

Community-based interventions require comprehensive process evaluation to track implementation and ensure adequate documentation of a wide range of activities and procedures. Regular reports compiled by the Project Managers documented the planning process, organisation and delivery of the project activities. The researchers carried out direct observation of project activities through attending meetings, workshops and the delivery of programmes. Finally, telephone interviews with the Joint Steering Group members monitored perceptions of the project's development, with a particular focus on the elements of sustainable cross-border co-operation and peace and reconciliation building.

### **1.6.4 Impact Evaluation**

Impact evaluation measures the range and scale of project interventions, examining to what extent they are based on the needs assessment findings and the extent to which they are reaching the intended target groups. Impact evaluation also assesses the degree of community participation and inter-sectoral collaboration in terms of the health, education and farming sectors.

For this project, impact evaluation examined three levels of programme components or interventions in the current project:

- 1) Awareness raising activities which included the use of talks, drama and community events to impart information at a local community level on mental health issues, service contact and supports e.g. the Schools' Mental Health Open Days.
- 2) Community education events and workshops on diverse topics such as stress management, depression, young people and mental health. These were designed to promote mental health knowledge in order to de-stigmatise the issue of mental health in rural communities.
- 3) Promotion of structured positive mental health programmes to run over a number of days or weeks designed to impart skills as well as knowledge and confidence. These included the men's holistic health programme, mental health programmes in schools and the Winning New Jobs programme for the unemployed.

Each intervention was assessed in regards to participants' socio-demographic profile and impacts on self-reported knowledge, skills and attitudes. For structured programmes such as the mental health module in schools, a randomised controlled design systematically established the impact on students' awareness, attitudes, behavioural intentions and mental health. The Winning New Jobs Programme for the unemployed employed a quasi-experimental design to examine the impact of the programme on the training participants in comparison to a control group of unemployed people.

### **1.6.5 Outcome Evaluation**

In order to assess the impact of the project on the participating communities, the research study employed a quasi- experimental design, which entailed undertaking cross-sectional surveys of the two project communities and a reference community in Co. Galway prior to and following implementation of the project. Approximately 250 randomly selected community residents were interviewed in each community prior to implementation of the project in 1997/8 and again in 2003 following project implementation. This design facilitated a comparative impact evaluation of the project activities on the intervention and reference communities over the life span the project. The 2003 survey was undertaken based on the original needs assessment and entailed re-visiting all three communities and carrying out a cross-sectional re-survey on attitudes and perceptions toward mental health.

In addition to the community survey, the evaluation of the research outcomes focused on the following subjects:

- Extent of programme penetration in both communities
- Success of the project in engaging local community members both within and across the two communities
- The degree of inter-agency collaboration in re-orienting existing services and community supports to meet local needs
- Evidence of effective cross-border working in facilitating understanding and co-operation around issues of mutual concern including joint planning and cross-programme programme delivery.
- Establishment of cross-sectoral partnerships such as community, health, education, business and farming sectors, in addressing the broader determinants of positive mental health and quality of life in rural communities
- Evidence of sustainability, integrating project activities into mainstream community and health agencies, and the application of tried and tested models of both community mental health promotion and cross-border working.

The research examined the mechanism for cross-border collaboration in the project including the working of the Cross-Border Joint Steering Group and the views of the project members regarding the perceived challenges, opportunities and barriers to effective

cross-border co-operation in this area. The establishment of sustainable collaborative links were also examined.

The research evaluation model used with this project aimed to link variability in programme implementation with variation in intended outcomes. The extent and quality of programme implementation was monitored throughout the project together with the degree of community participation and inter-agency collaboration. Findings were fed back into the project planning process at regular intervals in order to guide improved delivery and enhance programme reach and impact. In addition, findings from the evaluation were periodically disseminated to statutory and community organisations in terms of policy and practice implications, as well as to the wider community through a newsletter. The process of developing and implementing this novel mental health promotion project, both in terms of its rural community base and cross-border model of working, will have important implications in terms of future policy, practice and methodological developments.

## **CHAPTER 2                      CONCEPTUAL BASIS OF INTERVENTIONS**

### **2.1 ACHIEVEMENTS OF PHASE ONE**

A range of intervention activities were piloted and implemented in Raphoe and Draperstown during the first phase of the project. Each of the activities was planned jointly by the Cross-Border Joint Steering Group and undertaken through the networking and collaboration of several local community groups and agencies. Some of the intervention activities which took place during Phase 1 are as follows:

#### **2.1.1 Phase One: Farming Families**

A half day seminar entitled “Mental Health and Farmers” was organised in Raphoe and was attended by farmers from both the Raphoe and Draperstown communities. It was successful in increasing awareness of stress and depression among farmers, providing information and sources of support for farmers, offering advice, and reassuring farmers that they are not alone in dealing with difficulties.

The establishment of a Farm Family subgroup in each of the local steering groups was successful in mobilising the farming sector in both communities. The subgroup helped to promote local mental health and wellbeing among farm families as well as to raise confidence in relation to mental health issues in the farming community. The Draperstown subgroup posted information and consultation packs to 431 farming families and raised awareness through the publication of a series of five weekly articles in local newspapers.

Training programmes aimed at farming families helped to impart new skills and raise self-efficacy among farmers through a six-week computing course and a six-week course in improving farm family income and stress management.

#### **2.1.2 Phase One: Schools**

During Phase 1, the Mental Health Module “MindOut” was designed and implemented in five schools in the Raphoe and Draperstown area. Following extensive consultation and cross-border planning, the module was successful in raising students’ awareness of mental

health issues, enhancing coping skills, and diminishing stigma associated with mental health issues.

During Phase 1, a parents' evening also took place for parents of those senior cycle students who had participated in the mental health module. The evening was successful in explaining the promotion of mental health among teenagers, exploring how parents can help promote their children's mental health and providing information on local mental health services and accessing these services.

Finally, an inaugural cross-border drama workshop took place in May 2000 in partnership with the Pyramid Theatre Company, and students from both Raphoe and Draperstown attended. The workshop was successful in raising awareness of positive cross-border relationships by encouraging students to interact with other students from across the border in pairs and small groups. The workshop was also successful in increasing student's knowledge and awareness of mental health issues and building a positive self-image.

### **2.1.3 Phase One: Women**

During Phase 1, links were established with well-established women's groups in both Raphoe and Draperstown. An Open Day in February 2000 was useful in introducing the Rural Mental Health Project to these women's groups and facilitating positive initial contacts with group representatives.

Several once-off events took place. A nine-week personal development programme entitled "Chasing Rainbows" was designed to target individuals lacking in self-esteem or who suffered mental health difficulties in the past. A Women's Health evening was held in Raphoe to discuss women's physical and mental health issues. An event entitled "A Wealth of Health" was organised by the Rural Health Social Well-Being Project in Draperstown to provide women's groups with information about the needs and wants of women in the area. Finally, an eight-week positive childminding course was held in October 2000 to target women who would like to become registered childminders and for mothers with young children.

#### **2.1.4 Phase One: Men**

Several programmes were initiated to target young men between the ages of 18 and 25. A Sport/Exercise and Mental Health Workshop in Raphoe brought together young men to discuss the interaction of sports and exercise and mental health. In addition, focus groups were held in Raphoe with twenty-two young men to investigate

A holistic health programme was developed to provide men with more information of basic indicators of physical health, to increase understanding of the importance of regular health checks, and to promote discussions around the role of men in the family, stress, exercise, substance abuse, sexual health, and physical self-examination.

#### **2.1.5 Phase One: General Community**

Throughout Phase 1, there were many workshops and events aimed at increasing knowledge and awareness of both the Rural Mental Health Project as well as mental health issues. For example, three evening workshops were held in Raphoe on topics of parenting skills, stress management, and self-esteem. Information stands were ‘manned’ by Joint Steering Group members at health and craft fairs. A Community Celebration Week in Raphoe enhanced community networks and participation, and brought together groups that previously worked in isolation of one another. Finally, publicity advertisements, newspaper articles, and journal articles were composed and distributed both locally and regionally.

This chapter outlines the initial planning and consultation that took place at the commencement of Phase 2, forming the base of subsequent project activities:

- Re-organisation of the project structure
- Consultations with Sub-groups e.g. women’s’ groups and farming agencies
- Conceptual Basis of the Winning New Jobs Programme
- Conceptual Basis of the Schools Programme

## **2.2 RE-ORGANISATION OF THE PROJECT STRUCTURE**

The start of Phase Two included a transition period in which the role of project administration and grant holder transferred from the Centre for Health Promotion Studies at NUI, Galway to the Rural Health Mind Matters Project in Raphoe. A full-time Project Manager and part-time administrator were recruited in Raphoe to support this new role. The role of the research team at NUI, Galway, changed focus to concentrate more on project evaluation rather than on overall project development and management.

The Joint Steering Group from Phase One was re-established to serve as the key organisational structure for managing the cross-border project. Responsibility for the overall progress of the project rested with the Joint Steering Group. A series of sub-groups was formed to plan and oversee work in designated areas such as; farming, youth, schools, women, men, services and the Winning New Jobs Programme. Partner organisations were represented on each of the cross-border sub-groups.

### **2.2.1 Re-establishment of the Cross-Border Joint Steering Group**

The Cross-Border Joint Steering Group served as the key mechanism for the direction of the project and cross-border co-operation. As during Phase 1, Steering Group members from each community were nominated to represent their project and the total group comprised of 14 representatives from community organisations, the voluntary sector and university researchers. As members left the group, new members joined. The full membership is listed in Appendix I, and a brief biography of the members is available in Appendix II.

The key members of the Steering Group were the Project Managers. For the Rural Health and Social Well-being Project (RHSWP) these were Ms. Therese Lowry from the start of the project until September 2003 and Mary Duggan from that date until the end of the project. For the Rural Health Mind Matters Project these were Ms. Inga Bock from the start of Phase 2 until May 2004 and Ms. Anne Marie Nedelkovic from that date until the end of the project.

Group meetings were held alternately in the two communities every six to eight weeks. Meetings involved the joint planning of project activities, pilot interventions, and the

establishment of networks both within and across communities. Project members used teleconferencing facilities to ensure that there was ongoing information exchange. As in Phase 1, local steering groups continued to meet in each community with representation from the project staff, local community groups and health professionals. The local steering groups served as an important vehicle for enhancing local ownership and mobilising local support for project activities

### **2.2.2 Re-establishment of Local Sub-Groups**

Several local sub-groups that had been established in Phase 1 continued on into Phase 2, while other sub-groups were newly established in Phase 2. These groups dealt with specific issues for their sector through regular meetings in the local community. Sectors included: farming, women's health, the Winning New Jobs programme, and the schools setting. The purpose of these groups was to:

- Discuss relevant local issues
- Plan activities to support their aims and objectives
- Discuss the potential for cross-border interventions/ forum
- Provide support for each other

An example of Project Action Plan developed during the inaugural meeting of the women's sub-group is available in Appendix IV.

## **2.3 CONSULTATIONS WITH SUB-GROUPS**

At the beginning of Phase 2, a community mapping and consultation exercise was undertaken with local groups and organisations in both communities. This exercise sought to explore possible links and collaboration between these groups and the Rural Mental Health Project.

### **2.3.1 Consultations with Farming Families and Agencies**

A number of meetings were held with farming families in both communities as part of the Farming Sub-group. The aims of the meetings were to:

- discuss issues related to farming families
- plan activities in support of farming families

- discuss the potential for a cross-border forum and cross-border interventions

As a result of these meetings a Cross-border Farming Families Conference was held on the 3rd of April 2004 entitled ‘Ploughing a New Furrow for a Better Tomorrow’ (see Chapter 3 for more detail).

Consultative meetings were also held in the local areas with different agencies in the farming sector. These included: Teagasc, Irish Farmers Association, ICA, Donegal Farm Relief, Macra na Feirme, Donegal Local Development Company, Raphoe and Stranorlar Mart Societies, Donegal Creameries and Clonleigh Co-op, County Development Board, Money Advice and Budgeting Service, the Department of Agriculture (RoI), The Department of Agriculture and Rural Development (DARD – NI), Rural Support, Ulster Farmers Union, Magherafelt Area Partnership, Rural Community Network, Countryside Services, NAYPA, and Farming Family Bureau Magherafelt. The aims of these consultations were to:

- Inform participants about the Rural Mental Health Project
- Consult with the farming agencies regarding their needs and possible interventions to meet the joint needs of farming families and agencies.
- In the Raphoe area, to re-establish contact with farming community that was lost in 2001 due to Foot and Mouth disease

### **2.3.2 Consultations with Women**

Consultation meetings were held in both intervention communities to discuss women’s social and physical health. The needs of the women were expressed as follows:

- Need for one-to-one service
- More than listening is required, more sign posting and sympathy
- Local service, but not by local people
- Instant service provision for urgent problems, not next week or next day.

Local groups including the Raphoe Youth & Community Project, the Garda Diversion Project, Springboard, and the Raphoe Action Group all expressed an interest in the development of in-house training for a “listening ear” service in the Raphoe locality. Likewise, meetings were held with the Mid Ulster Women’s Network to explore the potential for cross-border collaboration. As a result of this work, a Cross-border Women’s

Event was held on the 9<sup>th</sup> and 10<sup>th</sup> of March 2004 entitled ‘Wellbeing and Togetherness’ (see Chapter 3 for more detail).

### **2.3.3 Consultations with the General Community**

A focus group took place with a local development association to discuss main issues or concerns in the area and what could be done to deal with these issues

Main issues or concerns in the area:

- There are problems with drugs and alcohol among young people
- Despite the playgroup being a very positive facility within the community, children from the area are not accessing the service
- There are many ill people in the area
- People in most need are not being targeted by ongoing interventions
- Consultations in the past have tended to focus on economic and rural development, rather than health and wellbeing.
- Management problems

Potential solutions for these issues included engaging local people in more activities and groups and the provision of information.

## **2.4 CONCEPTUAL BASIS OF THE “WINNING NEW JOBS” PROGRAMME**

### **2.4.1 Mental Health and Unemployment**

Strong evidence attests to the adverse effects of job loss and unemployment on social and psychological functioning and well-being (e.g., Barling, 1990; Dew, Bromet & Schulberg, 1991; Feather, 1990; Price, 1992; Vinokur, 1997). Epidemiological studies demonstrate that unemployment causes significant deterioration in mental health and well-being (e.g., Catalano & Dooley, 1977; Warr, 1983). Further studies show that reemployment reverses adverse mental health effects and restores the level of mental health that existed prior to job loss (Caplan & Williams, 1987; Iverson & Sabroe, 1988; Kessler, Turner & House, 1988; Vinokur, Vuori, Schul & Price, 2000). Following this, the National Task Force on

Suicide (1998) has recommended the use of primary prevention and promotion strategies in order to reverse the rising trends in suicide.

The JOBS Programme was originally developed in 1982 in Michigan, USA, as a response to the downturn in the motor industry. The Programme is intended as an intervention for job seekers to facilitate their return to the labour market and enhance a sense of empowerment. The programme is based on well-grounded theoretical principles, sound research methods and best international practice. While the intervention is aimed specifically at enhancing job search skills, it also incorporates several mental health promotion elements such as enhancing participants' self-esteem and sense of control, job search self-efficacy and inoculation against setbacks in order to combat feelings of anxiety, helplessness and depression.

The Programme is suitable for those that are recently unemployed, long term unemployed, or people who have never worked. It has shown to work in a variety of settings and with a wide range of groups including farmers, the disabled, and youth. Research shows the JOBS Programme is particularly beneficial to participants who are long-term unemployed (Vuori, Silvonen, Vinokur & Price, 2002). Randomised field studies have indicated that the programme can produce impressive results including:

- Better quality and higher paying jobs (at 2.5 years follow-up)
- Higher confidence in job seeking ability and improved job search skills
- Lower incidence and prevalence of depression at 2.5 years
- Finding re-employment sooner
- Enhanced sense of mastery and inoculation against setbacks
- Improved mental well-being and positive mental health
- Cost effective in terms of increased economic benefits for participants and the State
- Extended benefits to the family of the job-seeker

The Programme was so successful in Michigan, it was replicated in many other US states and several other countries including Finland, Russia, Sweden, China, the Netherlands, and Poland; however, it has only been evaluation in Michigan and Finland.

### **2.4.2 Consultation**

Much discussion and planning occurred with individual agencies on a cross-border level in conjunction with the North Western Health Board in Donegal and the Homefirst Community Trust in Derry/Londonderry. Initial dialogue focused on the practicalities of the programme and the schedule of the implementation and evaluation. The Michigan Prevention Research Centre (MPRC) at the University of Michigan agreed to work collaboratively in replication the JOBS programmed intervention, training the trainers, and providing data collection instruments for evaluation.

Two guest speakers provided information sessions in order to give a first-hand account of the programme as it has been implemented abroad and, thus, lead the planning for the Irish JOBS programme:

- Dr. Vuori, who has been extensively involved in implementing the JOBS Programme on a national scale in Finland
- Professor Price from the University of Michigan, who was involved in developing the original programme.

#### *Information Session with Dr. Vuori*

A one day information session in Londonderry/Derry regarding the JOBS Programme was held in April 2002. Many training and employment agencies were invited with approximately 40 people in attendance. Dr. Vuori addressed a number of key points including:

- The programme in Finland had positive outcomes for the long-term unemployed
- Full training of the trainers is provided.
- Despite some participants remaining unemployed after the programme, their mental wellbeing improved.
- Those participants most at risk benefit most from the programme.
- There was a low drop out rate among the participants.

A video presentation from the Michigan Prevention Research Centre at the University of Michigan USA depicted the JOBS Programme training in action. A question and answer session helped to clarify further details about the Programme. Finally, participants discussed how the programme might work in an Irish setting. Everyone that attended this meeting agreed that it was a very positive experience.

### *Information Session with Professor Price*

In July 2002, a visit by Professor Rick Price from the Michigan Prevention Research Centre was attended by members of various training and statutory groups (see Appendix V for a full list of those who attended). Professor Price was involved in the original development of the programme. He gave a background to the JOBS Programme in the United States since its inception in 1982 and its growing popularity worldwide. Professor Price and the attendees discussed several topics, including how to select participants and trainers and the vital importance of research and evaluation to prove that the programme works better than other programmes currently offered to the unemployed.

### **2.4.3 Planning the Programme**

Various statutory, voluntary and community groups who are engaged in training, employment and support were contacted in order to encourage them to participate in the “Winning New Jobs” Programme as it was named in Ireland (see Appendix VI for full listing of participating agencies). In total, twenty groups and agencies agreed to participate

Commencing in April 2002, the participating groups and agencies held eleven planning sessions on a cross border basis. The planning stage afforded an excellent opportunity for peace building and reconciliation, bringing together people who may not have traditionally worked together in order to reach a common goal. To facilitate those travelling long distances, meetings were held in various locations namely Donegal, Derry/Londonderry and Sligo. A number of key issues were discussed and agreed under the following headings:

#### *Participants*

Selection criteria were agreed and discussed (see Appendix VII for methodological details). The planning group determined that a group size of 14 - 22 participants was ideal for two facilitators. The group felt that the best way to promote the programme was by word of mouth, which would build up over time. Finally, the planning group felt that there would be low attrition.

### *Trainers*

The planning group discussed the issue of joint facilitation of training sessions with both a male and female trainer, though some felt that it would be difficult to source a sufficient number of male trainers. Participating organisations agreed to co-operate to bring trainers together to deliver this programme.

### *The Programme*

The planning group suggested that the Winning New Jobs programme could be offered as part of other existing job-training programmes. A schedule for the training was discussed. The planning group agreed that there was a need to take a long-term view to the implementation of the WNJ Programme. The group also agreed that the programme should involve senior management within the various organisations to ensure the sustainability.

#### **2.4.4 Adaptation of the Training Manual**

The original Michigan “JOBS Manual for Teaching People Successful Job Search Strategies” (1992) was used as a structured guide to set up and implement the programme e.g. the process of hiring trainers, the training period for the trainers and the intervention seminars. In several instances, however, the programme had to be adapted from its American origins to suit an Irish context; this constituted a major part of the study in Ireland. A key issue that was highlighted from the trainers and agencies was the use of language and examples more suited to an American sample. A full-day meeting was held in May 2004 in which all the trainers were invited to attend in order to review the programme and re-write the training manual. Issues discussed included: what works or does not work with each session; what needs to be changed, added or left out; format and layout of the manual; and availability of extra resources and materials.

Those who could not attend the meeting were asked for their contributions by email or telephone. As a result of this meeting, a draft copy of the manual was produced and made available to all trainers for feedback. Based on further feedback, more revisions were made and the newly adapted manual was used successfully.

#### **2.4.5 Programme Evaluation Materials**

Evaluation materials were selected to allow comparison with the US and Finnish JOBS Programmes by the Michigan Prevention Research Centre (MPRC) at the University of Michigan. These were modified to suit the Irish context, including additional process and qualitative elements. Evaluation materials included participants' questionnaires, trainers' measures and semi-structured telephone interviews. The evaluation was undertaken by the Centre for Health Promotion Studies at NUI, Galway.

#### **2.4.6 Training of the Trainers**

The training agencies selected a number of their staff to participate in this programme. Thirty-one trainers in total participated from a diverse range of voluntary, statutory and community agencies, consisting of 15 trainers from Northern Ireland and 16 trainers from the Republic of Ireland. These trainers were primarily from training and employment agencies, the health sector and the relevant government departments. Many of these trainers have had extensive experience in training, employment and support.

The training of trainers occurred for one week over six days in both Draperstown and Letterkenny (23<sup>rd</sup> September–5<sup>th</sup> October 2002) by Mr. Steve Barnaby from the Century Communications Group (part of the Michigan Prevention Research Centre) and Ms. Sarah Marsh from the University of Michigan. Both trainers have extensive experience in conducting training of trainers for the JOBS Programme in the United States. The full list of the trainers' is available in Appendix IX.

There were high levels of satisfaction with the training among the trainers. They stated that the success of the programme was not so much due to the content but more the methods of delivery and learning involved. Trainers reported that the programme was about empowering trainees, giving them a sense of motivation, and encouraging them to try to gain new opportunities. Most trainers were keen to commence training in the near future.

#### **2.4.7 Piloting the Winning New Jobs Programme**

Several trainers completed at least one pilot workshop before the main study commenced in order to gain experience running the programme. The researcher observed these sessions to monitor the training at first hand. In addition, all evaluation materials were piloted. There

were no reported difficulties with either the pilot sessions or the materials. Details of the pilots are available in Appendix VII. All pilots of workshops and evaluation materials were completed successfully.

## **2.5 CONCEPTUAL BASIS OF THE SCHOOLS PROGRAMME**

### **2.5.1 Background to the Mental Health Module**

A key feature of the Rural Mental Health Project has been the introduction of a post-primary school-based module promoting positive mental health among young people in the Raphoe and Draperstown areas.

Historically, health and personal development have been delivered on an ad hoc basis in Irish schools. The aim of this particular project was to develop, implement, and evaluate curriculum-based programme in order to promote positive mental health for 15 through 18 year olds in the school setting. An additional aim of this project was to include schools from both the Republic of Ireland and Northern Ireland in order to build relationships and share experiences between the two provinces.

The development of the module was an ongoing process throughout the lifetime of the project, involving extensive consultation with students, teachers and health promotion practitioners as well as a review of international best practice in the area of school-based mental health promotion in order to improve, revise and adapt the materials. Several reports (e.g. Byrne & Barry 2001) outlined the development these materials. The result of has been the compilation of two programme manuals for teachers: one containing ten curriculum-based sessions for delivery during the first year of the programme, and the second containing three ‘booster sessions’ designed to follow on from the original programme a year later. The programme is designed for young people aged 15-17 years. The module was named *Lifeskills MindMatters* in recognition of the two initiatives from which the content is principally drawn – the North Western Health Board’s *Lifeskills* materials (McAuley 1997, 1996) and the Australian *MindMatters* programme (CDHAC 2000). The module’s name was then shortened again to the “MindOut” module.

The aims of the programme materials were to focus explicitly on positive mental health issues, as part of a more general health education programme. The aims of the module materials are to:

- Identify a range of coping strategies available to young people in stressful situations;
- Develop rational thinking skills for use in managing negative emotions;
- Raise awareness of feelings and how to deal with them positively;
- Increase knowledge on sources of support, both informal and formal, for young people in distress;
- Explore attitudes towards mental health issues and towards seeking help.

The Mental Health Module was implemented and extensively evaluated over the course of three academic years, from October 2001 through May 2004. Approximately 728 students in the following schools took part:

- St. Colm’s High School, Draperstown
- St. Patrick’s College, Maghera
- Deelee College, Raphoe
- St. Columba’s College, Stranorlar
- Vocational School, Stranorlar.

**Table 2.1: Number of Teachers & Students Participating in “MindOut”**

	Newly Trained Teachers			Students		
	2001-02	2002-03	2003-04	2001-02	2002-03	2003-04
<b>Co. Derry/Londonderry</b>	6	4	7	124	120	154
<b>Co. Donegal</b>	6	5	0	75	124	131
<b>Subtotals</b>	12	9	7	199	244	285
<b>Totals</b>	<b>28</b>			<b>728</b>		

Demographic information for the 199 students who took part in the programme during the academic year 2001-2002 is available in “Report on the Development and Evaluation of a Mental Health Promotion Programme for Post-Primary Schools” (Byrne, 2003).

### **2.5.2 Teacher Training**

Training sessions for first-time teachers of the module took place in Draperstown and Stranorlar in September 2001 and January 2002 respectively. A further two sessions were held in December 2002, and in Magherafelt only in October 2003 and January 2004. These sessions were facilitated by Ms. Mary Byrne from NUI, Galway with either Ms. Anne Sheridan from the Health Promotion Departments of the North Western Health Board; Mr. David Porter and Ms. Beth Gibb from the Health Promotion Departments of the Homefirst Community Trust. A total of 28 teachers attended these sessions and went on to deliver the module. Photos from one of the training sessions is available in Appendix III.

After the initial training session, locally-based health promotion practitioners and the Centre for Health Promotion Studies at NUI Galway offered teachers ongoing support. In addition, an introductory section in the Teacher's Manual gave important guidelines on 'dealing with difficult situations in the classroom' and 'the role of the teacher'.

### **2.5.3 Booster Sessions**

Teachers who taught the original ten sessions of the module and who had access to the same group of students the following year were eligible to deliver the three follow-up booster sessions of the programme one year later. Between January 2002 and May 2004, five teachers in three schools (1 in Draperstown and 2 in Raphoe) delivered these sessions to approximately 120 students.

## **CHAPTER 3**

## **PROJECT ACHIEVEMENTS: PHASE 2**

### **3.1 INTRODUCTION**

This chapter describes the achievements of this project in meeting its original stated aims and objectives through a range of interventions implemented during the second phase of the project (January 2002- June 2004). Each of the activities detailed below were planned jointly by the Cross-Border Joint Steering Group. A process of networking and collaborating with a range of local community groups and agencies was instrumental in bringing about each intervention and activity described. The activities themselves included information and awareness-raising events, publications, workshops and implementation of structured programmes. A broad cross-section of community members was targeted by the various events:

- The General Community
- Youth and Teachers
- The Unemployed
- Farming Families
- Women's Groups

A key challenge for Phase 2 was to develop an exit strategy by ensuring that sustainable initiatives were established. This was through the means of embedding the project activities within local community structures and building on cross-sectoral links and support from local agencies. A project exit strategy has been achieved through the following actions:

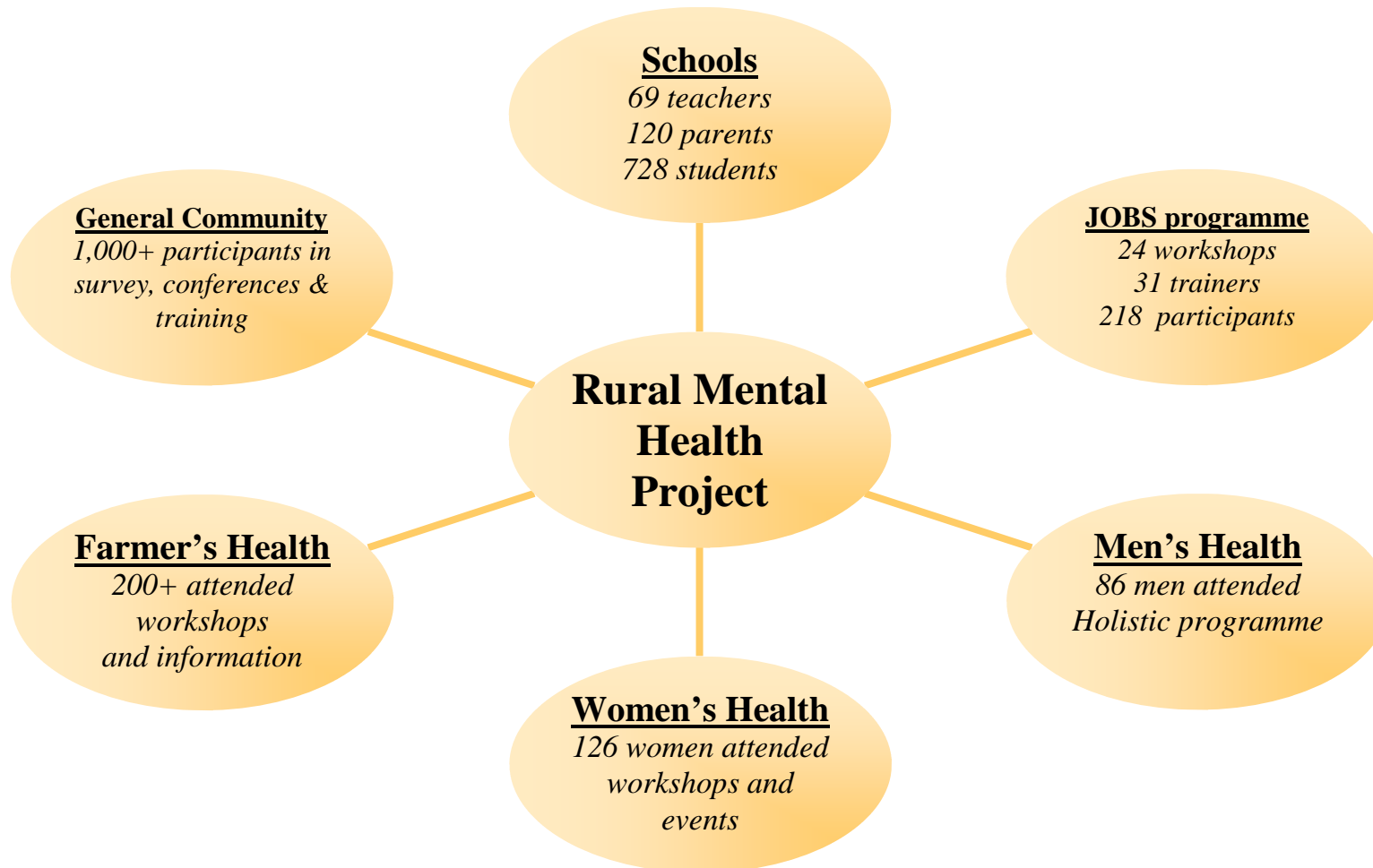
- Building on the work established in Phase 1 and continuing to reinforce the structures for effective collaboration at community level, as well as providing support for cross-community networking
- Developing joint planning within and across communities and sectors both sides of the border through a range of activities which focus jointly on various target groups
- Based on inter-agency collaboration, ensuring that effective programmes and strategies are mainstreamed into existing organisations and agencies which

ensures initiatives are sustainable because they are embedded within and supported by the local community

- Building community capacity to actively engage with local agencies and organisations in meeting local needs
- Developing an effective community-based model of co-operation between the two communities and the relevant voluntary and statutory agencies with regard to promoting positive mental health in rural communities which can be replicated elsewhere
- Informing models of efficient cross border working in facilitating understanding and co-operation around issues of mutual concern.
- Disseminating the findings from action research to inform good practice and policy at national and international levels.

The figure and tables on the next three pages give a graphical depiction of the level and reach of community participation, as well as the range and scale of Phase 2 Interventions. It is clear that the depth and breadth of this project has enabled it to touch the lives of a large number of individuals in the Draperstown and Raphoe areas. Where possible, the number of people who took part in each activity is indicated.

**Figure 3.1: Community Engagement: Single Events and Community Workshops**



**Table 3.1: Range and Scale of Interventions: Phase Two: January 2002 – June 2004 (approximate # of participants in brackets)**

Intervention Type	Setting				
	SCHOOLS / YOUTH (728+ pupils, 28+ teachers, 5 teacher trainers, 200+ parents)	UNEMPLOYED (218 participants, 31 trainers)	GENERAL COMMUNITY (1,000+ participants)	SPECIFIC COMMUNITY GROUPS	
				FARMERS (184+)	WOMEN & MEN'S HEALTH (186+)
<b>CROSS-BORDER INTERAGENCY COMMUNITY GROUP NETWORKING</b>	1. Cross-border consultations with the youth service and youth groups	1. Visit of Professor Price (8) and Dr. Vuori (40) 2. Cross-border joint planning meetings with agencies, trainers, and senior management	1. Cross-Border Joint Steering Group meetings (14) 2. Local Steering Group Sub-groups meetings (20) 3. Focus groups with local development associations 4. Cross-border "P.E.A.C.E." Conference (80)	1. Cross-border farming groups and agencies consultation meetings (30)	1. Cross-border women's agency consultation meetings 2. Meetings with local services & health professionals on men's health utilising cross-border collaboration
<b>INFORMATION &amp; AWARENESS RAISING</b>	1. "MindOut: Positive Mental Health in Schools and at Home" Leaflet for parents (180) 2. Mental Health Open Days (110 students) 3. Information stands at local schools and resource centre	1. Launch of WNJ programme, information sessions (60)	1. Cross-border Project leaflet distributed (300) 2. "Concerned About Suicide" leaflet to 30 organisations 3. Rural Health Mind Matters Project Leaflet (2,000) 4. Interviews with members of Joint Cross-Border Steering Group (12) 5. Established Finn Valley Alliance for positive mental health	1. Farming information sessions (184) 2. "Survive and Thrive on the Farm" and "Concerned about Suicide" leaflets distributed at info sessions 3. Consultations with GPs on Primary Care Services for rural stress	1. Consultations regarding parenting programmes for single fathers
<b>STRUCTURED PROGRAMMES PROMOTING POSITIVE MENTAL HEALTH</b>	1. Mental Health Module 2002 – 2004 (728 pupils) 2. Booster sessions (120 students) 3. Teacher training sessions (69) 4. Training of trainers (5) 5. Evaluation workshops (2 schools) 6. Teacher review sessions (10)	1. WNJ Programme training (24 workshops, 31 trainers, 218 participants)			

**Range and Scale of Interventions: Phase Two: January 2002 – June 2004 (continued)**

<b>Setting</b>					
<b>Intervention Type</b>	<b>SCHOOLS</b>	<b>UNEMPLOYED</b>	<b>GENERAL COMMUNITY</b>	<b>SPECIFIC COMMUNITY GROUPS</b>	
				<b>FARMERS</b>	<b>WOMEN &amp; MEN'S HEALTH</b>
<b>SINGLE EVENT / COMMUNITY EDUCATION WORKSHOPS</b>	<ol style="list-style-type: none"> <li>1. Cross-border Drama Workshop (42 pupils)</li> <li>2. Activities with children at Open Day (83+ children)</li> <li>3. Teachers' workshops at Open Day</li> <li>4. Parents' workshops at Open Day</li> </ol>	<ol style="list-style-type: none"> <li>1. Training of the Trainers (11 agencies, 31 trainers)</li> <li>2. Cross-border networking event involving DSFA and Rural Health Partnership</li> <li>3. Adaptation of WNJ manual to Irish context by trainers/agencies</li> </ol>	<ol style="list-style-type: none"> <li>1. Cross-border ASIST training (23 participants)</li> <li>2. Community Re-survey of Draperstown and Raphoe (1<sup>st</sup> round: 500, 2<sup>nd</sup> round: 500 )</li> <li>3. Computer Course for parents of the Toddler Group (5)</li> <li>4. Walking for Health (17)</li> </ol>	<ol style="list-style-type: none"> <li>1. Cross-border conference "Ploughing a New Furrow for a Better Tomorrow" (100+ attendees)</li> <li>2. Health Checks for farmers at local farming marts</li> </ol>	<ol style="list-style-type: none"> <li>1. Cross-border event "Celebration of Wellbeing and Togetherness" (24 groups, 41 attendees)</li> <li>2. Cross-border workshop "A Bit of Peace &amp; Quiet" (10)</li> <li>3. Cross-border residential events (75 participants)</li> <li>4. Men's Holistic Health Programme (86)</li> <li>5. "Fathers Matter" workshops</li> </ol>
<b>MEDIA / PUBLICITY</b>	<ol style="list-style-type: none"> <li>1. Report included in WHO "Mental Health Promotion: Case Studies from Countries"(2004)</li> <li>2. Presentation to Eastern Health and Library Board, Down and Lisburn Health Promotion Service</li> <li>3. Reports and papers as well as several conference presentations</li> <li>4. Presentation at "Investing for Health" Conference</li> <li>5. Jan 04 Information Session by M Byrne to organisations expressing interest (7)</li> </ol>	<ol style="list-style-type: none"> <li>1. Local newspaper &amp; community network articles</li> <li>2. Feature in report on cross-border mental health promotion (Barry <i>et al</i>, 2002)</li> <li>3. Presentation "European Perspectives on Promoting Health &amp; Well-being"</li> <li>4. Reports to North Western Health Board, National Interest Group for Health Promoting Mental Health Services &amp; National Suicide Review Group</li> </ol>	<ol style="list-style-type: none"> <li>1. Presentation of project at 2<sup>nd</sup> World Conference on Mental Health (London).</li> <li>2. Re-launch of Rural Mental Health Project (60)</li> <li>3. Visit of Irish President Dr. Mary McAleese to the Rural Health Mind Matters Project</li> <li>4. Posters &amp; community newsletters of the project distributed (800)</li> <li>5. Quarterly newsletter "Healthy Times"</li> <li>6. Press Release on "PEACE" Conference</li> </ol>	<ol style="list-style-type: none"> <li>1. Press release on "Ploughing a New Furrow for a Better Tomorrow"</li> </ol>	

## **3.2 TARGET: THE UNEMPLOYED**

### **3.2.1 WNJ Local Launch**

At the local launch of the WNJ Programme in the community, there were information sessions for members of the general community and local organizations. This introduction included a short “taster session” which gave an insight into how the programme worked with a number of volunteers from the audience. All those present were very impressed with what they saw and thought that it would be very useful for people in the community who were looking for employment or new opportunities.

### **3.2.2 Programme Participants**

The training and employment agencies involved in the programme selected individuals to take part in the WNJ Programme as well a “comparison group” of unemployed people who would not avail of the WNJ training. Those in the comparison group agreed to fill out the same evaluation questionnaires as those in the intervention group in order to analyse what effects the WNJ programme may have on individuals.

The following selection criteria were agreed with the training agencies as to the suitability of candidates for participation in the study:

- Unemployed for at least six months
- Age ranging from 18 to 60 years of age
- Looking for a job, training or other similar opportunity
- Being “opportunity ready”: able to commence employment, voluntary work or training

### **3.2.3 Programme Implementation**

The WNJ Programme was implemented over 18 months through 24 workshops (12 in both Northern Ireland and the Republic of Ireland). Each workshop took place for five half-days over a one-week period. Each workshop involved about 12-16 participants. Two trainers (usually one male and one female) facilitated each workshop. The workshops were based in health board centres and centres of the training and employment agencies.

### **3.2.4 Data Collection**

Questionnaires exploring general health, past employment, economic hardship and attitudes to job seeking were administered to both the intervention and comparison groups

**Table 3.2: Number of Respondents at Each Stage of Data Collection**

<b>Questionnaire</b>	<b>Intervention Group</b>	<b>Control Group</b>
Time 1 (baseline)	218	198
Time 2 (end of training)	184	N/A
Time 3 (two weeks post-training)	127	123
Time 4 (four months post-training)	152	120
Time 5 (twelve months post-training)	23	-

Control group responses were obtained generally in person or on the telephone, as rates of return in the post were very low. Please see Appendix VII for more details regarding the methodology and data collection.

### **3.2.5 Preliminary Results**

Preliminary data analysis was performed using multiple regression analysis to determine the impact of the training on a number of outcomes. Several conclusions were drawn and Irish results were compared, where possible, to results of the equivalent “Työhön” programme in Finland.

#### ***Sociodemographic Results***

Respondents varied in age from 15 to 71 years; the average age was 34 years. Of the total sample, 238 (59.2%) were women and 162 (40.3%) were men. On their last job, the respondents worked an average of 36.9 hours per week. The average weekly salary of the participants in their last job was €290.00. At the time of recruitment, the average duration of unemployment was 4.2 years. Sixty-four percent of respondents were unemployed for 12 months or longer.

**Table 3.3: Sociodemographic and Employment Profile of the WNJ Participants at Baseline (T1)**

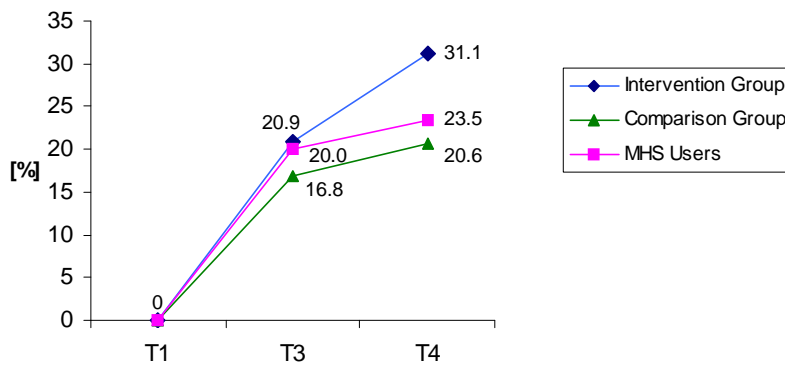
	<b>Mental Health Service Users (n=44)</b>	<b>Intervention Group (n=166)</b>	<b>Comparison Group (n=192)</b>
<b>Gender</b>			
Female	65.1%	70.5%	49.0%
Male	34.9%	29.5%	51.0%
<b>Average Age</b>	34.8 years min: 17 max: 71	34.3 years min: 15 max: 63	32.9 years min: 18 max: 60
<b>Marital Status</b>			
Married	35.0	26.1	28.6
Separated	2.5	7.9	4.9
Cohabiting	0	5.5	4.4
Divorced	2.5	3.6	3.3
Widowed	0	1.2	1.1
Single/ Never Married	60.0	55.8	57.7
<b>Socioeconomic Group</b>			
Professional	0.0	0.7	1.4
Managerial & Technical	9.1	14.6	13.7
Non-Manual	18.2	24.8	28.1
Skilled manual	27.3	27.0	18.0
Semi-skilled	45.5	25.5	36.7
Unskilled	0.0	1.5	2.2
Other / Not applicable	0	5.8	0
<b>Religion</b>			
Roman Catholic	75.0	80.8	82.4
Protestant Church of Ireland	15.0	10.9	5.1
Other	10.0	3.8	1.1
None	0	4.5	11.4
<b>Level of Education</b>			
No schooling / primary school only	5.1	8.0	6.1
Some secondary education	23.1	31.5	28.2
Complete secondary education	35.9	34.6	29.3
Some third level education	25.6	13.6	18.8
Completed third level education	10.3	12.3	17.7
<b>Avg length of time in previous job</b>	5.03 years	5.05 years	5.20 years
<b>Avg weekly wage rate in previous job</b>	€ 262.03	€ 257.04	€ 324.89
<b>Avg hours worked weekly in previous job</b>	36.69 hours	35.56 hours	37.97 hours
<b>Avg length of unemployment</b>	6.40 years min: 5 weeks max: 56 years	4.97 years min: 1 week max: 25 years	3.09 years min: 1 week max: 30 years
<b>Previously attended employment preparation or jobs training programmes</b>	36.8%	33.1%	35.4%
<b>Avg weekly take-home family income (current)</b>			
Less than €150 / £100	21.4	25.2	21.9
€150 - €300 / £100 - £200	31.0	29.5	36.0
€300 - €450 / £200 - £300	14.3	7.2	12.2
€450 - €600 / £300 - £400	7.1	9.4	9.8
€600 - €750 / £400 - £500	0.0	0.7	1.8
€750 - €900 / £500 - £600	2.4	1.4	1.2
€900 + / £600 +	0.0	1.4	0.6
Don't know / prefer not to answer	23.8	25.2	16.5

### *Participants' Feedback on the Workshops*

Questionnaire results from the end of the workshops (Time 2) demonstrated that participants felt an overall positive affinity for the programme, the trainers, and other group members. Overall, 77% of participants felt that the WNJ programme was very (“pretty much” or “a great deal”) beneficial. More than 75% of respondents felt positively about the trainers and the majority of participants felt positively towards the group as a whole. Finally, questions regarding how closely the workshops reflected the prescribed intervention, as per the JOBS manual, revealed a high level of programme adherence

### *Effects of the WNJ Programme on Re-employment*

**Figure 3.2 Employment Status over Time – WNJ Participants Employed**



*Note: T1= Time One (Baseline), T2= 2 weeks post-WNJ, T3=4 months post-WNJ*

As depicted in the figure above, at 4 months follow-up there is a trend of improved employment rates for the intervention group with 31% employed in comparison to 20.6% of the control group. The programme effect on re-employment is approaching significance level ( $\beta = -.151$ ,  $p < .10$ ). In the Finnish programme, the effects on re-employment were not in evidence at 6 months follow-up but were in evidence at 2 years follow-up (Vuori et al., 2002; Vuori et al. in press). It may, therefore, take a longer time period to see this effect in full evidence, but the initial findings are very encouraging.

### *Effects of the WNJ on Mental Health*

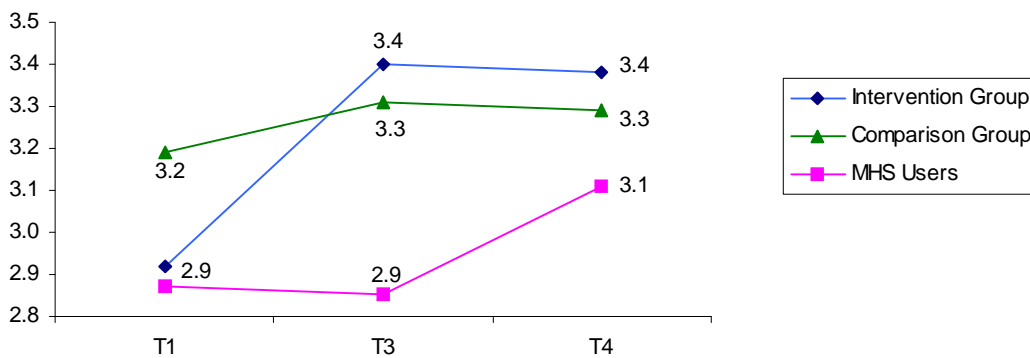
The impact of the WNJ training on depressive symptoms is approaching significance ( $p < .10$ ) at 4 months follow-up. Likewise, the Finnish programme did not report a significant

effect on depression at 6 months follow-up but the effect approached significance ( $p < .10$ ) at 2 years follow-up.

*Effects of the WNJ on Psychological Factors*

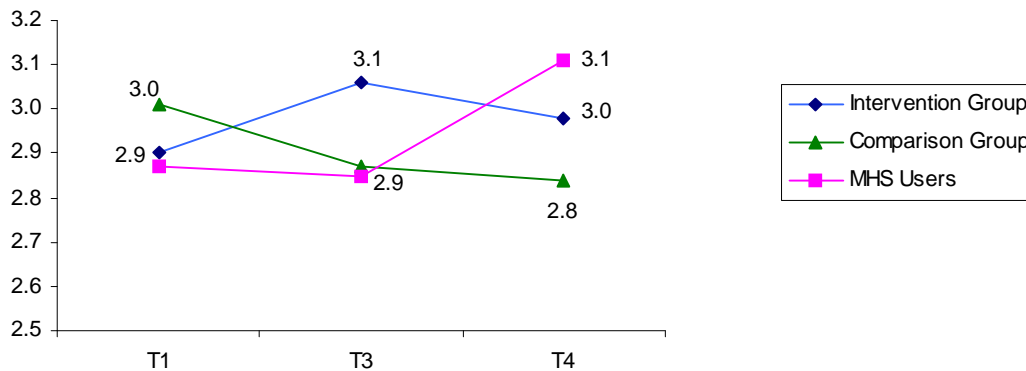
The WNJ training shows clear significant ( $\beta = -.183, p < .01$ ) effects on improving job seeking efficacy, i.e. people’s confidence in searching for a job. This result was evident in both the intervention group and the Mental Health Service Users (intervention) group:

**Figure 3.3: Job Seeking Efficacy Scale (1 low efficacy, 5 high efficacy)**



The WNJ Programme also had an effect which approached significance ( $\beta = -.163, p < .10$ ) on inoculation against set backs at 4 months follow-up. As per the figure below, the intervention group enjoyed higher inoculation against setbacks two weeks after the completion of the WNJ Programme, and the mental health service users achieved higher inoculation against setbacks four months after the programme ended. The comparison group did not experience an increase in inoculation over the same period.

**Figure 3.4: Inoculation Scale (1 low inoculation, 5 high inoculation against future difficulties)**



### *Conclusion*

In summary, the impact of the Winning New Jobs programme for the unemployed may vary depending on the social and cultural context in which it is implemented. It is, however, clear that the results of this initial pilot of the WNJ programme are positive and encouraging in an Irish context. The programme has had positive benefits in terms of improved confidence in job seeking skills, inoculation against setbacks and a trend towards improved mental health. The outcomes and impacts of the Irish programme are substantiated by the fact that they show many similar effects to those found in the Finnish Työhön Programme.

There were several differences between the Finnish Työhön programme and the Irish Winning New Jobs programme which must be noted. The sample size in the Finnish study (N= 1,261) was substantially larger than the sample in the Irish study (N= 402), mostly because the Finnish programme was rolled out nationally and the Irish programme was rolled-out in only one region. The sample also differed in that there was a random assignment to groups in Finnish study, while in Ireland the training agencies selected which participants would be in the intervention and control groups. The Finnish sample ranged in age from 18-61 years with a median age of 37; meanwhile, the Irish sample had an average age of 34 with a range from 15-71 years. There was a majority of women in both studies. In regards to the duration of unemployment, in the Finnish study the median duration was 5 months (M = 10.7, SD = 17.3) with 28% unemployed for 12 months or longer. In the Irish study, the average duration of unemployment was 4.2 years with 64% unemployed for 12 months or longer. Despite these differences, the findings from the Irish study at this stage compare well with those reported in the Finnish study at six months follow-up. Further analysis of data collected at 12 months follow-up will be used to draw additional conclusions on the long-term impact of the programme.

Most importantly, this research suggests that a 20-hour intervention can positively impact on both reemployment and mental health outcomes. It should also be noted that this programme has been successfully implemented with mental health service users, showing positive outcomes. Such encouraging outcomes support the call for a large-scale rollout of this programme nationally and longer-term follow-up with a larger sample.

### **3.2.6 Other Media and Publicity**

A number of diverse media activities and publicity ensured national and international awareness of the WNJ programme. For example, a poster presentation on the programme was made by Ms. Colette Reynolds, NUI, Galway at the European Health Promotion Conference entitled 'European Perspectives on Promoting Health and Well-being' in Galway in June 2004. Interest amongst those who attended proved to be keen and feedback was reported to the Joint Steering Group members. In addition, a report of the programme was sent to the North Western Health Board, the the National Interest Group for Health Promoting Mental Health Services, and the National Suicide Review Group (NSRG) in Galway.

## **3.3 TARGET: SCHOOLS / YOUTH**

### **3.3.1 The Schools "MindOut" Programme**

As detailed in Chapter Two, the MindOut Programme was implemented and extensively evaluated over the course of three academic years, from October 2001 through May 2004. Approximately 728 students took part in the intervention. A full report of the evaluation and findings from the 2001-2002 academic year is available in "Report on the Development and Evaluation of a Mental Health Promotion Programme for Post-Primary Schools" (Byrne *et al.*, 2003).

#### ***Programme Evaluation***

A detailed evaluation of the mental health module took place during the academic year 2001-2002. The evaluation research study employed a randomised controlled experimental design. A written questionnaire was administered to pupils at baseline, post-intervention, and at 12 months follow-up to assess the impact of the programme on pupils' awareness of mental health issues; attitudes towards mental health difficulties in others; behavioural intentions in a hypothetical situation; and their general mental well-being and coping skills. Comparisons were made between intervention groups receiving the MindOut programme and 1) control groups receiving a standard health education programme or 2) control groups receiving no health education programme.

Participatory evaluation workshops were carried out in St. Patrick's College, Maghera and Deele College, Raphoe in order to qualitatively supplement the data from the written questionnaires. These workshops involved young people as active partners in the research process, helping to ensure maximum participation and allowing increased insight into their views and experiences.

Teachers were asked to complete and return Recording Sheets after delivering each session in the module to document experiences of the programme. Each sheet asked for comments on the topic of the session; the suitability of the content to the time allotted; students' enjoyment, benefit and engagement; and the positive aspects or difficulties experienced in session. Teachers were also invited to attend half-day review sessions in Draperstown and Stranorlar following completion of the inaugural 10-session modules. These sessions gave teachers the opportunity to give qualitative feedback and to exchange experiences and ideas with other teachers.

Finally, a School Ethos questionnaire explored the promotion of positive mental health in each school as a whole, covering policies; ethos and environment; partnerships with families and community; availability of support staff; curriculum; and perceived barriers to mental health promotion and education.

### ***Results of the Mental Health Module in Schools***

#### **Impact on Knowledge, Attitudes and Skills**

In comparison to control students who had taken part in a standard health education programme, students who participated in the Mental Health Module:

- Were more confident about what to do if someone in their class was in distress e.g. talk to a teacher or another adult,
- Showed an increased awareness of a range of voluntary and statutory support services and organisations
- Demonstrated greater compassion towards others with mental health difficulties
- Felt they were more likely to engage in constructive help-seeking behaviour if they were in distress e.g. contacting an outside organisation for professional help

These results suggest that the Mental Health module can produce mental health benefits over and above programmes without an explicit focus on mental and emotional issues. No adverse effects were noted by teachers or students.

### Attitudes towards the Programme

Overall students and teachers expressed positive attitudes towards the programme. Teachers felt the materials were age-appropriate and user-friendly. Both students and teachers felt the programme was a good length and the balance of activity-based exercises with discussion activities was praised. Benefits to the teacher-pupil relationship were noted as well as overall benefits to students. Some statements from teachers include the following:

*I haven't a doubt at all in the world [that students gained].*

*They're not going to benefit from it now, not in the near future, but it's in the future when they're away from school, away from supports and all of that, that's when they're going to benefit, it's an investment that's going to pay off in the future.*

The majority of students enjoyed the programme and reported perceived gains in many areas, in particular the ability to cope with problems and emotions, and improved interpersonal relations. During the evaluation workshops, students gave their verdict on the programme to peers, stating that the programme was well-targeted at their age group and benefited both genders equally. Over three quarters of students in the workshops said the programme would make a difference to their lives outside the classroom.

### Booster Sessions

There was an overwhelmingly positive response to the three booster sessions amongst students who took part, with only 6.5% reporting that they did not find them useful. According to teachers reports, students' enjoyment, benefit and engagement, and overall ratings were high. When commenting on any difficulties in administering the booster sessions, most issues were practical (e.g. time) rather than content-related.

### Twelve-Month Follow-Up

Students who had participated in the original 10-session module were surveyed on their attitudes to the programme 12-months later. Overall, almost two-thirds of students rated the programme as very useful or quite useful; the figure for those who had recently taken the booster sessions was considerably higher at 85% finding the programme very useful or quite useful. As to what students believed they gained from the programme, responses were mostly positive and pertained to knowledge and awareness of mental health. None of those who had recently taken the three booster sessions reported that they had gained ‘nothing’ from taking the programme, and almost half said they found they were better able to cope with their problems or their emotions. Some comments from students are as follows:

*“I have learned to deal with various problems with the help of this programme.”*

*“I have learned more about the organisations available to help people in need.”*

### ***Training of Trainers***

To ensure sustainability of the delivery and extension of the Mental Health Module in Schools, training of trainers took place in June 2004. The training was provided by Ms. Mary Byrne of NUI Galway and Patricia Glass, a teacher involved in the programme from its inception. Those trained included three teachers from post-primary schools, Beth Gibb (Senior Health Promotion Officer, Homefirst) and Mary Duggan (Project Manager, Rural Health and Social Wellbeing Project). These five individuals are now able to train additional teachers to deliver the module.

### ***Mainstreaming of the Mental Health Module***

Between June and August 2004, 41 more teachers have been trained in the MindOut Programme in the Magherafelt area.

The North Eastern Education and Library Board (NEELB) and Investment for Health Partnership in Northern Ireland have become involved in mainstreaming of the Mental Health Module. In February 2005, 50 teachers from 50 schools in the NELB area will be trained by Beth Gibb and Mary Duggan. This extends the programme delivery beyond the initial project area in Northern Ireland. In addition, Lisburn and Down Trust have taken up the MindOut programme and are currently piloting the module in 5 post-primary schools.

In the Republic of Ireland, the North West Health Board funded a reprint of the module materials and training was extended to all teachers from the 27 post-primary schools in this region. The National Council for Curriculum and Assessment also has endorsed Mind Out as a suitable resource for the new Social, Personal and Health Education (SPHE) curriculum for 15 to 18 year olds. A project is underway to produce and disseminate a MindOut pack, which will help regional health authorities in Ireland to make the programme available to schools in their regions.

### **3.3.2. Cross-Border Schools Drama Workshop**

On the 15<sup>th</sup> of May 2003, a cross-border schools drama workshop was held in Draperstown and was facilitated by Ms. Gillian Kennedy from the Verbal Arts Centre, Derry/Londonderry. The workshop involved students working together in small groups to develop a script for performance and discussion based teen pregnancy, drugs, joyriding, and exam pressure.

Forty-two students attended the workshop: 18 from St. Columba’s College, Stranorlar and 24 from St. Colm’s High School, Draperstown. Both groups had recently completed the Mental Health Module in school. Table 9 below illustrates the age and gender distribution of the group, showing that the Donegal group were slightly older and had a greater proportion of female students than the Derry/Londonderry school.

**Table 3.4: Age and gender of students in Cross-Border Schools Drama Workshop**

	Mean Age (SD)	Gender	
		Male	Female
<b>All (n=42)</b>	16.0 (0.8)	34.1%	65.9%
<b>Derry (n=24)</b>	15.5 (0.3)	43.5%	56.5%
<b>Donegal (n=18)</b>	16.7 (0.6)	22.2%	77.8%

#### ***Pre-Workshop Questionnaire***

Before the workshop began, students were asked what expectations they had about the day. Specifically, they were asked to choose from a list of words which described how they were feeling about spending the day with people their own age from across the border. More than 60% indicated that they were “happy” or “interested” and more than 45%

indicated that they were “excited”; none reported that they were angry or sad and only 9.5% reported they were afraid.

### ***Post-Workshop Questionnaire***

Students completed a second questionnaire at the end of the workshop, and reaction was extremely positive. On a scale from 1(terrible) to 5 (brilliant), 97.6% of students gave the day an overall rating of 4 or 5.

When asked what they thought the overall message of the day had been, responses fell into three main categories:

1. Support is always available, e.g. *“there is always someone to talk to in moments of distress”*
2. Meeting and working with others e.g. *“that you can get on with people no matter who they are, or where they are from”*
3. Ways of coping, e.g. *“how to cope with different experiences we encounter”*

Over 90% of students felt that:

- They had learned “something new” or “a lot new” from the workshop.
- The workshop helped them to have a better understanding of people from across the border: *““I have learned to meet and enjoy my time with new people across the border”*.
- The workshop allowed them to explore topics which are important and relevant to young people

89 % felt that they day had ‘brought out the best in them’ and 79% felt the workshop helped them to have a better understanding of mental health issues.

### **3.3.3 Mental Health Open Days and Health Fairs**

The Rural Mental Health Project participated in Mental Health Open Days and Health Fairs at local schools and a family resource centre. Information stands were provided by different statutory agencies, voluntary and community groups including the project (see Appendix XII). The aims of these days were to:

- provide information about mental health for pupils, teachers and parents
- publicise the project
- assess the attitudes, perceptions and needs of the school children

### *Children*

Workshops for school children were held throughout the day covering topics such as anger management, managing stress, friendships and meeting the services. Facilitators also integrated a number of key messages through all workshops, such as alcohol abuse. Drama productions portrayed key issues to school children; for example, the Balor Theatre Company provided drama concerning the topic of bullying.

A brief needs assessment was conducted with the school children, in which they were asked what would improve their well-being. Responses included the following:

- less stress / pressure
- lots of friends to talk to
- being closer to friends and family
- not using alcohol or drugs to solve problems
- more confidence / being more open
- more coping skills
- physical activity.

Eighty-three children participated in colour association tasks in order to elicit their attitudes and perceptions towards various issues including alcohol, depression, drugs, exams, family, friends, school, etc. Some of the results were as follows:

- The colour black was most associated with alcohol, depression, drugs, exams, school and worries.
- The colour red was most associated with family, friends, love and relationships.
- More “neutral” colours of yellow, blue and white were less frequently mentioned with the above words.

### ***Teachers***

Several activities were targeted at teachers, including workshops on 'Time out for Me', health checks and supervising students. Teachers were also encouraged to attend the mental health services workshop to meet the local service providers.

### ***Parents***

At night, there were sessions for parents so that they might provide feedback on the Mental Health Open Day, discuss what is happening in the school regarding mental health, and hear from guests speakers on such topics as 'Parenting for Mental Health'. Parents also received leaflets entitled "MindOut: Positive Mental Health in School and at Home".

### ***Outcome of Mental Health Open Days***

The days were very well received by the pupils and teachers with parents attending in the evening. Some of the key achievements included:

- Increased awareness of mental health issues and mental health services.
- Dissemination of information on mental health services available; who provides what and how to access them
- Reduced fear of accessing the services by making personal contact with service providers - 'Putting faces to names'
- Generated interest in involvement in voluntary or community based services

### **3.3.4 Other Media and Publicity**

A number of diverse media activities and publicity ensured an awareness of the interventions targeting youth, as outlined above.

Four members of the Joint Steering Group Committee attended the Second World Conference on Mental Health entitled 'The Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders' in London on the 11<sup>th</sup>-13<sup>th</sup> September 2002.

Information on the Cross-Border project and the associated oral presentation were made by Dr Margaret Barry, Anne Sheridan, and Therese Lowry. A poster presentation on the Schools Programme was made by Ms. Mary Byrne NUI, Galway. Interest amongst those who attended proved to be keen and feedback was reported to the Joint Steering Group members.

In January 2004, Mary Byrne and Patricia Glass held a one-hour information session for Northern Ireland agencies interested in the “MindOut” schools project. It was attended by representatives from the Health Development Down & Lisburn Trust, Eastern Board Investment for Health, Health Promoting Schools, the Western Board Health Promotion Department (Derry Area), the North Eastern Education and Library Board (NEELB) and the Welfare Department. This was followed shortly after by meeting involving representatives from the NEELB, Homefirst Health Promotion, Investing for Health, Child & Adolescent Mental Health Service, some teachers from local secondary schools, and Health Promotion Commissioner. It was at this second meeting that finances were acquired with which to further develop and mainstream the MindOut programme in Northern Ireland through the NEELB.

The Mind Out project was one of six case studies from around the world that was selected for a commendation from the World Health Organisation and the World Federation for Mental Health. The award was given in September, 2004 to Mary Byrne and Margaret Barry of Health Promotion Department, NUI, Galway and Anne Sheridan of the Health Promotion Service, North Western Health Board for work in developing and evaluating the Mind Out schools-based mental health promotion programme.

### **3.4 TARGET: FARMING FAMILIES**

#### **3.4.1 Farming Family Bureau**

Funding was secured to develop a Farming Family Bureau for the Magherafelt District Council area. The Bureau was established through an obvious need within the farming community due to high stress levels, CAP reform, and several other issues. The bureau is lead by a co-ordinator who acts as a channel between the farming community and various support organisations. Administrative support is also available. This was advertised through a mail-shot that was distributed to farming families in the area.

### **3.4.2 Information Sessions for Farming Families**

Information sessions for farming families were held at local venues on both sides of the border. The aims of the information sessions were to:

- Provide information about the Rural Mental Health Project
- Provide information about general health particularly mental health
- Provide information about subsidies and funding for farmers
- Discuss problems for farming families in the past, current problems, the future for farming families, and necessary support services.

Each participant was provided with an information folder containing the 'Concerned about Suicide' leaflet and information about the project, particularly focusing on cross-border elements.

The participants discussed a range of issues facing farmers today. Major problems faced in the last 3-5 years and everyday included: loss of income; health problems; depression; loneliness; strict regulations; no sources of support; and no holidays, as farming is a 24-hour responsibility. The majority of farmers agreed that the future of farming was not very positive due to an increased trend towards a small number of large firms, a necessity to find work off the farm, and too much paperwork. Sources of support which the participants would like to see put in place include: financial support, business education and training; a mobile advisory service; meetings to reduce isolation; newsletters and sources of information; and relief work to provide a break for farmers.

Evaluation was conducted at these sessions, with a total of 104 participants completing questionnaires. The majority of the 104 participants surveyed were male, ranged in age from 18 to over 61 years, and had a Roman Catholic background though Church of Ireland, Presbyterian and other religions were also represented.

The following results were reported:

- The majority of the participants had heard about the project previously and a number had attended courses offered by the project before.

- The participants thought that the project could provide: education, support, advice, a listening service; help to “cut the red tape involved in farming”, and “some action (which) would impact and leave a lasting legacy for real help for the isolated”.
- Over half the participants stated that they felt more confident about making decisions regarding funding after the session.
- The most useful parts of the programme included: health checks, information on funding particularly grants, subsidies and CAP reforms. In addition information on the local project with its emphasis on rural development as well as the setting up of the local Bureau for information was found to be very helpful.

### **3.4.3 Information Sessions and Health Checks at Farming Marts**

Information sessions and health checks for cholesterol and blood pressure were provided to farmers at local farming marts in Stranorlar and Ballybofey. Leaflets entitled ‘Survive and Thrive on the Farm’ were distributed to disseminate information on stress, causes of stress, and what can be done to tackle stress with particular emphasis on sources of support. Information regarding the Rural Mental Health Project was also provided along with leaflets concerning the local project.

Eighty farmers in total filled out questionnaires. The majority of respondents were male, with age ranging from 18 to over 61, and came from Raphoe and the surrounding area.

The following results were reported:

The majority of respondents learned something new from the session; most said that the ‘Stress leaflet’ and health checks were useful. Asked if they believed other farmers would benefit from attending sessions like this most said they would. From their experience, they were asked the three greatest causes of stress in their lives. Similar to the responses at the information sessions for farming families, their replies included: farming work and associated paperwork; depression and worry; ill-health; money; family issues such as elderly parents; pressure; and social isolation.

In addition the farmers were asked ways to improve their health and well being. Replies included: less stress; more money and cheaper cost of living; better weather; more time to do things besides farming and less paperwork; and improved lifestyle including better eating habits and less alcohol.

#### **3.4.4 Cross-border Farming Families Conference**

Over 100 members of the farming community attended a Cross-border Farming Families Conference in Derry/Londonderry entitled 'Ploughing the New Furrow for a Better Tomorrow' on the morning of the 3rd April 2004. The conference provided an opportunity for farmers and their families to come together from both sides of the border to discuss health and wellbeing issues facing the contemporary farming community. This conference was organised by the Rural Health and Social Well-being Project in Magherafelt and the Rural Health Mind Matters Project in Raphoe after consultation with the various groups. These included the Ulster Farmers Union, the Irish Farmers Association, The North Western Health Board, the Homefirst Community Trust, Teagasc, Farming Families Bureau, the Department of Agriculture and Rural Development (DARD), Rural Support Network, Rural Connect- DARD , ICA, Camowen Partnership, rural Community Network, Partnership Companies and the Farming Community. Photos from the event are available in Appendix XIV.

The conference was jointly chaired by Mr John Gilliland, President of the Farmers Union and Chairman of Rural Support and Mr. Keith Roulston, Donegal County Chairman of the Irish Farmers Association. Information packs were distributed to each participant and included the leaflet on the Rural Mental Health Project as well as the leaflet entitled 'Survive and Thrive on the Farm'.

Presentations included information on the cross-border project, diversification and adapting to change, women and youth involved in farming, and general practitioners in the farming community. Discussion groups were also held to facilitate cross-border networking and dialogue. Please see Appendix XV for details of the presentations and activities at the conference

#### ***Evaluation measures***

A pre- and post-evaluation instrument was designed for the conference (see Appendix XVI). This short questionnaire consisted of seven questions to be completed before the session and nine questions to be completed afterwards. Questions were based on objectives supplied by the conference organisers and those presenting at the conference. The

questionnaire included questions on demographics, conference expectations, the usefulness of various elements of the conference, perception of the key message of the conference, and suggestions for future similar events.

Over 100 people in total attended the conference and 42 filled in both the pre and post evaluation questionnaires. The following table summarises the socio-demographic characteristics of the questionnaire respondents. The majority of the respondents at the conference were married, had attended some or all secondary school, and were from a Protestant background. The average farm size was 75.4 acres with a range of 20-200 acres.

**Table 3.5: Socio-Demographic characteristics of those attending the conference**

	# of Respondents	% of Respondents
<b>Age range</b>		
18-30	3	7 %
31-40	8	19 %
41-50	8	19 %
51-60	15	36 %
61-70	8	19 %
<b>Marital status</b>		
Single	7	17 %
Married	33	79 %
Widowed	2	5 %
<b>Level of Education</b>		
Primary	3	7 %
Some or complete secondary	29	69 %
Some or complete third level	10	24 %
<b>Religious affiliation</b>		
Catholic background	15	36 %
Protestant background	27	64 %

***Findings of the conference***

Prior to the conference, respondents were asked about their expectations. Responses including finding out about farmers’ health, stress and ways of improving their situation as well as highlighting the problems cross-border families face, sharing experiences and generating ideas, and finding out about the Rural Mental Health Project and its activities.

The second open-ended question asked the respondents what they would most like to achieve from the conference. The most common response was information and knowledge (55%), with the vast majority of respondents hoping for information in general regarding

future issues affecting farming families and possible solutions. A few respondents were looking for more specific information, for example, regarding diversification and the Rural Mental Health Project and mental health issues.

At the end of the conference, participants were asked which one of the four discussion groups they attended. The results of those responding as follows:

- 35% attended ‘Adapting to change’
- 30% attended ‘Stresses within farming’.
- 19% attended ‘Future for young people in farming’
- 16% attended ‘Women and agriculture’

As per the table below, almost all of the respondents found that, on a scale of very useful to very useless, each element of the conference was useful or very useful.

**Table 3.6: Percentages of attendees who rated elements of the Conference as “Useful” or “Very Useful”**

<b>Elements of the conference:</b>	<b>Useful or very useful</b>
The discussion group	100 %
The drama piece	97 %
The various talks	100 %
The conference overall in providing people with useful information	100 %
The conference overall in bringing farming families together from both sides of the border	100 %

In an open-ended question the respondents were asked what they thought the key message of the conference was. The majority of replies involved the many difficulties farmers face, the need to adapt and change and the necessity of making help available to farmers (38%). The need for co-operation on a cross-border level and its benefits was also mentioned. Five respondents noted the importance of looking after one’s health and well-being, in particular one’s mental health. Overall, as one respondent said, the key message was “positive” despite the many problems farmers have to deal with.

Respondents were asked for their suggestions for future events. Some respondents suggested that more people could get involved as well as the possibility of advertising it more widely. Others said that there could be a more substantial conference, more time for the speakers and discussion groups and “more time to discuss the way forward from here”.

Suggestions were made regarding having it at a different time to facilitate more people, maybe during autumn or at night. Yet, the majority of respondents had no suggestions to make (36%).

Finally, additional comments were very positive including “thoroughly enjoyable and informative time”; “excellent conference” and “good work, well done”.

### **3.5 TARGET: WOMEN**

#### **3.5.1 Cross-Border Women’s’ Residentials**

Cross-Border Women’s’ Residentials took place in November 2003, February 2004 and September 2004. Approximately seventy five participants were in attendance. These Residentials were the stepping stone for a myriad of subsequent developments including:

- A presentation of a drama piece at the PEACE Conference
- The planning of a 2-day cross-border networking event entitled “Celebration of Wellbeing and Togetherness” (see section 3.5.3)
- The achievement of external funding to finance future activities as a standalone and sustainable venture outside of the Rural Mental Health Project.

In order to evaluate the Residentials, participants were asked to explain aspects of the residential they enjoyed as well as the reasons why they will engage in cross-border work in the future.

For the two statements, participants’ answers can be categorised under the following themes:

- Networking.
  - “*I made lots of new contacts*” - echoed by the vast majority of women.
- Exchange of information and working collectively.
  - Learning more about other women’s groups, other communities, sharing problems and solutions.
- Participants acknowledged how vital this work is for the women individually and collectively as groups

- *“Some of the stories the women told showed how important women’s groups are for the health and well being of their members”.*
- Cross-border element
  - *“It is lovely to have a great connection with women who live in the same island and without this Cross Border project it would never have happened. We are no longer separated by fear of who each other are”*
- Underlying focus on building peace and reconciliation
  - *“Peace comes with networking”*

### **3.5.2 Computer Course for Parents of the Toddler Group**

Computer training took place in Draperstown for parents of a local toddler group. Despite the small turnout of five participants, the course was very successful based on the results of the pre-evaluation and post evaluation that was undertaken.

All participants were female, most were aged 26- 45 years, all were married or living with a partner and had completed some or all of secondary education while the majority had a Catholic background.

Nearly half of the respondents hoped to have improved ability to use computers for leisure purposes and 20% hoped to have an increased chance of gaining employment outside the farming sector. The majority agreed that it is important for farmers to have computing skills.

After the training, all participants

- strongly agreed or agreed that they enjoyed attending the computers course
- said that they felt more confident in their computing skills
- believed other people would benefit from attending courses like this one.

### **3.5.3 Cross-Border Women’s Networking Event**

A Cross-Border Women’s Networking Event entitled ‘Celebration of Wellbeing and Togetherness’ was held on the 9th and 10th March of 2004 at the Rural College, Draperstown. Women from local women’s groups in Donegal and Londonderry/Derry

were invited to this two day event. In total 24 groups were represented (list available in Appendix XVII). The core committee of women who had been involved in cross-border work were invited for the overall event and additional women were invited from the Mid-Ulster Women's network to attend the evening event.

The event began with a light lunch, followed by a session on stress management facilitated by Ms. Marie Heffron, Senior Occupational Therapist with the Community Mental Health Team, Homefirst. The aim was to increase participants' awareness of stress by exploring sources and signs of stress, coping mechanisms, and to learn a relaxing breathing exercise.

To start the evening there were a number of speakers from the Rural College, the Rural Health and Social Wellbeing Project, the Rural Health Mind Matters Project, the Mid Ulster Women's Network, and the Cookstown and Magherafelt Volunteer Bureau.

Following this, participants were divided into two groups and they went to two rooms to partake in a session entitled 'Sharing the Learning'. Two separate sessions were facilitated by Ms. Mary Duggan and Ms. Claire Henry; as well as Ms. Elaine Devlin and Ms. Inga Bock. The purpose of these sessions was to increase participants' awareness of other women's groups and their work and to provide information and background on each woman's group.

The next morning, the main event was a session on networking facilitated by Ms. Kate Clifford, Training and Education Co-ordinator with the Rural College, Draperstown. The purpose of this session was to increase participants' awareness of networking by exploring ways of working together, reviewing accomplishments to date, and planning future activities over the next 6-9 months through the development of action plans. A number of action plans were devised and individuals were identified who would take responsibility for certain areas (for example, please see Appendix XVIII).

### ***Evaluation measures***

A pre- and post-evaluation instrument was designed for the event (see Appendix XIX). This was a short questionnaire consisting of seven questions to be completed before the session and eight questions to be completed afterwards. A researcher distributed the

questionnaires. Questions were based on objectives supplied by the event organisers and the group facilitators.

A total of 41 women attended the evening and the overall event (16 for the overall event and 25 for the evening). Of these, 28 filled in evaluation questionnaires (11 for the overall event and 17 for the evening).

A summary of the socio-demographic characteristics of the women who attended the two day event and the evening part of the event are available in Appendix XX. Generally, the respondents from the overall event were married and the majority had attended some or completed secondary school and were from a Catholic background. Respondents for the evening were similar, except the majority had attended some or completed third level education and stated their occupation as housewives.

### ***Findings of the overall event and evening event***

Prior to the commencement of the event, respondents were asked about their expectations. . Overall the women had very positive expectations. The majority of respondents were hoping to get to meet new people and they wanted to network to share and learn from these experiences and to join together to help each other - *'find out how other groups tick'*. Several women at the evening event mentioned relaxation and enjoying the night. One woman brought up cross-border reconciliation - *'to bring peace, harmony and more understanding amongst the divides and to understand other cultures and faiths that presently live in Northern Ireland'*.

The second open-ended question asked the respondents what they would most like to achieve from the event. The most common response was sharing knowledge, networking, and understanding networking. Several mentioned they wished to achieve future dialogue, and follow-up this evening with more contacts - said *'meeting up at a later date'*. Social interactions, as well as making friends, releasing stress and gaining confidence were also mentioned.

At the end of the event, women were asked to rate how useful they found several elements of the sessions, on a scale from very useful to very useless. The vast majority found each element to be useful or very useful:

**Table 3.7: Percentages of attendees who gave ratings for the Cross Border Women’s Event (overall event and the evening part of the event)**

	<b>The overall event</b>	<b>The evening event</b>
	<b>Useful &amp; very useful</b>	<b>Useful &amp; very useful</b>
Ratings of the usefulness of :		
The stress management session	91 %	n/a
The networking session	82 %	n/a
The event in providing helpful knowledge	100 %	82 %
The event in bringing women together from both sides of the border	91 %	71 %

Respondents were asked what they thought the key message of the event was. The responses can be grouped as follows

- Women working together – *“we can work cross-border, cross-community”*
- Coming together as a way of improving women’s situations – *“women from many different groups coming together and letting our voices be heard”*
- Empowerment, being independent and taking control
- Communication in the sense of listening, talking and sharing
- Forming friendships and supporting each other
- Social health and wellbeing
- Showing there is a place for women outside of the home

Respondents were then asked what they found most useful about the event overall.

- Bringing women together to share experiences and network as well as socialising, making friends and chatting in between the sessions
- Getting information and new ideas - *‘food for thought’*
- Getting to know others
- The relaxing atmosphere - *‘this helped me learn to take time for me’*.

Respondents were also asked for their suggestions for future events. Most women had no suggestions to make as one woman said the *‘venue was excellent, food was great and the company was marvellous’*. “More time” was the suggestion that was mentioned most frequently, particularly more time for *‘just chatting and to open up about ourselves’* Some suggested some pampering session or beauty demonstration.

Finally the additional general comments were very positive ranging from ‘*we had a really great time*’, ‘*everything was fantastic*’ to ‘*everyone seemed to enjoy themselves*’ and ‘*keep up the good work*’. The facilitators were specifically mentioned by one respondent as being excellent, another mentioned the venue as being lovely and another said the crafts were great. One respondent suggested that International Women’s Day should be celebrated in the local area annually.

For more details of the feedback of the event, including benefits of cross-border women’s residential work, please see Appendix XXI.

#### **3.5.4 Cross-Border Women’s Peace Quilt**

One of the projects included in the action plan developed at the Networking Event ‘Celebration of Wellbeing and Togetherness’ was the fabrication of a Peace Quilt. Quilt panels were made by women in each of the participating organisations and ultimately stitched together as a symbolic representation of peace, reconciliation, and the networking of women to achieve mutual goals. This quilt is jointly owned by all of the participating women’s organisations, and it is showcased at a range of meetings, exhibitions, and conferences. A photo of this quilt is available in Appendix XI.

### **3.6 TARGET: GENERAL COMMUNITY**

#### **3.6.1 Re-launch of the Rural Mental Health Project**

The re-launch of the Cross-Border Rural Mental Health Project Phase 2 took place on World Mental Health Day on the 10<sup>th</sup> of October 2002 in the Nerve Centre in Derry/Londonderry. Approximately 50 invited guests from the statutory, voluntary and community sectors attended. Presentations were made concerning the “Legacy of Conflict” and the Rural Mental Health Project by the following:

- Dr. Marian Gibson, keynote guest speaker who addressed the ‘Legacy of Conflict’.
- Dr. Margaret Barry, Director of the Centre for Health Promotion Studies, NUI, Galway

- Ms. Therese Lowry, Project Manager in Draperstown
- Ms. Inga Bock, Project Manager in Raphoe
- Ms. Kate Clifford, representative of Oakleaf Network and member of the Cross-Border Joint Steering Committee.

### **3.6.2 Cross-Border ASIST Programme**

On the 22<sup>nd</sup> and 23<sup>rd</sup> of June 2004, a Cross-border ASIST (Applied Suicide Intervention Skills Training) programme was held at the Verbal Arts Centre in Derry. 23 participants attended this event, 12 from the North and 11 from the South.

The ASIST programme is a practical and well-recognised training course in suicide intervention skills. The aim of the programme is to equip participants with practical skills and to raise awareness of the issues around suicide. The two-day events was intense, as participants explored sensitive issues, and it was clear from the two days that suicide had touched almost all of the participants in some way. The training has been compared to that of life-saving techniques such as CPR or first aid. The facilitators used a step-by-step model of how to help a person on the verge of suicide or experiencing suicidal thoughts.

Following the training programme, a postal evaluation was distributed to all attendees and returned by twelve participants. The overall response was very positive, with comments including the following:

- *“Very beneficial, showed how important really listening to someone is and that nothing is hopeless”*
- *“Absolutely brilliant.”*
- *“Given me an insight into suicide and that anyone can be affected at anytime and that we can easily overlook a cry for help”*

Others felt that the two-day session was not long enough, and some mentioned they would like a follow-up session at a later date.

### **3.6.3 Creation of Finn Valley Alliance for Positive Mental Health**

In October 2002, the positive mental health is a forum Finn Valley Alliance was established through the Rural Mental Health Project in response to a meeting of individuals

from Raphoe, Ballybofey and Stranolar who were concerned about the level of suicides locally. A collection of schools and youth groups as well as local voluntary, statutory and charitable organisations, this cross-community Alliance meets monthly to plan interventions to address suicide. Sub-groups have been established to deal with more specific issues such as researching available services, lobbying, working with families and youth.

The Alliance has been instrumental in producing leaflets and posters, and in 2004 they ran a 6-week pilot programme on suicide awareness. The pilot programme was attended by 15 individuals, and received positive feedback indicating its success. The course will be rolled-out again in early 2005, specifically targeting men.

#### **3.6.4 “Walking for Health”**

On the 28<sup>th</sup> of July 2003, an event “Walking for Health” was organised by the Mind Matters Organisation in Raphoe in response to a local request earlier in the year at an Irish Heart Foundation workshop. A programme was developed based on examples from Sli na Slainte workshops. 17 local individuals who expressed interest in joining the walking group, comprised of 15 women and 2 men, attended planning sessions to order to determine appropriate routes, lobbying the town council for better footpaths and lighting, and one main group walking event. The attendees responded positively to the event, and details of the walk were highlighted in the local press. While there has been no further planning or events, the group may be re-established in the future on a more permanent basis.

#### **3.6.5 “Fathers Matters”**

In May 2004, the Rural Mental Health Project organised an information session in Derry/Londonderry on “Fathers Matters”, a programme supporting male parents. This session was conducted by David Simpson, Men’s Health Development Officer with the North Western Health Board, and was attended by representatives from 24 interested organisations. The information session was very successful in raising awareness of the programme, and a local Sure Start branch decided to take up the “Fathers Matters” programme and manage it on a longer-term basis in the area.

### **3.6.6 Cross-border Rural Mental Health Project Conference “P.E.A.C.E”**

On the 21st October 2004 there was a Cross-border Rural Mental Health Project Conference entitled ‘P.E.A.C.E –Partnerships, Equity And Community Empowerment’ as a showcase for the work and progress of the Cross-border Rural Mental Health Project.

Speakers included the following:

- Mr. Paul Skinnader, ADM /CPA
- Dr. Shelagh Sheerin, the Northern Board Trauma Advisory Panel
- Dr. Margaret Barry, NUI, Galway

Other presentations were made in regards to the Mental Health Module in Schools, achievements of the Cross Border’s Women Forum, the introduction and implementation of the Winning New Jobs Programme to Ireland, and the establishment of the Farmers Forum. A total of 80 delegates attended the PEACE conference. Photos from this event are available in Appendix XIII.

### **3.6.7 Other Media and Publicity**

A number of diverse media activities and publicity ensured an awareness of the Project and its interventions at local, national, and international levels. All project activities were advertised in the local media through posters, project leaflets, community newsletters, radio and the local newspapers (for an example of a press release, please see Appendix VIII). The project also promoted the services of other agencies particularly those providing sources of support. Examples of publicity included the following:

- A quarterly newsletter entitled ‘Healthy Times’ was distributed via mental health services and other community support organisations.
- A Cross-Border project brochure
- Rural Health Mind Matters Project Leaflet

#### ***Visit by the Irish President***

The Irish President Dr. M. McAleese officially opened the “Volt House” of the Rural Health Mind Matters Project: the Volt House in Raphoe. An information stand was on display for the visit, highlighting achievements of the project.

### ***Publication in Journals***

There have been several published papers, reports and conference presentations regarding the Rural Mental Health Project which contribute to the international dissemination of the research. These are as follows:

#### Published Papers

Barry, M.M. (2003) Designing an evaluation framework for community mental health promotion. Journal of Mental Health Promotion, 2(4), 26-36.

Barry, M.M., Doherty, A., Hope, A., Sixsmith, J. and Kelleher, C.C. (2000) A community needs assessment for rural mental health promotion. Health Education Research, Vol. 15 (3), 293-304.

Barry, M.M., O'Doherty, E. and Doherty, A. (1999) Mental health promotion in a rural context: Research and realities from a community-based initiative in Northern Ireland. International Journal of Mental Health Promotion, Vol. 1 , 9-14.

Byrne, M., Barry, M.M. and Sheridan, A. (2004). Implementation of a school-based mental health promotion programme in Ireland. International Journal of Mental Health Promotion, 6(1), 17-25.

Byrne, M., Barry, M.M. and Sheridan, A. (2004) Mind Out: The development and evaluation of a mental health promotion programme for post-primary schools in Ireland. In Mental Health Promotion: Case Studies from Countries. (Eds.) Saxena, S. and Garrison, P.J. pages 50-53. World Federation for Mental Health and the World Health Organization.

Byrne, M., Barry, M.M., NicGabhainn, S. & Newell, J. The Development and Evaluation of a Mental Health Promotion Programme for Post-Primary Schools in Ireland. In Jensen, B.B. & Clift, S. (eds) The Health Promoting School: International Advances in Theory, Evaluation and Practice, jointly published by Canterbury Christ Church University College and the Danish University of Education (in press).

#### Reports

Barry, M.M., Friel, S., Dempsey, C. and Avalos, G. (June 2002) Promoting Mental Health and Social Well-being: Cross Border Opportunities and Challenges: The Centre for Cross Border Studies, Armagh. (case study on Rural Mental Health Project included)

Byrne, M. and Barry, M.M. (March, 2000) Rural Health and Social Wellbeing Project: Report on the Planning and Consultation Stage. Centre for Health Promotion Studies, National University of Ireland, Galway.

Byrne, M. and Barry, M.M. (April, 2000) 'Mind Matters': Report on the Planning and Implementation Phase of a Community-Based Mental Health Promotion Project. Centre for Health Promotion Studies, National University of Ireland, Galway.

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## **CHAPTER 4                    ASSESSING WIDER COMMUNITY IMPACTS OF THE RMHP**

### **4.1 INTRODUCTION: *COMMUNITY RE-SURVEY***

In order to assess the impact of the project on the wider community, a repeat administration of the original community needs assessment survey (carried out in 1997/8) was undertaken in the Summer of 2003 in both project communities and in a reference community of similar size in Co. Galway. The reference community served as a control since it was not exposed to project intervention activity however, it was included in the original baseline and follow-up survey. The interviewer-administered questionnaire repeats the original survey questions, and consists of a series of Likert-type attitude scales addressing:

- Levels of awareness and knowledge concerning depression and suicide
- Current practices and attitudes in dealing with mental health problems
- Perceived barriers and benefits of service take-up
- Perceived confidence in dealing with mental health problems
- Awareness of project activity
- Perceptions of the local community and attitudes to cross-border co-operation
- Civic engagement, participation, perceived trust and social support
- Socio-demographic profile

This cross-sectional re-survey of the communities entailed interviewing approximately 250 adults, stratified according to age and sex, in each community. The re-survey was undertaken over the Summer, 2003 and the results sought to determine whether the project objectives, in terms of its community-wide effects, are being reached and also to update on community perceptions since the original baseline surveys. Interviews with key players and participants in the project were also undertaken in order to establish their views on the extent to which the project objectives have been achieved and the degree to which the project strategies and the cross-border model of working have been integrated in a sustainable manner.

Specific results of the 2003 Re-Survey are available in Appendix XXII.

### **4.1.1 Sample of Participants**

#### *Sample Selection*

The participants in this community survey were living in the rural communities surrounding Draperstown, Co. Derry / Londonderry and Raphoe, Co. Donegal. In addition a third community in Galway was selected to act as a reference area or control. Within each community, houses were selected by calling to every second house in the village and every house in the open countryside. The starting point in each community was the cross-roads at the centre of the town/ village. Up to two members of each household were deemed eligible to complete each questionnaire, although only one did so in the majority of cases. Anyone over the age of 15 was eligible to complete the questionnaire.

#### *Response Rates*

Response rates for the survey were high, with low levels of refusals. When unoccupied houses were excluded and houses from which there was no reply, the refusal rate was calculated at 14.7%. This resulted in a response rate of 85.3%

#### *Sample Characteristics*

Sample characteristics were analysed according to location (Draperstown, Raphoe or Galway), gender, age, level of education and social class. Ideally, the sample frame should have consisted of an equal male / female ratio; unfortunately this was not quite attained. Age was divided into two categories: under or over 40. Education was classified by the highest level of schooling attended and was divided into three categories: primary, secondary (some or complete) and third level (some or complete). For the purposes of analysis, job title was used to summarise social class which was classified on the basis of the Provisional Irish Social Class Scale – Classification of Occupations (1998).

Information on farming was also collected including whether the participant (or the main wage earner in the household) was involved in farming and whether this was in a full-time or part-time capacity. These variables were placed under the same classifications as in the baseline needs assessment stage of the project. Using the same classification allowed for comparison of the data with baseline findings. The following table contains the socio-demographic profile of the participants in the study for the three communities respectively.

**Table 4.1: Socio-demographic profile of participants in Draperstown, Galway and Raphoe at Time 1 and Time 2, % in brackets (excludes missing data)**

Demographic variable		Draperstown		Galway		Raphoe	
		T1	T2	T1	T2	T1	T2
<b>Sex</b>	Male	105 (43)	134 (45)	101 (40)	111 (43)	101 (40)	101 (39)
	Female	137 (57)	161 (55)	154 (60)	145 (57)	154 (60)	159 (61)
<b>Age</b>	-40	126 (52)	166 (56)	98 (39)	122 (47)	121 (48)	149 (57)
	+40	116 (48)	127 (43)	155 (61)	135 (53)	130 (52)	112 (43)
<b>Social class*</b>	1 & 2	79 (33)	136 (46)	82 (32)	85 (33)	65 (26)	64 (25)
	3, 4 & 5	84 (34)	61 (21)	85 (33)	66 (26)	47 (18)	54 (21)
	6 & 7	79 (33)	9 (3)	88 (34)	101 (41)	143 (56)	143 (55)
<b>Highest level of education</b>	Primary	50 (21)	27 (9)	97 (38)	55 (21)	88 (35)	68 (26)
	Secondary	111 (46)	151 (51)	108 (42)	113 (45)	113 (44)	130 (50)
	Third-level	81 (34)	110 (37)	50 (20)	89 (35)	53 (21)	61 (24)

\* *Social class categories are the following:*

1 & 2 = professional, managerial & non-manual

3, 4 & 5 = skilled, semi-skilled & unskilled

6 & 7 = other including retired, unemployed and students

## **4.2 MAIN FINDINGS OF THE COMMUNITY RE-SURVEY**

Key objectives of the Cross-Border Rural Mental Health Project through its mental health promotion interventions were to increase awareness of mental health, in particular depression and suicide, at a community level and to increase understanding of available sources of support and professional help. The means (or averages) of the following scaled attitudinal items were computed and analysed across the communities;

- I) Levels of concern about suicide, depression and access to services
- II) Attitudes to help-seeking from a range of professional help sources
- III) Perceived confidence in offering advice to those suicidal and depressed
- IV) Perceived effectiveness of professional services.

Tables shows the means (standard deviations in brackets) for each variable at time 1 (1997/8) and at follow-up time 2 (2003) and these are compared with the Galway community. To test for statistical significance, a four way factorial analysis of covariance (ANCOVA) was undertaken, taking account of location (x4), time (x 2), sex (x 2), and age (x2). The objective of the analysis is to control for any differences between the communities at pre-intervention in establishing the significance of changes over time. As there was a significant difference between the three communities at pre-intervention in relation to education level, which was also found to significantly influence expressed attitudes, the education factor was entered as a covariate in order to control for these differences. In interpreting the ANCOVA findings, a significant interaction effect for location by time is therefore taken as indicating the significance of the net changes that may be attributable to programme effects. A summary of the main findings will now be reported.

### **4.2.1 Levels of Concern**

Levels of concern included concern in relation to suicide, depression and access to mental health services.

**Table 4.2: Concern about Suicide: Differences in mean (SD) at Time 1 and Time 3 across the three communities, displaying overall means and means for gender**

	Draperstown		Raphoe		Galway	
Overall Means (SD)	Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
	3.33(1.07)	4.12(0.96)	3.78(1.09)	4.21(0.89)	4.02(0.86)	4.22(0.89)
Male	3.13(1.11)	4.01(0.93)	3.55(1.20)	4.12 (0.84)	3.99(0.87)	4.04(0.10)
Female	3.47(1.02)	4.21(0.97)	3.93(0.99)	4.26 (0.92)	4.05(0.86)	4.36(0.77)

1 = not at all concerned; 5 = very concerned

A significant programme effect (location x time) was found in relation to levels of concern about suicide ( $F = 12.98, p < .001$ ). Investigation of the data revealed that concern levels about suicide significantly increased from pre to post intervention in the two project communities of Draperstown and Raphoe in comparison to the reference Galway community, where such an increase was not in evidence.

Also of interest is the fact that a location by time by sex effect was found to be borderline significant for concern about suicide ( $F = 2.91, p = .055$ ). This finding indicates a larger increase in concern over time specifically for males in Draperstown and Raphoe.

Likewise in relation to concern about depression, a programme effect was found indicated by a location x time effect ( $F = 4.29, p < .05$ ). This showed that from Time 1 to Time 2 concern levels about depression increased to a significant degree in the project communities of Draperstown and Raphoe in comparison to the Galway community.

**Table 4.3: Concern about depression: Differences in mean (SD) at Time 1 and Time 2 across the three communities**

Draperstown		Raphoe		Galway	
Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
3.33(1.02)	3.79(0.99)	3.55(1.01)	3.82(0.99)	3.75(0.87)	3.87(1.02)

**Table 4.4: Concern about depression: Differences in mean (SD) according to age and gender**

	Male	Female
Under 40	3.43 (1.08 )	3.76 (0.94 )
Over 40	3.68 (1.00 )	3.81 (1.03 )

Levels of concern about access to mental health services did not show a significant programme effect. A significant main effect for time was found for levels of concern about access to mental health services ( $F = 9.28, p < .01$ ). Investigation of the data revealed that over time there was significantly more concern about access to mental health services (see Table below) across all three communities.

**Table 4.5: Concern about mental health services: Differences in mean (SD) at Time 1 and Time 2**

Time 1	Time 2
3.14 (0.84)	3.32(0.80)

Respondents were also questioned regarding levels of concern about themselves becoming depressed (1 = very worried to 4 = not worried). No specific programme effects were found. A significant main effect for sex was, however, found ( $F = 4.00, p < .05$ ), suggesting that males overall had lower levels of concern than females across all three communities.

**Table 4.6: Concern about becoming depressed: Differences in mean (SD) by gender**

Male	Female
3.59(0.84)	3.49(0.93)

#### **4.2.2 Attitudes to Help-Seeking**

Attitudes to help-seeking explored having no hesitation in contacting the GP, psychiatrist, psychologist and the Samaritans (1= strongly agree; 5 = strongly disagree). In relation to consulting the GP, a significant programme effect was found ( $F = 2.94, p < .05$ ) indicating improvements in attitudes to consulting the GP for a mental health problem (a lower mean value indicates less hesitation). This effect was most in evidence in the Raphoe community. A location x time x gender effect also approached significance ( $p = .066$ ) suggesting a particular impact for females in the project communities.

**Table 4.7: Hesitancy in seeking help from a GP: Differences in mean (SD) at Time 1 and Time 2 across the three communities**

Draperstown		Raphoe		Galway	
Time 1	Time 2	Time 1	Time 2	Time 1	Time 2
2.18 (1.08)	2.26 (1.09)	2.26(1.08)	2.10 (1.02)	2.06(0.99)	2.29 (1.16)

1=no hesitation, 5=strong hesitation

**Table 4.8: Hesitancy in seeking help from a GP: Differences in mean (SD) across the three communities according to gender**

	<b>Draperstown</b>	<b>Raphoe</b>	<b>Galway</b>
<b>Male</b>	2.36 (1.13)	2.32(1.07)	2.16(1.10)
<b>Female</b>	2.12(1.04)	2.10(1.04)	2.19 (1.08)

Across all three communities, there were generally higher levels of hesitation in consulting the GP for those under 40 years of age ( $F = 4.64, p < .05$ ), with a larger age gap in evidence in the reference community.

**Table 4.9: Hesitancy in seeking help from a GP: Differences in mean (SD) across the three communities according to age**

	<b>Draperstown</b>	<b>Raphoe</b>	<b>Galway</b>
<b>Under 40</b>	2.25 (1.09)	2.23(1.11)	2.42 (1.10)
<b>Over 40</b>	2.20(1.09)	2.19(1.00)	1.99 (1.04)

However, hesitation levels in consulting the GP were seen to decrease over time (a time x age effect;  $F = 38.01, p < .001$ ) for the under 40 age group across all three communities indicating no specific project effects.

**Table 4.10: Hesitancy in seeking help from a GP: Differences in mean (SD) across time according to age**

	<b>Time 1</b>	<b>Time 2</b>
<b>Under 40</b>	2.45(1.13)	2.14(1.05)
<b>Over 40</b>	1.92(0.91)	2.37(1.17)

In relation to consulting the psychiatrist, a significant location x time x sex effect was found ( $F = 3.02, p < .05$ ) which indicates there was an decrease in the reluctance to contact a psychiatrist over time especially for females in Raphoe with a decrease in mean values from 2.55 at time 1 to 1.65 at time 2.

**Table 4.11: Hesitancy in consulting a psychiatrist: Differences in mean (SD) across time according to location and gender**

	<b>Draperstown</b>		<b>Raphoe</b>		<b>Galway</b>	
	<b>Time 1</b>	<b>Time 2</b>	<b>Time 1</b>	<b>Time 2</b>	<b>Time 1</b>	<b>Time 2</b>
<b>Male</b>	2.68(1.13)	2.81(1.13)	2.57(1.10)	2.75(1.01)	2.54 (1.09)	2.52 (1.14)
<b>Female</b>	2.51(1.16)	2.63(1.15)	2.55(1.12)	1.65(0.88)	2.50(0.98)	2.74 (1.15)

A significant programme effect (location x time x sex) was also found in relation to seeking help from the psychologist ( $F = 4.12, p < .05$ ). Again, there was a decrease in the reluctance to contact the psychologist over time especially for females in Raphoe

**Table 4.12: Hesitancy in consulting the psychiatrist: Differences in mean (SD) across time according to location and gender**

	Draperstown		Raphoe		Galway	
	Time 1	Time 3	Time 1	Time 3	Time 1	Time 3
<b>Male</b>	2.78(1.12)	2.82(1.12)	2.74(1.09)	2.78(1.01)	2.63 (0.98)	2.66 (1.12)
<b>Female</b>	2.63(1.12)	2.69(1.13)	2.51(1.13)	1.80(1.01)	2.35 (0.93)	2.92 (1.08)

No programme effects were found in relation to seeking help from the Samaritans

However, a significant time x age effect was found ( $F = 5.01, p < .05$ ), suggesting that over time there was slightly less hesitation in contacting the Samaritans for the under 40's but increased hesitation was reported for the over 40's across all three communities.

**Table 4.13: Hesitancy in consulting the Samaritans: Differences in mean (SD) across time according to age**

	Time 1	Time 2
<b>Under 40</b>	2.91(1.13)	2.89(1.17)
<b>Over 40</b>	2.75(1.15)	3.02(1.14)

#### **4.2.3 Perceived Confidence in Offering Advice**

Two variables were included in this section, perceived confidence in offering advice to someone who was depressed and to someone who was suicidal (1= very easy; 5 = very difficult). No significant programme effects were found in relation to these two variables. With regard to offering advice to someone with depression, a time by sex interaction effect emerged ( $F = 4.80, p < .05$ ) indicating that males across all three communities perceived fewer difficulties in offering advice over time.

**Table 4.14: Perceived confidence in offering advice to someone who was depressed: Differences in mean (SD) across time according to gender**

	Time 1	Time 2
<b>Male</b>	3.41(1.08)	3.21(1.07)
<b>Female</b>	3.18(1.15)	3.19(1.07)

With regard to advising someone who was suicidal there was a significant interaction effect for time x age ( $F = 4.49, p < .05$ ). This was evident in that there was less concern expressed about advising someone suicidal over time and this was particularly so for the under 40's.

**Table 4.15: Perceived confidence in offering advice to someone who was suicidal: Differences in mean (SD) across time according to age**

	Time 1	Time 2
<b>Under 40</b>	4.11(0.98)	3.69(1.01)
<b>Over 40</b>	3.74(1.12)	3.64(1.09)

#### **4.2.4 Perceived Effectiveness of Services**

The perceived effectiveness of visiting the GP and the psychiatrist for depression was also examined (1= very effective; 5= waste of time). For perceived effectiveness of the GP a significant programme effect was found (location x time x sex x age;  $F = 3.93, p < .05$ ) suggesting specific positive effects for under 40 females in Raphoe.

A location by sex effect was found to be borderline significant for perceived effectiveness of the GP ( $F = 2.96, p = .052$ ). Males in Draperstown had the lowest levels of the perceived effectiveness of the GP in contrast to females in Draperstown.

**Table 4.16: Perceived effectiveness of visiting the GP for depression: Differences in mean (SD) across location according to gender**

	Draperstown	Raphoe	Galway
<b>Male</b>	2.71(1.09)	2.47(1.09)	2.50(1.01)
<b>Female</b>	2.36(0.95)	2.44(1.04)	2.41(1.04)

With regard to perceived effectiveness of the psychiatrist for depression there was a significant main effect for time ( $F = 12.28, p < .001$ ) with the general trend indicating a perception of decreased effectiveness of psychiatric help from Time 1 to Time 2 across all three communities.

**Table 4.17: Perceived effectiveness of visiting a psychiatrist for depression: Differences in mean (SD) at Time 1 and Time 2**

Time 1	Time 2
2.20(0.68)	2.41(0.80)

#### **4.2.5 Community Perceptions**

A number of questions were asked about how people perceived their locality and how close they felt as a neighbourhood. Respondents were first asked how long they lived in the neighbourhood and the number of neighbours they knew personally. Respondents were also asked to rate how satisfied they felt with the neighbourhood from 1= very dissatisfied to 5 = very satisfied. The highest percentage of people who reported living longest in the area (i.e. all their life) was in Draperstown (45.4%) with the lowest level in Raphoe (38.8%). In contrast a lower proportion of those in Draperstown reported knowing the most number of neighbours personally (69% knew more than 10 neighbours personally) in contrast with those in Raphoe and Galway (over 80 % knew more than 10 neighbours personally). Across the three communities satisfaction with the neighbourhood was similarly high with satisfaction levels over 75% (see Table below).

**Table 4.18: Details of the neighbourhood and neighbours expressed as percentages in 2003 (n= 258 - 294)**

	<b>Draperstown</b>	<b>Raphoe</b>	<b>Galway</b>	<b>Significance</b>
<b>Length live in neighbourhood/area</b>				
Less than 1 year	5.1	1.5	4.7	$\alpha^2 = 19.02$ (10) $p < .05^*$
1 - 2 years	7.8	3.8	5.5	
3 - 5 years	5.5	8.1	7.0	
6 - 10 years	8.5	10.8	6.3	
Over 10 years	27.6	36.9	34.4	
All my life	45.4	38.8	42.2	
<b>Number of neighbours known personally</b>				
None	3.7	2.3	1.6	$\alpha^2 = 21.10$ (8) $p < .05^*$
1-3	7.5	7.7	5.4	
4-6	9.5	2.7	7.4	
7-10	10.2	6.9	5.4	
10 +	69.0	80.3	80.2	
<b>Satisfaction with the neighbourhood</b>				
Very dissatisfied/ dissatisfied	14.6	15.0	12.0	F = 0.08 (2) $p = 0.93$
Neither satisfied/dissatisfied	9.2	6.5	6.2	
Satisfied/ very satisfied	76.2	78.0	81.7	

Questions were asked regarding the following: sense of belonging to the neighbourhood, similarity to neighbours, sense of community in the neighbourhood, people can be trusted, people are willing to help, neighbours don't share the same values, people in the area can

be trusted, this is a close knit area and people feel safe. Like previous questions respondents were asked to rate their level of agreement with the statements from 1 = strongly agree to 5 = strongly disagree. Significant differences were found among the three communities regarding all the variables except similarity to neighbours and neighbours not sharing the same values. Most respondents (over 70%) agreed they were similar to their neighbours but did not share the same values. Levels of perceived cohesion were highest in Galway as indicated by higher levels of agreement regarding belonging to the neighbourhood, sense of community, most people can be trusted (both generally and locally), willingness of people to help, closeness of neighbourhood and feelings of safety. In contrast levels of agreement were lower in Raphoe and Draperstown though they were generally very high, for example 82% of those in Draperstown and 79.9% of those in Raphoe felt they belonged to their community.

#### **4.2.6 RMHP Project Reach**

The number of people who stated that they had knowledge of the Rural Mental Health Project was over 30% in each of the two communities with the highest proportion in Raphoe (37.3%).

**Table 4.19: Respondents who had heard of the Rural Mental Health Project in 2003 (n = 261-264)**

<b>Knowledge of the Rural Mental Health Project</b>	<b>Draperstown</b>	<b>Raphoe</b>	<b><math>\alpha^2</math>, (df) and p values</b>
<b>Yes</b>	30.7	37.3	60.83 (2)
<b>No</b>	69.3	62.7	<.001*

\* denotes significance

Following on from this question, those who said they knew of the project were also asked “What do you know about it?” A number of categories emerged from the data, with the most frequently cited one referring to general issues (42.8% in Draperstown and 79.2% in Raphoe). Examples included: “it’s a community project”; “it works a lot with a lot of target groups” and “it promotes wellbeing and overall health”. Other categories included knowledge of the Project Manager or members of the project and the Steering Group (by about 10% of respondents). Activities involving men and farmers were mentioned particularly in Draperstown (by approx. 20% vs. 7% in Raphoe). Examples of items mentioned in these categories included: the Men’s Health Programme, as well as support

for farmers and farmers' groups. Finally, specific activities were mentioned particularly in Draperstown (by approx. 20%) and these included the Mental Health Lifeskills Module in the schools, the Winning New Jobs Programme, playgroups and night classes.

**Table 4.20: Knowledge about the Rural Mental Health Project's activities in 2003 expressed as percentages (n= 81-129)**

	<b>Draperstown</b>	<b>Raphoe</b>
<b>General</b>	42.8	79.2
<b>Project Manager/ members of the project</b>	9.5	12.4
<b>Specific Activities</b>	21.4	4.2
<b>Men</b>	19.0	4.2
<b>Farmers</b>	7.1	0

Following on from the last question, respondents were also asked: "Are you aware of whether any of the following Rural Health and Social Wellbeing/Mind Matters initiatives took place in your community over the last two years or so?" Among the project's activities, awareness of the Men's Health Programme, farmers' information sessions and publicity about the project was highest (up to 28.5%). Significant differences across the communities were evident with regard to the Men's Holistic Health Programme, the Schools Module and the farmers' information sessions. Generally, awareness levels were highest in Draperstown (18% to 28%) except for the Schools Module which had higher levels in Raphoe at 16.8%.

The second part of this question asked "Did you take part in any of these initiatives?" Among the project's activities, participation in the farmers' information sessions and publicity about the project was highest (up to 48% participation). Significant differences across the communities were evident with regard to the Men's Holistic Health Workshops and the farmers' information sessions. The Men's Holistic Health Programme was only conducted in Draperstown (over 25% of people said they participated) and this would account for the lack of participation in Raphoe. Regarding the farmers' information sessions there was three times the level of participation approx. in Draperstown compared to Raphoe (30% vs. 11.5%). Other borderline significant differences appeared between the communities regarding participation levels in the Schools Module (10% in Draperstown and 25% in Raphoe); as well as publicity about the project (22.9% in Draperstown and 48% in Raphoe). Finally, a slight difference emerged between the two areas relating to the School Mental Health Open Day (4.3% in Draperstown and 11.2% in Raphoe).

The last questions in this section assessed respondents' views of cross-border links and the impact of the Peace Process. Levels of awareness of cross-border links between the two communities were similar (about 10%). The vast majority of people viewed these links as 'very good / good' and over 75% valued the links as 'very important/ important'. Finally, the respondents' views on the impact of the Peace Process were quite mixed. Approximately 30% stated the impact was 'very much/ a good deal' while another 30% approx. stated they were unsure and the greatest number stated that the impact was 'a little / not at all' (nearly 40%).

**Table 4.21: Views on cross-border links and the impact of the Peace Process in 2003 expressed as percentages (n= 254-292)**

	<b>Draperstown</b>	<b>Raphoe</b>	<b>F, (df) and p values</b>
<b>Awareness of cross-border links</b>			
Yes	11.0	12.2	4.11
No	72.9	77.6	(2)
Don't know	16.2	10.2	0.13
<b>Views on cross-border working</b>			
Very good/ good	81.0	85.5	0.56
Unsure	17.6	9.8	(1)
Not good/ waste of time	1.4	4.7	0.45
<b>Value of cross border links</b>			
Very important/ important	75.9	84.6	2.75
Unsure	22.0	11.0	(1)
Not important/ not at all important	2.0	4.4	0.10
<b>Impact of the Peace Process</b>			
Very much/ a good deal	34.5	29.7	2.01
Unsure	27.4	30.1	(1)
A little/ not at all	38.1	40.2	0.16

### 4.3 SUMMARY OF MAIN FINDINGS

In summary, the findings from the community survey indicate a number of positive effects on attitudes at the wider community level in the intervention communities in comparison to the reference community. These include increased awareness concerning suicide and depression in the two intervention communities, with a trend toward increases in concern levels about suicide for males. These findings are encouraging as this was one of the key aims of the project and suggest that the project interventions have resulted in a positive

shift in community perceptions. Attitudes toward help-seeking were also seen to improve with less hesitation in consulting the GP, psychologist and psychiatrist especially among women in Raphoe. The higher attendance of women at many of the community events may account for the specific effects observed in the community survey findings. Overall, the project has had a significant impact on community perceptions in awareness levels and help-seeking attitudes concerning depression and suicide. Given the social stigma that exists regarding these matters, this positive shift in attitudes in the intervention communities is noteworthy. With a more sustained programme it should be possible to maintain and further enhance changes in community attitudes.

## **CHAPTER 5                    IMPLICATIONS FOR CROSS-BORDER CO-OPERATION & UNDERSTANDING**

In this chapter, the perceptions of the project coordinators, trainers, and participants in terms of Cross-Border working will be examined in order to determine the implications of Phase 2 project activities for mutual understanding and reconciliation.

### **5.1 PERCEPTIONS OF THE CROSS-BORDER JOINT STEERING GROUP**

#### **5.1.1 Results of Telephone Interviews**

Telephone interviews were conducted by a researcher at NUI, Galway with the members of the Cross- Border Joint Steering Group on three occasions: February 2000, March 2001, and February 2004. These interviews were conducted in order to ascertain perceived challenges, opportunities and obstacles to good cross-border co-operation. The purpose of the telephone interviews was twofold:

- to offer members the opportunity to reflect upon aspects of the Rural Mental Health Project in Phase 2 of the project
- to compare findings from telephone interviews at three stages of the project: before Phase 1 (February 2000), during Phase 1 (March 2001), and during Phase 2 (February 2003) in order to track process and changes over time

Interviews were carried out confidentially at a time and place named by the interviewee as being suitable for them. Interviews lasted between fifteen and thirty minutes and twelve steering group members were interviewed in all.

Questions covered: members' expectations of the project; perceived strong and weak points of the project; desirable achievements of the project over the coming year and the factors which would be important in making these achievements happen; feelings about the cross-border nature of the project. In addition, the 'Assessing the Cross- Border Partnership Questionnaire' was distributed to all members of the Joint Steering Group at the time of the February 2003 telephone interviews and five questionnaires were returned.

The questions used for the telephone interviews are available in Appendix XXIII, and the written questionnaire is available in Appendix XXIV.

As one can appreciate, from February 2000 through February 2003, there were many changes as well as continuity in the perceptions of the members.

### ***Looking Back: The Major Achievements of the Cross-Border Project***

In the 2000 and 2001 telephone interviews, there was a diverse range of perceptions as to the major achievements of the cross-border project, and many felt that major achievements had yet to be realised and expectations were still uncertain. This most likely reflects the fact that many interventions were not implemented prior to Phase 2. There was a sense of anticipation, especially with regard to the Winning New Jobs Programme and the expanded Schools programme. There was an anxiousness to get programmes “*up and running*”

In 2003, the steering group members noted that most major achievements took place during Phase 2. Several members mentioned the accomplishments and sustainability of the Winning New Jobs Programme and the Schools programme, the Men’s Health Programme, the engagement with farmers, the acquisition of funding, and the fact that people in the community were beginning to see the benefits of the project. Additional comments included:

- *“The fact that we are actually out on the ground doing very visual work and actually achieving”*
- *“Learning from others’ experiences: we’ve looked at structures that have worked on both sides of the border and we have taken the best of those. The fact that you have a partner to work with and share ideas and bounce ideas off”.*

### ***Strong Points of the Cross-Border Project***

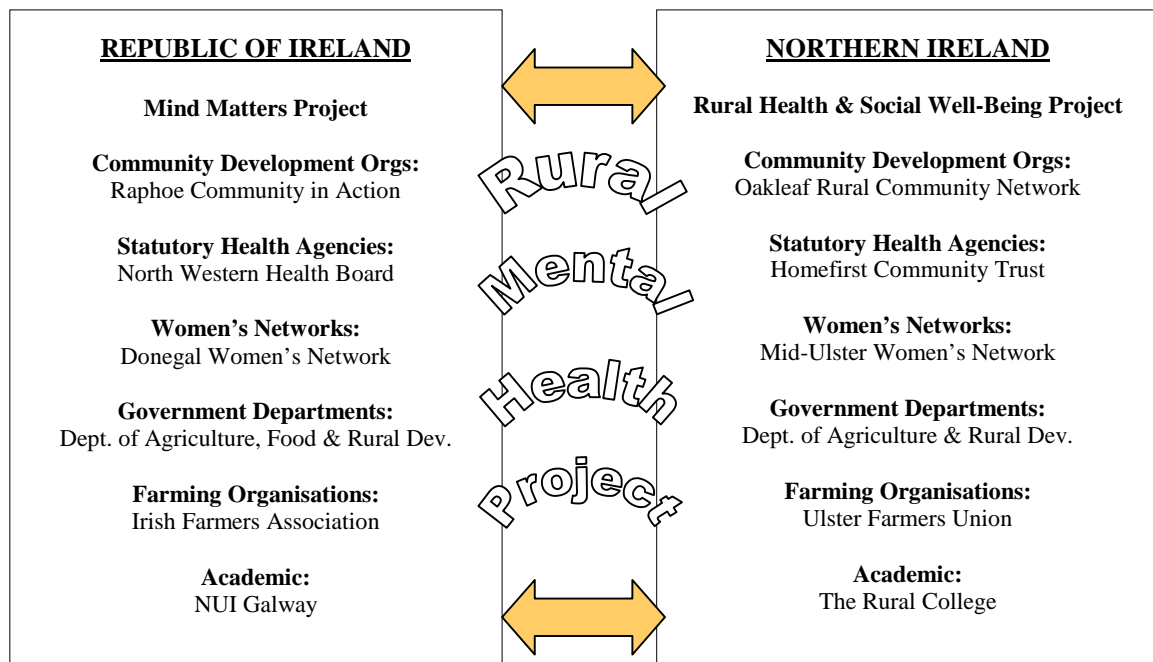
In the telephone interviews in 2000 and 2001, one of the strongest aspects of the project was the cross-border element and with this the sharing of ideas and experience that took place. There was, however, some doubt in regards to the benefits which the cross-border link brought to the project - *“It’s such a struggle to get things going at local level, that sometimes it feels that the cross-border bit can be an added pressure”*. In these earlier interviews, the skills and commitment by the Steering Group members were highlighted as

strengths of the project- “we aall want it to succeed”. There was also great belief in the success of the project – “I believe that the project is something that the community will benefit from greatly.”

In the 2003 interviews, there was an increased confidence in the cross-border element of the project, and in particular the networking and collaboration that occurred as a result of the project - “I suppose the relationships that have been established and the spin offs that have come such as an All Ireland Carers Conference”. This was also mentioned with regard to co-operating and liaising with others who are working in the area – “we don’t try to develop everything new ourselves, we tap into what other people are currently doing”. This was seen as quite novel in the sense that “It was totally unheard of in the past”. The collective work of all the project members was also highlighted as one of the major successes – “the shared working and to see what has worked well for one area and if it could be transferred to other areas”. As in the earlier interviews, again the members noted that the majority of people were committed to the project.

The project managers sought to engage a diverse range of community groups, organizations and statutory and voluntary agencies in the planning and development of project activities over the last 18 months. The project also endeavoured to support and facilitate the work of local groups; to work in co-operation with local agencies, and to collaborate with key service providers. For example, the range and extent of partnership working engaged in by the Rural Health and Social Wellbeing project is illustrated in the following pages, by way of demonstration. This level of networking, co-operation and collaboration is key to paving the way to more sustainable local and cross border partnerships. The following figure gives an example of the breadth and depth of cross-border interagency collaboration that occurred in the course of this project:

**Figure 5.1: Cross-border Interagency Collaboration\***



\* List not exhaustive

### ***Weak Points of the Cross-Border Project***

On all three interview occasions, steering group members cited the weakest point of the project was the large geographical distance between the two communities. This affected both the commitment required from Steering Group members in terms of time and effort, as well as the difficulty of increasing levels of contact between groups of community members. Comments included:

- *“It is that bit harder to get together because of the journeys. And not just ourselves but other groups as well, you know they’d probably get together more often if there wasn’t such a journey to go. I know it’s not maybe all that far but . . . it’s hard enough to get them out in their own community without telling them to go somewhere else”.*
- *“I think the distance has a big impact on why it does not work as well as it could”*
- *“I would say that distance is the major weakness of the project especially for the people who are on the ground working”.*

Another limitation noted in all three interviews was imposed by the funding situation, particularly the short-term nature of it- *“Often what we do has to be dictated by the funds*

*that we have and the time scales that are put on us*". In 2003, it was noted *"I think there is a lot of work being done at the moment and maybe we are being spread a bit too thin on the ground especially when we are coming with limited resources"*. A long-term focus was deemed to be more appropriate for obtaining funds to continue the project and ensure sustainability.

*"The reality of working cross border is very, very difficult"* re-appeared as a frequent theme on all the occasions. This was highlighted particularly by the following statement – there is *"the struggle"* to have genuine cross-border work *"rather than two single elements"*.

In the interviews in 2000 and 2001, a lack of focus in planning the activities of the project was raised from time to time. This was addressed during Phase 2, however, and in 2003, there was a consensus that the project seemed to be *"on the right tracks"* and in the future there should be *"the on going development of what already exists at the minute"*.

In the telephone interviews in 2000 and 2001, it was felt that the project might benefit by altering the membership of the Joint Steering Group in various ways, for example, *"the lack of community involvement in the Joint Steering Group"* and the need for increased representation from the various subgroups was suggested. Following this feedback, the issue was addressed with the establishment of additional subgroups for services, the Winning New Jobs Programme, and finance while efforts were continually made to involve the community as much as possible. The issue did not arise in the 2003 interviews.

The variation in operational mechanisms between the two communities was cited as a limiting factor by some in the 2000 and 2001 interviews, particularly during the initial stages of the project- *"Although the feasibility study pointed to a lot of similarities, there are a lot of differences in how things are organised and how things happen and where the two communities are at"*. Since then, members of the Joint Steering Group seemed to become more familiar and comfortable with these differences, possibly due to sharing of knowledge and the many cross-border relationships that were established. *"Learning from others' experiences: we've looked at structures that have worked on both sides of the border and we have taken the best of those. The fact that you have a partner to work with and share ideas and bounce ideas off (is a major achievement of the project)"*.

Two new issues were brought up in the 2003 interviews. The first was in regards to the difficulty of trying to engage different groups at times – *“Being able to engage more with the Protestant community at a local level and more work on the ground would need to be pursued”*. The second issue had to do with marketing the project, and it was felt that the project was not as well publicised as it could be- *“I think from my perspective we haven’t really marketed efficiently the work of the project”*.

### ***Achievement of Goals to Date***

The most consistent point made by the group on the three occasions of the telephone interviews was that this is a long-term project and some of its goals, particularly with regard to peace building and reconciliation, take a long time- *“It takes a lot of time, say 4 or 5 years to get it off the ground and really see what the real benefits are”*.

In the 2000 and 2001 interviews, members acknowledged that there was still much work to do - *“I would like to look at it as more of a programme instead of a project (in the future)”*. In the 2003 interviews, however, most people felt the majority of goals were being met - *“I think we are making a concerted effort here looking to engage the Protestant community, which up to this have been left out in the early stage of the project and in so doing we are addressing the goals”*. Other goals, however, still required more work - *“In some projects like the farmers you know we are kind of forcing the farmers to get involved in cross-border work and they haven’t sorted out their own local issues first”*.

The 2003 interviews also revealed that members felt there was a lot more potential in the project that was being recognised. Again, the distance between the two places was cited repeatedly as one important reason for this. Yet there was much optimism with regard to achievement of the goals in the future *“I don’t think there is any reason if we put in some hard work and effort that we should not be able to achieve those goals”*.

### ***Perceptions of the Cross-Border Joint Steering Group***

In the 2000 and 2001 interviews, most members felt the Cross-Border Joint Steering Group was democratic, balanced, there was good cooperation and people listened to each other. However, many also felt that some members did not have a clear sense of their role in the group, or that of the project in the community. This was especially true in 2000 when it

was highlighted that not everyone in the group felt they had a role in the group, or knew what their role was: *“I can’t feel the identity of the group yet”*. Taking this into account, a brief biography of each member of the Joint Steering Group was compiled for the benefit of those who may join the group at a later stage (see Appendix II) and efforts were made to bring the group closer together. The telephone interviews in 2003 reflected more agreement Steering Group was working well - *“I think it is improving, I know there is room for improvement but it is better than what it used to be”* and *“up until recently there was not enough cross border contact at different levels of the project”*.

In Phase 2, it was perceived that the two communities gained more ownership of the project. The role of NUI, Galway focused more on evaluation and monitoring the project’s work in phase 2. This level of activity by NUI, Galway is now perceived as a strong point of the project - *“The support from Galway University in terms of evaluation, it’s keeping us on track; it’s keeping us to the targets, keeping us focused on the project in hand (is a major achievement of the project)”*.

### ***Looking Forward***

There was unanimous agreement on the three occasions that sustainability was an important issue when looking ahead, particularly nearing completion of the project – *“Maybe (we can) take a step back and say right, we’ve done this and we’ve done that, and now what can we do to make it more sustainable?”*. There was also the call for *“focus on developing a good exit strategy”* to ensure the interventions would continue even when the project ends.

In 2003, members felt that the project agenda may have been too broad and ambitious during the first and second phase of the project. While this was perceived by some as a valuable learning experience, it was mentioned – *“maybe we are being spread a bit too thin on the ground especially when we are coming with limited resources”*.

While in 2003 there was unanimous agreement that the project had much potential, it was also agreed that some issues needed to be addressed to ensure sustainability, for example the issue of securing funding long-term *“I would like to move away from year round funding and have some stability and look at it as more of a programme instead of a project”* and the importance of developing *“a good exit strategy”* was regularly emphasised. Overall, however, the group were very positive about the future and were looking forward to it *“I think that it (the project) can only go from strength to strength if it’s sustained properly by a well run management committee”*.

### **5.1.2 Results of Questionnaire**

The ‘Assessing the Cross- Border Partnership Questionnaire’ was adapted from a measure developed by Vic Health, the Victorian Health Promotion Foundation in Australia as part of their Mental Health Promotion Plan (see Appendix XXIV). It has the following specific aims:

- To develop a clearer understanding of the range and purposes of collaborations
- To take a more planned and strategic approach to selecting partners
- To maximise the contribution agencies can make at different levels.

It has seven key areas:

- Determining the need for the partnership
- Choosing partners
- Making sure partnerships work
- Planning collaborative action
- Implementing collaborative action
- Minimising the barriers to partnerships
- Reflecting on and continuing the partnership.

This instrument was adapted to assess perceptions of cross-border partnerships in the Rural Mental Health Project. The results from ‘Assessing the Cross- Border Partnership Questionnaire’ showed that for the following statement only the majority of respondents disagreed: ‘There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership’. This was in agreement with the fact that the perceived distance between the two communities was mentioned by many members of the Joint Steering Group as a weakness of the Cross-border project during the telephone interviews. One member of the group stated in 2003 “I

would say that distance is the major weakness of the project especially for the people who are on the ground working”.

Regarding the following themes the majority of respondents neither agreed nor disagreed: ‘The goal of the partnership as well as the lines of communication, roles and expectations of partners are clear’. Respondents have mentioned during the two previous interviews (February 2000 and March 2001) that more clarity was necessary particularly with regard to roles and expectations of partners. It seems that more clarity would have been ideal.

‘All partners being involved in planning and setting priorities as well as the partners seeing their core business as partially interdependent’. Again it was mentioned during the previous interviews that all partners may not be equally involved in the partnership. This may be explained by the fact that many of the members are in full-time employment outside of the project work and have more difficulty than others in attending meetings during the day.

‘The structure of the partnership being as simple as possible (that is administration, communication and decision-making) as well as processes that are common across agencies (such as referral protocols, service standards, data collection and reporting mechanisms) been standardised’. This is a theme that has occurred during various meetings and discussions. There was a constant strive to work as efficiently as possible, given the large number of goals that were undertaken in a short time and with limited resources. One member of the group stated in 2003 “maybe we are being spread a bit too thin on the ground especially when we are coming with limited resources”.

‘The formal and informal ways for sharing information and resolving demarcation disputes and the processes for recognising and celebrating collective achievements and/or individual contributions’. Again similar to the last point there may have been more efficient ways of sharing information, resolving any disputes that arose as well as recognising and honouring collective achievements.

For all other statements, the majority of respondents agreed or strongly agreed with each one (that is 60% of the statements). Please see Appendix XXV for a summary of results from Assessing the Cross-Border Partnership Questionnaire.

## **5.2 PERCEPTIONS OF THOSE IN SCHOOLS / YOUTH PROGRAMMES**

The students who attended the Cross-Border Drama Workshop felt that the workshops helped to enhance cross border relationships and foster mutual understanding. Indeed, of those students who completed the post-workshop questionnaire, 90% felt the workshop helped them to have a better understanding of people from across the border and 100% felt the day was a rewarding experience. When asked personal gains from the workshop day, several noted the cross-border element e.g. *“I have learned to meet and enjoy my time with new people across the border”*

## **5.3 PERCEPTIONS OF FARMERS**

The cross-border aspect of this conference was considered a positive element to the day; 100% of those completing the post-conference questionnaire felt that the conference was very useful or useful in bringing together farming families from both sides of the border.

## **5.4 PERCEPTIONS OF WOMEN**

### **5.4.1 Cross-border Women’s Residentials**

Women who attended the cross-border residentials felt that the cross-border element was of important significance e.g. *“It is lovely to have a connection with women who live on the same island and without this Cross-Border project it would never have happened. We are no longer separated by fear of who each other are”*. Throughout the residentials, as the women were networking and working collectively, there was an underlying focus on building peace and reconciliation – *“peace comes with networking”* and *“collective activities [are] more powerful to look at innovation and new ways, to build peace and reconciliation, to dispel myths”*

### **5.4.2 Cross-Border Women’s Networking Event**

The Networking Event was successful in bringing women from both sides of the border to discuss issues and work collectively to seek resolutions and plan future events. Several

women noted opportunities that lay in cross-border work, noting “*we can work cross-border, cross-community*”. Women who attended the evening event voiced the idea of reconciliation, saying they wanted to “*bring peace, harmony and more understanding amongst the divides and to understand other cultures and faiths that presently live in Northern Ireland*”. In the post-event questionnaires, the majority of women felt the event was very useful in bringing together women from both sides of the border. One woman noted that one of the key messages of the evening was “*women from many different groups coming together and letting our voices be heard*”

## CHAPTER 6

## CONCLUSIONS

A wide range of interventions has been implemented over Phase 2 of the project from the start of 2002 through June 2004. These interventions, which encompassed specific target groups as well as community-wide events, engaged a large number of community members and local agencies within and across the two communities. The predominantly positive feedback from participants suggests that they found the interventions to be relevant, useful and informative, raising their awareness and understanding both of mental health matters and of cross-border community co-operation. A diverse range of community groups and agencies were brought together and actively engaged in project planning. This cross-sectoral collaboration enhances local community capacity in re-orienting services to address locally identified needs. The cross-border collaboration between agencies has also been a key feature of the delivery of the interventions. International models of best practice were successfully adopted and implemented in the lifetime of the project. Both the Mind Out schools programme and the Winning New Jobs programme were successfully adapted and produced significantly positive effects for both young people, unemployed people and mental health service users in both communities. Both of these initiatives adapted training materials to local needs and trained local trainers in order to ensure the consolidation and sustainability of the programmes after the lifetime of this project. Both programmes are now embedded within the local education and training and employment sectors in the region. Both the Cross Border Women's Forum and the Farmers' Forum were established during Phase 2 and provide a good foundation for both of these initiatives to develop further their cross-border networking and co-operation. The findings from the community survey suggest that the project has had positive effects on community awareness and attitudes at the wider community level. These include increased awareness regarding depression and suicide and improved attitudes to help-seeking.

In more general terms, the project demonstrated the feasibility of a community-based model of mental health promotion on a cross-border basis. The Joint Steering Group was critical to maintaining this, bolstered by the skills and expertise of the local Project Managers. This was a novel project in this sense, as there are few reported examples of such initiatives in the literature. The level of interest and support from statutory, community and voluntary groups was also vital to the project's success and indeed the

impact of the project at this wider level is difficult to document and to determine. However, the findings from the Rural Mental Health Project have been widely disseminated at regional, national and international levels in order to ensure that the learning from this initiative will inform practice and policy.

## **6.1 PROGRESS TOWARDS ACHIEVING STATED OBJECTIVES**

Based on findings over the last two and one-half years, an assessment can be made of the extent to which the project has achieved its stated objectives:

### **6.1.1 Promote Peace and Reconciliation**

Through contact and discussion between diverse community groups, North and South, the project sought to promote peace and reconciliation in addressing the shared mental health needs of the rural communities. The range of activities implemented across the different sectors brought together community and professional groups who traditionally have not worked together. The project created opportunities for cross-border collaboration in terms of developing innovative programmes in schools, training and employment agencies, women's groups and farming organisations. These initiatives sought to build meaningful dialogue and collaboration between groups and agencies in order to enhance both the mental health and quality of life of the two communities. In so doing this project essentially served as a tool for developing reconciliation and promoting greater cross-border understanding and collaboration. The project, using a community model, encouraged a bottom up approach to equitable partnership, learning and decision-making processes within the context of mental health promotion and wellbeing. In the second phase of the project particular emphasis was given to reaching difficult target groups including young men, members of the Protestant community and the unemployed. The holistic health programme and the schools programme successfully reached young men in the community, while the Wining New Jobs was specifically aimed at unemployed people and the Farmers' Forum and related initiatives was successful in engaging with members of the Protestant community. The community action model promoted inclusion from all sectors of the communities and aimed to build sustainable structures founded on positive cross-community relations. The development of skills in the area of reconciliation work was highlighted as being critical to further development of this work.

### **6.1.2 Facilitate Community Networking**

As outlined in previous chapters, a number of diverse community groups and agencies have been actively engaged in the project and the delivery of interventions over the past 2.5 years. For example, the various voluntary and community training and employment agencies from both sides of the border have collaborated with the statutory organisations for the Winning New Jobs Programme. This displayed collaboration both within and across communities, working together in planning information days, training and workshops around the shared problem of unemployment. Likewise, the farming groups have collaborated with health service professionals to address the mental health issues of the farming sector. A number of different professional and community groups have also worked co-operatively in organising the holistic health programmes for men. A positive result of these activities is that they have facilitated networking not only among community members but also among voluntary and statutory agencies in the area.

### **6.1.3 Partnership Model of Practice**

The project was based on a partnership model of practice. This is evidenced by the working of the Joint Steering Group in terms of shared project planning and monitoring and the positive perceptions of the Steering Group members concerning its cross-border function. It is recognised that working in partnership takes time, both in terms of building up trust and developing a common agenda. This is especially vital where cross-border working is involved. Therefore, an ethos of partnership, together with good working relationships, was established between the project partners. There was evidence of a sharing of experiences and expertise between the Steering Group, Project Managers and community members from both sides of the border, which has laid a solid foundation for the sustainability of interventions in to the future.

### **6.1.4 Inter-agency Collaboration**

The degree of inter-agency collaboration across the range of activities delivered is another mark of the success of the project. This is both in terms of engaging the involvement of local groups and organisations and beginning the task of re-orienting existing services to the needs of rural populations. Sustainable links have been established with health service providers, farmers' organisations, women's groups, school authorities, media personnel, training and employment agencies and a wide range of community and voluntary groups. As a result of their participation, all of these groups have collaborated in addressing mental

health issues for rural communities and have placed mental health firmly on the agenda of their organisations. As far as possible the project constantly aimed to impact on as wide a number of agencies 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 inhabitants. Strengthening the cross-border links between these agencies was an important focus of Phase 2.

#### **6.1.5 Extensive Evaluation**

The research component of this project provided an extensive system for intervention monitoring and feedback which enabled the Cross-Border Joint Steering Group to periodically review the effectiveness of the different project elements and their impact. This was particularly true with regard to the pilot implementation of the Winning New Jobs programme. This involved data collection before the programme was implemented, at the end of the programme and at three follow-up points. Qualitative and quantitative information from participants and trainers was collected as well as data from providers and participants. Likewise, all interventions were evaluated and feedback provided on an ongoing basis regarding the impact and effectiveness of the approaches used.

The findings for the project over the last 2.5 years have been summarised in this report. Progress on the project's development is disseminated to the local community via posters, local newsletters, project leaflets, media coverage and presentations. The action research model employed in this project, as depicted earlier, ensured that the research evaluation base was actively used to inform planning and development on an ongoing basis. The findings from the process and impact evaluation were used to refine the setting of action plans and provided an empirical foundation on which to base criteria for the internal monitoring and evaluation of the project effectiveness.

The use of a rigorous evaluation approach ensured that clear statements can be made concerning the efficacy or otherwise of the strategies used in this project in implementing a community-based approach.

#### **6.1.6 Enhance Capacities to Engage with Local Services to Address Local Needs**

The underlying principles of empowerment and community participation, as outlined in the Five-Stage Community Organization Model (see Chapter 1), was employed in this project. The project has therefore, worked to build up the confidence of community members in

addressing the broader determinants of mental health in their local communities and to enhance the capacity of local community groups in working pro-actively with a range of organisations and agencies in addressing local needs. This approach links with the partnership model of working and the community networking already outlined above. As far as possible the project has worked in co-operation with the existing community infrastructures in addressing the issue of positive mental health promotion in rural communities. As may be seen from the previous chapters, a wide range of activities has been facilitated in the two communities. This has served to bring the local community in active contact with those from a broad range of both statutory and voluntary health agencies. Members of the local community groups and organisations have actively participated in planning and organising a number of successful local events and this has helped to break down barriers regarding contact between the health services and local community groups. This is of particular importance with regard to mental health services as, due to the stigma surrounding this area, many mental health professionals and volunteers may hitherto have had low visibility in these rural communities. Breaking down the barriers through facilitated contact in a neutral community setting is an important step in de-stigmatising mental health issues in rural communities. Active involvement in the project by local community members also served to enhance local community capacities in engaging with services and agencies in re-orienting their services to address locally identified needs.

#### **6.1.7 Cross-border Co-operation and Networking**

The exchange of ideas and experiences across the two communities has enriched greatly the overall project development. At the Joint Steering Group level, the joint planning of initiatives has proved to be very successful. The Project Managers have worked together closely in programme implementation. For example, specific interventions were first piloted in one community with the lessons learnt being shared before being implemented in the second community. Also a number of intervention programmes have been jointly planned and delivered in collaboration with a range of groups and agencies.

The project has brought together community members, health professionals and other community workers in promoting contact and discussion around the issue of shared mental health needs in rural communities. This has provided a focus for sharing expertise and experiences in tackling issues of common concern. A diverse range of people from both

sides of the border have worked together sharing resources and expertise around planning and organising a number of cross-border project activities. These included:

- training and employment agencies involved in the Winning new Jobs Programme for the unemployed
- students and teachers from both communities coming together for the schools programme and the cross-border schools drama workshops
- co-operation between the voluntary, statutory and community groups in planning the various community and project activities
- developing the cross border women's forum to promote contact and networking among women's groups in the area
- collaboration between farmers and a range of farming groups in organising the cross-border farmer's forum.

These cross-border initiatives have provided a good foundation on which to build further co-operative efforts and build confidence and sustainability around positive cross-border collaboration in this area.

### **6.1.8 Sustainability**

One of the objectives of this project was to leave in place tried and tested strategies to ensure the sustainability of community-based programmes for enhancing mental health and improved quality of life and mutual understanding of rural communities. This has been achieved through the implementation and evaluation of structured programmes promoting positive mental health: the “MindOut” schools module and the “Winning New Jobs” programme for the unemployed.

In terms of the MindOut programme, comprehensive programme materials were developed, adapted and printed for wider distribution. Several teachers and community development officers have been upskilled to train new teachers in the programme, and subsequently have those teachers train others such that the programme is self-perpetuating. Finally, the programme is currently being mainstreamed in both the North and South, which contributes to its lateral geographic impact and longevity.

The Winning New Jobs programme also has several elements which ensure its sustainability. Through the extensive pilot, implementation, the programme has become

embedded with the training and employment agencies in both the North and the South. A preliminary evaluation of the programme has reported positive and encouraging results, which support the integrity and impact of the intervention and will no doubt contribute to its wider dissemination.

Apart from the structured interventions, several programmes and networking groups which originated as part of the Rural Mental Health Project later developed into sustainable initiatives in their own right. For example, the RMHP initially brought together several cross-border women's groups and farming groups for networking and collaboration around topics of mutual concern; the events were so successful, the collective groups have since developed action plans and procured funding to continue their collaborative work beyond the RMPH.

## **6.2 CONCLUDING REMARKS**

The Rural Mental Health Project has now completed its second phase, and as such much work has been done to ensure that it was be a phase of maintenance and consolidation of structures which have been established, as well as ensuring the sustainability of particular initiatives into the future. The project has built on its successes to date with regard to establishing effective partnerships and collaboration across a range of sectors. In particular, efforts to promote further cross-border and cross-sectoral working at the local community level have been galvanized, and a range of innovative programmes and initiatives has been established.

The research evaluation of this initiative documents the overall impact of the project against its stated aims. Regular feedback of the results has been provided to all stakeholder groups, guiding the project's development. The findings from the detailed process, impact and outcome evaluations have informed the development of good practice both with regard to the effectiveness of specific programme strategies and the overall process of implementing community models of health promotion practice based on partnership and sustainability principles. The project has left in place tried and tested strategies for enhancing mental health and quality of life in rural communities and the groundwork has been laid for sustained action and the continued development of cross-border working in this area.

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