INTRODUCTION

The Network for International Collaboration on Evidence in Suicide Prevention (NICE-SP) has conducted an international comparative study to examine time trends in deliberate self harm (DSH) and suicide in eight different European regions and how rates of DSH at regional level and national suicide rates co-vary in each region.

METHODOLOGY

Across the regions, the monitoring period ranged from 6 (1998-2003) to 14 years (1989-2003). Standard registration forms were used to collect information on demographic variables and self harm characteristics. Participants were patients aged 15 years and over presenting to general hospitals following DSH in defined catchment areas. Data on suicides were obtained from national statistics offices in the individual countries.

RESULTS

The international database comprised over 44,000 DSH episodes. Trends in DSH rates over time varied considerably across the different European regions, and by gender. Based on rolling averages, DSH rates per 100,000 for females were consistently higher than for males, with the highest rates in Manchester (580.9), Oxford (416.0) and Gent (305.7), and the lowest rates in Sor-Trondelag (148.4), Umea (128.6), and Ljubljana (71.9). The two Irish regions showed intermediate DSH rates, with 266.2 in Limerick and 216.5 per 100,000 in Cork. With the exception of Ljubljana, similar trends over time were found for female and male DSH rates. Based on average annual DSH rates at regional level and average annual suicide rates at national level, a similar ranking was found for female and male DSH rates across the European regions. Looking across countries, a significant correlation (Spearman’s rank correlation) was found between the rate of change in suicide rates nationally and DSH rates over time for males (r = 0.71, p <0.05).

CONCLUSIONS

While DSH rates vary considerably between European countries, regional DSH rates and national suicide rates follow similar trends over time in both males and females.
Thus, an increase in DSH may be accompanied by an increase in suicide, in particular among males. Based on the study outcomes, it is recommended that prevention programmes target both forms of suicidal behaviour.

PRESENTED

At the XXIV World Congress of the International Association for Suicide Prevention in Killarney, Co. Kerry from 28th August - 1st September, 2007 by Dr. Ella Arensman.
INTRODUCTION

Deliberate self harm is one of the strongest risk factors for suicide and a significant public health problem in its own right. In recognition of this, the Irish government requested the establishment of the National Registry of Deliberate Self Harm.

OBJECTIVE

The primary objectives of the Registry are to establish the extent of the problem of deliberate self harm presentations to all emergency departments in Ireland, to identify demographic groups and areas with elevated rates, to describe the nature of the self-harming behaviour involved, the treatment pathways followed and the risk of subsequent repeat self harm presentations.

METHODOLOGY

Between 2002 and 2005, the Registry collected data on self harm presentations to 39 of Ireland’s 40 hospital emergency departments. All data were collected by trained data registration officers working independent of the hospitals and following standard operating procedures.

RESULTS

Annually, approximately 11,000 deliberate self harm presentations were made to hospital by 8,500 persons. The majority of presentations (57%) were by women. The total annual incidence rate was approximately 200 per 100,000. The female rate (~235 per 100,000) was almost 40% higher than the male rate (~170 per 100,000). The peak female rate was among 15-19 year-olds and exceeded 600 per 100,000, double the equivalent male rate. Deliberate self harm presentations were most frequent on Sundays and Mondays and during the early hours of the morning. The vast majority of presentations involved an overdose of medication, most commonly minor tranquillisers, while self-cutting was the only other common method used.

CONCLUSIONS

In Ireland, the extent and pattern of hospital-treated deliberate self harm has been established thereby providing baseline data for Reach Out, the Irish National Strategy for Action on Suicide Prevention, which was launched in 2005. The Registry is ongoing and will continue to inform policy and service provision.
In line with Reach Out and relevant clinical guidelines, all deliberate self harm patients require an assessment of their psychosocial and mental health needs. In order to meet this requirement, there is a need to increase the availability of specialist services for self harm patients presenting to Irish emergency departments.

PRESENTED

At the XXIV World Congress of the International Association for Suicide Prevention, in Killarney, Co. Kerry from 28th August – 1st September 2007, by Dr. Paul Corcoran.

FUNDING

Health Service Executive National Office for Suicide Prevention.

FURTHER INFORMATION

National Suicide Research Foundation National Registry of Deliberate Self Harm Annual Reports, 2001-2005 (www.nsrfr.ie)
INTRODUCTION

There is a political and practical need to develop appropriate indicators for health promoting schools. As key stakeholders in education, students have the right to be fully engaged in this process. This research proposed a process for engaging with students to develop school level indicators of health; a total of 164 students generated and categorised indicators and developed schematic representations of their analyses.

METHODOLOGY

In the first classroom, students answered the question “If you moved to a new school, what would it need to have to be a healthy place?” on individual flashcards, which were classified into groups using a variation of the card game ‘snap’ in the second classroom. In the third classroom, students discussed the relationships between the developed categories and determined how the categories should be presented. These procedures were repeated twice in three schools, resulting in six developed schemas.

RESULTS

The six sets of categories showed remarkable similarity, physical aspects of the school predominated but emotional and social health issues also emerged as potential indicators. The schema demonstrated the holistic perspectives of students. They illustrate the importance of relationships and the physical and psycho-social environment within schools.

CONCLUSIONS

These data illustrate that students can productively engage in the process of indicator development and have the potential to act as full stakeholders in health promoting schools. The methods enabled student control over the data generation, analysis and presentation phases of the research, and provided a positive, fun experience for both students and researchers.
PRESENTED

As a Paper Presentation, to the Researching Children’s Worlds Conference in Galway in February, 2008 by S. O’Higgins, Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, Dr. Enda Delaney, M. Moore & Ms. Joanna Inchley in 2008.

As a Paper to WHO 5th Workshop on the Evaluation of the European Network of Health Promoting Schools in Sigriswil, Switzerland in June 2006, by S. O’Higgins, Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, Dr. Enda Delaney, M. Moore & Ms. Joanna Inchley.

As a Paper to the National Institute of Medical Research (Epidemiology and Public Health) in May 2007 in Toulouse, France by Dr. Saoirse Nic Gabhainn, Dr. Jane Sixsmith, S. O’Higgins, Dr. Enda Delaney, M. Moore. Indicators of success for health in schools: the development of schematic models by children.

PREVIOUSLY PUBLISHED AS

INTRODUCTION

School surveys are typically conducted in classrooms where children are clustered and thus each participating student is not fully independent of others. Such unavoidable cluster randomisation increases the size of standard errors, resulting in widened confidence intervals, larger probability values and therefore reduced statistical power and effective sample size. The need to address these issues is becoming more evident in the literature, with increasing impetus to publish on the effects of such sampling techniques and to consider more fully the analysis implications for complex survey data. A first step is to assess the design effects (DEFF), which is the ratio of the number of participants required to achieve precision using cluster randomisation to the number that would be required if all participants were independent.

OBJECTIVE

These analyses investigated the presence and magnitude of design effects in the Irish Health Behaviour in School-aged Children (HBSC) study.

METHODOLOGY

The Irish HBSC sample was constructed by stratifying school lists by region (n=8), randomly selecting schools within regions and then randomly selecting a class from within each school year. Therefore, classrooms served as the cluster or primary sampling unit (PSU). The sampling design was based on a 95% confidence interval of ±3% around a proportion of 50% and an estimated design factor of 1.2. The data were collected through self-completion questionnaires administered by teachers during a class period.

The dataset consisted of 2,365 males and 3,411 females post-primary school students. Males ranged in age from 11.2 years to 19.3 years, with a mean of 15.1 years and a SD of 1.4. Females ranged in age from 12.0 to 20.3 years, with a mean of 15.1 years and a SD of 1.4. All cases with missing data on stratification level (regions) or primary sampling unit (class) were deleted. Separate data files were created for each item. Each file was imported into Epi Info 6. The complex sample function was then used to compute the DEFF for each item, with region and class identifiers set a 'Strata' and 'PSU' variables.
RESULTS

Although the analysis was completed for all 189 survey items, only the DEFF values of those variables that were featured in the last international HBSC report are presented in Table 1.

Table 1 - DEFF values of selected HBSC survey items

<table>
<thead>
<tr>
<th>Survey item</th>
<th>DEFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived academic achievement</td>
<td>1.655</td>
</tr>
<tr>
<td>Self-rated health</td>
<td>1.486</td>
</tr>
<tr>
<td>Body image (perception of being fat)</td>
<td>1.056</td>
</tr>
<tr>
<td>Level of agreement with having a good life</td>
<td>1.044</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>1.031</td>
</tr>
<tr>
<td>Level of agreement that family is well-off</td>
<td>2.435</td>
</tr>
<tr>
<td>Occupational status of father</td>
<td>1.750</td>
</tr>
<tr>
<td>Level of agreement that the local area is well-off</td>
<td>1.556</td>
</tr>
<tr>
<td>Frequency of going to bed or school hungry</td>
<td>1.098</td>
</tr>
<tr>
<td>Attempting to lose weight</td>
<td>1.815</td>
</tr>
<tr>
<td>Frequency of eating vegetables</td>
<td>1.456</td>
</tr>
<tr>
<td>Frequency of drinking ‘diet’ soft drinks?</td>
<td>1.420</td>
</tr>
<tr>
<td>Frequency of drinking whole fat milk</td>
<td>1.273</td>
</tr>
<tr>
<td>Frequency of eating fruit</td>
<td>1.190</td>
</tr>
<tr>
<td>Frequency of snacking at weekend</td>
<td>1.187</td>
</tr>
<tr>
<td>Frequency of eating sweets</td>
<td>1.006</td>
</tr>
<tr>
<td>Age of onset of menstruation (girls only)</td>
<td>10.986</td>
</tr>
<tr>
<td>Frequency of moderate to vigorous physical activity</td>
<td>1.383</td>
</tr>
<tr>
<td>Frequency of drunkenness</td>
<td>6.069</td>
</tr>
<tr>
<td>Frequency of drinking alcohol</td>
<td>5.590</td>
</tr>
<tr>
<td>Frequency of cannabis use</td>
<td>4.338</td>
</tr>
<tr>
<td>Frequency of smoking tobacco</td>
<td>3.548</td>
</tr>
<tr>
<td>Frequency of being bullied</td>
<td>1.869</td>
</tr>
<tr>
<td>Frequency of being injured</td>
<td>1.681</td>
</tr>
<tr>
<td>Teachers treating students fairly</td>
<td>2.911</td>
</tr>
<tr>
<td>Students enjoying being together</td>
<td>2.532</td>
</tr>
<tr>
<td>Liking school</td>
<td>2.350</td>
</tr>
<tr>
<td>Teachers encouraging students to express views</td>
<td>1.796</td>
</tr>
<tr>
<td>Students accepting me as I am</td>
<td>1.750</td>
</tr>
<tr>
<td>Frequency of e-communication with friends</td>
<td>3.280</td>
</tr>
<tr>
<td>Ease of talking to mother</td>
<td>2.135</td>
</tr>
<tr>
<td>Frequency of evenings spent with friends</td>
<td>1.529</td>
</tr>
</tbody>
</table>
CONCLUSIONS

DEFF values vary substantially across survey items. Variables that measure school context, friendship groups and risk behaviours display the largest DEFF values. These analysis serve as insight into appropriate sampling requirements for subsequent HBSC and other school based surveys.

REFERENCES

Available on request.

FUNDING

HBSC Ireland is funded by the Health Promotion Policy Unit and the Office of the Minister for Children, Department of Health and Children. These specific analyses were funded as part of a research project grant from the Health Research Board.
INTRODUCTION

In order to support the implementation of the 2005 National Breastfeeding Strategy, the Health Promotion Research Centre, National University of Ireland, Galway has produced a comprehensive and definitive bibliography of published and unpublished studies and post-graduate theses related to infant feeding in Ireland.

OBJECTIVE

The purpose of this bibliography is twofold: to provide a platform for previous research and to identify research gaps and to reduce duplication of research. The bibliography will be indexed and searchable so as to enable it to form part of an eHealth library.

METHODOLOGY

A number of methods were used to source the reports included in this bibliography. Keyword searches for relevant research were made in the library catalogues and databases. A list was compiled of key informants in the infant feeding research area who were considered to have material to contribute to the bibliography. Those informants were contacted by letter and invited to send relevant material to the Health Promotion Research Centre for inclusion in the bibliography. Follow up e-mails and calls were made as necessary. Those who are known to have conducted research into infant feeding in Ireland, as identified by library searches and personal recommendation were contacted. Some informants suggested likely sources of material for inclusion which were pursued. All those contacted were also asked to further disseminate the invitation to submit.

A request for information about infant feeding related research conducted in Ireland appeared in the February 2008 newsletter of the Association of Lactation Consultants in Ireland. This request also appeared in the newsletter of the Cuidiú-ICT Breastfeeding Counsellors and on the Cuidiú e-digest.

RESULTS

Preliminary investigations using library searches revealed a dearth of published infant feeding research and therefore the project relied on the willingness of relevant bodies and individuals to assist in obtaining copies of grey literature.
However, there are over 190 pieces of research in the bibliography, which includes:
- Books/book chapters (n=3)
- Conference proceedings/abstracts (n=29)
- Government reports (n=10)
- Health Services reports (n= 34)
- Publications from International Organisations (n= 4)
- Non-Governmental reports (n=2)
- Non-peer-reviewed journals (n=16)
- Peer-reviewed journals (n=46)
- Reports from Research Units/ Academic Departments (n=9)
- Theses (n=39).

The dissemination format has been completed for each individual piece of research which includes the Full Citation, Publication status, Key Research Question(s), Study Design, Participant group(s), Study Conclusion(s), Key Words and Holding Status. The status of each piece of research has been documented in terms of public accessibility, length and subject matter and a hard and soft copy of each identified report has been procured where possible. The bibliography is to be indexed and searchable so as to form part of an eHealth library. The strengths of the Irish research base, and where gaps are found, will specify where there are total gaps or relative weaknesses. This work is ongoing.

CONCLUSIONS

Preliminary findings have shown a number of prominent gaps in infant feeding-related research that include the areas of breastfeeding mothers and babies being protected from discrimination in public places and mechanisms to enable hospital/community and volunteer breastfeeding support programmes to provide seamless, timely, co-ordinated, consistent, and comprehensive service to all mothers. In order to increase breastfeeding initiation and duration, further research on locally relevant approaches for improving breastfeeding promotion and support is required. This should include mother-to-mother support groups and peer counselors, especially given their documented success among disadvantaged population groups. The complete findings will be disseminated in due course. The research team would like to extend their gratitude to all that contributed and assisted in the search for infant feeding related research, both published and unpublished.

FUNDING

This project was commissioned by the National Breastfeeding Coordinator/National Breastfeeding Committee.

REFERENCES

Available on request.
INTRODUCTION

Food poverty and food insufficiency are important public health issues, frequently linked to poverty and deprivation. However, research on the nature, extent, epidemiology and etiology of food poverty in childhood is scarce. Previous work has demonstrated a lack of social class gradient in Ireland and has thus questioned traditional policy responses to this problem.

OBJECTIVE

This study aimed to test the utility of a cross-national question on food poverty with Irish children. The question was originally developed in Canada as part of the protocol for the 2002 Health Behaviour in School-aged Children (HBSC) study and was originally designed to tap into extreme poverty. It is possible that children do not understand the questions we use when trying to assess food poverty, and thus their understanding is crucial to progress in this field.

METHODOLOGY

Three post-primary schools were invited to participate and consent was obtained from school management, parents and children. Data were collected from students in 7 first year groups across the 3 schools. All students first completed a short questionnaire which included socio-demographic questions and the cross-national question on food poverty:

“Some young people go to school or to bed hungry because there is not enough food at home. How often does this happen to you?” The response options were always, often, sometimes, and never.

The questionnaire also asked children to indicate if they thought they understand what the question means, and if so to explain in their own words. A class discussion was subsequently facilitated by researchers without teachers being present.

RESULTS

In total, 143 first and second year post-primary school children participated, of whom 10% reported that they had experienced ‘food poverty’ or hunger – with no significant difference between boys and girls. When asked, 76% reported what they think this question meant. The majority understood it as being hungry for financial reasons (68%). For example, some thought the question was asking whether you are poor (n=30), or whether there is not enough money for food or if the family has a low income (n=26). Others thought it was asking if there is a shortage of food at home (n=17). One child suggested that the question is asking whether you are homeless.
Eleven percent of children thought it referred to family disorganisation (n=12), with 10 mentioning parents who are neglecting their children and 2 suggesting that the parents are not feeding their children.

Only a few thought the question was about ever being hungry because of not eating often enough (3%), with the same number believing the question refers to skipping breakfast (3%). Fewer again suggested that it meant if you don’t eat you will be hungry (2%) and the same number thought the question is about you bothering to prepare food for yourself. One child suggested that it is about children not liking the food that is being served. Six percent of children reported that they did not know what the question means (n=7) and 4% copied the question exactly as it appeared on the questionnaire (n=4).

The most striking feature of the classroom discussion was that they did not express any surprise that the question was being asked and thought it relevant to their peer group. In the classroom discussions, being poor, not having enough money to buy food or not enough food at home were what the children reported that they understood from the question. When prompted to give alternative reasons for going to bed hungry children suggested there may be no time for breakfast, parents are too lazy to prepare food, or that the children don’t like the food that is given to them. Other explanations included going to bed hungry as a punishment, staying up late and thus becoming hungry, or that a child has an eating disorder, but these responses were quite rare.

CONCLUSIONS

These data indicate that children are familiar with hunger and recognise that it is a feature of Irish children’s lives. The vast majority indicated that they understood the question and when probed they were clear on what the question meant. A sizeable minority suggested that hunger in children may be a consequence of family disorganisation, and this deserves further exploration. Most interestingly, very few thought that the question, as asked, was to do with not liking the food available to them or skipping meals.

FUNDING

HBSC Ireland is funded by the Department of Health and Children (the Health Promotion Policy Unit and the Office of the Minister for Children).

REFERENCES

Available on request.
INTRODUCTION

That children’s lives be better understood is a necessary contributing step to the development of child centred quality supports, services and policies and it would appear logical that actively seeking out children’s voices would facilitate this endeavour. This approach is supported by the National Children’s Strategy. However, traditionally adults have provided information on children’s policy and service needs with parents often considered the most appropriate and primary voice of the child. Adults, such as parents and teachers, have a unique perspective and hold key insights into the lives of children which could contribute to the development of child focused policy and practice. This study undertook an exploration of parents’, teachers’ and children’s perspectives on children’s understanding of well-being with the aim of illuminating and comparing the conceptualisation of well-being from these three perspectives.

METHODOLOGY

The participatory method developed to undertake this study stems from our adaptation of the ‘draw and write’ technique, with children taking photographs rather than drawing and participating in data analysis. Children aged 8-12 years took 723 photographs representing well-being, while a second set of children grouped the photographs into categories. A third set organised these categories, developing and illustrating through schema the pattern of relationships between categories. This process was repeated for parent and teacher groups drawing on the photographs taken by the children.

RESULTS

Differences and similarities emerged between parents and teachers and children and adults. Teachers developed 14 categories from the photographs with their schema depicting ‘home’ ‘family’ and ‘friends’ as core categories for children’s wellbeing. Parents provided a more detailed conceptualisation than teachers, generating 28 categories from the photographs all of which were linked in someway. Parents positioned the categories in clusters with, for example, ‘family’, ‘home’, ‘support’ and ‘friends’ grouped together. Children used 24 categories in their schema development, presenting the categories in a hierarchy with what they perceived as most important, ‘family’ closely followed by ‘animals and pets’ at the top graduating to the less important categories at the bottom. One and two way links were made between categories throughout the schema with the category ‘fun’ having the most connections.
CONCLUSIONS

The category ‘family’ can be seen in parents, teachers and children’s construction of children’s Wellbeing as a common central feature. However, differences can also be observed. Children included pets where adults perceived school as more important in children’s Well-being. The identification of the differing perspectives between children and adults suggests that this approach has enabled children to illuminate their own unique perspective on Well-being. It also demonstrates that children can express complex understandings of abstract concepts. The findings reinforce the need to gain children’s perspectives rather than relying on adult perceptions of children’s perspectives, in order to inform child centred quality service, practice and policy developments. Children’s contribution to these developments must not be under-estimated and should be actively sought.

SOURCE


REFERENCES

Available on request.
INTRODUCTION

This study reports on the evaluation of a youth-led initiative on the promotion of emotional well-being among young people aged 16-25 years. This project was developed under the auspices of the CAWT (Co-operation and Working Together) Mental Health Sub-Group and was implemented by the National Children’s Bureau. The project aimed to develop a youth friendly resource to promote emotional well-being which would be designed and delivered by young people for young people. Over a six month period, the Getting it Together project worked with a group of 12 young people from both the Republic and Northern Ireland in building their understanding of emotional well-being and developing and testing a youth friendly, needs-led resource.

METHODOLOGY

Employing a mix of research methods, including participatory methods, this evaluation documents the process of actual project development, partnership working and overall experience and impact of project participation for the young people. Following the development of the resource, its pilot implementation by the peer educators with 58 young people in the region was also evaluated.

RESULTS

The evaluation findings indicate that the key objectives of the project, were achieved i.e. a resource package was successfully developed and designed with direct input from the young people, and was assessed by their peers to be youth friendly. The project resulted in an intense, positive and productive experience for the participating young people, and enhanced their understanding of emotional well-being. The young people were successfully trained to deliver the resource to their peers, who assessed very positively both the resource and their experience of the training.

CONCLUSIONS

The project was successful in engaging the participation of a diverse group of young people in the process of project development. The process evaluation indicates that a positive partnership was established between the project leaders and the young people and that this contributed to achieving the project’s aims and objectives, within a relatively short time frame. The participatory and interactive approach adopted in the project process facilitated the sustained engagement and commitment of the young people. To achieve the full potential of this peer-led initiative, the use of the
resource now needs to be tested with a wider group of young people from the region. The implications of the evaluation findings for developing and disseminating such peer-led initiatives in the context of wider strategies to promote the well-being of young people are discussed.

PRESENTED

At a parallel session on “Joining Forces across Europe for Prevention and Promotion in Mental Health”, at Barcelona: 13-15th September, 2007 by Rowel, D, Meade, K and Barry, M.M.

PUBLISHED

Journal of Public Mental Health (in press)
INTRODUCTION

A variety of family and social factors influence children’s eating behaviours such as availability of and preference for particular foods, portion size, cultural values regarding food types and preparation, parents’ beliefs and practices, mealtime structure and feeding styles. With a decrease in average family size worldwide and many families consisting of one parent or two parents working outside the home, the influence of family structure on children’s eating patterns is of interest.

OBJECTIVE

This paper presents data from the Health Behaviour in School-aged Children (HBSC) survey, a WHO collaborative study, illustrating the influence of family structure on children’s reported food behaviour.

METHODOLOGY

This study utilised data from the 2002 Irish HBSC study, which is part of a WHO international collaborative study conducted in 35 countries in 2001/02 (www.nuigalway.ie/hbsc). The overall study aims to gain new insight into, and increase our understanding of young people’s health and well-being, health behaviours and their social context. In Ireland, a nationally representative sample of schools, stratified by region, was randomly selected and individual classrooms within these schools were subsequently randomly selected for inclusion. Data were collected via self-completion questionnaires from 8424 schoolchildren, administered by teachers in the classroom. The response rate was 83% of schoolchildren. Data entry was conducted according to the International HBSC protocol. Ethical approval was obtained from the Faculty of Public Health Medicine, Royal College of Physicians, Ireland.

Family structure was measured by students indicating who they live with, with eight response options provided: ‘mother’, ‘father’, ‘stepmother’, ‘stepfather’, ‘grandmother’, ‘grandfather’, ‘I live in a foster home or children’s home’ and ‘someone or somewhere else’. These variables were dichotomised to show if children lived with one parent or two.

Fruit and vegetable consumption was measured by a set of questions regarding the frequency of their consumption; these were dichotomised at daily consumption or more of the foodstuffs. Breakfast patterns during the week and the weekend were determined by asking children ‘How often do you usually have breakfast (more than a glass of milk or fruit juice)’? with response options of ‘never’ to the number of days
per week and per weekend, respectively. These variables were dichotomised into those who never ate breakfast during the week and those who never ate it at the weekend. Students were asked if they were on a diet to lose weight, with response options 'yes', 'no but I should lose some weight' and 'no because my weight is fine', which was dichotomised into those on a diet and those not on a diet. Students were asked how often they snack and were provided with a seven-point Likert-type scale with the response options: ‘rarely or never’, ‘once a day’ to six or more times a day’. These variables were dichotomised into snacking twice daily or less and more than twice daily. Separate questions for weekday and weekend snacking were provided.

Associations between family structure and the likelihood of the various outcome measures (food behaviours) are expressed in odds ratios from logistic regression models in SPSS, version 12.0. Considering the reported effects of age, gender, social class and family factors such as family size and maternal employment on eating patterns, these variables were controlled for in the analyses. See table 1.

Table 1 - Associations between Family Structure and Food Behaviours

<table>
<thead>
<tr>
<th></th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast consumption during the week</td>
<td>0.66 (0.53-.84)**</td>
</tr>
<tr>
<td>Breakfast consumption at weekends</td>
<td>0.92 (0.65-1.32)</td>
</tr>
<tr>
<td>Fruit consumption</td>
<td>1.12 (0.93-1.36)</td>
</tr>
<tr>
<td>Vegetable consumption</td>
<td>1.29 (1.07-1.55)**</td>
</tr>
<tr>
<td>Dieting behaviour</td>
<td>0.91 (0.70-1.18)</td>
</tr>
<tr>
<td>Snacking behaviour during the week</td>
<td>1.09 (0.91-1.31)</td>
</tr>
<tr>
<td>Snacking behaviour at weekends</td>
<td>1.15 (0.96-1.38)</td>
</tr>
</tbody>
</table>

OR: odds ratio; CI: confidence interval
*P<0.05, **P<0.01, ***P<0.001
Adjusted for age, gender, parental social class, family size and maternal employment.

RESULTS

Family structure was significantly associated with breakfast consumption during the week and with daily vegetable consumption. Children living in one parent families were more likely to miss breakfast during the week and less likely to report daily or more vegetable consumption.

CONCLUSIONS

Living in two parent families is associated with healthful dietary practices. Further work on investigating the barriers and constraints to healthy eating for one parent families is warranted. Health Professionals need to be cognisant of the influence of more recent changes in family structure in Irish society when promoting healthy eating practices.

FUNDING

HBSC Ireland is funded by the Health Promotion Policy Unit and the Office of the Minister for Children, Department of Health and Children, Government of Ireland.

REFERENCES

Available on request.
INTRODUCTION

Adolescence is a vital period in shaping behaviour patterns. Substance use is one of the most commonly studied risk behaviours among adolescents. There are three mutually exclusive levels of substance use: non-use, experimentation and current use. Understanding the social context of the experience of substance use is at the core of comprehending substance use among adolescents. Parental, peer and school influences have all been previously shown to be associated with adolescent substance use.

OBJECTIVE

This study investigates the role of relationships with parents, friends, within the school and school connectedness in predicting use of tobacco, alcohol and cannabis.

METHODOLOGY

The current study investigates the determinants of the levels of substance use examining 2 parental variables, 5 peer variables, and 3 school variables. This study is based on data collected from the 2006 Irish Health Behaviour in School-aged Children (HBSC) study (www.nuigalway.ie/hbsc). Participants for this study included 3346 students aged 15-17 years old from across the Republic of Ireland. There were 2089 males and 1842 females.

RESULTS

Sustained substance use rates were 29% for smoking, 47% for alcohol, and 11% for cannabis, with rates of experimentation at 24%, 28% and 9% respectively. Determinants for each of the nine models were established, and all analyses were controlled for gender and parental social class. The predictive power of relationships with parents, friends and the school variables were similar across substances.

Relationships with parents were positively associated with non-substance use, and negatively with sustained use (p<0.05-p<0.001). Relationships with teachers and school connectedness were also positively associated with non-substance use, and negatively with sustained use (p<0.05-p<0.001).
The patterns for relationships with friends were more complex; for all substances, the relationship with opposite sex friends was most important, compared to same sex or best friend. Relationships with opposite sex friends was negatively associated with non-substance use, and positively with sustained use (p<0.05-p<0.001).

Few of the tested variables were predictive of experimental use of any substance. None of the three models of experimentation were a good fit based on the Hosmer-Lemeshow goodness-of-fit statistics.

CONCLUSIONS

These findings demonstrate the etiological similarity of psychoactive substances, and have interesting implications for contextual models, particularly in relation to experimental substance use, and indeed for the conceptualisation of substance use itself. The data confirm within Ireland the extensive research on the importance of inter-personal relationships for health behaviour, which has been conducted on adolescent substance use in other countries. However, it also highlights the need for further investigation into the determinants of substance use. Particular attention should be given to both the parental and school variables that are important for both non-use and current use.

PRESENTED

As a Paper at the “Psychology, Health and Medicine, Annual Conference of the Division of Health Psychology, PSI & BPS”, in Derry, Northern Ireland during March 2008, by Aoife Gavin, Michael Molcho, Colette Kelly and Saoirse Nic Gabhainn.

FUNDING

HBSC Ireland 2006 was funded by the Health Promotion Policy Unit and the Office of the Minister for Children in the Department of Health and Children, Government of Ireland.
INTRODUCTION

In 2005, a national Steering Group, comprising HSE and Clinical Indemnity Scheme, initiated an Irish campaign (HeartBeat) to reduce mortality from acute myocardial infarction (AMI) using the American Institute for Healthcare Improvement (IHI) methodology.

OBJECTIVES

The goals of the programme were to:

- Increase the percentage of patients who receive all components of AMI care in the volunteer hospitals
- To reduce in-hospital mortality from AMI

METHODOLOGY

The programme methods were:

- Recruitment of five hospitals initially
- Establishment of data collection on the eight evidenced based components of AMI care (table 1)
- Analysis of data and regular feedback to the 5 hospitals
- Training in IHI methodology of sustainable improvement.
- 15 month review of progress

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<tbody>
<tr>
<td>Early ASA</td>
<td>99.5%</td>
<td>NA</td>
<td>96.6%</td>
<td>NA</td>
</tr>
<tr>
<td>ASA on discharge</td>
<td>100%</td>
<td>97%</td>
<td>96.6%</td>
<td>83%</td>
</tr>
<tr>
<td>Early b blockers</td>
<td>98.4%</td>
<td>NA</td>
<td>93.6%</td>
<td>NA</td>
</tr>
<tr>
<td>B Blockers on discharge</td>
<td>100%</td>
<td>92%</td>
<td>96.2%</td>
<td>83%</td>
</tr>
<tr>
<td>ACE for LVF</td>
<td>96.7%</td>
<td>NA</td>
<td>86.7%</td>
<td>83%</td>
</tr>
<tr>
<td>Reperfusion</td>
<td>74.7%</td>
<td>83% (T’lysis)</td>
<td>42.5%</td>
<td>80% (PCI)</td>
</tr>
<tr>
<td>Smoke Cess. advice</td>
<td>98.9%</td>
<td>NA</td>
<td>96.6%</td>
<td>NA</td>
</tr>
<tr>
<td>Lipid Low. meds</td>
<td>100%</td>
<td>96%</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
RESULTS

Analysis of the 15 month data (Oct 2006-Dec 2007) on 183 patients for the five hospitals showed:
• Seven of the eight components of care were delivered (unless contraindicated) to > 90% of patients in all hospitals
• Reperfusion within specified timeframes, was achieved in 74.9% of cases with improvement from 63.3% in the first quarter to 83.9% latterly
• In-hospital mortality was 12.5% (95% CI 8.2% - 16.8%)

CONCLUSION

In conclusion a high degree of implementation of evidenced based care is evident. Improving time to thrombolysis/PCI will require pre-hospital changes. These hospitals compare very well with US and Canadian hospitals.

PRESENTED

At the ISQSH Conference, April 14th & 15th, 2008, Radisson Hotel, Dublin Airport.
INTRODUCTION

Helicobacter Pylori (H. Pylori) is the primary cause of duodenal ulcer (DU). Guidelines recommend that all patients with DU be considered for Helicobacter Pylori Eradication Therapy (HPET). However, the proportion of patients with DU on long term anti-ulcer medication receiving HPET is small.

OBJECTIVE

This study examined the effectiveness of the continuing medical education (CME) network of the Irish College of General Practitioners (ICGP) in promoting best practice in DU treatment among GPs in an eastern region of Ireland.

METHODOLOGY

Ninety eight GPs recruited from the CME network of the ICGP were randomised in two cohorts. Cohort 1 received an (early) intervention; GPs were asked to identify their patients with DU receiving long term anti-ulcer medication and prescribe HPET according to defined criteria. Cohort 2 received the intervention later. Prescribing of HPET was monitored using routine prescribing data.

RESULTS

Twenty per cent (286/1,422) of patients in cohort 1 and 19.2% (127/661) in cohort 2 had a DU. After exclusions, 53% (152/286) in cohort 1 and 30.7% (39/127) in cohort 2, were eligible for HPET. A significantly higher proportion of patients in cohort 1 received HPET compared with cohort 2 during the early intervention period (13.8% vs. 0.0%, p<0.05). Reasons for not prescribing HPET included concurrent illness in patients, failure to comply with treatment.

CONCLUSIONS

Best practice guidelines on HPET treatment of DU can be successfully applied using CME networks. This model could be repeated in another therapeutic area where established research is not yet current practice.

PUBLISHED

Adherence to Anti-Retroviral Therapy among Patients in Bangalore, India

The School of Medicine, University of Aberdeen, Aberdeen, Scotland
GU/STD Clinics Mid-Western Regional Hospital, Limerick
Department of Mathematics and Statistics, University of Limerick
Department of Medicine, South Infirmary - Victoria University Hospital, Cork
Department of Respiratory and HIV Medicine, Rajajinagar and Wockhardt Hospital and Heart Institute, Bangalore, India
Infection Unit, Aberdeen Royal Infirmary, Aberdeen, Scotland

INTRODUCTION

Human Immunodeficiency Virus (HIV) has an estimated prevalence of 0.9% in India (5.2 million). Anti-retroviral drugs (ART) are the treatments of choice and non-adherence is an important factor in treatment failure and development of resistance, as well as being a powerful predictor of survival. This study proposes to assess adherence to ART in HIV positive patients in Bangalore, India, a country where only 10% of those who need get therapy.

METHODOLOGY

A cross-sectional anonymous questionnaire survey of 60 HIV antibody positive patients was proposed for patients attending HIV outpatient services at The Chest and Maternity Centre, Rajajinagar and Wockhardt Hospital and Heart Institute, Cunningham Road, Bangalore. Consent was to be obtained. Translation was done by a translator and doctors. Data was to be analysed using SPSS statistical analysis.

RESULTS

Response rate: 53/60 (88%).
Mean patient age was 39.85 years, with 50% aged 30-40. 73.6% of participants were male.
60% were fully adherent. Mean family size =4.8 (1-13). 21% lived <50kms and 21% >400kms from clinic.

CONCLUSIONS

Adherence was statistically significantly linked to regular follow-up attendance (70.5%, p=0.002). No other results were statistically significant but trends were found.

Better adherence were seen in older patients (>40 =50%, <40= 15%), males, those from larger families, those who had AIDS (AIDS=72%, Well= 50%), those taking fewer tablets (<5 =76%, 5-9=41%) and without food restrictions (without=70%, with= 48%).
Commonest side-effects causing non-compliance were metabolic reasons (66%) and GIT symptoms (50%). No differences were seen for education level, family income, distance travelled to clinic, time since diagnosis, or time on ART.

Regular attendance for follow up was statistically significant for adherence. Positive trends were seen in those in larger families, older, those who had AIDS, simple regimes, and without side-effects. Education income, distance travelled and length of time diagnosed or treated had no effect on adherence.

PRESENTED

List of presentations available on request.

PUBLISHED

HIV Medicine 2008 May;9 Suppl 1:42-43.
INTRODUCTION

Medical records serve many functions in modern healthcare environment ranging from provision of evidence of clinical decisions, good communication among different teams to availability of records for medico-legal purposes, clinical audit and research. In “Good medical practice” (GMC) has emphasized the need for doctors to keep ‘clear, accurate and contemporaneous patient records’. The European Working Time Directive will cause a change of working patterns for NCHDS. Shifts require handovers of information and standard quality documentation of information will ensure continuity of care.

OBJECTIVES

To compare standard of admission and in-hospital follow up entries in Nenagh General Hospital compared to set standards of Royal College of Physicians UK. (RCPUK)

METHODOLOGY

40 medical admissions notes were randomly selected from month of February 2007 and August 2007. Admission entry and five in-hospital follow-up entries for each patient were reviewed making a total of 200 follow up entries.

Headings for Admission Entries:
Date, time, signature, name in bold letters against signature, legibility, Any alterations or deletions co-signed, patient name, location, senior clinician present GP details, administration details, reason for admission, presenting complaint, history of presenting illness, current diagnosis, past medical illnesses, surgeries and procedures, allergies, social history, functional status, family history, systemic review, examination findings, result of investigations, overall assessment, problem list, management plan, intended outcome, information given to patient and relatives.

Headings for In-Hospital Follow-up Entries:
Date, time, signature, name against signature, legibility, alterations/ deletions, countersigned, patient name, location and name of senior clinician presentation.
RESULTS

Most frequently documented headings:

<table>
<thead>
<tr>
<th>Examination findings</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management plan</td>
<td>100%</td>
</tr>
<tr>
<td>Senior doctor present</td>
<td>100% (administration notes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>99%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for admission</td>
<td>95%</td>
</tr>
<tr>
<td>Past illnesses</td>
<td>95%</td>
</tr>
<tr>
<td>Signature</td>
<td>92%</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>80%</td>
</tr>
<tr>
<td>Medication/diet</td>
<td>87.5%</td>
</tr>
<tr>
<td>Overall assessment</td>
<td>80%</td>
</tr>
</tbody>
</table>

Less frequently documented: -

<table>
<thead>
<tr>
<th>Patient name</th>
<th>67.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history</td>
<td>60%</td>
</tr>
<tr>
<td>Functional status</td>
<td>50%</td>
</tr>
<tr>
<td>Allergies</td>
<td>50%</td>
</tr>
<tr>
<td>Systemic review</td>
<td>45%</td>
</tr>
<tr>
<td>Result of investigations</td>
<td>45%</td>
</tr>
<tr>
<td>Time</td>
<td>40%</td>
</tr>
</tbody>
</table>

Headings not documented: -

Location of patient at admission or as in-patient
Current diagnosis
Intended outcome
Information given to patient
Problem list at admission
Authors name in bold against signature

<table>
<thead>
<tr>
<th></th>
<th>Documented Headings admission Notes n= 40</th>
<th>Follow up Entries n=200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>99% (39)</td>
<td>98.5% (197)</td>
</tr>
<tr>
<td>Time</td>
<td>40% (16)</td>
<td>5.5% (11)</td>
</tr>
<tr>
<td>Signature</td>
<td>92% (37)</td>
<td>90.5% (181)</td>
</tr>
<tr>
<td>Authors name</td>
<td>0%</td>
<td>15% (30)</td>
</tr>
<tr>
<td>Pt name</td>
<td>67.5% (27)</td>
<td>28% (56)</td>
</tr>
<tr>
<td>Location</td>
<td>0%</td>
<td>2.5% (5)</td>
</tr>
<tr>
<td>Senior doctor</td>
<td>100%</td>
<td>80.5% (161)</td>
</tr>
</tbody>
</table>
CONCLUSION

Comparing our record keeping standards to that of RCPUK Version 5.0, we are significantly below the recommended standard of RCP. Some of the very important headings that are helpful for clinical decisions were missing such as problem list, information given to relative/patient.

RECOMMENDATIONS

1. NCHDs should familiarize themselves with standard of good record keeping in their early training years as part of good medical practice.
2. It would bring uniformity in record keeping in all hospitals and electronic record keeping would become easy.
3. Printed proforma would be of help to save time and overcome difficulty in remembering headings.

REFERENCES

Available on Request
The Feasibility of Using Health Related Administrative Databases in Ireland to Identify Older People Living at Home to be Targeted for Preventative Healthcare Interventions

Beaton, D. 
Health Service Executive - National Health Intelligence Team, Palmerstown, Dublin 20

INTRODUCTION

The prospect of changing demographics and of the reduced availability of informal carers results in a pressing need to explore approaches that can target health service resources in the most effective way to both meet the expressed needs of older people to remain living at home until the end of their lives, and to avoid unnecessary expenditure.

Targeted screening, health promotion, and preventative care activities may be effective, including being associated with a reduction in admission to institutional care, however, a difficulty for health services is in accurately targeting such interventions towards those older people who can benefit most. The literature supports the premise that it is feasible to deploy a systematic method, to ‘predict’ people most ‘at risk’ or most likely to benefit from preventative interventions.

OBJECTIVE

The study sought to evaluate the organisational and technical feasibility of the use of systematic screening, using a computer-based method applied to health-related administrative data, to generate referrals of community-dwelling older people for specialist geriatric assessment and possible follow-up with interventions designed to address issues of functional decline and hence result in delay or avoidance of hospitalisation or admission to a ‘long-stay’ setting.

METHODOLOGY

The study was undertaken in four parts. A literature review stage was undertaken in two parts:

• The first part was aimed at making an evaluation of the current ‘state of the art’ with regard to systematic screening and targeting of older people at home for preventative interventions.
• The second part aimed to evaluate examples of using data from ‘administrative’ information systems to select individuals to be targeted for interventions.
• The third part of the study was a survey of practising Consultant Geriatricians in the Republic of Ireland by use of an anonymous self-completion questionnaire. The survey sought to establish the current position with regard to key aspects of current practice in relation to the assessment and follow-up of community dwelling older people, and the current experience, knowledge and attitudes of
the respondents in relation to methods of systematic screening and in particular a computer-based method.

- The fourth part of the study, concluded before the survey design was completed in order that the findings could inform the question design, was a review of relevant documents pertaining to the data content and population coverage of candidate health related administrative information systems in the Republic of Ireland.

RESULTS

There were thirty questionnaires returned out of forty-five issued, which represented a 66% return rate. Respondents ranged between less than 5 years to more than 20 years in practice, and were in roughly equal numbers from the four HSE administrative areas. The data contents of the PCRS (formally GMS), the HIPE scheme, and the two leading GP practice systems were reviewed - for coverage, identifier data, and data relevant to envisaged screening method.

The survey found that the ‘case-mix’ of older people currently referred to Consultant Geriatricians represents a good match to those that are expected to benefit most from specialist geriatric assessment and follow-up, and that the follow-up interventions used are also a good match with best practice. However, the use of a home visit by a member of the clinical team as a usual part of the assessment or follow-up process is not common currently, and clinical teams often have a limited range of disciplines, both of which represent a mismatch with the suggested best practice approach for specialist geriatric assessment and follow-up of community dwelling older persons. The practitioners surveyed had a limited experience of any of the three prominent methods of systematic screening about which they were asked. Overall, twenty-one out of twenty-nine of the respondents, that is 72%, had no prior experience of receiving referrals based on any of the three prominent methods of systematic screening provided as options in the survey.

On the ability of computer-based methods to correctly identify older people most likely to benefit from preventative interventions, 51.7% of respondents strongly agreed or agreed. The same proportion, 51.7%, strongly agreed or agreed that the method would be beneficial to community-dwelling older people by helping them to remain at home longer.

There was less agreement that the method would be cost justified overall, in terms of overall expenditure by the ‘exchequer’, with only 37.5% of those who responded strongly agreeing or agreeing with this.

The findings reveal that only around one-quarter of practitioners would give priority to referrals generated using computer-based systematic screening by displacing the lowest priority referrals from other sources, for example those from General Practitioners (G.P.s), unless there was the provision of additional resources to their clinical teams.

Finally, the survey results suggest that those willing to take such referrals in preference to lowest priority referrals from other sources were the more experienced...
Consultant Geriatricians. The data essential to provide inputs to envisaged computer-based analysis are all available in the relevant type of health administration systems, with the exception of detailed data in regard to general practice consultations. The person identifier information recorded in these systems would appear to provide for sufficient linkages of records pertaining to an individual sourced from the systems. With respect to ‘population coverage’ the candidate information systems do have substantial coverage, except in relation to general practice care.

CONCLUSIONS

Resource constraints and differing practice model represents a constraint on organisational feasibility. The envisaged data-filtering approach appears technically feasible. Data quality and timeliness not tested. Data privacy issues not addressed in detail by the study. Analysis of specific indicators/ weightings for Ireland required.

REFERENCES

Available on request.

PRESENTED

As a poster presentation at the Health Policy and Management Conference in Trinity College, Dublin on Friday 13th June, 2008 by Mr. Dougie Beaton.
INTRODUCTION

The Family Meeting is a powerful intervention used regularly in Palliative Care Inpatient Units to facilitate communication between patients, their families and the Multidisciplinary Palliative Care team. Relatively little has been written about them compared with physician-patient interactions. Meetings can be for information gathering where current or future fears, expectations, concerns and worries of the patient/family can be discussed. Patients and families can ask about specific details regarding disease trajectory and prognostics, treatment options and palliative care services and supports available both as an inpatient and in the community. Meetings are resource intensive, often requiring the time and presence of Doctors, Nurses, Social Workers, Dieticians, Occupational Therapists, Physiotherapists and other Health Care Professionals. Meetings can be very emotional charged for all concerned especially when bad news is broken as patients are deteriorating.

During the family meeting, patients and families can express anxieties and share feelings. Staff can explain their roles and input to date. The meeting may aid health care providers identify family and patient strengths, address possible weaknesses, and explore pragmatic discharge planning and realistic levels of care needed. When there is a large family with lots of siblings or children, a meeting can level the playing field so that all family members are privy to the same information and have equal access to the health care team.

Current general ground rules in practice:
- It is endeavoured to introduce family meetings as a concept on admission
- Meetings are organised as needed at Multidisciplinary Team meetings or as need arises on the ward if crisis occurs.
- It is aimed to schedule most meetings in the afternoon. An effort is made to facilitate a relaxed environment in a quiet room with comfortable seating, all the while remaining flexible and facilitating bedside meetings when appropriate. Phones are usually on silent mode throughout.
- A general aim is to keep the meeting to under an hour or so.
- All meetings are usually chaired/co-facilitated by either a social worker or doctor
- It is usual to have a pre-meeting talk with all health professionals who will attend, to flag the major issues to be discussed.
- Patients themselves are invited to meetings if they feel able.
- An effort is made to give family and staff adequate notice and encourage them to have questions ready. The nursing staff have been traditionally integral in facilitating this.
• It is usual to have post meeting debriefing among staff members, which serves to aid trouble shooting possible problems and to organise delegation of tasks which may have arisen from the meeting.

Evidence Base for Family Conferencing: -
• More or less non existent, there is lots of scope for further research
• Recent research on the framework of the family conference in the ICU
• Several studies on the effect of family involvement in health care outcomes

OBJECTIVES

To gather some data about family meeting process and content. i.e.:
• Roll call of Family and Staff present
• Duration/Themes of meeting
• Whether index patient present
• Family/patient/staff feedback about content and process of meeting on Likert Scale to be gathered anonymously.
• To trial “virtual inclusion” of General Practitioners by post meeting telephone communication and documenting feedback from GP and also the Hospice Doctor who phones him/her.

METHODOLOGY

• Ethical approval for project from local hospital research ethics committee was obtained
• Patient information sheet about family meetings and the purpose of the study offering inclusion into the study was provided to families and patients
• Consent was obtained from patient and family member and co-signed by Doctor present at meeting. Questionnaires given to patient/family members and health care professionals present with Likert Scale format answers. These were filled out after the meeting and placed anonymously in an envelope which was in turn placed in a sealed box until all the data was examined at the end of three month period. Questionnaires included a section for free comment i.e. what they would change about the process of the meeting, any remarks or comments etc.

RESULTS

Average family members present was 8 per meeting. Average staff present was 5.25. Average duration meeting was 42 minutes. Average time pre-meeting preparation among staff was 5 minutes. Average post meeting debriefing took 6 minutes. 37.5% of patients chose to attend the meeting themselves. All other patients were either too sick, or else decided not to attend for personal reasons. Average time to contact GP 4.8 minutes; on one occasion, the GP was uncontactable as meeting coincided with his half day. All GPs contacted were delighted with the phone contact. All strongly agreed it was worth the imposition of being interrupted. All had valuable insights to give about the patients and their families. All hospice doctors strongly agreed contacting the GP was worthwhile.
Almost all feedback from patients/families was positive.

All family members or patients themselves who filled out the questionnaires either agreed or strongly agreed that the meetings were worthwhile, questions were answered adequately and time was adequately allowed for questions to be posed. All either agreed or strongly agreed that functions of each health professional was adequately explained and they communicated well. Interesting free comments from patients who attended their own meeting included “It felt it a bit fussy”

“I went along with the idea of the meeting more to please people rather than the conviction of it being necessary”. Family free comments included, “We as a family thought the meeting and the attentive care of the staff was fantastic and no words can express all the gratitude we feel toward you all for caring for our loved one”, “We felt free to ask questions and were glad of replies”, “It makes huge sense all who will be involved in my care get together and discuss discharge plans”

Themes discussed were primarily centred on updates in patients’ health status. Updating was about improvement of patients’ condition and discharge planning in 50% of cases. Updating about the deterioration in patients and issues around their end of life care was discussed in the other 50% of cases. It was felt a family meeting was necessary in 50% of cases to facilitate optimal communication as there was a large extended family involved.

CONCLUSION

This study affirms that family conferencing is indeed an excellent tool for communication and rapport building between patients their families and their health care workers. It highlights how they are used at flashpoints in caring for patients when goalposts are shifting. The dichotomy being
a) Patient improvement and attainment of symptom control with a view to discharge to the community
b) Patient deterioration as goalposts shift to end of life care.
It also underscores how emotionally fraught meetings can be for the patient and family. Meetings can be daunting, especially for a patient, as he/she enters a room full of loved ones and staff. One patient who opted to join the meeting halfway commented “I would have preferred to been present at the start and then left to allow family to ask questions”. Interestingly, data supports “inclusion” of the GP by brief phone call after the meeting, as a potentially feasible course of action. Hopefully, this study will the pave the way for further study in this important area.

PRESENTED
At Specialist Registrar in Palliative Medicine Day, Friday 9th March 2007 in Milford Hospice, Limerick.
INTRODUCTION

Understanding the process of programme implementation plays a critical role in advancing research, practice and policy in mental health promotion. This paper focuses on the implementation of community mental health promotion and considers the challenges presented in implementing and evaluating complex, multifaceted interventions carried out in the context of dynamic community settings.

METHODOLOGY

The Rural Mental Health Project\(^1\) is used as a case study to illustrate the practical and research challenges encountered in implementing and evaluating a community mental health promotion initiative. This case study highlights the factors that contributed to the successful implementation and evaluation of a community-based intervention for rural communities on the border region in the Republic and Northern Ireland. This project entailed delivering multi-faceted interventions to diverse population groups across mixed communities in collaboration with a range of cross-border agencies and community groups. Grounded in an extensive needs assessment\(^2\) the project delivered a range of interventions on awareness raising activities, community workshops, together with the adoption of structured mental health promotion programmes in schools and community settings based on international models of good practice.

A programme logic model was employed to provide a framework for evaluating project inputs, process, impacts and outcomes. The extent and quality of project implementation was monitored throughout the project, together with the degree of community participation, inter-agency and cross-border collaboration. This evaluation approach entailed using a multi-method approach, with both quantitative and qualitative data being collected from a variety of sources including project staff, steering group members, project participants, programme implementers and community members. In order to assess community level outcomes, cross-sectional surveys of the two project communities and a reference community were conducted prior to and following implementation of the project. Approximately 250 randomly selected community residents were interviewed in each of the three communities at baseline in 1997/8 and again in 2003/4 following project implementation.
RESULTS

The project embraced a partnership model of working both within and between the two local communities. Local agencies and groups were actively engaged in the planning, development and delivery of the project activities. The adoption of a structured planning model guided the implementation of the project and provided an overarching framework to steer the planning and implementation process. The project created opportunities for cross-border collaboration in developing innovative and evidence-based programmes in schools, training and employment agencies, women’s groups and farming organisations. These initiatives sought to build meaningful dialogue among community members and enhance strategic cooperation between agencies across the border in promoting the mental health and quality of life of their local communities.

The findings from the community survey indicated improved awareness concerning suicide and depression in both intervention communities, with a trend towards increases in concern levels about suicide for males, and more positive attitudes towards seeking professional help. Interviews with key players in the project were also undertaken to establish their views on the success of the project in meeting its objectives. Among the factors identified are: a partnership model of working; local coordinating structures and consultation mechanisms; use of a structured planning model to guide programme planning and implementation; mobilization of cross-community and inter-agency support; a comprehensive logic evaluation framework to assess the input, process, impact and outcomes of the project as it unfolded.

CONCLUSIONS

The Rural Mental Health Project case study illustrates the importance of a comprehensive evaluation framework when implementing complex community programmes. This project entailed extensive local, cross-border, and inter-agency collaboration. The evaluation model provided an opportunity for the research team, project staff and steering group members to work together in formulating project design, sequential planning and identification of project goals, desired outcomes and the project activities necessary to achieve them. The evaluation therefore, became integral to project planning with the results from impact and process evaluations being used to refine the setting of action plans. The evaluation also provided a solid foundation on which to build sustainable actions and ensure that a balance was struck between addressing competing local agendas and developing sustainable effective initiatives. The case study illustrates that implementation research enhances knowledge of the relationship between process and outcomes and from a research perspective increases our ability to map the critical connections between the local context, programme activities and the intended intermediate and long-term project outcomes. This information is critical to the effective adoption of programmes and the translation of research into practice.
PRESENTED

As a Paper on Bringing the evidence to life: Connecting and evidence and practice for the promotion of mental health at “Roundtable discussion with policy makers, researchers and practitioners” at McCaughey Centre for the Promotion of Mental Health and Community Wellbeing, School of Population Health, University of Melbourne, Australia. Melbourne: 7 March, 2007, by Barry, M.M.

As a Plenary address on Applying Evidence into practice: Lessons from a cross border rural mental health project, at “Public mental health: the art, science and politics of creating a mentally healthy society: A four nations debate”, Edinburgh: 26 October 2004, by Barry, M.M.

PUBLISHED

INTRODUCTION

The first Research Ethics Committees (RECs) were introduced in the 1960s to ensure participants’ rights in research. In Europe, increased attention has been paid to REC procedures since the 2001 European Clinical Trials Directive came into effect. Historically in Ireland there has been an absence of standardisation with respect to such committees resulting in variation in practices across committees. The difficulties arising from these variations are not unique to Ireland. Internationally there is a move to improve REC approved systems and processes.

RATIONALE

The REC review group of internal Health Service Executive (HSE) staff and external agencies was established in January 2007. The group was tasked with conducting a comprehensive review of RECs on behalf of the Medical Education, Training and Research Committee (METR) of the HSE. The overall review aimed to identify the current RECs and their processes of gaining research ethics approval. This review was conducted collaboratively with the Office of the Minister for Children who commissioned research in this area.

OBJECTIVES

- To quantify the number and location of RECs in Ireland
- To identify what processes they use for granting REC approval
- To collect any documented processes or Standard Operating Procedures (SOPs) that are available from the RECs
- To record their activity levels in 2006
- To identify the scope and amount of research they approve
- To identify the training needs of RECs
- To ascertain their preferred mode of training
- To ascertain REC members, researchers and participant views, attitudes and expectations for improving current RECs structures and processes

METHODOLOGY

A multi-method approach was used in the review. These were:
1. An exploration of the research ethics systems used in other countries through online searches and personal communications with experts in those countries.
2. A questionnaire sent to the Secretaries of all known RECs.
3. A consultation day with members of RECs, researchers, patients’ representatives, experts and policy makers.
4. Interviews with REC chairpersons and administrators. The review at the time (August 2007) identified 50 Research Ethics Committees in the Republic of Ireland.

RESULTS

Key issues raised were:

1. The need for standardisation. Participants expressed a resounding desire for standardised processes across research ethics committees. Facets of this include the development of a single application process, the agreement of standards for turnaround times of ethics applications, and guidelines for consent with vulnerable populations, composition of membership and competencies of committees and workload.
2. The need to increase the support capacity for RECs. Such support includes dedicated administrative support, access to training, and access to specialist knowledge, IT support systems, and dedicated time for participation on RECs.
3. The need for high level leadership on issues such as governance, quality and accountability in a way that supports local structures.
4. Communication was raised as an issue at all levels of the research review process. This includes the need for improved systems at local and national levels between all stakeholders.
5. The enthusiasm of participants involved in this area and the desire to formalise a network to support the development of knowledge and expertise is clearly evident. There is a commitment to optimising the research experience to improve the health of the population while minimising the burden on RECs, researchers, and in particular, the population.

RECOMMENDATIONS

The report makes four main recommendations to address these areas of improvement to enable RECs meet their functional responsibilities.
1. A national REC resources unit should be established which would be responsible for a number of functions such as standardisation of the REC application process and procedures as well as training and advice.
2. A database/panel of individual experts should be available to steer the implementation of the recommendations of this review and as required provide expert advice on specific dilemmas for committees and the implementation of the recommendations of this review.
3. Resources should be made available to support committees locally and the national resources unit. A budget needs to be made available for this purpose.
4. Communication needs to be improved at all levels and strategy developed for its implementation.
CONCLUSIONS

Many of the recommendations of this review complement and support the recommendations of the METR strategy. The engagement of key REC stakeholders in this review provides the foundation for collaborative working to implement these recommendations in line with HSE priorities.

Appendix of full review group available on request.