Shared Island: Projects, Progress & Policy

A Shared Island Perspective on Mental Health

SECRETARIAT PAPER

No.29 January 2022

NESC
An Chomhairle Náisiúnta Eacnamaíoch agus Shóisialta
National Economic & Social Council

An Oifig Náisiúnta um Fhorbairt Eacnamaíoch agus Shóisialta
National Economic & Social Development Office NESDO

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Abbreviations

ABC	Area Based Childhood Programme
ACEs	Adverse Childhood Experiences
BAME	Black, Asian and Minority Ethnic [communities]
CAWT	Co-operation and Working Together
CHO	Community Healthcare Organisation
C-SSHRI	Connecting Suicide and Self-Harm Researchers on the island of Ireland
CSO	Central Statistics Office
ETC	European Territorial Co-operation
GP	General Practitioner
HRB	Health Research Board
HSC	Health and Social Care
HSE	Health Service Executive
ICT	Information and Communications Technology
NI	Northern Ireland
NIMC	National Implementation and Monitoring Committee
NIMDM	Northern Ireland Multiple Deprivation Measure
NISRA	Northern Ireland Statistics and Research Agency
NSMC	North South Ministerial Council
OSR	Office for Statistics Regulation
PSNI	Police Service of Northern Ireland
SEUPB	Special European Union Programmes Body
TBUC	Together: Building a United Community
WHO	World Health Organization

Executive Summary

As part of its work for the Department of the Taoiseach in producing a comprehensive report on the Shared Island, NESC has prepared a secretariat paper on mental health, with a focus on common priorities and potential areas for co-operation.

It is timely to address the issue of all-island co-operation on mental health, as the Covid-19 pandemic has highlighted not only mental health issues but also broader issues of public health responses on the island.

Over the last decade in particular, mental health has been given increased prominence in the media and in public debate generally. Mental health and wellbeing are more openly talked about, and information about self-help and supports are readily available through a range of media.

Despite this increase in awareness, and the move towards de-stigmatisation of mental health issues, many people still find it frustrating, difficult and sometimes even impossible to access mental health supports in both Ireland and Northern Ireland.

The pandemic has increased the pressure on mental health services that were already strained. There is a consensus that additional efforts and resources will be needed to address the increased demand for mental health services as a result of the pandemic, and also to catch up in some areas where services were cut back as a result of lockdowns and restrictions.

There is a well-documented shortage of some health professionals, particularly in specialised areas, and this is a factor in mental health services both north and south.

The issue of resourcing and workforce planning is an important one, and while it is not explored specifically in this paper, as it relates more to the delivery of health services – it is nevertheless important to note as a factor in any discussion around co-operation and the potential sharing of resources.

There have been increased efforts from both the Irish Government and the Northern Ireland Executive to promote and support mental health services in the last couple of years. In Ireland, a new policy for mental health was published last year, and some extra funding was also provided to strengthen mental health supports in the context of the pandemic.

Northern Ireland's first mental health strategy and funding plan was published in early 2021. This was preceded by a mental health action plan and the creation of a new role, a Mental Health Champion for Northern Ireland.

Policy context

While mental health services in the two jurisdictions are facing many of the same problems around funding, staffing and waiting lists, the context is different in some respects. It is difficult to establish exact numbers and comparisons in relation to the incidence of mental health issues in the two jurisdictions, as there are many ways in which the data varies. However, an OECD Health At a Glance Report from 2018 indicates that, in Ireland, 18.5 per cent of people have a mental health problem in any given year. The figure is slightly above the EU average of 17.3 per cent. [1]

[1] This is an estimated figure from the year 2016. More data available at https://www.oecd.org/els/health-systems/Health-at-a-Glance-Europe-2018-CHARTSET.pdf (accessed 11.11.2021)

There is evidence that Northern Ireland has a high incidence of mental illness, and the suicide rates are the highest in the UK (O'Neill, Heenan and Betts 2019).[2] According to the Northern Ireland Health Survey 2014/15, 19per cent of individuals showed signs of a possible mental health problem.[3]

In 2018, the official suicide rate for Northern Ireland was 18.6per cent per 100,000 population,[4] while England had a rate of 10.3per cent , Scotland was 16.1per cent and Wales had a rate of 12.8per cent.[5] In Ireland, the provisional rate of suicide in the same year was nine per cent.[6]

It should be pointed out that International comparisons can be problematic as there are different standards of legal determinations of cases of suicide, and late registrations can affect numbers. Nevertheless, the above figures do illustrate that Northern Ireland is at the higher end of the scale.

The legacy of the Troubles still has a significant impact on mental health in Northern Ireland, and mental health issues are most prevalent in deprived areas and in areas affected by the violence – a clear example of health inequality.

The social determinants of health – such as income, education and employment status[7] – play a big part in mental health, and this is particularly pronounced in Northern Ireland as a result of the conflict.

Over the last decade, the broader ambitions for the development of mental health services have been similar in Ireland and in Northern Ireland.

Both jurisdictions have seen a move away from institutionalised and hospital-based services, and the emphasis has shifted towards community-based services, early intervention, and preventative measures to avoid and alleviate mental health problems.

Current Co-operation

There is evidence of good collaboration in the mental health area between public, community, and voluntary stakeholders on an all-island or north-south basis. Some of this co-operation happens through network approaches, in areas such as suicide prevention, but also through more formal structures on an operational level. Ireland's HSE EU & North South Unit is a joint partner in the Co-Operation and Working Together (CAWT) partnership, alongside Northern Ireland's Western and Southern Health & Social Care Trusts, the Public Health Agency, and the Health and Social Care Board. Along with Action Mental Health – an NI organisation that supports people with mental health issues – CAWT plays an important role in bringing together stakeholders from both jurisdictions. Both organisations are leading European-funded cross-border and all-island projects that are focused on mental health.

There is the potential to build on the knowledge and experience already in existence in these organisations, by providing them with consistent support to enable them to further develop and mainstream successful programmes.

Despite the existence of some structures of co-operation, the consensus seems to be that a more formalised setting or forum , dedicated to mental health co-operation, would be desirable. Many stakeholders said that it would help to place, and keep, mental health issues on the agenda, and that it could be useful in ensuring consistent funding for mental health initiatives.

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2 NI suicide rates are currently being reviewed. It is likely that a significant number of deaths initially categorised as suicide may be re-categorised. See https://www.nisra.gov.uk/news/guidance-note-users-suicide-statistics-northern-ireland (accessed 11.11.2021)

3 Available at https://www.mentalhealth.org.uk/sites/default/files/FF16%20Northern%20ireland.pdf (accessed 10.11.2021)

4 For an explanation of how suicide rates are calculated, please see https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4664 (accessed 10.11.2021)

5 Figures available at https://www.assemblyresearchmatters.org/2019/11/28/suicide-statistics-and-strategy-in-northern-ireland-update/ (accessed 10.11.2021)

6 https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-cso-july-21.pdf (accessed 11.11.2021)

7 For the WHO definition of social determinants of health, see https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (accessed 10.11.2021)

Future Co-operation

This paper aims to convey, not only that there is scope for more all-island co-operation on mental health, but that it also makes a lot of sense. Mental health is an area well-suited for work across borders, as the public health aspect, and the focus on prevention and early intervention in particular, are universal. While mental health statistics can sometimes be difficult to compare between countries, partly as a result of the self-assessment element involved in much data, there are some well-established facts around both the causes and prevention of mental ill-health.

It is well known, for example, that there is a reciprocal relationship between deprivation and mental health; and that suffering from one of them increases the risk of also experiencing the other.

A number of the topics discussed in the paper would be suitable for further consideration, including:

- possible benefits from enhancing the level and range of settings for cross-border engagement between the two administrations, and in professional and clinical terms, on mental health co-operation;
- how to ensure consistent funding and subsequent mainstreaming of successful cross-border and all-island projects;
- the possible role of a Mental Health Champion in Ireland, building on the experience in Northern Ireland;
- improved and more standardised data collection on mental health, as a tool for comparing policy outcomes, and to help share learning and information;
- how to build on and use the growth in online supports as a tool in cross-border co-operation;
- whether scope exists for more policy co-operation, and, given the public health aspect, whether there is potential for more co-operation around prevention and early intervention.

1. Introduction

At the request of the Department of the Taoiseach, NESC will produce a comprehensive report on the Shared Island in Q1 2022. This report will inform the development of the Shared Island initiative as a whole of government priority. The NESC research will contribute to building a shared knowledge base and understanding about possible ways in which greater co-operation can emerge across a number of economic, social and environmental areas in Ireland, north and south, and also between these islands, East and West.

The research will seek to engage with all communities and traditions on this island to build consensus around a shared future, with a focus on actionable areas of co-operation. The work will be underpinned by the Good Friday Agreement and absolute respect for the principle of consent. The research will ***not*** address the constitutional question, but will focus on sustainable economic, social and environmental development issues in line with NESC's strategic remit.

NESC's approach to this work is focused on building over time a shared knowledge and understanding about the scope for greater co-operation. NESC's work in 2021 focused on a number of areas, selected for more detailed description and analysis. These areas are being documented in state-of-play reviews, which seek to build on NESC's existing areas of competence and expertise. The work on these areas is informed by consultation and discussion with key interests across the island.

This state-of-play review is on mental health policy and practice, and on current and potential areas of co-operation on the island of Ireland.

The preparation of this paper involved discussions and interviews with a range of stakeholders in Ireland and Northern Ireland. They included:

- the Departments of Health in Ireland and Northern Ireland;
- the Health Service Executive (HSE);
- the Institute of Public Health;
- the Office of the Mental Health Champion;
- Co-operation and Working Together (CAWT); and
- Action Mental Health.

Important feedback was also provided by a range of organisations in an online focus group on poverty and mental health. This was organised by NESC as part of a series of focus groups with stakeholders in the north-west under the Shared Island initiative.

1.1 Structure of this Paper

Section 2 provides the context for a discourse on mental health in both Ireland and Northern Ireland, including information on funding and availability of mental health data. It also focuses on the effects of the pandemic on mental health.

Section 3 gives an overview of the current mental health policies in Ireland and Northern Ireland, and also includes a short summary of mental health policies in the rest of the United Kingdom. It is not intended to provide an evaluation or progress report in relation to these policies, but rather to provide an insight into priorities and current thinking on the provision of mental health services.

Section 4 looks at current cross-border co-operation and gives some examples of mental health-focused projects.

Section 5 sets out a number of themes that are particularly relevant in the context of cross-border co-operation.

The final section, Conclusions, summarises some of the learning from the preparation of this paper.

2. Context

Mental health is a wide concept and covers a broad range of conditions, from temporary feelings of dejection through to severe depression and conditions such as schizophrenia. The HSE's information portal for mental health services states that:

> *It is estimated that one in four or five of us will experience some mental health problems in our lifetime (HSE, 2021).*

Most mental health issues are addressed through primary care, through GPs and public health facilities; while for those who need them, specialist and emergency services are available through the hospital-based system.

There are some fundamental differences between the healthcare systems in Ireland, north and south (Heenan, 2021). The funding mechanisms differ and – most notably, from a service user perspective – Northern Ireland provides a system of universal healthcare where access is free. In Ireland, there is a mix of private and public provision, with charges for many services provided free in the North, including GP visits and prescriptions. However, the resulting bottom line appears similar in relation to mental health services. A complex combination of factors – such as poor delivery structures, workforce planning issues, increased demand, and underfunding – has resulted in long waiting lists in some geographical areas, and a lack of access in both jurisdictions to services, such as help for those experiencing a mental health crisis or emergency (Freyne, 2021; McCambridge, 2021).

2.1 The Development of Modern Mental Health Services and the Current Context

Over the last decade the broader ambitions for mental health services have been similar in Ireland and in Northern Ireland.

Both jurisdictions have seen a move away from institutionalised and hospital-based services, with the emphasis shifting towards community-based services, early intervention, and preventative measures to avoid and alleviate mental health problems.

Recovery is a key ethos in many modern mental health strategies, including those in Ireland and Northern Ireland. The focus is on enabling those with mental health issues to maximise their ability to participate in all areas of life, and to minimise exclusion and stigma.

Health inequalities, the social determinants of health, and the links between poverty and health have become more prominent in the discourse around mental health. In parallel with the development of modern mental health services, there has also been a significant and positive shift in public perception, knowledge, and awareness around many aspects of mental ill-health. While it is difficult to quantify the effects of this shift, it is undoubtedly of huge benefit that more people now know, not only the signs of mental ill-health, but how to alleviate and even prevent them, and how to seek help to address them.

At the same time, the criticism is sometimes voiced that mental health awareness is often focused on the 'softer' or 'milder' presentations of mental health issues, and that the discourse sometimes suggests that all mental health issues can be prevented, and that things such as exercise and self-care can help in all cases. This may lead to a disproportionate focus on prevention and early intervention, at the expense of specialist services for those with more complex or severe needs (Freyne, 2021).

The move from institution-based care towards community-based interventions has taken place gradually in Ireland and in Northern Ireland. Over the course of the last four or five decades, mental health policy and service provision has been influenced by a number of reports and movements in the wider health services in both countries.[8] A number of reports are particularly relevant as references for current policy and thinking.

A Vision for Change, published by the Irish Department of Health in 2006, and *The Bamford Review of Mental Health and Learning Disability (Northern Ireland*), completed in 2008, are the main publications that have informed the continued vision for the development of modern mental health services in the two jurisdictions in recent times.

A Vision for Change is a policy document focusing on the future provision of services in Ireland, while *The Bamford Review* includes a review of current provision in Northern Ireland, along with a range of recommendations. The overarching principles and recommendations in the two documents are similar and include:

- a continued move to community-based services and away from hospital-based services and institutions;
- an increased role for primary care;[9]
- investment in specialist services; and
- a focus on early intervention.

This is very much in line with the goals that the World Health Organisation (WHO) provides for the organisation of mental health services: to deinstitutionalise mental health care; to integrate mental health into general healthcare; and to develop community mental health services (WHO, 2021).

The scope and success of implementation of the respective reports' recommendations have been varied on both sides of the border. In the North, the continued development of mental health services has shown progress in some areas such as health promotion, suicide prevention and the continuous move from hospital-based to community-based services (O'Neill *et al.*, 2019).

Both jurisdictions have current and relatively new mental health policies. *Sharing the Vision* was published in Ireland in 2020, and the Northern Ireland Executive published its first such strategy, the *Mental Health Strategy 2021-2031,* earlier this year. These are described in more detail in Section 2.

The contexts in which the strategies have been written are somewhat different. In Northern Ireland, the legacy of the Troubles is still having a substantial impact on mental health, and there is a strong link between deprivation and high rates of mental illness in the areas most affected by the violence (O'Neill *et al.*, 2019).

Northern Ireland has the highest prevalence of mental health problems in the UK, with a suicide rate per 100,000 people in 2018 of 18.6 per cent.[10] This is twice as high as in Ireland, where the rate was nine per cent for the same year.[11]

Suicide statistics are complex and their relationship to mental health statistics is not always straightforward, but what is known is that both suicide and instances of mental ill-health increase in disadvantaged areas.

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8 See for example (Department of Health, 2016; Bengoa *et al.*, 2016; Houses of the Oireachtas, 2017; HSE Mental Health Service, 2019).

9 For a definition of Primary Care, see HSE website: "Primary Care services cover many of the health or social care services that you find in your community, outside of the hospital setting. This includes GPs, Public Health Nurses and a range of other services provided through your Local Health Office." Available at https://www.hse.ie/eng/services/list/2/primarycare/ (accessed on 10.11.2021)

10 Please refer to footnote 2.

11 Available at https://www.nisra.gov.uk/publications/suicide-statistics (accessed 10.11.2021) https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-briefing-jan-2021.pdf (accessed 20.11.2021)

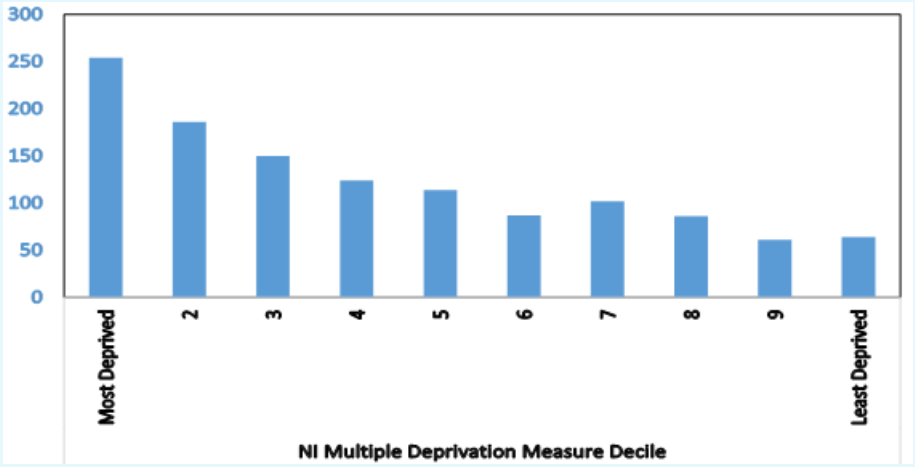
A report by the Samaritans in 2017 looked at the links between inequality and suicidal behaviour and concluded that:

> *There is a strong association between area-level deprivation and suicidal behaviour: as area-level deprivation increases, so does suicidal behaviour. Suicide rates are two to three times higher in the most deprived neighbourhoods compared to the most affluent (Samaritans 2017).*

The link between deprivation and suicide rates in Northern Ireland are well documented – see for example Black, 2021. Figure 1 gives a brief but clear illustration of this relationship.

Some 1,228 suicides were registered between the years 2015-2018 in Northern Ireland.

Figure 1: Number of Deaths from Suicide registered in NI by Multiple Deprivation Measures (2017) in the years 2015-2018[12]



Note: In the UK, in considering suicide events it is conventional to include cases where the cause of death is classified as either 'Suicide and self-inflicted injury' or 'Undetermined injury'.
All deaths data supplied by NISRA Vital Statistics Unit is based on the year of registration rather than the year of occurrence unless otherwise stated. Events such as suicide are likely to be referred to the coroner. This can take some time, therefore deaths recorded each year may have occurred prior to the registration year.
Analysis is based on Northern Ireland Multiple Deprivation Measure (NIMDM) 2017. As the NIMDM 2017 was produced using 2015 and 2016 data, suicide figures have been provided for 2015 onwards.
Source: further data and notes available at https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Suicide_2018.xls (accessed 10.11.2021)

[12] Please refer to footnote 2.

Despite many shared concerns and ambitions around mental health and mental health services, there is apparently relatively little co-operation between north and south on these issues. There are some examples of past and current successful cross-border projects in the mental health area, generally EU-funded , and supported and led by community organisations, but there is little evidence of much formalised interaction on a policy level.

It is also worth noting that the Institute of Public Health, based in Dublin and Belfast, has an all-Ireland remit, but as yet has done limited work on mental health.

In the wider health services, established and formalised cross-border co-operation occurs in a number of areas. These tend to be specific, specialist, hospital-based areas such as cancer care, in situations of clear advantage or necessity.(Heenan, 2021). Although mental health services do include community-based and some hospital-based services, they are not generally considered exclusively specialist services. In Ireland, mental health services are provided on both specialist and primary care levels, but the vast majority of people who use mental health services will access supports through their GP (HSE Mental Health Service, 2019).

It is useful to make a distinction between healthcare services and the wider concept of health, when looking at possible benefits of cross-border co-operation in this particular field. Many of the areas highlighted in the preparation of this paper as suitable for increased interaction, relate to the wider idea of public health and health promotion rather than the operational organisation and delivery of health services.

As mentioned, it is well established and documented that the incidence of mental health issues increase in disadvantaged areas, and that health inequalities[13] play an important role in the prevalence of mental ill-health. This applies in both jurisdictions, and looking at co-operation on mental health from a wider public health perspective would offer space to explore both the structural and social determinants of mental ill-health, and put the focus on prevention and early intervention, a stated priority for both Departments of Health.

2.1.1 Mental Health Funding and Data

In Ireland, mental health services have shown an increase in both funding and service activity over the last decade (HSE Mental Health Service, 2019), but there has also been an increase in demand for mental health services. The long waiting lists for access to services in some parts of the country are well documented.

Spending on mental health as part of the wider health budget remains comparatively low in both jurisdictions, with a figure of around six per cent for Ireland[14] and the same for Northern Ireland. In England, the figure is 12 per cent, meaning that the funding per capita is substantially less in Northern Ireland, despite the incidence of mental health problems being significantly higher.[15]

In Ireland, some data relating to mental health is provided by the Central Statistics Office (CSO) and the Health Research Board (HRB), which publish in-patient data on a regular basis. The HSE also provides service-related data, notably on waiting lists for mental health services, some of which is published and often publicly debated in response to parliamentary questions and Freedom of Information requests. Among the main data resources on mental health are Health at a Glance (published bi-annually by the OECD), The Wellbeing of the Nation[16] and Census 2016.[17]

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13 According to NHS England: 'Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.' Available at https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/ (Accessed 11.11.2021)

14 The figure is stated as being between five and seven percent, depending on how it is calculated. For a detailed explanation by Minister of State for Mental Health, Mary Butler TD, see the transcript of her appearance at the Joint Subcommittee on Mental Health, 14 September 2021, available at https://www.oireachtas.ie/en/debates/debate/joint_sub_committee_on_mental_health/2021-09-14/2/ (accessed 10.11.2021)

15 Both figures are taken from The Northern Ireland Affairs Committee hearing in London, 12 December 2019 , available at https://parliamentlive.tv/event/index/22b455cf-2a2c-45e8-b375-2a0df775460c (accessed 10.11.2021)

16 Available at https://www.cso.ie/en/media/csoie/releasespublications/documents/health/Wellbeing_of_the_Nation_FINAL_OFT_-_web.pdf (accessed 11.11.2021)

17 Available at https://www.cso.ie/en/census/census2016reports/ (accessed 10.11.2021)

In addition to official statistics, a number of other bodies contribute to the mental health knowledge base with their own surveys and research pieces, some of which are mentioned in this paper.

One aspect to bear in mind in relation to mental health data, and prevalence data in particular, is that much of the information is based on self-assessment. While the individual experience is obviously important, it is also subjective and recorded at a particular moment in time in response to a particular question, meaning that the statistics are individualised and difficult to compare and use as illustrations of objective fact.

In relation to data sources such as Census 2016, it can be difficult to gauge whether increased prevalence really refers to an increase in numbers experiencing mental health issues, or whether it arises from people being more willing to declare them, as a result of society becoming more open and accepting of mental health problems.

The majority of NI Official Statistics are published by the Northern Ireland Statistics and Research Agency (NISRA). Some statistics are also published by the NI Department of Health, and the Public Health Agency (PHA), which produces statistics on health and social care (Office for Statistics Regulation (OSR), 2021).

The report *Review of mental health statistics in Northern Ireland*, published by the OSR in September 2021, gives a comprehensive overview of the availability of mental health statistics in Northern Ireland and identifies shortcomings in three areas: data gaps, data quality, and data accessibility. The report discusses how such deficiencies make it difficult to get a clear picture of areas such as access to services, outcomes, and how to prevent poor mental health.

It further states that there is a lack of funding for data collection across bodies and agencies, meaning that a complete picture of the actual cost of service delivery and how this has changed over time is missing. Information is available on historical and current figures for hospital admissions and discharges as NISRA, in common with the CSO and the Health Research Board, collects data in such settings. However, there are gaps in knowledge around non-hospital-based activity.

> *As a result of the Bamford review in 2009, more treatment and services are community-based. Despite this shift in service delivery, there are limited official statistics capturing mental health service activity in the community and voluntary sectors – meaning part of the picture is missing (OSR, 2021).*

While the point relates specifically to Northern Ireland, it also has validity south of the border, where a large proportion of services are provided by the community and voluntary sectors, and are not always captured along with the statistics for state providers.

The current Irish mental health policy, *Sharing the Vision* includes strong commitments to improving data and accountability across services, as does the Mental Health Strategy for Northern Ireland.

While this will improve data availability in the two jurisdictions, it could also be beneficial in the context of all-island collaboration, making comparison and information-sharing on policy outcomes easier.

2.2 Mental Health and the Pandemic

There is no doubt that the current pandemic has pushed the issue of mental health and mental health services up the public policy agenda. Since the start of 2020, the media has consistently reported on increases in mental ill-health and the surge in demand for mental health services almost everywhere.

Although there is already evidence of increased demand for mental health supports, the consensus is that the full impact of the COVID crisis on mental health will be revealed over the next few years. A detailed article on these impacts was first published by the Irish Journal of Psychological Medicine in May 2020. It outlined four different waves of health need associated with the pandemic and stated:

> *The largest and longest fourth wave of healthcare need will encompass the psychosocial and mental health burden associated with this pandemic. This final tsunami will not peak until sometime afterwards (months) and will sustain for months to years after the COVID pandemic itself (O'Connor et al., 2020)*

A Northern Ireland Assembly research report on suicide from early 2021 paints a similarly stark picture:

> *The increased mental health burden associated with the COVID-19 pandemic is likely to be profound and felt for many years. Staff and services have had to work under even greater pressure, and in new ways. Demand for services, such as GP care, has increased and is anticipated to continue to rise after the pandemic subsides. (Black, 2021)*

The COVID crisis has brought with it a range of different issues with the potential to negatively impact on mental health. The fear and anxiety around catching COVID has been a constant, and public health measures such as restrictions and lockdowns have further increased anxiety and worry for a lot of people, some of whom might have experienced mental health issues previously, but also for many more who have struggled with this 'new reality'.

Other factors with a negative impact include enforced curbs on social interaction, school closures, separation from family and friends, and uncertainties around work and travel. Those who work in the health services and other frontline roles have experienced unique and prolonged stress in the day-to-day management of the pandemic. Organisations providing mental health supports have seen their activities curtailed, and some have lost the ability to fundraise, causing further stress and anxiety for service providers and users.

In recognition of the increased demands brought on by COVID, the WHO has made mental health one of its flagship priorities for the next five years. It has established a mental health coalition to support European countries in their efforts to improve mental health supports:

> *The pandemic has shone a light on the fragility of existing institution-based systems and the need for community-based support and care (delivered through digital means where necessary or applicable). The mental health flagship will encourage efforts and investments to relocate care away from institutions and towards community services, including through the integration of mental health into primary health care and other priority programmes such as adolescent health and non-communicable diseases.*[18]

It is expected that, over the coming years, an ever-increasing body of research will illustrate the pandemic's longer-term negative mental health impacts on different groups, but already a number of studies and surveys show an increase in mental ill-health across populations, much of it focusing on the initial periods of lockdown. In England, a mental health policy briefing from earlier this year (Parkin, 2021) lists a number of studies detailing the mental health impact on healthcare workers and minority groups, among others.

A report by the charity Mind, *The mental health emergency: How has the coronavirus pandemic impacted on our mental health* (MIND, 2020) highlighted that more than half of adults and over two-thirds of young people said that their mental health had deteriorated during the period of lockdown restrictions.

Public Health England, in their report on *Understanding the Impact of COVID-19 on BAME groups* (Public Health England, 2020) highlighted poorer health outcomes for people with mental illness, and that this has had a disproportionate effect on BAME communities.[19]

Several reports highlight the effects on children and young people, among them *Generation Lockdown* (Barnardos, 2020). This survey polled 4,000 children and young people, and 41 per cent of respondents said they were lonelier than before lockdown, more than a third said they were more worried (38%), more sad (37%) or more stressed (34%). As this

[18] Available https://movendi.ngo/news/2020/08/28/who-europe-establishes-mental-health-coalition/ (accessed 10.11.2021)

[19] BAME communities are Black, Asian and Minority Ethnic communities.

survey was conducted in 2020, it would seem reasonable to assume that those figures could be even higher after another year of restrictions and further school closures.

An Irish perspective on the effects on children can be found in the annual report by the Ombudsman for Children: *2020 Childhood paused* (Ombudsman for Children's Office, 2021). This report gives a comprehensive overview of how children were adversely affected by the pandemic, and much focus is on education and the lack of supports for children with additional needs. In relation to mental health specifically, the report states:

> *While the complaints made to the OCO may have related to calculated grades, digital poverty or other issues, 100per cent of the children who contacted us mentioned the mental health of children (Ombudsman for Children's Office, 2021).*

2.2.1 Cross-Border Issues

The COVID crisis has illustrated the difficulties inherent in having two different public health responses in such close proximity. While the broader COVID response is outside the scope of this paper, it is nevertheless interesting to note some of the points made in the Ulster University's scoping study *Collaborating on HealthCare on an All-island Basis* (Heenan, 2021). That study states that despite the existence of a Memorandum of Understanding between the Departments of Health in Ireland and Northern Ireland:

> *(…) the response to the global emergency demonstrated a shortfall in meaningful co-operation. Lockdown measures were introduced at different times, in varying ways, there were limitations on data sharing, and there was no all-island public health messaging (Heenan, 2021).*

In the wider health services, efforts will continue to evaluate COVID responses. This work will undoubtedly illuminate areas where increased all-island co-operation can be beneficial. In relation to mental health, there are some obvious areas, specifically highlighted during the pandemic, that are worthy of further exploration, such as the provision of online supports.

During the pandemic, both jurisdictions moved by necessity towards increased provision of online supports. While they are not suitable for every individual and situation, there does seem to be consensus around their many potential benefits, not least in increasing the reach of services to those that might be unable or reluctant to attend in-person services. The main advantage of online supports in the particular context of north-south co-operation is, of course, that there are no physical borders inherent in these types of interventions.

The term 'online interventions' might make us think primarily of talking therapies delivered on a one-to-one basis. However, the scope of virtual interventions is much broader and includes assessments and group sessions, as well as mental health and wellbeing education and training targeted at the general public, and information sharing between clinicians. Different aspects already form part of cross-border co-operation in mental health. A number of EU-funded programmes, including CAWT and the community and voluntary sector, which have some specific focus on remote supports, are outlined in Section 4.

3. Overview of the Policy Landscape

Both jurisdictions have current and relatively recently published mental health policies in place. To evaluate the progress in implementing the strategies is beyond the scope of this paper, and they should perhaps also be seen as longer-term aspirations, forming part of a larger healthcare context, dependent on ongoing funding commitments and other factors.

The policies are summarised below, and it is fair to say that there are many common denominators in the two documents, north and south. The preparation of both policies involved extensive stakeholder engagement, and they emphasise a person-centred, trauma-informed delivery of services. Notably, in the context of this paper, neither policy contains stated overall commitments to cross-border or all-island working.

3.1 Mental Health Policy in Ireland

Current government policy on mental health services in Ireland is set out in *Sharing the Vision*, a comprehensive and wide-ranging document launched in June 2020. The document is the successor to *A Vision For Change*, published in 2006. *Sharing the Vision* describes the vision as follows:

> *The vision embodied in this policy is to create a mental health system that addresses the needs of the population through a focus on the requirements of the individual. This mental health system should deliver a range of integrated activities to promote positive mental health in the community; it should intervene early when problems develop; and it should enhance the inclusion and recovery of people who have complex mental health difficulties. Service providers should work in partnership with service users and their families to facilitate recovery and reintegration through the provision of accessible, comprehensive and community-based mental health services.*

The ambition is to create a policy which reflects a population-wide approach to mental health. An Oversight Group was established in 2017 to set out current and future priorities for the new mental health policy.[20] As part of that work, the group undertook a thorough review of *A Vision for Change* and looked at which parts should be carried forward and which new items needed to be added. In conducting this work, they also had to take into account the work of an Expert Evidence Review of international best practice, and progress on current service developments in Ireland.

The new policy contains many of the elements found in *A Vision for Change* but it has been updated and amended in order to reflect the current situation and importantly, it also aligns with the overarching, ten-year vision for reform of Ireland's health and social care services, outlined in the Sláintecare report (Houses of the Oireachtas, 2017).

Previous criticism of *A Vision for Change* focused on the lack of an implementation plan to accompany the many recommendations, and an adequate way to measure outcomes (Johnston, 2014; Mental Health Reform, 2015). In order to improve these areas, the new document contains an enhanced implementation structure.

The new policy is underpinned by an emphasis on performance management and is overseen by a National Implementation and Monitoring Committee (NIMC). The NIMC was established to oversee implementation of the policy, and to monitor progress at national level and strategically across the HSE. The Committee has been tasked with driving reconfiguration, monitoring progress against outcomes, and assessing the delivery of commitments made in the policy. The policy also suggests that a separate structure be set up in the HSE, to liaise with and participate on the NIMC to ensure that policy programmes are implemented in line with the *Sharing the Vision* strategy, and to ensure performance is managed.

[20] The Oversight Group contained representatives from a range of stakeholders including both service providers and service users. The Terms of Reference for the group included looking at new areas such as the development of e-health and the emerging needs of vulnerable groups.

Sharing the Vision details 100 actions, organised under four different domains, all with their own, high-level individual outcomes, detailed under each of the four headings:

- Promotion, Prevention and Early Intervention Domain;
- Service Access, Coordination and Continuity of Care Domain;
- Social Inclusion Domain; and
- Accountability and Continuous Improvement Domain.

The first domain is focussed on health promotion. It mentions a range of plans and programmes already underway or in the planning stages within the Department of Health and/or the HSE. These include the Women's Health Taskforce, *Healthy Ireland*, a proposed national stigma reduction programme, and *Connecting for Life,* the national strategy to reduce suicide.

The importance of learning from and connecting with the work of other Departments in relation to children and young people is also reflected in the first domain. Tusla's *Area Based Childhood Programme (ABC),* as well as *First 5*, the whole of government strategy for babies and young children, are both referenced. In this context, there is also a mention of cross-border programmes addressing the impact of Adverse Childhood Experiences (ACEs)

The second domain, Service Access, Coordination and Continuity of Care, is the most extensive in the policy. Almost half the 100 actions are found under this heading, which focuses on the organisation of, and access to, service provision. It includes the *stepped care* approach, where the level of complexity and/or severity of a person's presentation determine the care pathway. There are also detailed illustrations of the continuum of supports envisaged, and the interlinked relationships between community and voluntary supports, primary care, and specialist mental health services.

The social inclusion domain focuses on those who are living with complex mental health difficulties, and who are most vulnerable to social exclusion. Equity of access is emphasised which, in this context, includes not only access to health services but to wider supports such as housing, employment and social welfare supports.

The final domain deals with accountability and continuous improvement. Under this heading, the document addresses a number of related issues such as information sharing, ICT enabled health systems, and research. The use of digital technologies is also mentioned here and an interesting point is that it is discussed not only as a tool for direct interaction between a health professional and a patient, but also in a wider context, where health professionals can provide expertise to Primary Care and also in the use of recorded digital information.

It is worth noting that there are no specific actions mentioned in relation to cross-border or all-island work, apart from a reference to work around Adverse Childhood Experiences, mentioned under Domain 1.

3.2 A New Mental Health Strategy for Northern Ireland

In June 2021, Northern Ireland's Health, Minister Robin Swann, launched the new *Mental Health Strategy 2021-2031*.

Speaking in the Assembly, Minister Swann said:

> *The Strategy is built on a vision of a society which promotes emotional wellbeing and positive mental health for everyone, which supports recovery and seeks to reduce stigma and mental health inequalities. In the vision we set out the objective of a system that is consistent and provides equity of service. We also want to break down barriers so that individuals and their needs are right at the centre – a truly person centred care.*[21]

[21] Available at https://www.health-ni.gov.uk/news/minister-health-publishes-new-10-year-mental-health-strategy (accessed 10.11.2021)

The publication marked the culmination of a well-documented ambition to improve mental health services in Northern Ireland, and also of a number of years of extensive consultations undertaken by the Department of Health in Northern Ireland.

The suspension of the Northern Ireland Assembly during the years 2017-2020 delayed the finalisation of the mental health strategy. However, a Mental Health Action Plan, and a COVID-19 Mental Health Response Plan, were published in 2020 and Northern Ireland's first Mental Health Champion was appointed on an interim basis.

The published Strategy sets out the future strategic direction of mental health services in Northern Ireland for the next decade.

It sets out 35 actions under three overarching themes:

- **Theme 1:** Promoting mental wellbeing, resilience and good mental health across society;
- **Theme 2:** Providing the right support at the right time; and
- **Theme 3:** New ways of working.

Seven core principles have been developed, which represent the foundations upon which each of the actions set out in the Strategy are based:

1. meaningful and effective co-production and co-design at every stage, involving all partners equally;
2. person-centred care and a whole life approach – a system that meets the needs of the person and their family and support network, rather than expecting the person to fit into a rigid system;
3. care that considers and acknowledges the impact of trauma – where staff have the appropriate knowledge and skills and are aware of the impact of trauma, particularly in the context of Northern Ireland;
4. choice in treatment to fit the needs and preferences of the person;
5. early intervention, prevention and recovery as a key focus – all decisions should be made with this in mind;
6. evidence-informed decisions - services and interventions built upon sound evidence of what works; and
7. the specific needs of particularly at-risk groups of people, and the barriers they face in accessing mental health services, should be recognised and supported.

The strategy came with a funding plan attached. Minister Swann emphasised that the strategy could not be implemented with current levels of funding, but will require additional and sustained funding of around £1.2bn over the next 10 years.

The 35 actions in the Strategy are wide-ranging and contain high-level commitments, but also propose tangible and specific actions around the organisation of services and care pathways.

Central to its vision is the expansion of therapy hubs across the country, accessed through primary care and local GPs. A regional structure will be developed across the five Health and Social Care (HSC) Trusts, which will have responsibility for consistency in service delivery and development.

As part of the research for this paper, discussions were held with departmental officials responsible for preparing the Strategy. Much emphasis was put on the ambition to reorganise services with more community focus, and crucially, more formalised involvement of the community and voluntary sector in the delivery of mental health services. The emphasis is on integration of services and co-operation, and on putting the expertise of this sector to better use. The

point was made that this sector has often been overlooked, and that there is a need for more consistent and guaranteed funding in order to maximise its contribution to service delivery.

The preparatory work for the Strategy involved consultation with more than 2,000 people, further illustrating the ambition for an inclusive and consultative approach.

The area of cross-border work is not addressed in the strategy.

3.2.1 The Mental Health Champion

In June 2020, Professor Siobhan O'Neill, a leading authority on mental health and mental health services in Northern Ireland, and Professor of Mental Health Sciences at Ulster University, was appointed Interim Mental Health Champion in Northern Ireland. She was subsequently appointed to the post on a permanent basis in September 2021.

The post came about as a result of representations by community and voluntary groups, and the position is funded jointly by all government departments.

When the appointment was announced, the Minister outlined the functions of the Mental Health Champion to include:

- acting as a public advocate for mental health, and participating in the public debate around mental resilience, suicide, mental health and recovery;
- acting as a consensus builder to integrate mental health and wellbeing across government; to encourage government to think about mental wellbeing, resilience, mental health and recovery; and to help integrate the ideas of mental resilience and mental health in all public policy making; and
- acting as an adviser to senior stakeholders; supporting research into mental health; and providing a voice for those who otherwise would not be heard.

Engagement for this paper with a leading Department of Health official, and with Professor O'Neill, suggests that the exact role of the champion is still to some extent being explored. However, there is consensus that it is very much a co-operative, rather than a commissioner-type, role. The Champion is not primarily intended to critique and oversee the public implementation of mental health policy, but rather to advise, raise awareness and act as a liaison with community and voluntary groups, and with individuals in order to improve policymaking.

The Champion's role is fully supported by the NI Executive, and there is a desire to weave a mental health-friendly ethos into all policies and services, advised and assisted by the Champion.

While the Champion is not a decision-maker with respect to government policy, she will play a key role in influencing and enhancing the implementation of the Department of Health's Mental Health Strategy 2021-31.

3.3 Mental Health Policy in Wales, Scotland and England

Separate health services were in place for each part of the UK between 1948 and 1999, prior to devolution. The health systems in Northern Ireland and Scotland were managed by UK government departments, the Scottish Office and Northern Ireland Office respectively. Similarly, in 1969, the Welsh NHS was separated from the English NHS and was put under the authority of the Welsh Office.

In relation to mental health specifically, Wales, Scotland and England all have current, substantial strategies in place.

3.3.1 Wales

In Wales, *Together for Mental Health – a Strategy for Mental Health and Wellbeing in Wales* (Welsh Government, 2012) provides a 10-year plan for increasing mental health provision and providing a vision for service delivery. The strategy emphasises a whole of population approach, and is the first mental health strategy that covers all ages. Previously, there had been separate strategies for different age cohorts. One of the ambitions in the strategy is to provide more seamless, joined-up services throughout a person's lifetime, and there is an emphasis on individual need rather than age boundaries in access to services. The strategy has been accompanied by delivery plans during its lifetime. The most recent strategy, published in October 2020, has since been updated in response to the impact that COVID-19 has had on the mental health and wellbeing of people in Wales.

3.3.2 Scotland

Scotland's current mental health strategy spans the years 2017 to 2027, and details forty actions under a number of headings. An interesting aspect is its emphasis on poverty as a cause of mental ill-health. It states:

> *Poverty is the single biggest driver of poor mental health. The Fairer Scotland Action Plan sets out how we will help tackle poverty, reduce inequality and build a fairer and more inclusive Scotland. We will work with partners in local government, the third sector and communities to deliver this ambition and to recognise the importance of this activity in delivering good mental health for the whole population of Scotland (Scottish Government, 2017).*

It further states:

> *This Strategy is part of a wide range of measures that the Scottish Government is taking to help create a Fairer Scotland. The inequalities that drive differences in physical health outcomes are the same inequalities that detrimentally impact on mental health. Poverty and social exclusion can increase the likelihood of mental ill-health, and mental ill-health can lead to greater social exclusion and higher levels of poverty.*

While the other strategies discussed in this paper do address the issues of social exclusion and poverty, both as a cause and an effect in relation to mental ill-health, the Scottish strategy seems to be uniquely framed as part of the wider context of The Fairer Scotland Action Plan (Scottish Government, 2016). This suggests a stronger and more pronounced sense that addressing inequalities in society as a whole is important to getting to grips with health inequalities and mental ill-health.

NHS Scotland (now Public Health Scotland) published an inequality briefing paper in November 2017, which specifically addresses mental health inequalities, as well as the social and health inequalities experienced by people with mental health problems. It places further emphasis on a whole of society approach in striving towards better mental health for all:

> *Achieving good mental health for all is the responsibility of all agencies and policy areas. Actions across health, social, economic and environmental policy areas can have an impact on mental health (NHS Scotland, 2017).*

3.3.3 England

In England, the current mental health policy was published in 2016. A taskforce made a number of recommendations to NHS England and the Government, all of which were accepted. *The Five Year Forward View for Mental Health* (NHS England, 2016) is a comprehensive document, which emphasises the need for improvements in access to more joined-up and timely care across the country. It also emphasises parity of esteem between physical and mental health in the delivery of services.

One recommendation relates to a review of the Mental Health Act 1983, in order to ensure stronger protection of people's autonomy. Interestingly, the Act has appeared in public debate more recently when temporary changes were made to it in a schedule to the Coronavirus Act 2020.[22] Those changes arguably had the opposite effect on individual autonomy, and were later withdrawn without being commenced, on advice from a number of Select Committee reports.

The pandemic led to a variety of NHS responses with regard to mental health services. A briefing paper from March 2021 outlines resources and guidelines issued to staff during the pandemic, and also details some studies examining the impact of the pandemic on mental health (Parkin, 2021). This field of research is likely to continue to grow, but it is notable how much data is already available on the adverse effects of the pandemic on mental health for a range of groups.

3.4 Common Themes

Looking at mental health policy in the different jurisdictions, it is apparent that countries share many of the same problems, and proposed solutions, in the articulation and execution of mental health policy.

Ireland and Northern Ireland both place strong emphasis on the views of citizens, and on how and where services users want to access services. Significant engagement with individuals and other stakeholders has been part of the development of the policy documents

Both jurisdictions prescribe and practise trauma-informed service delivery, which is based on an understanding of the wider effects of trauma on individuals, families and communities. Service delivery aims to promote a culture of healing and recovery, and to avoid re-traumatising.

Other recurring themes include an increased emphasis on early intervention, including improvements in services for children and young people; more joined-up services; and an emphasis on community-based, primary care-led mental health services. Stepped care services are promoted as part of this model, and those countries that rely heavily on the voluntary sector are seeking better and more formalised relationships and care pathways.

Parity of esteem between physical and mental health services is also emphasised in several of the policy documents. One major aspect is ensuring that acute and crisis mental health services are available on a twenty-four hour, seven days a week basis. There are also many references to suicide reduction strategies, access to help for eating disorders, and perinatal services.

The main differences between the strategies are not so much found in the individual chapters and actions, but in the wider context in which they are framed. In Northern Ireland, the Troubles and their long-term effects on the mental health of communities, such as high rates of suicide, as well as consistently underfunded mental health services, provide some of the backdrop. In Ireland, the overall vision for reform of health services under Sláintecare is the dominant framework. In Scotland there is a strong emphasis on the links between poverty and mental health.

The strategies for Wales, Scotland and England were all published prior to 2020, and do not address issues specifically related to the pandemic. In Ireland and in Northern Ireland, the strategies are more recent and the ministerial forewords of both documents reference the COVID crisis and its impacts.

[22] Coronavirus Act 2020 (UK Government 2020 Schedules 10 & 11)

4. Cross-Border Collaboration and Co-operation

In the wider health services, there are many examples of areas of co-operation between Ireland and Northern Ireland. Cancer services, ambulance services and paediatric hospital services are all areas that have benefitted from different levels of co-operation. The North South Ministerial Council (NSMC) has health as an area within its remit, but mental health has so far not been given particular attention under this heading.

The nature of existing co-operation in the wider health services, and its current limitations, have been detailed by Professor Deirdre Heenan in her scoping paper commissioned by the Shared Island Unit *Collaborating on Healthcare on an All-Island Basis: A Scoping Study* (Heenan, 2021). The paper includes mental health as an area with potential for further co-operation.

It is worth noting that, while the terms health and healthcare are sometimes used interchangeably, it is useful to make a distinction between the two in this context, and specifically in relation to mental health.

Healthcare relates more to the delivery of medical, health-specific services. This is an area where co-operation is governed not only by need, but by the constraints and possibilities inherent in the close geographical proximity of two different jurisdictions governing healthcare services.. Co-operation on health service delivery, in a mental health context, is likely to be focused on specific geographic areas where cross-border flexibility in service access makes practical sense, rather than on an all-island basis, as the majority of mental health service provision is not considered specialist.

The wider concept of *health* includes public health measures, prevention, and awareness raising – all very important areas in a mental health context.

With regard to mental health policy, it is worth reiterating that neither of the current mental health policies – *Sharing the Visio*n and *Mental Health Strategy 2021-2031* – makes much mention of cross-border or all-island commitments.

Discussions with the Department of Health in Northern Ireland suggest that co-operation between the jurisdictions, north and south, is less evident than co-operation with other parts of the United Kingdom. In addition, there are statutory complications in relation to some aspects of health service co-operation across the island of Ireland, e.g. there is no legal framework for detention, making it difficult to move individuals for treatment across the border, (see Box A).

Possible, albeit complex, solutions to this problem exist in various pieces of legislation. While the Mental Capacity Act (NI) 2016 allows for the transfer of patients, the legislation has not been commenced in Northern Ireland, and there is no equivalent legislation in Ireland.

The point was made by the Department, that it would make sense to have cross-border flexibility on this issue, and that facilities could be shared and utilised more efficiently in some areas. For example, the Western Health and Social Care Trust Mental Health unit (Grangemore) in Derry, which has a 30-bed capacity, could accommodate patients from across the border were it legally possible.

It is important to acknowledge that in the day-to-day operation of mental health services, informal liaison and linkages do take place in the border counties. Service review teams often consult each other across the border, and people can be provided with services in the neighbouring jurisdiction if this is desired and/or more practical.

HSE representatives in Community Healthcare Organisation (CHO) 1, which encompasses Donegal, Sligo, Leitrim, Cavan and Monaghan, emphasised that there is a good history of co-operation and no ‘wall’ between services.

There are also examples of co-operation in relation to particular types of mental ill-health. A newly established group, he Connecting Suicide and Self-Harm Researchers on the island of Ireland (C-SSHRI), is a research community specific to suicide and self-harm, which provides a forum for members to connect with each other as well as organising meetings and events.

Additionally, despite a lack of formal arrangements on a departmental level, it is apparent that cross-border project co-operation has existed over the last few decades, and continues to exist, in many areas of health and social care, and also specifically within the area of mental health and wellbeing. Much of this work is done under the banner of EU funding, specifically the Interreg and Peace programmes, and is facilitated by the CAWT Partnership.

Box A: The transfer of patients across jurisdictions

Writing about her experience as a psychiatrist in Cavan and Monaghan, Dr. Rachael Cullivan states:

If you are from the North of Ireland and require admission under the Irish Mental Health Act because you have become ill while visiting or because you are sheltering or hiding here based on a persecutory delusional belief, there is no legal mechanism by which you can return under the protection of Mental Health Legislation to be treated in your local hospital by a familiar team close to your family and community supports.

It is exactly the same should an individual from the Republic of Ireland find themselves admitted to a Northern Irish Mental Health Facility. Whilst too ill to be treated in a voluntary capacity they may nonetheless request to be transferred to their local Psychiatric Hospital or Ward for ongoing care. But each Mental Health Act "expires" upon crossing the Border so no patient can be legally transferred from one hospital to the other. The Irish Solution has been to either keep the individual under the Mental Health Act until well enough to be discharged (at variance with their and their families' wishes) or to drive them to the Border and then "hand them over" to a treating team from the other jurisdiction possibly involving the Gardaí/PSNI/Social Worker at the meeting point.

Source: Example taken verbatim from Cullivan, 2020.

4.1 European funding

The Special European Union Programmes Body (SEUPB) is responsible for the implementation of the EU's PEACE IV and INTERREG VA Programmes. [23]

Interreg has been one of the EU's key instruments in supporting co-operation across borders through project funding. Its aim is to tackle common challenges jointly, and to find shared solutions in fields such as health, environment, research, education, transport, and sustainable energy.

The **PEACE** programme, which has been implemented in different phases since 1995, is a cross-border co-operation programme Co-operationbetween Ireland and the UK, in the context of European Territorial Co-operation (ETC).It aims to promote economic and social stability and cohesion between communities involved in the conflict in Northern Ireland and the border counties of Ireland.

The **Peace Plus Programme 2021-2027** combines the existing PEACE and INTERREG cross-border EU funding strands into a cohesive new north-south programme, funded by the EU, the UK and Irish Governments, and the Northern Ireland Executive. .It will promote peace and reconciliation and contribute to the cross-border economic and territorial development of Northern Ireland and the border region of Ireland, with some capacity for all-island co-operation.

[23] Their website is an extensive information resource for European funding and can be accessed at https://www.seupb.eu/

Funding will be allocated under six themes: Building Peaceful and Thriving Communities; Delivering Economic Regeneration and Transformation; Empowering and Investing in Young People; Healthy and Inclusive Communities; Supporting a Sustainable and Better Connected Future; and Building and Embedding Partnership and Collaboration.

A range of investment areas are included under the themes, and although mental health does not have its own theme or heading, it is expected that a range of projects could meet the criteria.

The indicative funding for the programme is around €1bn, shared between the European Union, the Irish and British Governments and the Northern Ireland Executive.

4.2 The Role of CAWT

Co-operation and Working Together (CAWT) is a cross-border health and social care partnership, which has been in existence since the early 19902. It was founded as part of the Ballyconnell Agreement[24] and in recognition of the need for collaboration in order to develop health services in cross-border areas.

The Agreement was initially made between the North Eastern Health Board and the North Western Health Board in Ireland, and the Southern Health and Social Services Board and the Western Health and Social Services Board in Northern Ireland.

Since 2007, following local government re-organisation in Northern Ireland, the agreement now includes the Southern Health and Social Care Trust and the Western Health and Social Care Trust in Northern Ireland. In Ireland it includes the border counties of the HSE regions of the Dublin North East and the West. The current agreement states that the CAWT area embraces the whole of the land boundary between Ireland and Northern Ireland. Between them they comprise a population of over 1.26 million, 21 per cent of the island, and some 25 per cent of the land area.

CAWT's vision is to realise opportunities and develop new ways to improve health and social care services for the wellbeing of people through collaboration across borders and boundaries.

It is clear that CAWT plays a central role in cross-border relations in the area of health and social care. In addition to bringing the publicly funded sides from both jurisdictions together in a formal manner, CAWT interacts frequently with the community and voluntary sector. It has a robust network, and one of its core functions is to bring people together. Another important function is to manage and deliver EU-funded programmes. In 2008, both Departments of Health on the island appointed CAWT as the delivery agent for the new EU Interreg theme of *Co-operation for a sustainable cross-border region/Collaboration*. Twelve large scale projects were subsequently delivered under this programme.

In 2017, a further five CAWT projects secured funding, one of which was for Mental Health Innovation Recovery (the recovery colleges), described below.

CAWT therefore represents a significant locus of healthcare co-operation, including on mental health, between the two jurisdictions on the island. substantially enabled by the INTERREG programmes, and the current PEACE PLUS programme.

[24] The purpose of the 1992 Ballyconnell Agreement, (named after the town where it was signed) was to exploit opportunities for cross-border co-operation in the planning and provision of health and social care services and to take advantage of funding from the European Union or other parties. The agreement is available at http://www.cawt.com/wp-content/uploads/2018/02/The-Ballyconnell-Agreement-page-1.pdf (accessed on 10.11.2021)

4.3 Current projects

The examples described below are current cross-border projects receiving funding through the Interreg or PEACE programmes, with a specific focus on mental health.

4.3.1 Recovery Colleges

Led by CAWT, the Innovation Recovery project is a large scale cross-border initiative, part-funded through the Interreg VA Programme,[25] and match-funded by the Departments of Health in Ireland and Northern Ireland.

The purpose of a Recovery College is to support people's recovery from mental health difficulties through learning and education.

To date, nearly €7.6m has been provided for the project which sees education as a route to building wellness and recovery and which encourages people to take greater personal control of their mental health.

Recovery Colleges have been established to cover the following areas:

- **Area 1 West:** Derry, Letterkenny, Strabane and West Donegal
- **Area 2 South:** Cavan, Monaghan, Sligo, Leitrim and Fermanagh
- **Area 3 East:** Belfast, Armagh, Newry, Dundalk.

As of October 2021, over 4,300 people have taken part in a diverse range of courses with a strong emphasis on lived experience. The project employs 14 people as peer educators, who are all individuals with personal experience of mental health issues. All courses are designed and delivered by people with lived experience, in tandem with health professionals.

The project will be subject to an in-depth evaluation and, if deemed effective, the hope is that the recovery colleges will be mainstreamed and remain a permanent fixture. It is worth noting that recovery education is included in the current mental health strategies both in Ireland and in Northern Ireland.

Courses in the recovery colleges have been delivered both in-person and through Zoom. In June 2021, Northern Ireland Minister for Health, Robin Swann and Ireland's Minister of State for Mental Health and Older People, Mary Butler, jointly launched the first online recovery college to complement existing services.[26]

The use of an online portal – **MyMentalHealthRecovery.com –** will increase the reach of the recovery colleges. Courses can now be accessed by people who are unwilling or unable, for any number of reasons, to access the physical colleges. In addition to providing improved access, the online education is a cost-effective way of learning, which enables students to learn in their own time and at their own pace and to be selective in choosing material that feels particularly relevant to them.

[25] Interreg V covers the fifth period of the programme 2014-2020 and the VA strand focuses on four areas: Research & Innovation for cross-border enterprise development; Environmental initiatives; Sustainable Transport projects; and Health & Social Care services on a cross-border basis.

[26] Information available at https://cawt.hscni.net/health-and-hope-in-your-hands-irelands-first-online-recovery-college-launched/ (accessed 10.11.2021)

4.3.2 ChatPal

The organisation Action Mental Health was set up in Northern Ireland in 1963 by a group of psychiatrists who wanted to see an integration of patients into the community and out of hospitals. The early focus was on recovery and on getting people back to work.

It has since evolved into providing a wide range of services and programmes with the aim of building resilience. Since 2006, outreach work has also emphasised getting to people where they are, rather than getting them to physical locations where services are based.

Work has been ongoing to see how people in rural locations can be supported.

Against that background, ChatPal has been developed as a chat bot to support people without easy access to services. It is a free app that gives users a personal text-based tool to manage their mental health, which is interactive and instantly accessible.

The project is funded by the Northern Periphery and Arctic 2014-2020 Programme, part of the Interreg funding framework.

ChatPal has been developed as a partnership between experts and psychologists in Finland, Sweden, Scotland, Ireland and Northern Ireland, who work on different aspects of the project and meet (virtually) on a monthly basis for updates and problem-solving. The technical aspects of the app are worked on by Münster University, while Action Mental Health deals with user interaction.

One particularly interesting aspect of ChatPal is that it has become increasingly timely due to the COVID pandemic. Action Mental Health believes that the advent of online supports within mental health services can be very beneficial to individuals who might be reluctant to take part in a physical group or individual session.

4.3.3 Our Generation

Our Generation is a Peace IV funded project specifically focused on stopping the intergenerational impact of trauma, by building emotional resilience and peace for current and future generations.

It is a three- year programme involving seven partners, led by Action Mental Health in Northern Ireland.[27]

Our Generation works with existing community-based groups, and each partner has its own remit and programmes. The programmes are delivered to school-aged children, primarily in a school or community setting. The main access criterion is geographic location including the five counties in HSE CHO 1[28] and the urban villages areas.[29]

The project commenced in December 2019, and hopes to reach 36,000 people, including 5,000 key contacts, who are professionals such as teachers and social workers, but also parents and carers.

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27 The full list of partners is: Action Mental Health, Donegal Youth Service, Co-Operation Ireland, Youth Action NI, Youth Work Ireland, PlayBoard NI and Ulster University.

28 They include Donegal, Sligo, Leitrim, Cavan and Monaghan.

29 The Urban Villages Initiative is a headline action within the NI Executive's Together: Building a United Community (TBUC) Strategy, and is overseen by the Executive Office. It is designed to improve good relations outcomes and develop thriving places where there has been a history of deprivation and community tension. Areas included are Ardoyne and Greater Ballysillan (North Belfast), Colin (West Belfast), EastSide (East Belfast), Sandy Row, Donegall Pass and the Markets areas (South Belfast), The Bogside, Fountain and Bishop Street (Derry/Londonderry) Available at https://www.executiveoffice-ni.gov.uk/articles/urban-villages-initiative (accessed 10.11.2021).

5. Potential for further collaboration

A number of themes recur when talking to mental health stakeholders in both jurisdictions about current and potential all-island or cross-border co-operation..

5.1 Policy

On a policy level, mental health sits in two very different healthcare systems, north and south, with different funding mechanisms, systems and structures. This can make consistent co-operation difficult; at present co-operation mostly appears to take place in local border areas where it benefits the provision of services in both jurisdictions.

Co-operation across jurisdictions depends in some respects on physical location and criteria such as sharing of health infrastructure, treatment beds, and specialist doctor and nursing services. While several examples of such co-operation exist in the wider health service, there are legal impediments to certain types of co-operation in the mental health field, as outlined in the opening to Section 4. What is clear is that any joint schemes that involve changing the fundamentals of service delivery in the physical, operational space, would have to be politically led, with a mandate on both sides, and form part of the wider health care context in both jurisdictions.

However, in the context of overall policy frameworks, the WHO goals of deinstitutionalising mental health care and developing services in the community are principles that both jurisdictions have strived towards for a number of years (Bengoa *et al.*, 2016; Department of Health, 2009; Houses of the Oireachtas, 2017). Their wider policy ambitions and clinical programmes show many similarities, making a case for increased dialogue on a mental health policy level also.

Cross-border and all-island co-operation on policy could help the sharing of ideas and solutions in particular areas of mental health. There are some examples of this having happened, notably in the area of suicide prevention.

The National Self-Harm Registry Ireland has been operating in Ireland since 2002, via the National Suicide Research Foundation. As part of the Northern Ireland Suicide Prevention Strategy, Protect Life – A Shared Vision, the format of the Registry was mirrored and piloted by CAWT within the Western Health & Social Care Trust area from 2007. The pilot proved successful, and the Registry was implemented across all five Health and Social Care Trusts in 2012.[30]

5.2 Public Health and Mental Health Promotion

Looking at mental health from a public health perspective means being more focused on the wider causes of mental ill-health, rather than the mechanisms for treatment and the delivery of healthcare services. There are many advantages to emphasising this perspective in discussions on co-operation, and thereby focusing on issues such as good health promotion, awareness raising, and early intervention – all areas that could potentially see initiatives and campaigns implemented on an all-island basis.

In border areas in particular, it is important to work co-operatively to address underlying causes such as poverty and trauma, which show a particularly high prevalence in these areas. The CAWT Partnership and other voluntary sector organisations play a major role in this, and it is important that they are consistently supported to do so.

[30] Information about the Self Harm registry available at https://www.publichealth.hscni.net/news/northern-ireland-self-harm-statistics-published-pha (accessed 10.11.2021)

The Institute of Public Health is a public body with an all-island remit. Although it has provided input into mental health policy in both jurisdictions, it has not conducted any recent work specifically on mental health. Nevertheless, much of its work in areas such as alcohol abuse, and its strong focus on health inequalities and determinants of health, is highly relevant in the context of mental health.

5.3 Funding

The funding mechanisms that govern health spending, and thereby spending on mental health services and promotion, are fundamentally different in the two jurisdictions.[31]

As outlined in Section 4, cross-border co-operation in the mental health area has largely taken place under the banner of EU funding. Although there are some concerns around the sustainability of this model as a result of Brexit, the Peace Plus programme does provide a substantial €1bn resource and a number of initiatives in the mental health area could meet its criteria.

Nevertheless, the view was often expressed, during interviews in the preparation of this paper, that it would be desirable not to have to rely on European funding due to the high levels of cross-border mobility of people living in border regions, and the common challenges relating to mental health among our shared populations. What was highlighted was the need for joint policy development, planning, and delivery in areas such as suicide prevention; prevention and treatment of eating disorders; recovery-orientated practice; and mental health promotion. Multi-annual cross-border funding would facilitate sustainability of successful projects by ensuring public buy-in from the outset, and also ensure consistency of funding and service delivery. There is also, of course, a relationship between consistent funding and official, permanent structures.

5.4 The value of official settings for co-operation

Relevant actors believe that official settings, structures and bodies are important in getting key mental health issues on the official agenda, while providing oversight, direction, endorsement and encouragement for co-operation.

The North South Ministerial Council, which has a strong health remit, and which oversees the work of CAWT and of cross-border EU-funded programmes, would appear to be very well-placed to enable further mutually beneficial co-operation and exchange on mental health issues between the two administrations. The desire for more formalised settings for co-operation not only applies to the higher, political North South Ministerial Council level, but also to the more local, cross-border level.

It is clear that there is frequent, informal contact and co-operation between services in the border counties. However, there is also desire among stakeholders for a high level, formal network focusing on clinical, professional and leadership issues and encompassing representatives from both jurisdictions.

Formalising some such type of co-operation could serve to make it more visible and organised, and send a signal that such co-operation is not only desirable but vital, including in new and emerging areas of care, such as online supports.

5.5 The Role of a Mental Health Champion

The appointment of a mental health champion is something that could be considered in Ireland. Bearing in mind that the exact function and responsibilities of the role in Northern Ireland are still to some extent being established, early signs are that the position will be key in furthering the mental health agenda and, importantly, providing a semi-formal line of communication between the public sphere and the community and voluntary sector.

The strength of such a position could be that, while it has public funding and endorsement, it exercises much of its remit in the community sector. If such a role was considered for Ireland, it would be an opportunity to include north-south co-

[31] See for example https://www.instituteforgovernment.org.uk/explainers/devolution-nhs (accessed 10.11.2021)

operation in its remit. There might then be an opportunity to engage with its counterpart in Northern Ireland, to assess if there would be support for expanding the role there to include north-south co-operation.

5.5 Data and Research

A recurring theme in the preparation of this paper has been the difficulty in accessing comparable data that can be used in analysing the situation in the two jurisdictions of a range of different topics such as access to mental health services, the incidence of mental health issues, and their causes.

Substantial benefits could arise from the work of the CSO and NISRA being more unified, consistent ,and comparable in the collection and presentation of mental health statistics.

The issue of data sharing and the transfer of knowledge between jurisdictions is a recurring theme in Professor Heenan's scoping paper on collaboration. There seems to be a consensus around shortfalls in both jurisdictions in relation to the collection of quality, accessible data. The view is also expressed that:

> *An all-island approach in terms of data could be viewed as ensuring that significant decisions about population health are informed by data and trends, which can only be a good thing (Heenan, 2021).*

The report *Review of mental health statistics in Northern Ireland,* published by the Office for Statistics Regulation in 2021, provides robust recommendations for the improvement of data availability in Northern Ireland. *Sharing the Visio*n also focuses on data improvement under one of its domains. It is hoped that these measures together can provide better and more comparable data in order to look at mental health and mental health services from an all-island perspective.

In terms of topics of research, there seem to be many areas of research within the mental health field that could benefit from a shared approach. One example given was to conduct a research project on the efficacy of web-based interventions. As these have increased dramatically in both jurisdictions over the past two years, it will become increasingly important to assess their impact and outcomes over time.

5.6 Online Supports

Most of us have experienced a shift towards online interactions in many aspects of life over the last two years. While there is understandable fatigue around the reliance on online tools as a replacement for human interaction, it has undeniably also opened up a huge range of possibilities, not least in the delivery of health and social care services.

The pandemic has moved many services towards using online platforms and, although therapies delivered remotely will never be appropriate for every individual, they do have the advantage of removing physical borders as an impediment to service access.

As the example of ChatPal illustrates, online supports can play an important role for some people who experience isolation for any number of reasons. Some people may have difficulties physically accessing services or meaningful social interactions, while others can find the virtual medium less intimidating that physical attendance, thus encouraging participation that otherwise would not have taken place.

While online services are likely to form part of health service delivery into the future, there seem to be many potential advantages to the wider use of online resources – for example, training course delivery, information-sharing, and mental health education could all benefit from borderless co-operation. Similarly, increased dialogue between and among policymakers, clinicians, and networks across jurisdictions could be made easier and more instantly accessible. The pandemic is likely to have prompted many innovative uses of technology, and these ideas and applications should be harnessed and shared as much as possible. A more official basis for co-operation on mental health on the island could facilitate new online service delivery options, north and south.

6. Conclusions

Mental health is an increasingly important concern in both Ireland and Northern Ireland. The pandemic has had a significant impact and what is likely to be a long-lasting effect on the instance of mental health issues for many different groups in society.

It is of some comfort in this context that mental health issues have already been more visible in the public arena for some time. Prior to the pandemic, the public discourse on mental health issues had already moved towards greater awareness, less stigmatisation and the promotion of good mental health for all.

What the pandemic has shown is that there is scope for development, and much value to be found, in increased cross-border co-operation. This arguably applies across the health services, but mental health seems to be a particularly important area to explore , both in light of its increased prominence as a result of COVID, and because many aspects of mental health services and promotion well-suited to cross-border working, such as different aspects of on-line supports, mental health promotion, and training and education.

Our discussions with stakeholders during the preparation of this paper have made it clear that north-south co-operation is seen as positive and desirable. Various stakeholders have mentioned specific areas such as suicide prevention, and the treatment of eating disorders, as areas where there are stated commitments for improvement in both jurisdictions and where cross-border co-operation could add value. However, a formalised process or body that can continuously support such co-operation is currently absent.

What has become apparent in this scoping process is that, where co-operation on mental health exists, organisations such as CAWT and Action Mental Health have played a crucial role in establishing connections and maintaining co-operation and interaction between health service actors, north and south.

It would be important to build on this progress and to harness the knowledge and networks that have already been established. In tandem with this, future co-operation could possibly benefit from a more specific structure focused on mental health.

In this area, as in many others, simply 'getting people together' can have significant benefits regarding the exchange of ideas and for acknowledging shared problems. The community and voluntary sector is often the dominant force in informal networks, and it tends to have a reach that is potentially much broader than that of public bodies. This is one of its main strengths, and is particularly important in an area such as mental health where public services are often stretched. Mental health services can be geographically difficult to access for some people, many of whom may be vulnerable. Thus, for many current and potential service users, community and voluntary organisations may be an easier, more immediate and more comfortable option than publicly provided services.

Less complex areas of co-operation potentially exist in the mental health area, which have been suggested as being immediately possible and beneficial. The pandemic has moved many services towards using online platforms and although therapies delivered remotely will never be appropriate for every individual, they do have the advantage of removing physical borders as an impediment to service access.

Online tools and supports have a very wide range of uses, some of whom have been successfully deployed in cross-border projects such as ChatPal and Recovery education, as outlined in section 4.

Finally, the strong, established links between poverty, inequality and mental illness, remain highly relevant in both jurisdictions. In addition, the legacy of the Troubles in Northern Ireland continues to have a negative impact on mental health in many communities. A public health perspective on mental health could allow for exploration of its links to poverty and deprivation, and how to promote good mental health on an all-island basis.

Bibliography

Barnardos (2020), *Generation Lockdown*, London: Barnardos.

Bengoa, R., Stout, A., Scott, B., McAlinden, M. & Taylor, M.A. (2016), *Systems, not structures: Changing health and social care (Belfast: Expert Panel Report, 2016)*, Department of Health: Belfast.

Black, L. (2021), *Suicide: Northern Ireland , Research and Information Service*, Research Paper No.23/21, Belfast: Northern Ireland Assembly.

Cullivan, R. (2020), *When Mental Health Legislation Really Matters*, Armagh: Centre for Cross Border Studies.

Department of Health (2009), *Bamford Review of Mental Health and Learning Disability*, Belfast: HM Government.

Department of Health (2016), *Health and Wellbeing 2026: Delivering Together*, Belfast: Department of Health.

Freyne, P. (2021), 'Ireland's mental health pandemic: From crisis to emergency', *The Irish Times*, 18 February.

Heenan, D. (2021), *Collaborating on Healthcare on an All-Island Basis: A Scoping Study*, Belfast: Ulster University.

Houses of the Oireachtas (2017), *Committee on the Future of Healthcare: Sláintecare Report*, Houses of the Oireachtas, https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf, 17/01/20.

HSE Mental Health Service (2019), *Delivering Specialist Mental Health Services*, Dublin: Health Service Executive.

Johnston, H. (2014), *All Vision But No Change? Determinants of Implementation: The Case of Ireland and Mental Health Policy,* Dublin: Institute of Public Administration.

McCambridge, J. (2021), 'Northern Ireland facing unprecedented mental health challenges, Robin Swann warns', *The Irish Examiner*, 13 May.

Mental Health Reform (2015), *A Vision for Change Nine Years on: A coalition analysis of progress*, Dublin: Mental Health Reform.

MIND (2020), *The mental health emergency: How has the coronavirus pandemic impacted on our mental health*, London: MIND.

NHS England (2016), *The Five Year Forward View for Mental Health*, The Mental Health Taskforce,London: NHS England.

NHS Scotland (2017), *Mental Health Inequality briefing paper*, Edinburgh: NHS Scotland.

O'Connor, K., Wrigley, M., Jennings, R., Hill, M. & Niazi, A. (2020), 'Mental health impacts of COVID-19 in Ireland and the need for a secondary care mental health service response', *Irish Journal of Psychological Medicine,* 38(2): 99-107.

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

Ombudsman for Children's Office (2021), *2020 Childhood Paused*, Dublin: Ombudsman for Children's Office.

OSR (2021), *Review of Mental Health Statistics in Northern Ireland*, London: Office for Statistics Regulation.

Parkin, E. (2021), *Mental Health Policy in England*, Briefing paper Number CBP 07547, London: House of Commons Library.

Public Health England (2020), *COVID-19: understanding the impact on BAME communities* London: HM Government.

Scottish Government (2016), *The Fairer Scotland Action Plan*, Edinburgh: Scottish Government.

Scottish Government (2017), *Mental Health Strategy: 2017-2027*, Edinburgh: Scottish Government.

Welsh Government (2012), *Together for Mental Health – a Strategy for Mental Health and Wellbeing in Wales*, Cardiff: Welsh Government.

WHO (2021), *Comprehensive mental health action plan 2013–2030 (updated)*, Geneva: World Health Organization.

Additional Resources:

For references (HSE, 2021) and further information on HSE Mental Health services see: https://www.hse.ie/eng/services/list/4/mental-health-services

For further information on the cross-border programmes outlined, please see organisation websites: CAWT at https://cawt.hscni.net and Action Mental Health at https://www.amh.org.uk

Publications

Council Reports					
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