young men
& positive mental health

PROJECT REPORT
Nuala Brady Project Officer

This Project was funded through the Mental Health Association of Ireland by the EU Special Programme for Peace and Reconciliation, NWHB and WHSSB
Photographs taken from Images of Men Photographic Exhibition.
A joint project between The Men's Project at Parents Advice Centre and The Southern Education and Library Board Youth Service.
Acknowledgement

Thanks to the funding bodies and to all those who took part in this project either by participating in the first year's research or in the interventions which followed. Thanks also to the staff and management of the Mental Health Association of Ireland, Health Promotion Service, North Western Health Board (NWHB) and Western Health and Social Services Board (WHSSB) for their support and assistance and to Paddy Hannigan, Barry McNulty and Charlene Logue for all their hard work.
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1. BACKGROUND TO THE PROJECT:
The Young Men and Positive Mental Health Project (YM&PMH) arose from concerns regarding the rising rate of suicide among young men. The target group were men aged between 15 and 30 years living in the Finn Derg Valley area, a rural cross-border area covering parts of Counties Donegal and Tyrone. The Project was funded through the Mental Health Association of Ireland by the Programme for Peace and Reconciliation and the two Health Boards, North Western Health Board (NWHB) and Western Health and Social Services Board (WHSSB).

1.1 Aims and objectives:
The Project aimed to:
- Promote positive mental health among young men aged 15 - 30 years, living in a rural, cross-border area, the Finn Derg Valley.
- Reduce the suicide rate among this group.
- Raise local awareness regarding the emotional needs of men and other related issues.

In order to meet these aims, objectives were set to include:
- Assessing the current situation regarding the mental health needs of men living within the study area.
- Designing interventions based on the findings of research conducted locally, as well as elsewhere, which will provide young men with alternative ways of coping with problems.
- Feeding back research findings to the local community and working to raise men's mental health as a local issue of priority.

1.2 Design of the Project:
The Project was carried out over two years, with the first year dedicated to research and the second to implementing and evaluating interventions based on Year One research. In this way, it was hoped that planned interventions would be acceptable to the community members living and working within the study area, who had contributed their views and attitudes to this research.

Work for each year is laid out in the Project Plan (Table 1) below:

<table>
<thead>
<tr>
<th>Project Stage</th>
<th>Task</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
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<td>STAGE I</td>
<td>Literature Review</td>
<td>May 1998</td>
<td>Aug 1998</td>
</tr>
<tr>
<td></td>
<td>Focus Group Study</td>
<td>Oct 1998</td>
<td>Dec 1998</td>
</tr>
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<td>STAGE II</td>
<td>Feedback research findings</td>
<td>Jan 1999</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree interventions</td>
<td>Feb 1999</td>
<td></td>
</tr>
<tr>
<td>STAGE III</td>
<td>Plan interventions</td>
<td>Feb 1999</td>
<td>Mar 1999</td>
</tr>
<tr>
<td></td>
<td>Interim Report</td>
<td>Apr 1999</td>
<td></td>
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<tr>
<td></td>
<td>Action interventions</td>
<td>Apr 1999</td>
<td>July 2000</td>
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<td></td>
<td>Evaluation of project</td>
<td>Apr 2000</td>
<td>July 2000</td>
</tr>
<tr>
<td></td>
<td>Final Report</td>
<td>Aug 2000</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Project plan May 1998 - August 2000.
2. LITERATURE REVIEW:
As an "Action Research" Project, this piece of work aimed to look at issues within the local communities which may impact upon the mental health of young men, and to involve community members in working to improve this.

The literature review looked mainly at two areas, mental health and the evidence supporting a community-based approach to promoting positive changes.

2.1 Mental health, men and rural communities:
Much of the literature reviewed relates to mental illness and more specifically suicidal behaviour among men, the young and those living in rural areas. Special attention has been paid to research based in Ireland and Great Britain and to the role of health professionals in dealing with issues identified.

Of major concern is the reported rise in rates of suicide among young men. The suicide rate for men aged 15 and over in Ireland in 1977 was 8.9/100,000 population (Swanwick, 1997). By 1996 this had risen to 17.38/100,000 population (NWHB, 1998). While the increase in suicide figures recorded over the last 20 years may partly be due to better recording, this accounts for only 40% of the rise and should affect data relating to both men and women of all ages (Kelleher, 1998). The rise is real rather than artifactual and affects most dramatically men aged 20 to 24 years and those in rural areas. The ratio of male to female suicides in the age group 15 - 24 years, for 1988-1992 was 7:1:1 (Kelleher, 1998). Suicide rates for young men in England and Wales reflect this rise with rates for each age group, 15-24, 25-34 and 35-44 between 1975 and 1987 increasing significantly (p<0.0001) (Burton et al, 1990). In Ireland the suicide rate for young men has doubled since 1977 while that for young women has levelled off (Swanwick, 1997).

Studies using birth cohort methods further confirm the shift in suicide towards the younger ages, especially young men.

Being unemployed (Pritchard, 1992; Heikkinen et al, 1995) appears to be implicated in youth suicide as does living alone or with parents for young males and being married for young females (Heikkinen et al, 1995).

Rural living has also been identified as a possible risk factor in male suicide. Farmers are ranked fourth in the UK among professions likely to take their own lives. Increased access to guns and poisons is reflected in methods used by farmers (Malmberg et al, 1997). Other factors in farmers' suicides are identified (Hughes, 1996; Malmberg et al, 1997) as:

- social and geographical isolation
- poverty and economic hardship
- low status
- changes in farming including increased paperwork due to Common Agricultural Policy
- family and relationship problems due to insular community and working at home
- retirement and loss of social contacts (in one third of 84 suicides among farmers studied by Malmberg et al, 1997)

Underlying mental illness or personality disorders are also identified as major factors in suicides and youth suicides. Foster et al (1997) conducted "psychological autopsies" on 118 of 154 deaths from suicide in Northern Ireland (July 1992 - July 1993) and ascribed DSM-III-R axis I and/or axis II diagnoses to 90% of these. Major DSM-III-R axis I diagnoses were:
• alcohol dependence (37%)
• unipolar depression (32%)
• anxiety disorders (10%)

Individuals who completed suicide aged under 30 years were less likely than older adults to have a current axis I disorder and were also less likely to have a history of contact with mental health services.

Using similar "psychological autopsy" techniques, Lesage et al (1994) compared 75 young men (18-35) who had completed suicide with 75 living young men matched for age and socio-economic factors. Eighty-eight per cent of the suicide group compared with only 37% of the controls had DSM-III-R axis I disorders. Furthermore, young people who have been psychiatric patients during childhood and adolescence are known to be at increased risk from suicide (Hulten et al, 1998).

A combination of these factors then: being aged under 30 years; being male; having mental illness and belonging to the farming community may contribute to the increasing rate of suicidal behaviour among young men.

2.2 Services, community based research and mental health promotion:
Several studies point to the role of mental health professionals in helping to reduce the suicide rate. Special care should be taken by General Practitioners in assessing suicidal risk. Appleby et al (1996) looked at 61 cases of suicide in those aged under 35 years who were known to have attended GPs in the three months prior to death (42% of all youth suicides in Greater Manchester 1991-1992). In this group, the number of visits to their GPs increased significantly in the period before the suicide - in the last month for young men and in the last week for young women. The study found that significant risk of suicide was noted for none of these final GP visits. GPs obviously have an important role to play in preventing youth suicide and more training in assessing suicidal risk is recommended.

The quality of psychiatric care, especially in terms of continuity of care, is another important factor in the rate of suicide among those under 25 years of age who have had contact with psychiatric services (approximately 50% of suicides aged under 25 years have had contact with adult psychiatric services). Care of these already high-risk individuals should be continued with the same care provider up to 25 years of age (Hulten et al, 1998).

Nursing staff also have the potential to affect outcome for patients who have been treated for deliberate self-harm, (Anderson, 1997) and should receive training in order to avoid reacting negatively in such cases and thus reinforcing feelings of rejection.

"Working With Men", a London-based organisation, have published a report on work carried out by charitable agencies dealing with young people (Working With Men, 1997). It was found that young men aged 16 - 25 years tended to approach agencies seeking advice on practical issues rather than counselling for emotional problems. Younger boys seem to prefer short visits and want immediate answers to problems. Men tended to come alone to agencies, leave help-seeking until later (48% left their problem for more than one month) and have difficulty asking for help. Recommendations of this report include:
• working with young men on help-seeking, feelings recognition and relationships in school or youth club environments
• public education initiatives around young men
• improved drop-in services as self-referral to the agencies seems most popular with young men
• information sharing among those working with young men in order to identify best practice.
This last point is supported by Meyer (1997), who points out that the success of action research relies on the network to support it, since this facilitates the subsequent taking of action.

Work with men in a rural environment, and farmers in particular, is described by Hughes (1996). She emphasises the need to be aware of the "farming culture" and adapt services to be acceptable within the farming community.

All of the research outlined above is of relevance to the work of the YM&PMH Project. It is vital that initiatives taken should be grounded on foundations of solid research and the experience of others in working with young men, a group generally resistant to health promotion messages.

3. RESEARCH:
Over the first twelve months of the Project several areas considered relevant to the mental health of young men in the area were examined. Quantitative data was collected as a means of looking at suicide and mental health service uptake. Attitudes towards men's emotional needs were assessed using a small questionnaire-based Community Attitude Survey. Finally, a Focus Group Study was used to shed more light on the problems faced by local young men and the ways they deal with these.

Findings from each of these areas are outlined below.

3.1 Data Collection:

3.1.1 Population:
Figures collected from population census data (Northern Ireland and Republic of Ireland) showed the overall population of the study area to be approximately 23,184 persons. Of these males numbered 11,601 and females 11,583. The Derg Valley area has a population of approximately 8,687 and the Finn Valley a population of approximately 14,497 (Table 2).

<table>
<thead>
<tr>
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<th>MALES</th>
<th>FEMALES</th>
<th>TOTAL</th>
</tr>
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<tbody>
<tr>
<td>FINN VALLEY</td>
<td>7226</td>
<td>7271</td>
<td>14497</td>
</tr>
<tr>
<td>DERM VALLEY</td>
<td>4375</td>
<td>4312</td>
<td>8687</td>
</tr>
<tr>
<td>TOTAL STUDY AREA</td>
<td>11601</td>
<td>11583</td>
<td>23184</td>
</tr>
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</table>

Table 2. Population of the study area by sex and region.

The target group of the project, young men aged 15-30 years living in the Finn Derg Valley area number approximately 2,805.

3.1.2 Suicide:
As revealed by the literature review, young men aged between fifteen and thirty years are at an increased risk of death from suicide. While it is uncertain whether the higher suicide rate in this group is due to age (Swanick et al, 1997; Kelleher, 1998), gender differences (Swanick et al, 1997), mental illness (Foster et al, 1997; Lesage et al, 1994), rural environment (Malmberg et al; Hughes 1996), social secularisation (Kelleher, 1998) or unemployment (Pritchard, 1992; Heikkinen et al, 1995), this was thought to be an issue of central importance to the present study.
Figures collected for Northern Ireland and the Republic of Ireland indicate the expected high level of suicide among young men in the target age group. Figures are available for County Donegal as a whole and for Strabane District but due to issues of confidentiality regarding the identification of individuals, suicide figures within the study area alone cannot be collected within the remit of this study.

Figure 1, below, illustrates the heightened risk of death by suicide among young males in Northern Ireland.

Deaths from suicide in N. Ireland 1997
(By Age and Sex)

![Deaths from suicide in N. Ireland 1997](image)

Figure 1. Suicide deaths in Northern Ireland 1997. Source: Registrar General’s Report.

Figure 2, below, illustrates deaths from suicide in the Western Health Board Area (1996-1998) and reveals the familiar pattern of higher levels among males.

DEATHS FROM SUICIDE WHSSB
(By Sex and Year)

![DEATHS FROM SUICIDE WHSSB](image)

Figure 2. Suicide deaths WHSSB by sex and year.

It must be stated that the number of deaths from suicide within the study area is small, in the Strabane District Council area there were a total of 2 suicides in 1996, 2 in 1997 and 4 in 1998. Nevertheless, the devastating effects of suicide upon the local community must be recognised.
3.1.3 Service Uptake:
In order to examine whether young men, and men in general, were underrepresented in their usage of mental health services within the study area, data was collected to look at service uptake. Difficulties were experienced in accessing this information since NWHB records were not computerised at this time, therefore data was collected for one year only - 1997.

Figures collected in the NWHB for 1997 indicate that men are using Mental Health services in similar numbers to women. Again, numbers are too small to be tested for statistical significance, but differences can be seen in the pattern of service use. More men than women are seen by Addiction Counsellors (AC) and Behavioural Therapists (BT), while more women are seen by Community Psychiatric Nurses (CPN) and Psychiatric Social Workers (PSW). Equal numbers of males and females were seen in 1997 by Child and Adolescent Psychiatric services (C&AP) (Figure 3).

![NWHB STUDY AREA CLIENTS 1997](image)

**Figure 3.** NWHB service uptake 1997.

Services accessed by each age group of men are shown below, Figure 4. Younger males were most often seen by Addiction Counsellors followed by CPNs.

![STUDY AREA: MALE CLIENTS OF MENTAL HEALTH SERVICES 1997](image)

**Figure 4.** 1997 male clients of NWHB by age group and mental health service.
At the time of the study there were 876 clients of WHSS8 mental health services from the study area. Of these 365 (42%) were male and 511 (58%) were female. Males aged between 15 and 30 years accounted for 8% of this total (N=73).

In an area with the population evenly distributed between males and females, it would seem that neither sex is underrepresented in service uptake. The fact remains, however, that many young men who complete suicide are not under the care of mental health services and this is of prime concern to the present project. It may be the case that those young men who most need to access services are simply not doing so.

3.2 Adult Community Attitude Survey

3.2.1 Background:
As an action research project, this work was community based and interventions community led. It was considered important to look at local attitudes towards men's emotional needs as these attitudes may have a negative effect on men's mental health in general and help-seeking behaviours in particular.

3.2.2 Subjects:
Subjects were householders who were aged over eighteen years living in the study area. Due to constraints of time, randomisation was not possible. Since the primary aim of this survey was to provide an insight into local attitudes this methodological weakness was considered acceptable.

Eighty-six individuals took part in this survey by questionnaire. Table 3, below, gives a breakdown of subjects by area and sex. Other data relating to subjects (age, marital status, number of children) is to be found in Appendix 2, along with a more detailed description of results.

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<thead>
<tr>
<th></th>
<th>MALES</th>
<th>FEMALES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINN VALLEY</td>
<td>19 (79% males)</td>
<td>39 (63% females)</td>
<td>58 (67% of subjects)</td>
</tr>
<tr>
<td>DERG VALLEY</td>
<td>5 (21% males)</td>
<td>23 (37% females)</td>
<td>28 (33% of subjects)</td>
</tr>
<tr>
<td>TOTAL STUDY AREA</td>
<td>24 (28% of subjects)</td>
<td>62 (72% of subjects)</td>
<td>86 (100% of subjects)</td>
</tr>
</tbody>
</table>

Table 3. Community Attitude Survey: Subjects by area and sex.

3.2.3 Method:
A questionnaire was designed and piloted for use in collecting this information (Appendix 1). Households throughout the study area were selected by the researcher in a random manner and questionnaires administered. Anonymity of respondents ensured confidentiality. Subjects were asked to rate how much they agreed or disagreed with eighteen statements, on a five-point, Likert-type scale. Statements included "Men should not cry or get upset in public" and "Young boys should be discouraged from being sissies". Some personal information was collected for purposes of statistical analysis and subjects were asked about their own experience of and views towards mental health services as well as their coping strategies.

3.2.4 Results:

3.2.4.1 Adult Survey:
Appendix 2 contains a detailed breakdown of results from the Community Attitude Survey, but to summarise the findings in relation to men:
Male respondents comprised only 28% of all subjects. Those with whom the researcher had first contact were asked to complete the questionnaire. Even when men were the first contact they were often unwilling to participate and deferred to a female partner.

Male respondents tended to be older - 63% males were aged 51 years and over compared with only 27% of females. It is likely that younger men may spend less time at home, especially in a rural, farming community.

Regarding help-seeking behaviour, men were just as likely as women to talk to a family member, a GP or be willing to talk to a psychiatrist about a problem but less likely to talk to a friend (men 29% Vs women 56%). Men were also less likely to utilise all four of the above help sources (men 8% Vs women 29%). They were more likely to keep problems to themselves (men 17% Vs women 8%).

Subjects were asked about their experiences of mental health services in the area and their views on information relating to these services. Men were happier with the quality of Mental Health services. Twenty-one per cent of men Vs 5% of women described services as good while no men described them as poor as opposed to 6% of women who did. Likewise, men were happier with the quality of information available than women - 25% of men Vs 13% of women said information was good while 21% of men Vs 24% of women said it was poor.

Results of this study are recorded in Appendix 2. Some of the findings may reflect unhealthy attitudes regarding the wellbeing of men. For instance, 29.2% of men agreed that "Men should not cry or get upset in public", while 64.0% of men and women agreed that "Women need more emotional support than men" (Figure 5).

**Adult CAS Response to Questionnaire Item 2:**
"Women need more emotional support than Men"

![Figure 5. Adult CAS, response of men and women together to Item 2.](image)

There was a strong feeling that women worry more about things and that men would rather keep a problem to themselves than discuss it. Given the statement "Young boys should be discouraged from being 'Sissies'", 79.1% of men agreed as opposed to only 41.9% of women (Figure 6, below).

Of the men who agreed with this statement (N = 19), 68.4% (N = 13) had children and all of these had sons. Furthermore, 29.1% of men and women agreed that "Fathers should teach their sons to be strong, even if this means hiding their feelings".

Attitudes towards men, in particular regarding men showing their emotions, remain conservative in the study area. It is seen as "unmanly" to talk about emotional problems or show emotional feelings. Male
children are still discouraged from crying. Women are seen as more emotionally weak and as needing to talk more than men. This pervasive attitude may contribute to the view that emotional needs are feminine in quality and not to be expressed by men. In turn, it is felt that this belief may prevent men from acknowledging the existence of and seeking help to deal with emotional or mental health problems.

**Adult CAS Men Only Response to Questionnaire Item 8:**
"Young boys should be discouraged from being 'sissies'.”

---

**Figure 6.** Adult CAS, men only response to Item 8.

3.2.4.2 School survey:
An adapted version of the same questionnaire was administered to 245 young people aged 14 -16 years in local schools. Results show similar attitudes among this group when compared to the local adult population. In some cases attitudes among the young people were even more conservative than among adults.

In response to the statement "Men should not cry or get upset in public", 43.3% of boys and 12.8% of girls agreed. Over 70% of boys and almost half the girls (47.3%) agreed that "Women need more emotional support than men" and 38.1% of boys agreed that "It is more manly to 'suffer in silence' than to talk about problems", similar to the figure for adult men (41.2%). Given the statement "Young boys should be discouraged from being 'Sissies'", 69.1% of boys agreed (32% agreed strongly) and 48.6% of girls supported this. Only 11.3% of boys disagreed with this statement (Figure 7, below). Again, 40.2% of boys agreed that "Fathers should teach their sons to be strong, even if this means hiding their feelings" as opposed to only 11.4% of girls.

**School CAS Boys Only Response to Questionnaire Item 8:**
"Young boys should be discouraged from being 'sissies'”

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**Figure 7.** School CAS, boys only response to Item 8.

*(Full results of Adult and School Surveys Appendix 2).*
3.3 Focus Group Study:

3.3.1 Background:
In order to further investigate the attitudes and experiences contributing to the mental health of young men living in the study area, it was decided to run a small focus group study.

The use of focus groups is recommended when it is felt that additional information can be obtained from the group situation rather than by conducting individual interviews. Taking part in a group carefully selected to contain individuals with shared characteristics and experiences is generally felt to be less intimidating for subjects and, given a relaxed and supportive atmosphere, can generate lively and critical discussion of the subject matter. Focus group methodology is particularly recommended when attempting to identify group norms and cultural values affecting behaviour (and specifically health-related behaviour). In an action research project such as this, focus groups have the added advantage of involving members of the community in which the study is based (Kitzinger, 1995).

It was felt that for the purposes of this study focus groups could be used to elucidate the thoughts and feelings of:
- **Young Men** - Local young men themselves, regarding their lives, the things that cause them problems and the ways they deal with these (including use of available statutory health services).
- **Professionals** - Those in Mental Health, youth and community services who work with young men in the study area.

3.3.2 Subjects:
In all, five groups were organised and four completed (Table 4) giving a total of 28 participants.

FG1, a group for school-age young men (N = 8 males), was organised with the help of Principals and teachers from three schools in the study area. This was the only focus group made up of subjects from both sides of the border.

Young men for FG2 (N = 8 males) and FG3 (N = 8 males) were contacted through individuals and organisations in the local area. Problems were experienced in recruiting subjects for FG2 (Northern Ireland young men), and this was cancelled after three unsuccessful attempts. Likely reasons for the failure to hold this group, are general apathy and disinterest of young men and stigma attached to the "mental health" related project title.

Professionals who took place in FG4 (N = 4, 2 males and 2 females) and FG5 (N = 8, 4 males and 4 females) were either employed by mental health services or worked in the local area in a paid or voluntary capacity.

3.3.3 Method:
Topic guides were drawn up based on information gained from the literature search and the earlier Community Attitude Survey. The topic guides used to address both young men and professionals covered the same areas:
- Meaning of "Mental Health"
- Problems young men face (personal/social/political)
- Dealing with problems and seeking help
- Seeking professional help
- Improving the situation for the future
In addition, professionals were encouraged to talk about their experiences in working with young men.

Five focus groups were organised to take place between 23/02/99 and 22/03/99. The make-up and location of these is described in Table 4 below.

<table>
<thead>
<tr>
<th>FOCUS GROUP No</th>
<th>DESCRIPTION</th>
<th>AREA</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FG1</td>
<td>School-age young men (N = 8)</td>
<td>NI/ROI</td>
<td>Completed</td>
</tr>
<tr>
<td>FG2</td>
<td>Young men aged 18-30 (N = 8)</td>
<td>NI</td>
<td>Cancelled (3 attempts)</td>
</tr>
<tr>
<td>FG3</td>
<td>Young men aged 18-30 (N = 8)</td>
<td>ROI</td>
<td>Completed</td>
</tr>
<tr>
<td>FG4</td>
<td>Mental health &amp; community (N = 4)</td>
<td>NI</td>
<td>Completed</td>
</tr>
<tr>
<td>FG5</td>
<td>Mental health &amp; community (N = 8)</td>
<td>ROI</td>
<td>Completed</td>
</tr>
</tbody>
</table>

Table 4. Description of Focus Groups.

As described above, FG2 was cancelled due to difficulties in recruiting young men. The four completed focus groups were held in either Ballybofey (N = 2) or Castlederg (N = 2) at the convenience of those attending. FG1 was held in the early afternoon (1.00 - 2.30 pm) and the other groups were held at night. The research officer facilitated all groups and was assisted in three of the four by a young male co-facilitator. All groups were recorded on audio-tape with the permission of participants. These tapes were later transcribed for the purposes of analysis.

At the beginning of each focus group "ground-rules" were agreed upon. Confidentiality and respect for each individual's right to contribute were emphasised and participating subjects were asked to speak one at a time to ensure clarity of the tapes. Groups lasted between one and two hours. A Topic Guide was adhered to loosely in order to ensure that all relevant points were raised for discussion but conversation was encouraged to be as natural as possible to allow for other issues to be introduced.

3.3.4 Results:
As with all qualitative research methods, the analysis of Focus Group results depends largely on the interpretation of the researcher. One way to quantify the content of group transcripts is to identify and code main themes and then measure how often these occur. In order to do this a list of themes was drawn-up based on the Topic Guide, Table 5.

The number of times themes occurred is a good measure of how important these themes were in the discussion of each group and is also recorded in Table 5 below. A more detailed analysis of some of these major themes follows:

3.3.4.1 Alcohol and drugs:
The most frequently occurring theme in all groups was 3b Alcohol and drugs. Alcohol was mentioned by the young men of FG1 and FG3 as a way of coping with the pressures of living and as a source of recreation and enjoyment. Indeed, the younger men of FG1, all aged sixteen or seventeen continually returned to this theme throughout their discussion. Two members of this group did not drink alcohol but for the rest drinking was described as vital to a good night out:
"What's in a typical night out? What would you do?"
"Go out just and get full (laughing from group)". (FG1)
Table 5. Themes occurring in Focus Groups.

Drinking was desired as a way to lower inhibitions and enable social interaction, especially with girls: “You’re able to mess about and you don’t care what you’re doing”. (FG1)

“It’s easier to talk to women when you’re ... a few drinks in you... for if you’re sober you’d be saying “What am I after doing”, but if you’re drunk you don’t care, she says “Nah” that’s alright”. (FG1)
The older young men of FG3 expressed concern regarding the extreme youth of children drinking nowadays with 12-13 year olds drinking where these young men would have started at 15 - 16 years. All the young men were worried about the increasing availability of illicit drugs and were very much opposed to using these drugs. It was felt that adults, and parents in particular, were either unaware of the extent to which drugs are available or were adopting a "head in the sand" attitude.

The professionals in FG5 and FG6 were concerned about the amount of underage drinking and the effect of this on the development of young men's social skills:
"...young guys go into the disco you know, at that age, they're maybe 14 or 15 and they're really drunk...and then they go up to ask the girl out to dance, and, I mean, they're not going in there sober.."(FG5)

There was concern that resulting deficits in social skills could lead to low self-esteem and mental illness. Alcohol could also be used to self-medicate for symptoms of serious mental illness or might, in extreme cases, induce psychotic symptoms.

3.3.4.2 Family:
While the young men from FG2 reported that the study area was, for them, a good place to live due to the closeness of the community, this was seen as a negative thing by the school-age men. All of the participants in FG1 lived at home with their families and all reported some degree of frustration and anger resulting from family relationships:
"Does that happen a lot with your parents, that they would frustrate you?"
"Oh aye" (Several voices)...
"'Cos they annoy you, sick of them". (FG1)

Parents were not always seen as a source of support:
"...your mother like, if you told her anything, she'd just sit and laugh at you, "Catch yourself on", but my aunt like, she'd have more time and she'd want to help me or whatever, 'cos my father couldn't give a s**te and my mother just wouldn't want to know". (FG1)

The young men of FG3 expressed concern for the wellbeing of family members, particularly younger siblings:
"Would you be worried about [drugs]?"
"I've a wee sister of eleven, like, and like, anyone else with younger brothers and sisters would be worried". (FG3)

FG4 spent quite a bit of time in discussion regarding the effect of family breakdown upon young people in general. Youth services were seen as a free "Babysitting service" (FG4), and it was felt that drunken and promiscuous parents provided poor role models for young men.

3.3.4.3 Being a man:
For the younger men (FG1) "being a man" (2a) was generally viewed in relation to either "community attitudes" (2g) or "relationships and sex" (2c). Community attitudes towards young men were perceived as being very negative, especially in relation to the attitudes of the police, a theme which also occurred in FG5. One schoolboy described the attitude of local people towards himself and his friends:
"Well, if you're hanging around in a crowd, if anybody sees you "Them boys are up to no good!"...You know, they see you hanging around in groups and...badness, police would stop". (FG1)
Many young men were living up to this image with destructive and violent behaviour but this was put down to boredom and "Childish behaviour" (FG1) by the younger men.

One young man gave an example of how young men and young women are treated differently in the community:

"I was out with the girlfriend's mother and father there, and, aw, they sat and bought me pints and all, and the girlfriend, she's the same age as me like, aw, they sat and fed me with fags and...pints and I said to them "Is it alright if she drinks?" like, and "Oh no, she's not drinking!" FG1

Perhaps surprisingly there was consensus among this group regarding the traditional way women were expected to behave:

"It's wild bad seeing a girl puking all over the place" (group laughs)
"And then turning around and snogging the face of some boy!" (laughing)...
"So is it more acceptable do you think, for a boy to be puking all over the place?"
"Aye, and snogging the face of the girl!" (laughing). FG1

The younger men felt some pressure on them to at least report being sexually active and talked about competition between friends to "go further". The older young men did not feel under pressure from their peers to be sexually active but desired this for themselves. For this older group being a man was more to do with work (2f) and financial security (2j). Debt was seen as a major concern and something which might have a negative effect on mental health:

"They're living beyond their means you see...they get higher and higher in debt and that'll lead to more depression". (FG3)

The professionals from FG4 and FG5 felt that young men were under a lot of pressure and were especially scared of being seen as a failure, particularly in their attempts to become independent from their families (FG4). It was felt that there was much more support available for women in the community and men were expected to cope alone.

Violence was a part of life for the younger men with frequent fights to settle arguments or just for fun. The dangers of being seriously hurt deterred these young men from fighting as they got older and the fights became more serious, perhaps involving knives. Sectarian violence and the threat of it was mentioned in FG1 and FG4, both of which were held in Castlederg. The young men of FG1 spoke about the fear of being attacked and about having to be careful about where they went depending on their religious identity. The professionals of FG4 acknowledged "The Troubles" as being a possible cause of stress in young men's lives.

3.3.4.4 Suicide and help-seeking:
The subject of suicide (3g) was the most frequently mentioned reaction to stress apart from alcohol and drugs. Professionals from FG4 and FG5 and older young men (FG3) all talked about the risk of suicide among young men and saw it as a way that children were exerting control over their parents. This was seen to lead to over-indulgence and lack of discipline. The younger men of FG1 saw suicide as a means of dealing with problems, albeit a last resort. Many of these young men had direct experience of suicide, either in the family or at school, and seeing the aftermath was viewed as a deterrent: "Definitely I wouldn't even think about it because my uncle, he committed suicide, he hung himself, and the family just...just couldn't believe it and they were crying and, och, for months after...I would never try it, I would never even think about committing suicide because I wouldn't do that on my family again". (FG1)
Mental illness and alcohol/drug misuse were recognised as major causes of suicide by groups 4 and 5: "Well in the end, it never seemed...it just like...I can just compare to someone stealing...they just let it grow bigger and bigger to stealing and less and less to reality...And I just don't think they were well enough..." "Was that mental illness?" "Aye, exactly. They just could not seem to find any sensible way out, you know?" (FG5)

Both groups of young men saw relationship problems as a major cause of suicide and warned against men becoming involved in serious relationships at too early an age. "I've one of my friends shot himself and I know, like, a lot of that was over a relationship". (FG3)

All groups talked of the need both to have someone to talk to and to encourage young men to talk about personal problems. However, the men themselves reported that they could not confide in their friends: "They're just classified as sissies or whatever for opening up about their feelings and all this". (FG1)

Talking about or showing feelings was associated with women and with homosexuality: "You can't cry". "Why can't you cry ___?" "You can't be seen to cry anyway, I'll tell you that". (Others agree and laugh)... "What would they say about it, anyway, or what would you say about it if there was somebody crying?" "Fruit". (Others agree and repeat). "Mammy's boy". "Prize f***** queer, that's it!" (Laughing). (FG1)

The taboo around crying was strong enough even to forbid crying alone: "Not even in secret" "No?" "'Cos then you'd feel yourself like, ah, "I'm a bit of a wain, here I'm crying!" (FG1)

Professionals acknowledged this aspect of being a man: "It's very hard to get a young man or any man at all to talk about problems". (FG4)

Anger was seen as a much more acceptable response to situations causing hurt or frustration: "...you'd just want to take your frustration out on something". "You'd feel angry more, would you?" "Yeah, hit whatever's closest". (Laughs) (FG1)

In relation to suicidal feelings though, even this group acknowledged the need to seek help: "I think the worst thing you can do is bottle it up. That's the worst you can do". (FG1) "It's best to talk to somebody". (FG1)

The young men of FG3 were most likely to talk to a female friend or a parent about a personal problem. For the younger men it seemed preferable not to discuss a problem at all: "Aye, I just keep it to myself". (FG1)
Friends were not seen as a source of help and even parents would only be consulted out of desperation. The younger men all laughed at the thought of discussing sex with their parents. This group felt that GPs would not be interested or have the time to listen to their problems and one young man thought that things would have to be very bad for young men to seek help at all: "If they're as far as committing suicide they would talk". (FG1)

There was some feeling among the professionals of FG4 that today's young men would be more likely to talk about a problem than their older peers but that it is still difficult to build up a trusting relationship with young male clients.

Confidentiality was a great concern for FG1. The family doctor was not seen as someone it would be safe to talk to because s/he was most often also the parent's doctor:

"Even though they say it's confidential like, Jesus, at the same time my mother goes to the same doctor as I go to, my mother and father go to the same doctor, the family go to the same doctor as I go to, like, half the town go to that doctor!" (FG 1)

3.3.4.5 The Future:
Young men in both groups seemed to be aware of the need to seek support in times of emotional stress. FG3, the older group, identified female friends, family members and male acquaintances trained in listening skills as possible sources of help. In general they felt that men's need to act, to solve problems, stood in the way of listening and support-giving. The younger men felt that there was nowhere for them to go with a problem and were unlikely to talk to a GP because of fears about confidentiality and being seen as a time-waster. The Samaritans were seen as a last resort and only for the suicidal. Stigma around showing or talking about emotions was very strong among this group. Even the older men acknowledged that it would be difficult to admit to having a problem and needing help: "It's kind of a macho thing. You don't want to admit that you're not a success in your life, that everything's not going your way"(FG3).

Professionals in FG4 and FG5 spoke of the difficulties in even getting young men to think about their emotional lives and mental health - a truth perhaps supported by the difficulty in engaging young men in the present study.

Asked what type of service they would like to see young men felt that to be acceptable it should be confidential and not connected with other services:

"...One thing we talked about...is where you would go to talk about a problem or what kind of place you would like to have available that you could go if you had a problem?"

"Places like this" (Agreement from others)

"Cos there's no places like this for people to go to"

"And what is a place like this?"

"Good crack".

"Where you can chat freely"

"Say whatever you want"

"It's better if...if the people don't know you personally but. It's a great help like." (Others agree) (FG1).

3.4 Conclusion:
It seems from the discussions undertaken with these focus groups, that there are many factors which may be negatively impacting upon the mental health of local young men. The younger men seemed in general to feel under pressure to conform to a "stereotyped" view of manhood - strong, violent, hard-drinking, womanising and denied the opportunity to discuss their emotional lives. The older young men were aware of the dangers of this lifestyle and were more concerned with earning a living and
achieving independence. These men acknowledged the advantages for personal health and growth of sharing problems but this was seen as something to be learned rather than naturally occurring. Many of the findings from the Focus Group Survey are supported by other recent work of this type (Geraghty et al., 1997; Harkin, 1997).

4  RESEARCH SUMMARY:
The research conducted throughout the first year of the Young Men and Positive Mental Health Project paints for us a picture of what it is like to be a young man living in the study area.

Here, as elsewhere, a number of factors: social, economic, geographical and personal contribute to an increased risk of death from suicide. Young men are aware of the need to talk about their problems but find this an almost impossible task. They are expected to be strong and able to cope with those things which bother them. They dare not talk about their problems to their friends. They are expected not to show hurt feelings openly and are not permitted to cry, even when they are alone.

Young men face pressures in school, work, family and relationships. They are likely to start drinking alcohol at an early age and some will engage in frequent fighting. They are often faced with the negative attitudes of the communities in which they live.

The young men who took part in this research were also lively, energetic and good-humoured. They were keen to start working or to hold down a job. Many of them were looking forward to fatherhood and achieving independence. As they grow older they come to appreciate the closeness of their community and show concern for those younger. The reality of being a young man does not appear to be as bleak as the data suggests!

It is the aim of this project to promote "positive mental health" among young men and thus reduce the suicide rate. The research above indicates that stigma surrounding men's emotional needs is very strong. These attitudes may prevent men from acknowledging and seeking help with problems. As a result, many of the interventions in the Action Phase of the Project described below, aim to inform and educate the entire community about young men's issues, rather than targeting young men alone.

5  RECOMMENDATIONS RESULTING FROM YEAR ONE RESEARCH:
A meeting of the YM&PMH Project's Research Sub-group, was held on 13th April, 1999. The research findings outlined above were presented to this sub-group and suggested recommendations based on the research were formulated. The recommendations highlight several possible areas where action may be taken to improve the mental health of young men:

- The Project should establish/maintain links with other projects promoting "Men's Work", mental health issues and rural / cross-border issues.
- Training programmes in men's mental health needs should be developed, perhaps piloted with teachers in schools or youth workers in the community, and adapted to inform other individuals working with young men.
- Health providers should be encouraged in providing an environment and a service geared towards young men's needs. The possibility of informal counselling/advice for young men in conjunction with youth services should be investigated.
- All interventions should aim to promote men's right to good mental health and should facilitate the destruction of negative stereotypes towards both men and mental health.
- Work should continue to raise awareness among the broader local community regarding men's mental health needs. This work should contribute to the reduction of stigma surrounding mental health in general.
The Project to support efforts to tackle problems related to underage alcohol.

6 YEAR TWO INTERVENTIONS BASED ON RECOMMENDATIONS:
These recommendations were considered by the Project’s Steering Committee and decisions reached regarding interventions to be implemented and evaluated over the next sixteen months.

The following are three areas identified for the implementation of:

6.1 Pilot Mental Health Module for Schools:
The course content of this module was to be based on the research conducted in Year One of the Project and on literature reviewed. Four schools within the study area (two in Tyrone and two in Donegal) agreed to take part in this pilot intervention. Teachers were to be given training and the module run over ten weeks in the first school term (September - December 1999). Male and female teachers were to facilitate groups of same-sex students and the module was to be evaluated by participating teachers and students.

6.2 Information Dissemination:
Youth and community workers, voluntary groups, farmers and sports groups in contact with young men were to be targeted to participate in Information Days/Evenings which were seen as serving several purposes:
- Provision of information regarding men’s mental health based on Year One research
- Raising awareness of issues relating to men’s mental health and emotional wellbeing
- Facilitating assessment of further training needs for this group and level of interest in such training.

By targeting those already working with young men in the area it was hoped that many of the problems common in trying to engage this group directly could be avoided.

6.3 Training for local service providers and others working with young men:
It was suggested that information relating to positive mental health, again based on research findings, should be made available to those working with the target group. Training would concentrate on issues relating to creating a safe environment and engaging young men in self-awareness/development work.

It was envisaged that through training teachers from schools in the study area and those in the local community who work with young men, the Project would have a sustainable, positive effect on the mental health of men.

7 INTERVENTIONS:

7.1 Pilot Mental Health Module for Schools
7.1.1 Training:
Training was held for eighteen teachers from two post-primary schools in County Tyrone and two in County Donegal, as well as three youth workers. It took place on 31/09/99 and 01/10/99 in County Donegal. The two days' training were run in a way which was intended to reflect the way classes could be run with young people. Many of the active learning techniques proposed were borrowed from the informal education sector. Training was facilitated by the YM&PMH Project Worker and a local Youth Worker. Findings from the NWHB Health Promotion Service’s Schools Programme were also presented.

Five key topics were identified from Year One research, as covering many of the issues relevant to local young people:
Mental health  
Positive coping  
Relationships  
Help-seeking and services  
Gender and youth

These formed the core content of the module, but it was suggested that the young people themselves might decide the issues most relevant to them.

Following training, the module was run in all of the schools. Classes were led in a much less formal way than usual, with teachers making use of the tools and techniques more commonly found in the informal education sector. Much of the training was given over to demonstrating the use of these facilitative methods as well as exploration of the need to "create a safe environment" in which young people (in particular young men) can work on personal issues.

The module was run with small single-sex groups led by a same-sex facilitator, and was evaluated by both young people and facilitators. It is hoped that similar modules could be run in the informal education sector, with training for Youth and Community Workers.

The two days’ training received a very positive evaluation from those participating, receiving an overall rating of 7.9 out of 9 (88%) on the scales described in Table 6, below.

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<th>Enjoyable</th>
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Table 6. Participants’ evaluation of Schools Module training

In particular, teachers felt that they had benefited from sharing the experience of the Youth Workers who attended. The Donegal-based teachers may have been at an advantage in that the module fits very well within the existing "Lifeskills Programme".

7.1.2 Evaluation:

The module was completed in all schools by the end of January 2000. Participants reporting back to the Project gave a very positive evaluation of their experience in facilitating the module. The responses given to set evaluation questions are summarised in Appendix 3, below.

Male facilitators (N = 11) hoped that outcomes of the pilot project would include increased awareness among the young men of their own mental health and an improved ability to express their feelings. These facilitators made extensive use of the active learning techniques demonstrated and found that after some initial difficulty this work in creating a "safe environment" paid off. The young men were said to respond "Very positively. They could open-up a bit more" and "...responded very enthusiastically...this was reflected in much laughter and enjoyment and a marked willingness to participate".

Training was felt to have increased the confidence of facilitators in covering mental health topics, though some were still unsure of how to handle sensitive issues such as suicide. Male facilitators reported having found the module a positive experience and many resolved to carry on working in this way.
Again, female facilitators (N = 10) felt that with time the young women became more relaxed and willing to participate although they seemed to miss the boys! Assumptions about girls' abilities to cope better with problems were challenged, with one teacher expressing surprise at "...their reluctance to share with anyone what they were most anxious about". Here also, the more relaxed and informal approach seemed to work well.

The most commonly mentioned difficulty was lack of time. All but one school ran the module over ten or more single class periods and this was felt to inhibit active discussion and use of warm-up techniques etc.

Another difficulty was experienced by one male facilitator, who had different group members each week. This was found to impede the establishment of a safe environment so that discussion tended to remain superficial and groundrules were not respected.

7.1.3 Outcomes:
Overall, the pilot Mental Health Module for Schools appears to have been successful in having the following outcomes:
- Content and methods were acceptable to young men and women taking part
- Positive reactions of participating teachers and youth workers
- Desire of facilitators to continue work with future groups
- Single-sex format creating "safe environment" in keeping with best practice identified for working with boys and young men

The module has been timetabled for the next school year (2000-2001) in at least one of the pilot schools.

7.1.4 Recommendations:
Several aspects of the Pilot Mental Health Module for Schools appear to have worked well. The following recommendations are based on these:
- Schools to include a module on mental health in Social, Personal and Health Education (SPHE) programmes
- Training for teachers to emphasise facilitation skills and active learning techniques as well as methods for creating a "safe environment"
- Consideration to be given to including workers from informal education sector in training for and running of SPHE programmes
- Facilitators to be made aware of gender issues in mental health
- Schools to consider small single-sex groups with same-sex facilitators for discussion of some issues
- Health Boards to offer support for facilitators of Mental Health modules, including up-to-date information and resources

7.2 Information Dissemination
Qualitative research undertaken during the first year of the Project looked at two main areas -
1) problems faced by local young men and how they deal with these.
2) attitudes of the community towards men seeking help and showing emotion.

Young men who took part in focus groups identified several areas which cause concern - alcohol and drugs; pressure to "be a man"; family issues; relationships and sex; school; the attitudes of the community towards young men; work and unemployment and suicide. They acknowledged that sharing problems is the best way to deal with them but often could identify no-one to talk to. Problems could never be discussed with male friends; family, community and police were seen as uncaring and the confidentiality of the GP was not trusted.
The prevalent ideas in local communities were shown to be very negative with regard to men's emotional needs. Men are expected to be strong, hide their feelings and cope alone. Seeking help and talking about problems are seen as "unmanly". It is suggested that these attitudes contribute to the situation in which young men find themselves - unable to discuss a problem before it becomes overwhelming and unable to seek help to deal with it. It is clear that the community as a whole, needs to examine its expectations of young men and work to facilitate them in finding positive ways to deal with difficulties. Dissemination of the Project's findings was felt to be vital to beginning this process.

7.2.1 Information Evenings:
Community Meetings were planned for Ballybofey and Castlederg, and the first of these was held in County Donegal on Monday, 29/11/99. This Information Evening, "Young Men's Lives", was held in order to feed back the research findings to all those in the local community who are concerned about young men. Those who work with young men in the community through work schemes, sports, farming, youth groups and so on were targeted specifically and invited to attend this event. The meeting was to be used to identify further training needs for these individuals and organisations. Parents and other interested individuals were also welcomed.

The meeting was chaired by a youth worker from the Lifford/Clonleigh Resource Centre and there were three speakers. The YM&PMH Project Officer presented the research findings and recommended a whole community approach to improving the situation. It was specifically recommended that the community work to provide an alternative to alcohol for young people socialising. The Suicide Resource Officer (NWHB) gave a factual presentation with recent suicide figures and some of the reasons behind young men's suicide. He also outlined warning signs of suicidal ideation as reported in the National Taskforce on Suicide Report, 1998. The Men's Health Development Worker, Health Promotion, NWHB, gave a talk based on his own experiences in working and living with men. The ways in which boys are conditioned were also outlined and tips given to parents and others. Finally actors from the Balor Developmental Community Arts Group performed a short drama piece based on the words of young men who took part in the research.

Much media interest was generated, with both local and national radio and newspapers featuring the work of the Project. An excellent turn-out far exceeded the expectations of the organisers and initial responses to the Information Evening were very positive. The mixture of factual, anecdotal and dramatic presentation was particularly well received. Many of those attending expressed their delight that mental health issues, and particularly suicide in young men, were being discussed openly. The aim of raising awareness regarding Young Men's issues was certainly met.

A further Information Evening was held in County Tyrone on Thursday 17/02/00, so that local organisations in the Derg Valley area could hear more about the Project and also become involved in training. A small audience heard talks from YM&PMH Project Officer, NWHB Men's Health Development Worker and the Suicide Awareness Co-ordinator, Sperrin Lakeland Trust. Again, those attending were given the opportunity to come forward for further training. In all, 24 of the 70 plus who attended these meetings put their names forward for training based on the Project's work and there was interest from several other locally-based organisations as well.

7.2.2 Other Presentations:
The findings of the YM&PMH Project were also presented to the National Suicide Resource Officer's full team meeting. This group expressed a keen interest in the Project and, in particular, the community-based nature of much of the work.
The Project Officer also delivered a presentation on the Project to a Public Meeting attended by community workers and parents, in Downpatrick, County Down. Again, interest generated by the Project was high and plans have been made to conduct similar research into attitudes in this area.

The work of the Project will also be presented at the Annual Conference of the Irish Association of Suicidology in September and the Annual Conference of the Mental Health Association of Ireland in October 2000.

7.2.3 Recommendations:
The Project has made efforts to raise public awareness regarding issues affecting young men. Recommendations for further work in this area include:
- Health Boards to give priority to men's general and mental health
- Links with other "Men's Work" projects to be continued
- Further events making information on men's mental/health needs to be made available to the local communities.

7.3 Training for local service providers and others working with young men.

7.3.1 Training for the Community:
All those who expressed an interest in this Project were invited to receive training based on the School's Module and adapted to their particular needs.

The first to receive this training were a group of Samaritans volunteers, from the Omagh branch, which covers much of the study area. The Project recognises the importance of the voluntary sector in providing help for distressed individuals and, in particular, helplines such as the one provided by this organisation are known to be an especially acceptable source of help for men. It is noted that The Samaritans was the helping organisation named most often by young people taking part in the School based Community Attitude Survey, with 34.9% (N = 101) mentions.

Training took place for 24 volunteers on 6/4/00, in Omagh, County Tyrone. This evening workshop concentrated on the findings of the research and looking at attitudes towards young men. Issues relating to masculinity and mental health were explored. Participants evaluated the training on each of the scales in Table 7, below, with an overall rating of 8 out of 9 (89%).

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Table 7. Participants evaluation of community based training (Samaritans)

Volunteers who attended the training reported that their awareness of the issues facing young men had been increased and their confidence in dealing with this group improved. They felt that the training would be of benefit in their work although further training looking at ways of dealing with specific calls may be needed. Other groups expected to benefit from this type of training were teachers, youth workers, police, parents and doctors.

A further group of ten individuals working in their communities within the Finn Valley area received this training on 31/7/00, in Stranorlar. All participants had contact with young men, either through work,
family or other informal contact and all had come forward for training as a result of the earlier Information Evenings. Participants came from health, education, religious ministry and voluntary/community sectors.

Again work centred on gender issues and identifying issues affecting the mental health of local young men. Evaluation was positive (Table 8) although several participants expressed a desire for further training workshops of this sort.

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Table 8. Participants evaluation of community based training (Community Workers)

Reported benefits of attending this training were heightened awareness of issues relating to young men and the chance to learn from those working in different areas.

7.3.2 Training for Services:
7.3.2.1 Youth and Gender Training

Training based on the first year's research as well as other "good practice" identified by the Project (in working with young people and working with men) has been developed and piloted. The Project Officer and an experienced youth worker have adapted the School's Mental Health Module Training for use in a clinical/community mental health setting, while David Simpson (NWHB Health Promotion Service) has devised a one-hour Masculinity Module to accompany this.

Staff based in the new Day-Hospital facility in Letterkenny requested training from the Project Officer, and this opportunity was used to pilot the one-day training. It is hoped that young men from the study area will be able to use this facility, rather than being admitted to the Psychiatric Unit, and a six-week education course for single-sex groups based on the School's Module is under consideration.

The Project Officer held two consultative meetings with staff during which they were given a presentation regarding the Project and discussed their own training needs in relation to the Project's work. The two main areas identified for training were:

- Working with men - engaging men in group work and encouraging active participation
- Working with young people - understanding of issues and increasing staff confidence in this area.

Training took place on 10/02/00 and concentrated on increasing participant's confidence in relation to these areas and on developing the content of the Mental Health Module for use by those in mental health services. Once again local youth workers were included and contributed much of their experience to this training.

The day was run using practical and participative methods which could be used by participants in their own work. Areas covered included:

- Creating a safe environment for work with young men
- Masculinity and messages about men
- Young people
- Mental health issues from the research
- Outline of sessions to be run with patients

Evaluation was, once again, very positive with an overall rating of over 8 out of 9 (93%) on the scales below (Table 8).
Participants reported finding the use of practical, participative methods, the inclusion of youth workers and information on issues affecting young people especially useful. It was suggested that two days training would allow more time to explore these issues. A follow-up evaluation three months after training was also very positive. Comments from staff included:

"I do not feel threatened being with young men now"

and

"[It] improved my awareness and made me more open and understanding".

Separate Men's and Women's Groups are now planned for patients using this facility.

7.3.2.2 Suicide Risk Assessment Training

A one-day training workshop was held on Friday 03/03/00, in County Donegal. Training was facilitated by the North West Training Consortium, WHSSB. Among those invited to participate were Community Psychiatric Nurses, District/Public Health Nurses, Addiction Counsellors and psychotherapists working within the Project's study area (Finn Derg Valley). A number of psychiatric nurses from the nearby Psychiatric Admissions Unit and Day Hospital facilities covering the Study Area were also invited to attend.

A total of fifteen health workers attended training. Due to annual leave and difficulties in covering staff, only one worker from the Castlederg area was able to attend. Participants came from the following services (Table 9):

<table>
<thead>
<tr>
<th>Participant's Service</th>
<th>Number attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Psychotherapy/Counselling</td>
<td>3</td>
</tr>
<tr>
<td>Addiction Counselling</td>
<td>2</td>
</tr>
<tr>
<td>Community Psychiatric Nursing</td>
<td>3</td>
</tr>
<tr>
<td>Public Health Nursing</td>
<td>5</td>
</tr>
<tr>
<td>Acute Psychiatric Unit</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Day Hospital</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 10. Participants in Suicide Risk Assessment Training by service.

The Project's Year One research indicated that men were not underrepresented, in any age group, among those seen by mental health services within the Study Area. It would seem likely, however, that very vulnerable and suicidal young men are not seeking help from or being referred to mental health services. Suicide Risk Assessment training was, therefore, offered by the Project to community-based health and mental health staff and to local General Practitioners (at a later date). Outcomes anticipated were:

- Increased awareness regarding the prevalence of suicide/suicidal behaviour
- Increased knowledge regarding risk factors
- Increased skills in carrying out psychosocial assessment
• Awareness of risk assessment scales
• Increased knowledge regarding good practice

The training included up-to-date information about suicide, including statistics for Northern Ireland, WHSSB and Republic of Ireland. Risk factors were discussed in detail, with special attention paid to mental health related factors such as psychiatric illness, addiction and deliberate self-harm.

An overview of psychosocial assessment, stressing the importance of using skills to enable a suicidal person to talk about his/her feelings, intentions and plans was followed by some discussion of assessment tools, in particular the Beck Hopelessness Scale (BHS) and Beck Depression Inventory (BDI). Participants were given the opportunity to practice use of either the BHS or psychosocial assessment. Client and counsellor were role-played, with the counsellor aiming to assess the suicide risk presented by the client. Time was allowed for each pair to sample the use of the alternative method and discussion centred on a comparison of the two. Participants concluded that the psychosocial assessment method was a better therapeutic approach while the BHS provided a useful tool to be used alongside other methods.

7.3.2.2.1 Evaluation:
Fourteen participants completed evaluation forms in which they were asked to rate aspects of the training on a scale of 1-9. Table 10, below, gives the mean for each aspect of training:

<table>
<thead>
<tr>
<th>Score (Out of 9)</th>
<th>Useful</th>
<th>Interesting</th>
<th>Well Organised</th>
<th>Enjoyable</th>
<th>Met Expectations</th>
<th>Met Needs</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>7.6</td>
<td>7.9</td>
<td>8.2</td>
<td>8.3</td>
<td>8.1</td>
<td>7.6</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Table 11. Participants' rating of Suicide Risk Assessment Training.

Responses to the question, "Was there anything especially good about the training?" included, [Number of times comment made appears in brackets):
• mixture of disciplines attending (4)
• relaxed/informal atmosphere (2)
• information provided (3)
• psychosocial assessment (2)

Most responses to the question, "Was there anything especially poor about the training?", related to the physical environment (3). One person mentioned the Beck Hopelessness Scale, and one person expressed concern regarding "where do we go from here?"

When asked "Will this training help you in the work you do (if so how)?", all participants answered in the affirmative. Specific improvements included:
• raised awareness of suicide risks (3)
• increased confidence (2)
• skills learned (4)
• use of scales (1)
• improved ability to help specific client groups (3)
Among others expected to benefit from the training, participants mentioned:

- GPs (8)
- teachers/educators (8)
- nursing staff in hospitals, community and psychiatric settings (7)
- clergy (4)
- social workers (1)
- voluntary agencies (1)
- other health workers (4).

General comments alluded to the skilled facilitators and enjoyable atmosphere throughout the training. Participants identified further training needs relating to:

- suicide risk assessment (encouraging other professionals to be involved)
- dealing with families bereaved by suicide
- interpersonal skills
- risk management in the community
- dealing with bullying/harassment in the workplace

Overall the training received a very positive evaluation and was seen as a worthwhile exercise by all who participated. All the desired outcomes expressed by the YM&PMH Project, above, were met.

7.4 Recommendations:
Training has been well received by all those in services and community sectors who have participated. Recommendations are:

- Further training for teachers and schools in facilitating discussion of mental health issues.
- Inclusion of informal education sector in work to promote positive mental health among young people.
- Gender & Youth training piloted by this Project to be made available to mental health services, community and voluntary organisations and those working with men to be targeted specifically (eg. farming and sporting organisations).
- Suicide Risk Assessment Training be made available to all health board staff dealing with clients in either hospital or community settings. This training to be adapted for use with other community/voluntary organisations.

8 CONCLUSION
Local research carried out by the Young Men & Positive Mental Health Project has indicated a need for work with young people and the communities in which they live to raise awareness of difficulties facing young men and improve their means of coping with these.

Through interventions involving schools, services, community and voluntary agencies and local people this process has been started. Training has been devised for use with each of these groups and piloted successfully. The response of those involved in the Project's work has been overwhelmingly positive and these interventions are seen to be timely and beneficial.

In order for this work to impact positively on the mental health of local young men training should be made available in a wider geographical area and to a larger number of people. It is hoped that the work of the Project can be continued in the coming months and years.
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Harkin K: Young Men Talking...Voices from Belfast. Working With Men/YouthAction Northern Ireland, 1997


Hughes H: Preventing suicide among isolated farmers. Community Nurse, July 1996


Kelleher MJ et al: Suicide as a complication of schizophrenia. Ir J Psychological Medicine, 15(1), 1998, 24-25


NWHB Report: A Health Profile of the North West Region, January, 1998


APPENDIX 1

ADULT COMMUNITY ATTITUDE SURVEY QUESTIONNAIRE
### ATTITUDE SURVEY: YOUNG MEN & POSITIVE MENTAL HEALTH

Below are statements relating to people's beliefs. Please identify how strongly, if at all, you agree with these statements by circling one number after each. For example, if you strongly agree that "Men should not cry or get upset in public" then your response will look like this:

<table>
<thead>
<tr>
<th></th>
<th>Men should not cry or get upset in public</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>2</td>
<td>Agree</td>
</tr>
<tr>
<td>3</td>
<td>Neither Agree nor Disagree</td>
</tr>
<tr>
<td>4</td>
<td>Disagree</td>
</tr>
<tr>
<td>5</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

Please circle one response for each statement, avoiding "Neither agree nor disagree" where possible as this response does not give us much information.

Please remember to complete the first section, "Personal Information", do NOT put your name on the form.

### SECTION 1: PERSONAL INFORMATION

Please tick or complete as appropriate:

1. **Sex:** MALE _______  FEMALE _______  
2. **Address:** ___________________  
3. **Age:** Under 16 years _______  16 - 20 years _______  21 - 30 years _______  31 - 40 years _______  41 - 50 years _______  51 - 60 years _______  61 - 70 years _______  Over 70 years _______  
4. **Employment:** (Please write down your job title or if you are unemployed or retired)  
5. **Marital Status:** Single _______  Married _______  Separated/divorced _______  Widowed _______  
6. **No. and sex of children (if any):** Boys _______  Girls _______  

Please turn to the next page.
SECTION 2: STATEMENTS

Please indicate how strongly you agree with the following statements by circling one number:

(1) Men should not cry or get upset in public

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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</tr>
</tbody>
</table>

(2) Women need more emotional support than men

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
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<td>4</td>
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</tbody>
</table>

(3) Men should feel free to discuss their feelings at any time

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
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<th>Disagree</th>
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</tbody>
</table>

(4) It is more manly to "suffer in silence" than to talk about problems

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
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</thead>
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<td>3</td>
<td>4</td>
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</table>

(5) Women worry more about things like relationships and family

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
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<td>4</td>
<td>5</td>
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<td></td>
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</tbody>
</table>

(6) Most men would prefer to discuss problems rather than cope alone

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
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<td>4</td>
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</table>

(7) Women are not any more likely than men to feel upset about things

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
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</table>

(8) Young boys should be discouraged from being "cissies"

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
<th>Disagree</th>
<th>Disagree</th>
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<td>3</td>
<td>4</td>
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</tbody>
</table>

(9) A man who showed that he felt upset would not be seen as weak

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
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</table>

(10) Fathers should teach their sons to be strong, even if this means hiding their feelings

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Neither Agree</th>
<th>Agree</th>
<th>Agree</th>
<th>nor Disagree</th>
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<tr>
<td>(11)</td>
<td>Women do not prefer the &quot;strong silent type&quot; of man</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<tr>
<td>(12)</td>
<td>Men are just as good as women at coping with their problems</td>
<td></td>
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<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
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<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<tr>
<td>(13)</td>
<td>Alcohol is useful as a way to cope with problems</td>
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<td></td>
<td>Strongly</td>
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<td>2</td>
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<tr>
<td>(14)</td>
<td>You shouldn't worry about things until they are really serious</td>
<td></td>
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<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
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<td>Disagree</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>(15)</td>
<td>If you are feeling stressed you should work hard and distract yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>(16)</td>
<td>Young boys are no more independent than girls and need the same attention</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>(17)</td>
<td>Suicide is never the way to deal with problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<td>1</td>
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</tr>
<tr>
<td>(18)</td>
<td>Women need to talk about things more than men do</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Strongly</td>
<td>Neither Agree</td>
<td>Strongly</td>
<td>Agree</td>
<td>Agree nor Disagree</td>
<td>Disagree</td>
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<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
SECTION 3: USE OF SERVICES

Do you have any personal experience of mental health services (self or family)? If so please detail:

________________________________________________________________________________________

Do you know of any professional or voluntary services available to help you?:

________________________________________________________________________________________

Where would you go for help if you had any emotional difficulties?:

________________________________________________________________________________________

Friend ☐ Family ☐ GP ☐ Psychiatrist ☐ Other ______________________________

Comments on services: __________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Many Thanks For Your Help in Completing This Questionnaire!
APPENDIX 2

SUMMARY OF FINDINGS

LIST OF TABLES

Table 1: Adult responses to questionnaire items by statement and sex
Table 2: Subjects by area and sex
Table 3: Age of subjects by sex and area
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Table 7: Subjects who would talk to family about a problem
Table 8: Subjects who would talk to a GP about a problem
Table 9: Subjects who would talk to a psychiatrist about a problem
Table 10: Subjects who would use all four sources of help
Table 11: Other sources of help mentioned by subjects
Table 12: Subjects views of mental health services
Table 13: Subjects experience of mental health services
Table 14: Schools responses to questionnaire items by statement and sex
ADULT COMMUNITY ATTITUDE SURVEY

Responses to questionnaire items by statement and sex

1 = Strongly agree
2 = Agree
3 = Neither agree nor disagree
4 = Disagree
5 = Strongly disagree

<table>
<thead>
<tr>
<th>SCORE</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>2</th>
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<th>3</th>
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<tr>
<td>M%</td>
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<td>Tot %</td>
<td>M%</td>
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<td>Tot %</td>
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<td>M%</td>
<td>F%</td>
<td>Tot %</td>
<td>M%</td>
<td>F%</td>
<td>Tot %</td>
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</tr>
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<td>19.3</td>
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</tr>
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<td>3.2</td>
<td>2.3</td>
<td>87.5</td>
<td>95.2</td>
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<td>59.7</td>
<td>62.8</td>
<td>4.2</td>
<td>1.6</td>
<td>2.3</td>
<td>25.0</td>
<td>38.7</td>
<td>34.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<td>3.2</td>
<td>2.3</td>
<td>62.5</td>
<td>62.9</td>
<td>62.8</td>
<td>4.2</td>
<td>6.4</td>
<td>5.8</td>
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<td>0.0</td>
<td>41.7</td>
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<td>20.8</td>
<td>3.2</td>
<td>8.1</td>
<td>37.5</td>
<td>27.4</td>
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<td>12.5</td>
<td>4.8</td>
<td>7.0</td>
<td>54.2</td>
<td>50.0</td>
<td>51.2</td>
<td>0.0</td>
<td>6.4</td>
<td>4.6</td>
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<td>0.0</td>
<td>0.0</td>
<td>4.2</td>
<td>9.7</td>
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<td>0.0</td>
<td>0.0</td>
<td>66.6</td>
<td>48.4</td>
<td>53.5</td>
<td>29.2</td>
<td>41.9</td>
<td>38.4</td>
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<tr>
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<td>45.8</td>
<td>59.7</td>
<td>55.8</td>
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<td>0.0</td>
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<td>0.0</td>
<td>0.0</td>
<td>75.0</td>
<td>53.2</td>
<td>59.3</td>
<td>4.2</td>
<td>3.2</td>
<td>3.5</td>
<td>20.8</td>
<td>41.9</td>
<td>36.0</td>
<td>0.0</td>
<td>1.6</td>
<td>1.2</td>
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<td>79.2</td>
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<td>0.0</td>
<td>16.6</td>
<td>61.6</td>
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<td>0.0</td>
<td>0.0</td>
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<td>47.7</td>
<td>37.5</td>
<td>54.8</td>
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<td>1.6</td>
<td>2.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
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<td>3.2</td>
<td>5.8</td>
<td>70.8</td>
<td>62.9</td>
<td>65.1</td>
<td>4.2</td>
<td>1.6</td>
<td>2.3</td>
<td>12.5</td>
<td>32.3</td>
<td>26.7</td>
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<td>0.0</td>
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</tbody>
</table>


Table 1: ADULT RESPONSES TO QUESTIONNAIRE ITEMS BY STATEMENT AND SEX

SUBJECTS:

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>5 (21% of males)</td>
<td>23 (37% of females)</td>
<td>28 (33% of all Ss)</td>
</tr>
<tr>
<td>ROI</td>
<td>19 (79% of males)</td>
<td>39 (63% of females)</td>
<td>58 (67% of all Ss)</td>
</tr>
<tr>
<td>Total</td>
<td>24 (28% of all Ss)</td>
<td>62 (72% of all Ss)</td>
<td>86 (100% Ss)</td>
</tr>
</tbody>
</table>

Table 2: SUBJECTS BY AREA AND SEX
AGE OF SUBJECTS:

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE (NI)</th>
<th>MALE (ROI)</th>
<th>TOTAL MALE</th>
<th>FEMALE (NI)</th>
<th>FEMALE (ROI)</th>
<th>TOTAL FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
<td>1</td>
<td>2 (8%)</td>
<td>0</td>
<td>2</td>
<td>2 (3%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>21-30</td>
<td>1</td>
<td>1</td>
<td>2 (8%)</td>
<td>3</td>
<td>11</td>
<td>14 (23%)</td>
<td>16 (19%)</td>
</tr>
<tr>
<td>31-40</td>
<td>0</td>
<td>3</td>
<td>3 (12.5%)</td>
<td>7</td>
<td>5</td>
<td>12 (19%)</td>
<td>15 (17%)</td>
</tr>
<tr>
<td>41-50</td>
<td>0</td>
<td>2</td>
<td>2 (8%)</td>
<td>8</td>
<td>9</td>
<td>17 (27%)</td>
<td>19 (22%)</td>
</tr>
<tr>
<td>51-60</td>
<td>1</td>
<td>4</td>
<td>5 (21%)</td>
<td>0</td>
<td>7</td>
<td>7 (11%)</td>
<td>12 (14%)</td>
</tr>
<tr>
<td>61-70</td>
<td>1</td>
<td>4</td>
<td>5 (21%)</td>
<td>2</td>
<td>3</td>
<td>5 (8%)</td>
<td>10 (12%)</td>
</tr>
<tr>
<td>&gt;70</td>
<td>1</td>
<td>4</td>
<td>5 (21%)</td>
<td>3</td>
<td>2</td>
<td>5 (8%)</td>
<td>10 (12%)</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>19</td>
<td>24 (100%)</td>
<td>23</td>
<td>39</td>
<td>62 (100%)</td>
<td>86 (100%)</td>
</tr>
</tbody>
</table>

Table 3. AGE OF SUBJECTS BY SEX AND AREA

MARITAL STATUS:

<table>
<thead>
<tr>
<th></th>
<th>MALE (NI)</th>
<th>MALE (ROI)</th>
<th>TOTAL MALE</th>
<th>FEMALE (NI)</th>
<th>FEMALE (ROI)</th>
<th>TOTAL FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>3</td>
<td>5</td>
<td>8 (33%)</td>
<td>6</td>
<td>14</td>
<td>20 (32%)</td>
<td>28 (33%)</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>13</td>
<td>15 (62.5%)</td>
<td>15</td>
<td>17</td>
<td>32 (52%)</td>
<td>47 (55%)</td>
</tr>
<tr>
<td>Sep/div</td>
<td>0</td>
<td>0</td>
<td>0 (0%)</td>
<td>0</td>
<td>2</td>
<td>2 (3%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Widow</td>
<td>0</td>
<td>1</td>
<td>1 (4%)</td>
<td>2</td>
<td>6</td>
<td>8 (13%)</td>
<td>9 (10%)</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>19</td>
<td>24 (100%)</td>
<td>23</td>
<td>39</td>
<td>62 (100%)</td>
<td>86 (100%)</td>
</tr>
</tbody>
</table>

Table 4. MARITAL STATUS OF SUBJECTS BY SEX AND AREA

CHILDREN:

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>1</td>
<td>18</td>
<td>19 (68%)</td>
</tr>
<tr>
<td>ROI</td>
<td>14</td>
<td>26</td>
<td>40 (69%)</td>
</tr>
<tr>
<td>Total</td>
<td>15 (62.5%)</td>
<td>44 (71%)</td>
<td>59 (69%)</td>
</tr>
</tbody>
</table>

Table 5. SUBJECTS WITH >=1 CHILD (M & F)

TOTAL N CHILDREN = 200 (113 M, 87 F)
RANGE CHILDREN = 0-8
MEDIAN = 4 (those with children only)
AVERAGE = 3.4 (those with children only)
Ss WITH BOTH MALE & FEMALE CHILDREN = 42

WHERE DO SUBJECTS GO FOR HELP?

WOULD TALK TO FRIEND

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>2</td>
<td>10</td>
<td>12 (43%)</td>
</tr>
<tr>
<td>ROI</td>
<td>5</td>
<td>25</td>
<td>30 (52%)</td>
</tr>
<tr>
<td>Total</td>
<td>7 (29%)</td>
<td>35 (56%)</td>
<td>42 (49%)</td>
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</table>

Table 6. SUBJECTS WHO WOULD TALK TO A FRIEND ABOUT A PROBLEM
**WOULD TALK TO FAMILY**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>2</td>
<td>20</td>
<td>22 (79%)</td>
</tr>
<tr>
<td>ROI</td>
<td>15</td>
<td>32</td>
<td>47 (81%)</td>
</tr>
<tr>
<td>Total</td>
<td>17 (71%)</td>
<td>52 (84%)</td>
<td>69 (80%)</td>
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Table 7. SUBJECTS WHO WOULD TALK TO FAMILY ABOUT A PROBLEM

**WOULD TALK TO GP**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>4</td>
<td>14</td>
<td>18 (64%)</td>
</tr>
<tr>
<td>ROI</td>
<td>12</td>
<td>23</td>
<td>35 (60%)</td>
</tr>
<tr>
<td>Total</td>
<td>16 (67%)</td>
<td>37 (60%)</td>
<td>53 (62%)</td>
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Table 8. SUBJECTS WHO WOULD TALK TO THEIR GP ABOUT A PROBLEM

**WOULD TALK TO PSYCHIATRIST (IF REFERRED)**

<table>
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<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>3</td>
<td>16</td>
<td>19 (68%)</td>
</tr>
<tr>
<td>ROI</td>
<td>13</td>
<td>22</td>
<td>35 (60%)</td>
</tr>
<tr>
<td>Total</td>
<td>16 (67%)</td>
<td>38 (61%)</td>
<td>54 (63%)</td>
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</table>

Table 9. SUBJECTS WHO WOULD TALK TO A PSYCHIATRIST ABOUT A PROBLEM

**WOULD USE ALL FOUR SOURCES OF HELP**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI</td>
<td>1</td>
<td>8</td>
<td>9 (32%)</td>
</tr>
<tr>
<td>ROI</td>
<td>1</td>
<td>10</td>
<td>11 (19%)</td>
</tr>
<tr>
<td>Total</td>
<td>2 (8%)</td>
<td>18 (29%)</td>
<td>20 (23%)</td>
</tr>
</tbody>
</table>

Table 10. SUBJECTS WHO WOULD USE ALL FOUR SOURCES OF HELP

**OTHER SOURCES OF HELP:**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>MALE (NI)</th>
<th>MALE (ROI)</th>
<th>TOTAL MALE</th>
<th>FEMALE (NI)</th>
<th>FEMALE (ROI)</th>
<th>TOTAL FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>2</td>
<td>2</td>
<td>4 (17%)</td>
<td>3</td>
<td>2</td>
<td>5 (8%)</td>
<td>9 (10%)</td>
</tr>
<tr>
<td>Counsellor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (2%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Police/gardai</td>
<td>0</td>
<td>1</td>
<td>1 (4%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Priest/minist</td>
<td>1</td>
<td>2</td>
<td>3 (12.5%)</td>
<td>4</td>
<td>4</td>
<td>8 (13%)</td>
<td>11 (13%)</td>
</tr>
<tr>
<td>Samaritans</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (2%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Colleague</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2 (3%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Total (other)</td>
<td>3</td>
<td>5</td>
<td>8 (33%)</td>
<td>8</td>
<td>9</td>
<td>17 (27%)</td>
<td>25 (29%)</td>
</tr>
</tbody>
</table>

Table 11. OTHER SOURCES OF HELP MENTIONED BY SUBJECTS
SUBJECTS VIEWS OF MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>VIEW</th>
<th>MALE (NI)</th>
<th>MALE (ROI)</th>
<th>TOTAL MALE</th>
<th>FEMALE (NI)</th>
<th>FEMALE (ROI)</th>
<th>TOTAL FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Info good</td>
<td>3</td>
<td>3</td>
<td>6 (25%)</td>
<td>4</td>
<td>4</td>
<td>8 (13%)</td>
<td>14 (16%)</td>
</tr>
<tr>
<td>Info poor</td>
<td>1</td>
<td>4</td>
<td>5 (21%)</td>
<td>4</td>
<td>11</td>
<td>15 (24%)</td>
<td>20 (23%)</td>
</tr>
<tr>
<td>Service good</td>
<td>1</td>
<td>4</td>
<td>5 (21%)</td>
<td>1</td>
<td>2</td>
<td>3 (5%)</td>
<td>8 (9%)</td>
</tr>
<tr>
<td>Service poor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4 (6%)</td>
<td>4 (5%)</td>
</tr>
</tbody>
</table>

Table 12. SUBJECTS' VIEWS OF MENTAL HEALTH SERVICES

SUBJECTS WITH EXPERIENCE OF MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>EXPERIENCE OF MH SERVICES</th>
<th>NUMBER OF Ss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated for depression</td>
<td>7 (8%) (F=6, M=1)</td>
</tr>
<tr>
<td>Relative received treatment</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>Friend attempted suicide</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Received counselling/bereavement couns</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Work in MH (psychiatric nurse)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>18 (21%)</td>
</tr>
</tbody>
</table>

Table 13. SUBJECTS' EXPERIENCE OF MENTAL HEALTH SERVICES

OF THESE 18 Ss:
- 8 (44%) would like to see more info available
- 2 (11%) found the service they received good
- 4 (22%) found the service they received poor
- 1 (6%) would like to see more counselling available
- 3 (17%) made no comment about service received

MENTAL HEALTH RELATED COMMENTS FROM ALL SUBJECTS (N = 86):
- 5 (6%) would like to see more counselling avail (3 bereav couns)
- 1 (1%) would like to see more education re. suicide
- 1 (1%) would like more help for boys
- 2 (1%) thought people more educated re. Mental Health nowadays
- 2 (2%) thought Samaritans provide good service
- 1 (1%) thought alcohol/drugs main problem for young people
- 1 (1%) thought exam stress main problem for young people
- 1 (1%) would like GPs to have more time with patients
SCHOOLS COMMUNITY ATTITUDE SURVEY (As Adult except Item 17 removed and replaced by Item 18)

Responses to questionnaire items by statement and sex

1 = Strongly agree
2 = Agree
3 = Neither agree nor disagree
4 = Disagree
5 = Strongly disagree

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Table 14. SCHOOLS RESPONSES TO QUESTIONNAIRE ITEMS BY STATEMENT AND SEX
APPENDIX 3

FACILITATORS' EVALUATION OF SCHOOLS MENTAL HEALTH MODULE

FACILITATORS OF BOYS' GROUPS:

What did you hope to achieve as outcomes of the pilot project?
- More awareness among boys to talk about things which cause unhappiness
- Enable students express feelings better
- Better understanding of mental health for myself and students
- More positive attitude to mental health
- Change of teaching style to address these topics
- Students able share anxiety and worries with others
- Increase own competence and comfort level dealing with mental health issues
- Improve mental health of the students and benefit families and community
- Greater sense self-awareness in young men, realise their inner feelings legitimate, importance of healthy state of mind and how to achieve it

What methods and styles did you use (games, active learning techniques etc) and why?
- Trust games and ice-breakers
- Group work
- Newsprint displays
- Posters
- Learner-centred: buzz groups, brainstorming, case studies and a little lecturing
- Practical tasks were most successful with the young men

What assumptions did you make about the young men?
- Was concerned they might have no interest in the materials
- Lack of knowledge
- Homogenous and highly integrated
- All quite literate
- Would be manageable and more mature than given credit for
- Would be interested in subject matter and willing to communicate with each other, and would have developed relationships with each other by now

What happened - session by session?
- Some silliness and skittishness at first - became more serious as time went on discussion improved
- Very positive feedback - seemed to enjoy
- Pupils felt they knew more about each other, life and laughing
- From start I had different individuals and size of groups - very difficult. Young men seemed to get more interested with time
How did the young men respond to the sessions?
- Very positively, able to open-up more. I will use this approach with other classes
- Mostly very enthusiastic - much laughter and enjoyment
- Difficult to gauge - number of individuals offered their opinion and some only when asked directly. Lot of bravado and superficial responses - joking and dismissive. Relationships work shop made more progress

Were the outcomes achieved? If not, what factors inhibited?
- Yes and no - some seemed a bit afraid of serious discussion
- Not all-sometimes the discussion would lead elsewhere
- Pupils seemed able to express feelings better
- Yes - largely. Students very open in large or small groups
- Difficult to say whether individual mental health improved or community benefited
- Length of class inhibited - double period would be better, lack of continuity
- Remains to be seen.
- Inhibitors: different groups each week
  Lack of respect for ground rules
  Insecurity of young men re. mental health issues
  Young men's lack of respect for each other
  Mixing of class groups
  Dismissive attitude of school staff and management

Were the methods and styles you used helpful?
- Students seemed to take good interest in exercises
- Always caught for time - a good sign
- They enjoyed practical work and used strong descriptive terms
- Pupils said they enjoyed outside speakers more
- Yes
- Yes - very much
- Practical exercises coupled with discussion and case studies were very helpful and enjoyable for the young men. Helped clarify views on issues, opportunity to challenge attitudes

What did you learn about the young men?
- Tried to be funny sometimes but did take the work seriously and took part well
- They respond to a different type of teaching
- Willing to speak better, most opened up more
- Some were very poor spellers, some more intellectually capable than I had given them credit for
- They would not speak to a teacher if they had a problem
- They were (mostly) very co-operative, friendly and good for a laugh
- They were a very young and immature group at a difficult stage in their lives
- The young men come from all kinds of backgrounds and this has an impact on their lives

What did you learn about your assumptions?
- I was pleasantly surprised in many classes
- That they were correct
- My assumptions could be tested by use of evaluation
- Attention span and interest levels were very erratic
- Some were threatened by changing group - safe environment important
Did the pilot project increase your confidence? If so, in what ways?
- Despite my experience working with a small group of boys is very challenging
- No
- Mainly by making me aware of my own mental health and promotion of same. Learned that life is something to be enjoyed not endured
- Increased my confidence in facilitating discussions on mental health - feel more confident in my ability to handle an awkward situation

Did the project increase your skills? If so, in what ways?
- More that it reinforced old skills and re-energised me
- No-I would have used the techniques before
- Pupils still relate to teacher as "teacher" despite "different hat"
- Class management - breaking the 35minutes into different periods has improved my teaching
- Reinforced idea that relationships are more important than curricular content
- Improved my understanding and application of groundrules
- Encouraged me to do something simple like a line-up as warm-up in a maths class
- Already quite familiar with the learning methods but enjoyed the experience of using them in a mental health context

Having carried out this pilot project, what will it now lead you to do?
- Try to incorporate more work on mental health issues in all my classes. Revisit the topic of teenage drinking and relationships education
- From whole school point of view the development of staff training needs to include how to deal with and control certain issues in the classroom
- Project worthwhile
- Continue nourishing my own mental health
- Include as a module in SPHE programme in future
- Organise some mental health training for Youth Organisation leaders and assist if Project is run again in future
FACILITATORS OF GIRLS' GROUPS:

What did you hope to achieve as outcomes of the pilot project?
- Increase awareness of mental health issues among girls
- Remove taboos re. mental health
- Raise awareness of problems of boys
- Create a comfortable and safe environment for discussion
- Explore coping skills
- Help young people cope with stress

What methods and styles did you use (games, active learning techniques etc) and why?
- Ice-breakers and games
- Posters
- Small group work
- Large group discussion
- Handouts
- Brainstorming
- Outside visitors
- Photocopies of self-help books
- Role-play
- Relaxed, friendly, informal approach
- Useful to energise and encourage participation of all

What assumptions did you make about the young women?
- Always seem to have problems
- Can be manipulative/hurtful
- Two-faced, not up-front
- Break trust/confidence
- Cry and talk about problems
- Rebellious
- Worry about appearances, boyfriends and school
- Would be happy to contribute in sessions
- Know each other well
- Do not know how to cope positively
- Would have a negative attitude towards sessions, feel like guinea pigs

What happened - session by session?
- Classes became more relaxed with time
- Girls became more talkative
- Often ran out of time
- I got more confident and tried out different methods, but very conscious of issues re. suicide
- Happy to take part but level of participation did not increase
- Willing to participate, but missed the boys!
- What they wrote was more personal than what they shared, even in small groups
- One student who remained aloof/bored/angry throughout seems a little more relaxed
How did the young women respond to the sessions?
- Quite well - in many cases I did most of the talking
- Found the sessions: thought provoking; altered their thoughts on men; concerned/helpful re. men's problems; interesting; some fun; surprised by some of the information
- Positively but fairly quietly
- Very well
- Initially thought would be like teacher/pupil learning but became more responsive and at end agreed that informal approach to this subject was far more beneficial

Were the outcomes achieved? If not, what factors inhibited?
- I hope so, they seem more AWARE of what it means to be mentally healthy
- Yes, following outcomes achieved: awareness of difficulties increased
  Need for more sensitivity re. issues of men
  More conscious of damage of name-calling
  Realised many shared same problems
  Discussed issue of relationships
  Learned from each other
  Inhibitors: Time constraints
  Need to deal with issues as they came up
- Yes, to an extent. Inhibited by their shyness and reluctance to give an opinion
- Difficult to know - hope the message got through. Inhibited by timetabling - last class Wed and Fri morning
- Yes - I hope
- On the whole yes, though class periods too short

Were the methods and styles you used helpful?
- Yes, but group of six a bit too small to be comfortable to speak out
- Warm-up games worked well but sometimes too enjoyable - difficult to end game and start work!
- Charts and magazine cut-outs worked well - easier for some girls to express views
- Yes but time was too short
- Yes - I tried to introduce as much variety as possible.
- Very helpful
- Relaxed, informal approach seemed most conducive to learning

What did you learn about the young women?
- Fixed ideas about things, especially psychiatric hospital - very negative views
- When environment right will open up and express views
- Can be secretive about some issues
- Freely speak about relationships
- Can be insensitive to others
- Break trust placed in them, can be underhand and hurtful in less obvious ways than boys
- Can take advantage of their parents
- Nothing new
- Not as in touch with feelings as one might assume
- Appear outwardly confident but some are fearful, poor self-image and self-conscious
- Reluctant to share anxieties - surprisingly
- Relationships with family and friends a source of stress
- Wanted to know as much as possible about positive coping
- Able to apply own experiences/backgrounds in sessions
- Very mature for their age
What did you learn about your assumptions?
- Assumptions fairly accurate but pleased that group made genuine efforts. Actions often due to lack of awareness of others rather than trying to be hurtful
- I have learnt to make little or no assumptions!
- Assumed they knew each other - not true. They were very pleasant and co-operative
- The girls didn’t know how to cope but willing to discover how to
- Assumptions were correct and once I clarified where I was coming from they opened up

Did the pilot project increase your confidence? If so, in what ways?
- To some extent - more guidance on precise lesson plans would have helped
- Yes - I felt it easier to speak about these issues now and group felt more comfortable with me which was essential for progress to be made
- Gathered more resource material and how to facilitate rather than teach
- Yes - students were positive in their comments
- Smaller group made the work easier
- Not really - felt I was very much pulling on my own resources. Booklet is very much needed.
  I had to prepare and pre-plan all lessons myself - very time-consuming
- Yes and gave me tips for sessions I can still use and have adapted for other people

Did the project increase your skills? If so, in what ways?
- Yes - games, ideas etc. were useful
- Yes - my listening skills. Gained ability use wide range of aids, games etc. Creative approach - crafts and projects
- Practice makes perfect
- Used skills and resources from other training
- Yes - more in tune with young peoples' needs and wants

Having carried out this pilot project, what will it now lead you to do?
- Many areas on the course can be linked to this Pilot Project - hope to look at drug education, sexuality and relationships
- Delivery of similar classes to other senior groups
- More watchful eye towards students in case they are experiencing problems
- Get involved in similar programmes as I benefited personally as well as the group
- To continue with Health and Lifeskills Programme and encourage others to do same
- Continue help young people make healthy choices in life and challenge their negative self-beliefs
- Hopefully a book/manual on mental health will be produced, specifically designed with lesson plans and suggestions. Also need an up-to-date video with findings of the young person's attitude survey
- Continue and offer part of the learning gained to other groups