

ENGAGING YOUNG MEN PROJECT

A report on the Mapping Exercise conducted in Ireland during 2014

ENGAGING YOUNG MEN PROJECT

A report on the Mapping Exercise conducted in Ireland during 2014

PREPARED BY:

Grace B.¹, Richardson N.¹, Carroll P.²

¹ Centre for Men's Health, Institute of Technology, Carlow

² Centre for Health Behaviour Research, Waterford Institute of Technology

on behalf of the Men's Health Forum in Ireland (MHFI)

December 2014

This report has been funded by the National Office for Suicide Prevention



FOREWORD

Between March 2011 and October 2012, the Men's Health Forum in Ireland (MHFI) coordinated an all-island action learning project which involved a broad range of stakeholders. This initiative sought to identify a range of possible means to promote positive mental health among young men on the island of Ireland and to assess the efficacy of these approaches. The final report on this project included a 'Conclusion and Recommendations' section which made twelve key proposals.

MHFI submitted a successful funding application to the National Office for Suicide Prevention to support the roll-out of one of these recommendations - Recommendation 10. The core aim of this initiative (titled 'Engaging Young Men Project') is to develop a training package which will increase the capacity of service providers and practitioners to effectively engage with young men in relation to programmes which promote positive health and wellbeing.

There are four key objectives to this project:

1. Conduct a **mapping exercise** to identify the training needs of a wide variety of organisations, seek feedback on how the training might be delivered most appropriately, and shape the focus, content and structure of the training package.
2. Create a dedicated **Course Unit on Engaging with Young Men** within the 'Engage' National Men's Health Training Programme. This Unit will be offered to qualified 'Engage' Trainers as a top-up module, as well as being offered to service providers and practitioners throughout Ireland as a workshop.
3. Apply a **'gender lens'** to organisations, by developing an audit tool and a self-assessment classification system to help agencies to ascertain how male-friendly they currently are.
4. Act as a **portal** for information on young men and mental health in Ireland.

This report documents the outcomes of the first of these objectives i.e. the Mapping Exercise. It provides data on suicide and young men; names some of the risk factors; explores the role of masculinity in determining the choices that young men make; highlights key issues and challenges facing workers in this field; establishes the policy context for supporting young men; offers suggestions for key principles / models of effective practice; and informs the development of the practitioners' training package.

We believe that this report will, however, also be useful to other organisations and programmes which have a specific interest in the mental health and wellbeing of young men in Ireland and further afield.



Gerry Raleigh

Director
National Office for Suicide Prevention



Michael Lynch

Chairperson
Men's Health Forum in Ireland

CONTENTS

Abbreviations	4
Executive Summary	5
1. Introduction	10
2. Methodology	12
2.1 Literature Review	12
2.2 Focus Groups and Interviews	12
2.3 Challenges	14
2.4 Data Analysis	14
3. Literature Review	15
3.1 Suicide and Young Men	15
3.2 Deliberate Self-Harm	17
3.3 Risk Factors for Mental Health Problems	20
3.4 Young Men and Masculinities	20
3.5 Overcoming Barriers to Effectively Engage with Young Men	24
3.6 Issues and Challenges Concerning Young Men and Mental Health	27
3.7 Research and Policy Context	29
3.8 Principles and Evidence of Best Practice	33
3.9 Interventions, Initiatives and Programmes	34
3.10 Mentoring and Peer-led Initiatives	35
4. Findings from Focus Groups and Interviews	37
4.1 Introduction	37
4.2 Mental Health Issues Affecting Young Men	37
4.3 Meeting the Challenges of Stigma Associated with Mental Health	39
4.4 Gender, Masculinity and Help-Seeking	39
4.5 It's not what you say, it's how you say it - Finding the Right Language for 'Mental Health'	41
4.6 Paucity of Services for Young Men in Relation to Mental Health	42
4.7 Communication, Technology and Social Media	44
4.8 Barriers to and Opportunities for Engaging Young Men	45
4.9 Strategies and Approaches to Mental Health Promotion with Young Men	47
4.10 Training Requirements for Service Providers	50
5. Conclusion	54
5.1 Recommendations for Training	55
Reference List	58
Appendix A: Focus Group and Interview Topic Guide	63
Appendix B: Interventions, Initiatives and Programmes	64
Appendix C: Unpublished and Non-Evaluated Interventions	78

ABBREVIATIONS

ASIST	Applied Suicide Intervention Skills Training
BME	Black and Minority Ethnic
BRAVE	Bradford Reducing Anger and Violent Emotions
BTN	Back of the Net
CASE	Child and Adolescent Self-Harm in Europe
CBT	Cognitive Behavioural Therapy
CF	Community Facilitator
CLAN	College Lifestyle and Attitudinal National Survey
CMHT	Community Mental Health Team
CSO	Central Statistics Office
CTC	Coach the Coach
DIGM	Dance Initiative Greater Manchester
DoH	Department of Health
DSH	Deliberate Self-Harm
EAAD	European Alliance Against Depression
FAI	Football Association of Ireland
GAA	Gaelic Athletic Association
GHQ	General Health Questionnaire
GP	General Practitioner
GRCS	Gender Role Conflict Scale
IRFU	Irish Rugby Football Union
ITC	Institute of Technology Carlow
MAN	Men's Action Network
MBSR	Mindfulness Based Stress Reduction
MDN	Men's Development Network
MHFI	Men's Health Forum in Ireland
NI	Northern Ireland
NMHP	National Men's Health Policy
NOSP	National Office for Suicide Prevention
NSMHWB	National Survey of Mental Health and Wellbeing
OECD	Organisation for Economic Cooperation and Development
PLH	Premier League Health
REASON	Racial Equality Accessing Support Opportunities Now
ROC	Reach Out Central
RoI	Republic of Ireland
SPSS	Statistical Package for the Social Sciences
TRACS	Transition Resources and Community Supports
UK	United Kingdom
WHO	World Health Organisation
YMCA	Young Men's Christian Association

EXECUTIVE SUMMARY

Over 450 million people worldwide suffer from mental health disorders. Today, approximately 14% of the global burden of disease has been attributed to psychiatric disorders, mainly due to depression and other common mental disorders, psychoses and substance-use disorders. Mental health is more than the absence of mental disorders or disabilities; it is a state of wellbeing where an individual can work productively, cope with the normal stresses in life, contribute to his or her community and, ultimately, realise his or her abilities. In Ireland, suicide is a major public health issue, and there is a significant sex discrepancy in suicide rates; particularly where young men are concerned. There is also a clear gendered aspect to suicide. For example, men are more likely to use more violent methods of suicide (Varnik et al, 2009) and young men, who live in isolated rural areas, are more likely to die by suicide and less likely to seek professional help for a mental health disorder (Caldwell et al, 2004). Deliberate self-harm (DSH) is an increasingly significant issue for many young men, and there is a clear link between DSH and suicidal ideation. A correlation is evident between DSH and problems with friends/peers and bullying, whilst concern about sexual orientation is also related to DSH. Furthermore, boys appear to have less knowledge about mental health issues, and experience higher mental health stigma than girls.

There are no apparent sex differences in the prevalence of mental disorders. However, there are significant differences in the symptoms and patterns of the disorders which vary across age groups. The prevalence of depression, for example, is higher in adolescent girls and women. Yet, the prevalence of suicide is higher in men - where it is between 3 and 7.5 times that of women. The risk factors for mental ill health in adolescents can be broken down into biological, psychological and social categories. Much research has focused on whether gender differences exist in relation to attitudes to mental health and patterns of help-seeking. It has been argued that many young men feel pressurised to adhere to values and behaviours that are consistent with expressions of a more dominant or 'hegemonic masculinity' which, in particular, discourages expressions of vulnerability. The pressures upon many young men to conform to ideals of hegemonic masculinity, and to 'put up' with depression, can be particularly prevalent where men feel a need or obligation to preserve their role as partner or father. Conversely, there is also evidence of men rejecting aspects of hegemonic masculinity, particularly in contexts where men retain a sense of control by choosing to embrace certain aspects of masculinity and to reject others.

There is general consensus in the literature that young men tend to be reticent about seeking help for a mental health problem, more likely to turn to alcohol and substance misuse as coping strategies, and less likely to approach key informants for support. Young men also appear to use the Internet and technology as a way to seek help for mental health issues in preference to more conventional health services. A variety of issues and challenges have been documented concerning young men's capacity to seek help for a mental health issue. These range from embarrassment and stigma to problems recognising symptoms. Boys and young men generally tend not to have the same supportive friendships or the ability to identify and handle emotions as young women. Consideration also has to be given to limitations or barriers at a service provision level to reach out to young men.

Engaging young men in services that may support their mental and emotional wellbeing poses unique challenges to service providers. Many service providers are unsure of how to effectively reach young men, and are unclear about the type of services to which young men might respond. The wider research and policy context serves as an important backdrop to build from in terms of identifying best practice approaches in engaging young men.

Programmes that centre on sport and physical activity appear to engage young men - if such programmes provide a supportive environment for young men where they feel safe and comfortable. Sport and physical activity can act as a 'hook' to engage young men in mental health - especially if there is involvement from peer mentors and role models. Many young men use technology and the Internet for information on mental health, highlighting the significant influence and future role of technology in mental health work.

Building from this basis, the aim of the 'Engaging Young Men' initiative is to develop a training package which will increase the capacity of service providers and practitioners to effectively engage with young men in relation to programmes which promote mental health and wellbeing.

Qualitative data was collected via focus groups and interviews, which were then thematically analysed to inform the development of a training programme. Each focus group and interview was transcribed verbatim, and analysed using the principles of grounded theory.

A variety of themes emerged from the data which highlighted the significance of mental health issues, the barriers young men and service providers encounter, and the needs of young men and service providers where the promotion of mental health is concerned. The findings suggest that young men face a myriad of mental health issues, from depression to social anxiety, and that these issues are often inter-connected with the misuse of substances. Moreover, it is apparent that an adverse socio-economic environment (for example, unemployment) plays a significant role in the mental health of many young men who lack routine and purpose in life. Stigma in relation to mental health is still a prevalent issue for young men and affects their help-seeking behaviour. Stigma is seen to be directly related to peer influence, and these influence further negate notions of help-seeking.

The findings indicate that many young men feel pressurised to conform to more negative forms of masculinity that have cultural and social influence, and that these pigeon-hole many young men into behaving within a narrow and constrained gender-script. The negative forms of masculinity that many young men adhere to are characterised by competitiveness, risk-taking and stoicism, which negatively impact upon their help-seeking behaviour. It became evident in this research that it is necessary to reframe masculinity into a more strengths-focused approach, and that this needs to begin as early as possible in the education system. The relevance of language in relation to mental health is clearly supported by the findings. These reveal that many young men do not have an adequate vocabulary to accurately express their feelings and emotions. It is equally important for service providers to use appropriate language when navigating the issue of mental health. Furthermore, the findings reveal that the word 'mental' deters young men from engaging in mental health initiatives, and that this word should be avoided. Providing young men and boys with the correct language and a vocabulary to express their mental health is required in their formative years.

The paucity of services for young men, as well as a lack of information on services that are available, is a prominent theme throughout this research. Many respondents felt that mental health services are not of sufficient quality, and never have been - even in times of affluence. Some participants argued that hospital services portray ambivalence towards young men with mental health issues, and choose pharmacotherapy as the primary method of treatment, despite having other options. Many believed there was a lack of collaboration and shared learning between service providers, as well as a lack of knowledge of international best practice in relation to young men and mental health. The findings suggest that young men regularly use technology and social media for information and socialising; often to the detriment of their social lives. Social media, in

particular, can be a forum for cyber-bullying and harassment, which can negatively affect the mental health of young men. Conversely, social media could be used to promote positive mental health, and could provide a platform for young men to express their feelings and emotions. It became apparent that young men do engage in mental health services if the environment is conducive to do so. An appropriate environment consists of the right format for mental health exploration along with suitable personnel. Young men need to be offered a safe environment, to which they feel a sense of connection and belonging, and wherein trust and confidentiality are sacred. The findings suggest that young men engage in mental health in informal settings when least expected, for example, a sports setting.

Many attempts to engage young men in mental health focused pursuits are cited. However, many of these are not evidence-based, though well intentioned. The relevance of sport and 'doing' activities are deemed to be of paramount importance when attempting to engage young men with mental health issues. Consistent with previous findings, the promotion of positive mental health needs to be done in the formative years of young men's lives in conjunction with other domains of health. Positive mentors and role models are seen to have a significant role in future work in relation to young men and mental health. It is evident that there is a need for more gender-specific training and, also, a need for training in relation to awareness of the specific issues that young men encounter today. The findings suggest that there is a need for a greater understanding of what interests young men and how to approach them using appropriate language. It is apparent that potential training should be tailored to a variety of service providers and to volunteers as well. The training should take the form of workshops that are facilitated by professionals with considerable experience of engaging young men. Case studies and role playing should also be part of the training, which should take a day or two to complete. The training that is provided must have a follow-up and a refresher component in order to be up-to-date with any new developments in relation to young men and mental health.


It was suggested that service providers should be offered a holistic understanding of masculinity at the training, as well as an opportunity to explore their gendered identity / develop their own emotional intelligence before delivering programmes to young men. It was felt that this would help them to develop empathy with the world of young men.

RECOMMENDATIONS FOR TRAINING

The following are the recommendations arising from this mapping exercise ...

- R1 Current services that provide for the mental health needs of the population should prioritise the needs of young men. Specifically, these services need to become more:
- Effective with respect to how they engage young men.
 - Accessible to young men.
 - Collaborative with other services, so that together they may appropriately meet the needs of young men.

- R2 Training should include key generic components, but should also be flexible and adaptable so that it can be tailored to the needs of specific groups within the community, including:
- Parents.
 - Those working with boys in the formative years e.g. childcare workers.
 - Teachers.
 - Any service provider who works directly with young men.
 - Volunteers who work with young men, for example, sports coaches.
- R3 Trainers who deliver training in this area should undergo the training themselves, so that they can have an understanding of, and empathise with, those they work with. Trainers should also have experience of engaging young men.
- R4 The training should be delivered in small groups using experiential methodologies (e.g. case studies and role playing), so that participants get an opportunity to: (a) explore the content of the training from a personal perspective, and (b) experience and deal with scenarios that mirror real life situations.
- R5 Training for teachers, service providers and volunteers who work with young men should apply a gender lens to mental health that includes:
- An educational component on young men and mental health in terms of signs, symptoms and coping strategies.
 - A significant component on masculinity, wherein participants get an opportunity to explore their gendered identities and the concept of 'hegemonic masculinity'.
 - The development of emotional intelligence amongst participants via experiential learning methodologies - so that they can develop emotional intelligence among boys and reframe the normal gender script into a more strengths-focused approach.
 - A component on language and communication - to equip service providers with a vocabulary that is appropriate for working with young men in this area.
 - The importance of building relationships with young men - by developing trust and offering a confidential space, a safe environment will be created which is conducive to engagement.
 - The importance of supporting young men to find a purpose in their life and to be confident in their abilities.
 - The potential for piggy-backing on other 'doing' activities. Mental wellness activities can be incorporated into something which young men are already engaged with e.g. sport and physical activity. In such non-threatening environments, talking can often come after doing.
 - The use of technology and social media to ensure service providers have an understanding of how it can be used to engage young men.
- R6 Training should be supplemented by innovative and accessible resource materials that contain concise guidelines for action.



R7 The timescale for the training should be adaptable, in order to meet the training requirements and time constraints of the participants.

R8 Post-training, participants should be offered opportunities for follow-up / refresher training, so that they can be supported in their work and kept up-to-date with the latest research and developments in relation to young men and mental health.

R9 The training should be incorporated into the formal certification of those who work with young men.

R10 The effectiveness of training for service providers on engaging young men would be strengthened by the development of additional training for parents and those who work with boys in the formative years. Such training should focus on the development of emotional intelligence and positive masculinities among boys.

1 INTRODUCTION

According to the World Health Organisation (WHO, 2010), over 450 million people worldwide suffer from mental health disorders such as depression, schizophrenia and anxiety. Mental health is more than the absence of mental disorders or disabilities; it is a state of wellbeing where an individual can work productively, cope with the normal stresses in life, contribute to his or her community and, ultimately, realise his or her abilities. Mental health is determined by a range of factors including socio-economic, biological and environmental factors. There are no apparent sex differences in the prevalence of mental disorders. However, there are significant differences in the symptoms and patterns of the disorders which vary across age groups (WHO, 2002). The prevalence of depression in an international context, for example, is higher in adolescent girls and women. Yet, the prevalence of suicide is higher in males - where it is between 3 and 7.5 times that of women (Bilsker and White, 2011). Over the last ten years in Ireland, the rate of death from suicide has been approximately five times higher in men than in women (Richardson et al, 2013). Much research has been conducted as to why this gender difference exists, with a lot of focus on psychosocial factors and masculinity. The traditional male gender role is characterised by attributes such as courage, independence, invulnerability and efficiency. In Western cultures, the male gender role implies not perceiving or admitting concern or anxiety (Moller-Leimkuhler, 2003). This culture, or masculine stereotype, does not allow help-seeking, even if required and available.

In Ireland, this masculine stereotype has been associated with denial of vulnerability and rejection of help-seeking, and has been attributed to Ireland also having one of the highest rates of suicide among young people - particularly men among the 30 Organisation for Economic Cooperation and Development (OECD) countries (Richardson et al, 2013). Engaging young men in services that may support their mental and emotional wellbeing, poses unique challenges to service providers. Many service providers are unsure of how to effectively reach young men, and are unclear about the type of services to which young men might respond. As stated earlier, even when services are required and available, the gendered norm mitigates against using them. Consequently, service providers require support to fill the existing service gap for young men. A vision of Ireland's National Men's Health Policy (NMHP) was to see a gender mainstreaming approach to service provision and planned policy action. This offers a pluralist approach that values diversity among both women and men. In order to adopt a gender mainstreaming approach and integrate it into practice, the NMHP called for training for service providers that would enable them to work with men of all ages more effectively [R7.2].

Training for service providers was also recommended in the 'Young Men and Suicide Project' report, and the Men's Health Forum in Ireland (MHFI) developed the 'Engaging Young Men' initiative as a direct response to Recommendation 10 in this document (Richardson et al, 2013, p13):

'Develop a one day training programme for all frontline staff on how to effectively engage with young men'.

With funding from the National Office for Suicide Prevention (NOSP), this initiative is coordinated by MHFI and overseen by an Advisory Group convened by the Forum. The aim of the Engaging Young Men initiative is to develop a training package which will increase the capacity of service providers and practitioners to effectively engage with young men in relation to programmes which promote mental health and wellbeing. For the purpose of this report, the term 'young men' is defined by the age range 18-30 years.

In order to achieve this aim, the current research focuses upon work to meet the first objective of this initiative, that is to:

'Conduct a mapping exercise which will identify the training needs of a wide variety of organisations, seek feedback on how the training might be delivered most appropriately, and shape the focus, content and structure of the training package'.

This research also aims to ascertain:

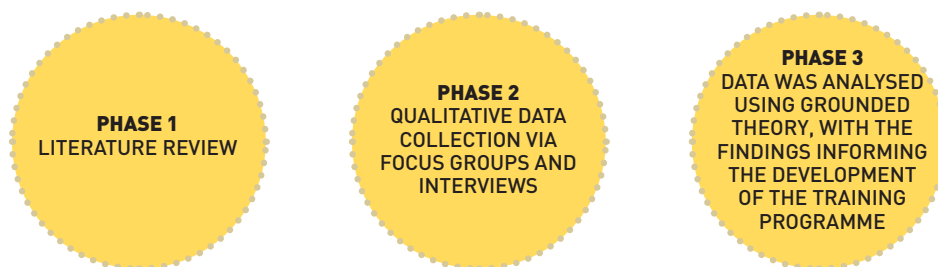
1. What factors support young men to engage or disengage on matters of mental health?
2. What are the challenges that service providers encounter when trying to engage young men around their mental health?

Section 2 describes the literature review process and provides an overview of the methodology used for data collection. It also describes the process of compiling the focus group and interview topic guide, along with the challenges in relation to data collection. Section 3 outlines the most relevant literature on young men and mental health, while the findings from the focus group and interview process are detailed in Section 4. The principal conclusions from the study, along with the recommendations for training, are presented in Section 5.

2 METHODOLOGY

This section describes, in detail, the investigative methods used to achieve the aims of this research. An overview of the phases of work is outlined in Figure 1. Following a thorough review of the current literature, qualitative data was collected via focus groups and interviews. This was then thematically analysed to inform the development of the training programme. Written informed consent was given by all participants in this research, which was approved by the Research Ethics Committee in the Institute of Technology Carlow (ITC).

FIGURE 1: RESEARCH PHASES



2.1 LITERATURE REVIEW

A review of relevant literature was conducted. This entailed a thorough search of the academic and 'grey literature' on: the rate and prevalence of mental health issues that young men experience; issues and challenges service providers encounter when attempting to engage young men around mental health issues; evidence of effective practice in the field of young men and mental health. The researcher had access to ITC's library of electronic databases. A search was conducted using the most relevant databases (PubMed, Medline, Cinahl and Scopus) and key search words ('mental health' AND 'boys', 'mental health' AND 'young men', 'mental health promotion' AND 'boys', 'mental health promotion' AND 'young men', 'mental health programmes' AND 'boys', 'mental health programmes' AND 'young men', 'mental health' AND 'engaging young men', 'engaging young men' AND 'best practice'). A review of the grey literature was also conducted using Advanced Google Search - using the same key search words. There was a particular focus on identifying evidence of effective practice when engaging young men, evaluated interventions, and policy responses (national and international) in the area of young men and mental health.

2.2 FOCUS GROUPS AND INTERVIEWS

In advance of the interviews and focus groups, a topic guide was developed in consultation with the Advisory Group and with due regard to the relevant literature (see Appendix A). This was used to guide the group discussion. The questions centred on:

- The type of mental health issues that young men experience.
- The mental health needs of young men.
- The challenges and barriers that service providers typically encounter when attempting to engage young men around mental health issues.
- Awareness of current mental health programmes for young men.
- Information and resources that could help service providers engage young men around mental health more effectively.
- The possible content and format of training to engage young men.

A number of unplanned questions were also asked during each individual focus group and interview. Table 1 provides a summary of each focus group and interview, including a description of the participants and the date of completion. These service providers were chosen because it was felt that they had the most contact with young men and the most opportunities to engage with them. An individual report was compiled for each focus group. One report was compiled for the three interviews with young men, as well as one report for the three interviews with personnel from mental health organisations. The aim was to engage with as broad a range of service providers as possible who were deemed the most relevant and appropriate in the context of young men and mental health. In the interest of confidentiality and anonymity, all quotations used in chapter 4 are reported with pseudonyms.

TABLE 1: SUMMARY OF FOCUS GROUPS AND INTERVIEWS

Name of Group	Description of Participants	Date/Place of Completion
Youth Workers (Rol)	Youth workers and those working with young men from the Waterford and South Tipperary Regional Youth Services (n = 6)	Completed on 9th April 2014, Dungarvan, Co. Waterford
Sports	Representatives from GAA Healthy Club (Leinster): St. Colmcilles GAA Club, Bettystown (n = 6)	Completed on 7th May 2014, Bettystown, Co. Meath
Sports Coaches	GAA, FAI, IRFU: IT Carlow (n = 5)	Completed on 20th May 2014, Carlow, Co. Carlow
Youth Workers (NI)	Youth workers from various parts of Northern Ireland (n = 5)	Completed on 21st May 2014, Belfast
Clergy / Chaplains	Chaplains who provide services for young men in the various Institutes of Technology throughout Ireland (n = 8)	Completed on 28th May 2014, Letterkenny, Co. Donegal
Probation Services	Probation Officers / Senior Probation Officers / Community Service Supervisors (n = 7)	Completed on 5th June 2014, Cork City
Back to Education Personnel	People who help young men return to the workforce (n = 6)	Completed on 19th June 2014, Waterford City
Statutory Primary Health Care Staff	Clinical Psychologists (n = 2)	Completed on 30th June 2014, Naas, Co. Kildare
Personnel from Mental Health Organisations (interviews)	Volunteers / employees in mental health organisations who have experience of working with young men (n = 3)	Interview 1 - Completed on 3rd July 2014, Waterford City Interview 2 - Completed on 4th July 2014, Callan, Co. Kilkenny Interview 3 - Completed on 7th July 2014 via telephone (interviewee based in Kilkenny)
General Practitioner (telephone interview)	GP (n = 1)	Completed on 4th July 2014 (interviewee based in Mayo)
Young Men (interviews)	Young men aged between 18-30 years (n = 3)	Interview 1 - Completed on 11th July 2014, Carrick-on-Suir, Co. Tipperary Interview 2 - Completed on 16th July 2014, Carrick-on-Suir, Co. Tipperary Interview 3 - Completed on 18th July 2014, Carrick-on-Suir, Co. Tipperary

2.3 CHALLENGES

Numerous challenges arose whilst trying to convene some of the focus groups and interviews. The primary challenge was a logistical one - it was difficult to get a sufficient number of participants to attend some groups on a given date and time. For example, it was difficult to convene the focus group with youth workers in Northern Ireland, principally due to potential candidates' busy schedules. A low number of primary care personnel took part. This was, mainly, due to logistical issues and travel restrictions imposed on interested candidates. It was difficult to convene a focus group with personnel from mental health organisations, primarily due to concerns around confidentiality - despite assurances from the researcher. This sometimes resulted in a change of data collection methodology from focus groups to interviews, as can be seen in Table 1. Interviews were conducted with three young men instead of a focus group due to concerns around confidentiality and, also, because it was the time of year when many of them were on holiday or busy with sports clubs. The topic of the research (i.e. mental health) presented another barrier to convening a focus group.

2.4 DATA ANALYSIS

Each focus group and interview was transcribed verbatim, and analysed using the principles of grounded theory. This involved searching out the concepts behind the actualities by looking for codes, then concepts and categories. A grounded theory approach comprises simultaneous data collection and analysis (known as 'constant comparative analysis'), with each informing and guiding the other as the research process unfolds (Strauss and Corbin, 1998). By beginning the analysis of data early, this helps to direct further collection of data which, in turn, refines emerging theory. A grounded theory approach means that emergent concepts are derived from analysis of empirical data rather than applying existing concepts to them (Strauss and Corbin, 1994). For this reason, it was deemed to be the most appropriate form of analysis in this study.



3 LITERATURE REVIEW

This literature review looks at the prevalence of suicide in young men, the risk factors for suicide, and the factors that influence suicide rates, trends and methods (Section 3.1). Section 3.2 examines the prevalence and risk factors for self-harm, while Section 3.3 reviews the risk factors for mental health problems more generally. The attitudes and behaviours of young men are explored through the prism of masculinity and how these attitudes and behaviours impact on their help-seeking behaviour (Section 3.4 and Section 3.5). The issues and challenges concerning young men and mental health, and the limitations or barriers at a service provision level, are explored in Section 3.6. This is followed by a review of policy documents in this area from a national and international perspective (Section 3.7). The principles and evidence of best practice when working with men are investigated in Section 3.8, and this is followed by a look at interventions, initiatives and programmes in Section 3.9. The last section of the review looks at various mentoring and peer-led initiatives (Section 3.10).

3.1 SUICIDE AND YOUNG MEN

The prevalence of suicide in young men is explored in this section, as well as the risk factors for suicide and the factors that influence suicide rates, trends and methods. Rural and urban disparities in help-seeking behaviour are also explored.

Suicide - the act of intentionally causing one's own death - is a significant public health and social concern. According to the Central Statistics Office (CSO, 2014), 554 people died by suicide in Ireland in 2011, with 458 (83.3%) of these deaths being among men. The suicide rate among young men aged 15-24 and 25-34 in 2011 was 22 per 100,000 and 28.6 per 100,000 respectively (NOSP, 2014a). Provisional figures for 2012 and 2013 show a decrease in male suicide, although these figures are subject to future revision. A disproportionate number of men, in comparison to women, die by suicide in Ireland every year. This sex difference is a constant feature of deaths by suicide over the last decade in Ireland, and a similar trend can be seen in many countries throughout the world. A survey of young people in Ireland aged 12-25, revealed that young men engage in more risk-taking behaviour than young women, including substance misuse, problem drinking and violence towards others (Headstrong, 2012). These behaviours have been correlated with suicide and suicidal ideation. The survey also revealed that rates of suicidal thoughts, self-harm and suicide attempts were found to be higher in young adults who did not seek help or talk about their problems.

Burns et al (2008) examined suicides in Londonderry, Northern Ireland, between the years 2000 and 2005. They particularly focused on factors linked with the occurrence of suicide, namely: gender, method used, employment status and age. There was a large sex discrepancy, with 83.3% of those who died by suicide being male. Over one third of these occurred between the ages of 21 and 30, which is consistent with trends in the Republic of Ireland. The most frequent method of suicide was hanging.

According to Hendin (1964, as cited in Lester, 2008), suicidal behaviour is determined differently, and has different meanings, in different societies and cultures. Adinkrah (2010) examined the concept of masculinity and male suicidal behaviour in Ghana, where there are clear gender roles and assumptions regarding gender. The data for this study were obtained from Ghanaian police records for the time period 2006-2008. A content analysis was then performed, and motives for suicidal behaviour were coded and organised into various categories. Similar to Ireland, the incidence of suicide was found to be most common in boys and young men, specifically those aged 10-35 years.

The majority of men who engaged in suicidal acts did so to counteract feelings of dishonour and shame. These suicidal acts and completed suicides were seen as moral actions. This is also a feature of Japanese culture, where it is seen as upholding honour and a last place to practice one's free will in a generally conformist society (Doi, 2001 as cited in Ozawa-de Silva, 2008). As the study period was for three years only, the generalisability of the findings are limited. It is also possible that the true scope of the phenomenon was under-estimated by the police recorded data on suicidal behaviour. The study does, however, contribute to the literature on suicidality in Africa, and offers important insights into the relationship between gender and suicidal behaviour in Ghana.

Varnik et al (2009) investigated whether differences existed in suicide rates, trends and methods used among 15-24 year olds by gender across 15 European countries. The data were collected from countries participating in the European Commission funded project the 'European Alliance Against Depression' (EAAD). The findings showed that suicide rates ranged from 5.5-35.1 for males and 1.3-8.5 for females. There was a significant decline in suicides after 2000 in four countries, for example, Germany ($p < 0.0001$) and Scotland ($p < 0.0001$). Males were more likely than females to use firearms and hanging, which is consistent with current literature. The fact that there are small numbers by specific suicide methods in some countries raises challenges regarding methodology. Hence, caution is required in drawing conclusions. With respect to individual countries, the data from Belgium is only representative of the Flemish region and, although England and Scotland are two separate sites in the EAAD, they are cautiously reported as two distinct countries.

Caldwell et al (2004) looked at suicide and mental health in rural, remote and urban areas in Australia. They aimed to compare the prevalence of mental health disorders and the use of professional help by sex, age and area of residence, and to consider whether any observed differences mirrored differences in suicide rates. This retrospective, cross-sectional analysis of Australian national mortality data and the National Survey of Mental Health and Wellbeing (NSMHWB) showed that higher suicide rates were evident for men, in particular young men in rural and remote areas compared with urban areas. It was also found that young men with a mental health disorder from rural and remote areas were significantly less likely than those from urban areas to seek professional help for a mental health disorder. It is necessary to examine why young men in non-urban areas, with the greatest suicide risk, either chose to or chose not to engage with mental health services.

The study had a number of limitations, such as the cross-sectional nature of the design, which limited the capacity to ascertain causal relationships. The data used did not include adolescents, so it was not possible to explore this population. It is also important to note that the NSMHWB data reflect self-reported symptoms, and that young men - mainly those in rural areas - may have been less likely to report, recognise or be concerned about symptoms than their urban counterparts. These findings are consistent with Hirsch (2006) who, in his review of rural suicide, noted that suicide in rural areas is a public health concern, with rates often greater than in urban areas. A better understanding of the role of rurality in the maintenance and development of suicidal thoughts and behaviours is required, and may inform prevention and intervention efforts.

In summary, statistics in Ireland show that suicide is a major public health issue, particularly where young men are concerned, and that there is a significant sex discrepancy in suicide rates (CSO, 2014). There is also a clear gendered aspect to suicide. For example, men are more likely to use more violent methods of suicide (Varnik et al, 2009) and young men, who live in isolated rural areas, are more likely to die by suicide and less likely to seek professional help for a mental health disorder (Caldwell et al, 2004).

3.2 DELIBERATE SELF-HARM

This section examines the prevalence of Deliberate Self-Harm (DSH) in young men, explores the various risk factors for DSH and looks at positive ways of coping with mental health issues.

DSH is recognised, worldwide, as a major public health problem. It includes a range of behaviours linked with various levels of medical severity and different levels of suicide intent. According to Hawton et al (2012), a history of self-harm is a significant risk factor for repeated self-harm and ensuing suicide. The National Registry of Deliberate Self Harm Ireland's Annual Report 2012 shows that the male rate of DSH was 195 per 100,000, which was 5% lower than in 2011 (Griffin et al, 2012). This decrease followed an increasing trend in the rate of DSH between 2007 and 2010, with a 19% increase overall during this period. The biggest increase during this period was seen amongst males, where the rate rose from 162 per 100,000 to 211 per 100,000 (+27%). Overall, the rate of DSH in males has increased by 20% since 2007, with the peak rate being among males aged 20-24 years.

In a study of bullying among Irish adolescent boys, McMahon et al (2010) examined the link between bullying and a wide variety of risk factors, as well as factors associated with self-harm among boys who had been bullied compared to their peers who had not been bullied. Analyses were based on data from the Irish Centre of the Child and Adolescent Self-harm in Europe (CASE) study. Information was acquired on DSH, school bullying, lifestyle and psychological factors, and also negative life events. It was found that the odds ratio of lifetime self-harm was four times higher for boys who had been bullied compared to those who has not been bullied. There were a number of factors that correlated with self-harm among bullied boys. These included academic problems, worries about sexual orientation, and psychological factors. Conversely, family support was protective against self-harm.

Due to the cross-sectional nature of the design, it was not possible to draw conclusions on causal or temporal associations between a history of bullying and related factors, or between self-harm and related factors among boys who had been bullied. Also, there was no definition of bullying in the questionnaire - which could have led to under-reporting of bullying victimisation, as participants may not have considered the different forms that bullying can take. However, the strength of this study was the multivariate analyses used to describe the variety of factors linked with bullying, and the identification of factors linked with self-harm among bullied boys.

Daine et al (2013) conducted a systematic review of the influence of the Internet on self-harm and suicide in young people. Only articles that included empirical data on self-harm and suicide, young people and the Internet, were accepted. Thematic analyses and data extraction were conducted on the accepted articles. It was found that those who self-harm often make use of the Internet for constructive purposes such as help-seeking and coping strategies. However, the study also highlighted that the Internet could exert a negative influence, for example, discouraging professional help-seeking, and normalising and condoning self-harm. There were also connections between Internet exposure and violent methods of self-harm. Internet use can have both positive and negative effects on young people at risk of self-harm or suicide. Greater high quality research is required to better comprehend how Internet use may wield negative influences, and it should also focus on how the Internet might be used to intervene with at risk young people.

There were a number of limitations in the review, most notably the exclusion of non-English publications and also grey literature. Thus, there is a possibility of publication bias. A report by NOSP (2014b) revealed that young people who were the victims of cyber-bullying experienced a range of negative consequences that were



similar to victims of traditional methods of bullying. Such consequences included anxiety, academic problems, depression, self-harm and suicidal ideation. The same report revealed that victims of cyber-bullying seem to be at risk of the most severe psychological, emotional and social problems, and tend to be rejected by their peers.

Building on an earlier study, McMahon et al (2013) used a cross-sectional design in 39 schools in Counties Cork and Kerry to examine associations between coping styles, mental health factors, self-harm ideation, and self-harm actions among Irish adolescents, to ascertain whether coping style mediates relations between mental health factors and self-harm. Emotion-focused coping was strongly linked with poorer mental health and self-harm ideation and actions. Problem-focused coping was linked with better mental health. Like McMahon et al (2010), the cross-sectional nature of the research design means it was not possible to draw conclusions regarding causal relationships between coping style and related factors. Also, the study examined lifetime history of self-harm, yet coping style was only assessed at one time point. The promotion of positive coping skills, with a simultaneous decrease in emotion-focused approaches, could build resilience to self-harm ideation and acts among those young people who experience mental health problems.

Madge et al (2011) examined the findings from the CASE Study. The links between psychological characteristics, self-harm history, and life events among young people within a large international dataset were investigated. Particular attention was given to the hypothesis that an increase in adversity, with regard to life events and psychological aspects, is related to an increase in the level and frequency of self-harm. Over 30,000, predominantly 15 and 16 year olds, completed anonymous questionnaires at various secondary schools throughout Europe. The findings showed that an elevated severity of history of self-harm was linked with greater anxiety, impulsivity and also depression. It was associated with lower self-esteem and an increased prevalence of all negative life event categories, namely, serious illness of family or friend, problems with or between parents, physical or sexual abuse, difficulties with friends or peers, death of someone close, suicide or self-harm of family or friend, trouble with police, bullied, problems with school work, and worries about sexual orientation.

Whilst the rate of DSH has traditionally been higher in females, more recent data indicates that rates of DSH are now increasing in males (Griffin et al, 2012). Similar to McMahon et al 2010 and 2013, this study used a cross-sectional design. This implies that the type of relationships between life events, self-harm and psychological characteristics cannot be assumed to be causal. Also, other potentially significant factors like alcohol abuse were not considered. The representative nature of all national samples could not be guaranteed. The study did, however, provide a clear definition of self-harm, and had a large school-based sample that was representative. In addition, the methodology used was standardised across all countries.

Toprak et al (2011) investigated self-harm in non-clinical samples of college students. The sample comprised a mixture of males and females from two colleges in a rural and urban setting in Turkey. Two questionnaires were used; the first comprising basic demographic characteristics, and the second consisting of seven sections which included questions relating to health, self-harm, family, peer pressure and traumatic experience. While self-harm was significantly higher among males than females, no gender difference was reported in the prevalence of suicidal ideation and suicide attempts. Self-harm and suicide attempts were significantly more common among adolescents sampled in the rural area. Like some of the previous studies mentioned, the cross-sectional nature of this study was its primary limitation; limiting the capacity to ascertain causal relationships. As analyses were based on self-reported data, there may have been an under-reporting of DSH. Also, there were only two schools in the study, which raises questions around generalisability.

In summary, therefore, it has been shown that DSH is an increasing and significant issue for many young men, and that there is a clear link between DSH and suicidal ideation (Madge et al, 2011; Toprak et al, 2011). A correlation is evident between DSH and problems with friends / peers and bullying (McMahon et al, 2010; Madge et al, 2011), whilst concern about sexual orientation is also related to DSH (McMahon et al, 2010; Madge et al 2011). Boys also appear to have less knowledge about mental health issues, and experience higher mental health stigma than girls (Chandra & Minkovitz, 2006).

3.3 RISK FACTORS FOR MENTAL HEALTH PROBLEMS

This section will provide a brief overview of risk factors for mental health problems.

According to Prince et al (2007), about 14% of the global burden of disease has been attributed to psychiatric disorders, mainly due to depression and other common mental disorders, psychoses and substance-use disorders. The burden of mental disorders is likely to have been undervalued because of the limited appreciation for the relationship between mental ill health and other health conditions. The risk factors for mental ill health of adolescents can be broken down into three broad categories: Biological, Psychological and Social (Department of Health South Africa, 2003, as cited in Patel et al, 2007). Biological factors can include things like head trauma, pregnancy and substance abuse. Learning disorders and maladaptive personality traits are examples of psychological factors, while issues like family conflict, bereavement, bullying, discrimination and marginalisation are social factors.

Chandra & Minkovitz (2006) explored the gender differences in teen willingness to use mental health services in two mid-Atlantic state public schools. Self-administered questionnaires were conducted with 274 eighth graders, where it was found that boys had less mental health knowledge and experience, and higher mental health stigma, than girls. Boys were also less likely to report willingness to use mental health services. They concluded that stigma starts early, in early adolescence specifically. Unresolved mental health problems can be a risk factor for DSH and, in more extreme cases, for suicide.

3.4 YOUNG MEN AND MASCULINITIES

The adoption of a gendered approach to men's health, as proposed in Ireland's National Men's Health Policy (Department of Health, 2009), enables us to recognise how different patterns of socialisation and gender conditioning impact upon the value that men place upon their health, and how they manage their health within the healthcare system. This section looks at the consequences to young men and their mental health of conforming to more negative or narrow types of masculinity, and also looks at how masculinity can be shaped in positive, health-enhancing ways.

Gender should be considered as something we do, rather than who we are. Whilst we are born male or female, we actively negotiate what it is to be 'masculine' or 'feminine' in ways that typically reflect societal expectation of particular masculine and feminine roles. Therefore, it is not only about power relationships between men and women, and between different groups of men, but also includes power relationships between different groups of women who adopt masculine or feminine behaviours. It is more appropriate, therefore, to think about masculinities rather than masculinity.

The term 'hegemonic masculinity' (Connell, 1995) refers to the culturally exalted position afforded at any given time to one form of masculinity over others, and accentuates many of the masculine traits associated with more traditional constructions of masculinity (e.g. 'big boys don't cry', 'no sissy stuff', 'man up' etc.). This type of masculinity most typically describes the 'ideal male' as one who is macho and takes risks, but also one who is independent and does not demonstrate weakness or vulnerability (Connell and Messerschmidt, 2005). Hegemonic masculinity is defined against a range of subordinated or marginalised masculinities (e.g. straight versus gay masculinity).

The extent to which men endorse traditional or dominant definitions of masculinity has been shown to be related to unhealthy behaviours such as poor diet, excessive alcohol consumption, and not seeking help during times of ill-health or distress. Young men sometimes display their masculinity by dismissing emotional pain they may have and appearing unemotional to others. By suppressing certain feelings and emotions, young men may believe they are conveying an important aspect of their masculinity i.e. that men do not need support from others (Harland, 2000). These traits are related to suicidal ideation and DSH.

Mac an Ghaill and Haywood (2010) questioned the viability of using normative models of masculinity as an explanatory tool for explaining boys' behaviours, and suggested that researchers in the field of gender and suicide ought to consider how boys' genders may be constituted differently. The authors conducted a qualitative study using semi-structured interviews with 28 children aged 9-13 years (16 females, 12 males) and 12 school staff at a school in North East England. The focus of the study was on certain themes which emerged relating to, for example, masculinity and emotional disclosure. The findings showed that it was institutional, not individual, anxiety around gendered identities that appeared to be impacting upon emotional disclosure. Emotional distress was produced through institutionalised gender confusion. Boys were being judged through a standard adult masculinity yet, on the other hand, it contravened a standard feminine code that aligned itself with the institutional dependence on childhood. Boys' identities were being controlled and regulated through the interplay of adult masculinity and feminised childhood. A significant limitation of this study was the non-random selection of the school and the small sample size i.e. only one school in the study.

Landstedt et al (2009) explored 16-19 year old students' perceptions of what is relevant to mental health, and applied a gender analysis to the findings to improve understanding of the gender pattern in adolescent mental health. A grounded theory approach was used, based on 29 focus groups, with participants recruited from schools in a county of Northern Sweden. Significant factors were identified in three social processes categories, including both positive and negative aspects: (1) performance, (2) social interactions and (3) responsibility.

Boys' more positive mental health appeared to be linked with their low level of responsibility-taking relative to girls. It was also apparent that open expressions of feelings by boys seemed to be seen as potentially negative for mental health, which is consistent with the concept of hegemonic masculinity. Interestingly, some girls discussed how boys, who do not talk about their feelings, might feel even worse. The expression of feelings and emotions in public situations seemed to be unacceptable for boys, and was seen as a risk factor for bullying or other adverse responses.

The study emphasises that social processes and factors, constructions of masculinities and femininities, and gendered power relations should be recognised as significant in shaping adolescent mental health. Power relations and hierarchies within the groups could have restricted some participants from speaking out or from



raising certain issues. In relation to self-selected and single sex groups, familiarity can suggest that some things are not discussed, since they are taken for granted or are seen as potentially taboo or sensitive. Research bias may also have been unintentionally communicated to the adolescents. Despite these limitations, the transferability of the study is strengthened by the fact that some of the findings are consistent with previous research; suggesting that the findings could be transferable to adolescents in similar contexts.

Houle et al (2008) aimed to determine whether characteristics associated with the traditional male gender role may be linked with a greater risk of suicidal behaviour in men who experienced at least one severely stressful life event in the preceding year. They proposed, and empirically evaluated, a mediation model of suicidal behaviour in men, wherein adherence to the traditional masculine gender role was associated with an increased risk of suicidal behaviour in men. Structured interviews were administered to measure compliance to more stereotypical constructions of masculinity, suicide acceptability and mental health. The Gender Role Conflict Scale (GRCS) was used to assess adherence to the traditional masculine gender role. The findings indicated that 'attempters' were more likely to hold on to this gender role, and analysis showed that this association persisted even when the presence of mental disorders was statistically controlled.

The study indicates that the effects of the traditional male gender role on suicidal behaviour are mediated through protective and risk factors for suicide i.e. mental health, social support and help-seeking. A number of limitations are evident in the study, most notably the small sample size. Also, the causal relationship between masculine role adherence, the mediator variables, and suicide risk cannot be determined from the data due to the correlational nature of the study design. All of the mental disorders that could be linked with suicidal behaviour were not evaluated, while the suicide acceptability measure used comprised only a single item, which raises issues around validity.

Emslie et al (2006) conducted a qualitative study to explore respondents' accounts of depression, and examined the links between their narratives and social constructions of masculinity. Sixteen interviews were conducted with men to see, primarily, how depression influences their gender identities. The findings showed that it was important for men to reconstruct a valued sense of themselves and their own masculinity in their recovery from depression. Incorporating values associated with hegemonic masculinity into narratives was the most common strategy. There was evidence, however, that the pressures of conforming to the standards of hegemonic masculinity could add to suicidal behaviour. Some men found ways of being masculine outside of hegemonic discourses. Generalisations about depressed men showing strength can be deceptive, despite the men in this study openly talking about their depression.

An argument could be made that the sample consisted of an uncommon group of men with depression who were eager to volunteer to be filmed or recorded for a website, hence making their story public. Approximately half of the participants chose to do this, despite the option to hide their identity. The 'strong and silent' depressed men may have been missed in this study. However, access to this group of men would have been challenging. Awareness is required by health professionals of the issues raised by men's accounts which stress strength, control and responsibility to others.

Cleary (2011) explored suicidal action, emotional expression and the performance of masculinities through in-depth interviews with 52 young men (18-30 years) over a two and a half year period between 2000 and 2003. The data were analysed using a modified version of grounded theory. The findings show that these men had problems identifying symptoms and revealing stress, despite experiencing high levels of emotional pain.

This, as well as the coping methods used, was associated with a form of masculinity ubiquitous in their social environment. Similar to Emslie et al (2006), prevailing or hegemonic masculinity norms discouraged admission of emotional vulnerability. A limitation in this study was the non-random selection of the hospitals and the common demographics of the participants.

Oliffe et al (2010) explored suicide from the perspectives of men who had experienced depression. Thirty eight men between the ages of 24 and 50, who had experienced depression, were interviewed using a grounded theory approach similar to Emslie et al (2006) and Cleary et al (2011) to try to better understand the processes they used to counter and contemplate suicide. Almost three quarters of the participants consistently represented their masculinity within 'connecting' contexts, for example, the men wanted to be a good partner and father, and recognised that suicide meant abandonment, pain and despair for loved ones. Family ties were so strong that the men were committed to enduring depression regardless of its severity. The findings verify that approaches to depression and suicide prevention that exclusively target masculine practices may offer more success than those that are gender-neutral. This is consistent with the wider literature on men's health. Overall, the grounded theory approach allowed the researchers to map their findings across distinct and diverse pathways.

According to Link et al (1997), depression signals vulnerability, attracts considerable stigma, and directly challenges the strength and power synonymous with masculine ideals. Depression, and seeking help for depression, are at odds with masculine ideals, and also openly situated as a feminine problem and action. Men are not diagnosed with depression as often as women and are, instead, diagnosed with disorders such as personality disorder or substance abuse disorder, despite a hidden depression (Kilmartin, 2005).

Sloan et al (2010) looked at how masculinities can be 'healthy', and aimed to focus particularly on how men may construct healthy behaviour with respect to masculine identities. They reported on an analysis of semi-structured interviews with 10 'healthy' men. All of the participants rejected a direct interest in talking and thinking about health, which was seen as excessive and feminine and, instead, rationalised their practices variously in terms of action-orientation, appearance concerns, being independent and sporting targets. There was not much evidence of appearance-related concerns among the sample - despite the increasing coverage in the media of image-conscious men. Body image has not been traditionally associated with hegemonic masculinity, yet more men appear to be body conscious. This could have positive implications for breaking down the stigma around men's mental health in particular.

The healthy men in this study found themselves rejecting traditional forms of masculinity, and also took an active interest in health. For example, some unhealthy behaviours associated with hegemonic masculinities were rejected, but only by repeating other aspects of hegemonic masculinity such as independence and rationality. By criticising the practices of other men, the participants were able to situate themselves as making sensible decisions, remaining autonomous and, therefore, safeguarding their masculine status.

There were a number of limitations in the study. For example, the men were more likely to talk about other men's practices, hence implicitly positioning themselves as healthy, rather than directly talking about their own health practices. Also, a more narrative interviewing process might have elicited more personal data. In terms of mental health, there is sometimes a fear in men that the counselling process will 'feminise' them (Kilmartin, 2005). The focus should turn to traditional masculinities like courage, independence and leadership, and frame them in such a way that it takes courage to express your feelings: not always doing what other men do demonstrates independence, and showing other men healthier versions of masculinity shows leadership.

In summary, it has been demonstrated that many boys and young men feel pressurised to adhere to values and behaviours that are consistent with expressions of a more dominant or 'hegemonic masculinity'. This, in particular, discourages expressions of vulnerability (Emslie et al, 2006; Cleary, 2011). Constructions of more dominant or hegemonic masculinity are also reinforced by gendered institutions such as schools or workplaces. For example, one study found that boys were being judged through a standard adult masculinity, and their identities were being controlled and regulated through an interplay of adult masculinity and feminised childhood (Mac an Ghail & Haywood, 2010). The literature also highlights that the open expression of feelings by boys can be seen as potentially negative for mental health.

The pressures on many young men to conform to ideals of hegemonic masculinity and to 'put up' with depression can be particularly prevalent where men feel a need or obligation to preserve their role as partner or father (Oliffe et al, 2010). There is also evidence of men rejecting aspects of hegemonic masculinity, particularly in contexts where men retained a sense of control by choosing to embrace certain aspects of masculinity and to reject others. For example, Sloan et al (2010) demonstrated that many young men did not adhere to unhealthy behaviours linked with hegemonic masculinity, but adopted other aspects of it like rationality and independence.

3.5 OVERCOMING BARRIERS TO EFFECTIVELY ENGAGE WITH YOUNG MEN

Building on the findings from Section 3.4, it has been shown that young men who feel pressurised to adhere to negative forms of masculinity, and those who may be suffering from mental health problems, may not seek help professionally or otherwise. This section explores the barriers to, and patterns of, help-seeking among young men in relation to mental health, and considers effective strategies for how to engage with young men. According to Cleary (2011), men's inability to seek help, specifically for mental health problems, is influenced by low educational attainment, low socio-economic background, and by adopting the traditional hegemonic masculine ideal. In the College Lifestyle and Attitudinal National (CLAN) Survey on the health of Irish students, male students reported being less likely than female students to seek help for mental health problems and more likely to turn to alcohol and drugs as coping strategies (Hope et al, 2005). This was particularly the case for first and second year students. In the same study, a higher number of males than females reported an unwillingness to talk to anyone if they were feeling anxious or depressed.

In a study by Begley et al (2010), men were less likely to recognise a mental health problem than women, less likely to report personal susceptibility to depression, and less likely to confide in family members about emotional issues. In the same study, young males who died by suicide were reported to be less likely to contact their General Practitioner (GP) prior to their death than older males. A 2013 report from the Australian Institute of Health and Welfare revealed that almost 1 in 4 males aged 16-24 years had experienced symptoms of a mental disorder in the previous twelve months, yet help-seeking rates are low among young males. According to Hickie et al (2007, as cited in Suicide Prevention Australia, 2010), young men are among the least likely demographic to seek help from a professional for a mental health problem, despite the support they convey for other people to do so.

Russell et al (2004) explored the problems experienced by young men in a rural setting and their attitudes towards help-seeking. Focus groups were used to create themes for a qualitative and quantitative questionnaire, which

was issued to 71 young men in the community as well as to 79 key informants. The findings revealed that respondents would most likely look for support from a family member or close friend. Conversely, a nurse, social worker, teacher or principal were least likely to be contacted for support. Twenty seven per cent of respondents believed there was little help for young men in crisis. The key informants rated themselves highly in their ability to deal with and detect mental health problems in young men. However, as previously mentioned, young men are least likely to approach key informants for support. They also agreed that the skills required to help young men in crisis included having a non-judgemental attitude, having a balanced approach to problems, along with a friendly disposition.

There were a number of limitations to the study. For example, there were questions around the representative nature of the sample and that the sample was non-clinical; suggesting it was unrepresentative of those who were most at risk. It is also likely that the key informants were not in contact with vulnerable men in the community. Overall, the study supports the possibility of building a partnership between the local community and the health services in creating future suicide prevention strategies for young men.

Ellis et al (2013) explored young men's attitudes in relation to mental health and technology, with the aim of increasing understanding of young men's behaviours and attitudes towards mental health, technology use, and online habits. Their experiences of utilising the Internet for information support or help were also explored. A survey was run online for a three-month period. Seventeen focus groups were conducted, which involved 118 young men. The findings showed that young men use the Internet for help and support and are less likely to seek professional help for themselves; citing a desire for self-help and action-oriented strategies instead. The majority of survey participants reported that they had looked for help online and were content with the help that they had received. This corresponds with the My World Survey in Ireland which revealed that almost half of respondents (49%) used the Internet as a source of help (Headstrong, 2014). This highlights the growing relevance of technology and the Internet, specifically in helping young men with mental health problems. The sampling procedure in this study provided the main limitations. The sample was limited to those with Internet access - due to the survey being distributed online. Also, the snowball sampling and the advertising methods raises questions around the generalisability of the findings. Another limitation was the representativeness of the focus group sample. The mixed method quantitative and qualitative nature of the design was a significant strength of the study.

Johal et al (2012) identified a number of barriers related to young men's reluctance to engage with health services. They found that young men are sometimes more reluctant to seek help from others than young women and, when they do, the prognosis can be more negative due to late diagnosis. Young men may be reluctant to go public with a mental health problem that they may perceive to be embarrassing or not 'manly' - possibly due to the fear of stigma. They also identified a lack of visibility of male role models in health services as a barrier, while their research revealed that some groups of men are harder to reach than others, for example, young men.

The authors suggest a range of contributory factors for this such as language, cultural barriers and vulnerability to peer influence. They also noted that engaging with young men is influenced by a lack of discourse and a resistance to engage with gender as an issue from a male perspective. The Big Lottery Fund (2012) identified that lack of engagement between young men and health services could be because many health services are administered by a higher volume of female workers than male workers, possibly leading to a tendency among young men to feel out of place or unwelcome. The differences in the way men respond to communications were also seen as a likely barrier.

Harland (2009) outlined a number of key considerations when trying to engage young men, for example:

- Many young men believe that it is by 'acting tough' that they will gain respect and status.
- The contradictory nature of masculinity, and its relationship with risk-taking behaviour, are key reasons why young men refuse to seek emotional support.
- Young men often report feeling enormous pressure to prove that they are 'real men' and not boys.
- Young men report that they are rarely given opportunities to reflect upon their behaviour.
- Young men report a lack of access to mentors / role models.

According to Harland (2008), it is necessary for service providers and practitioners to reflect on the key influences and people who fashioned their own lives as this, in turn, can help them have greater empathy towards young men and their issues. Personal reflection may help service providers to:

- Better comprehend factors that shaped their self-esteem as a young person.
- Better value youth transitions and the magnitude of accessible role models for young men.
- Become more proficient at sharing feelings and emotions.
- Improve relationships between service providers, practitioners and young men.

Research has demonstrated that young men are rarely asked how they feel and what they think (Harland 1997, as cited in Harland, 2008). Therefore, the ability to listen actively to what young men say is of paramount importance if engagement is to be successful. The Men's Health Information and Resource Centre in Australia suggests four key elements when seeking to engage men: environment; language; initial contact and marketing; service provision. Creating a safe environment that makes young men feel welcome is very important, for example, visuals of men and boys in a positive display. Language can influence the way that the service's views on men are communicated. Moving past negative views of young men may lead to better engagement. Marketing geared towards young men is important, and is an area where a positive viewpoint can pay dividends. Marketing to young men includes the design of the services through to how it is promoted and communicated to them. Service provision influences how young men relate to the service, including their level of involvement, compliments / complaints and processes around feedback.

According to Youth Action Northern Ireland (2002, as cited in Harland, 2008) the skills, knowledge and commitment of the service provider or practitioner is deemed to be more important than the gender of the practitioner. Young men look for humour, honesty, trust, listening skills, good knowledge that is based on fact, and the ability to control a group.

Harland (2008) identifies some of the factors for success in engaging young men:

- Combining reflection with creativity.
- Identification of issues affecting young men and the use of innovative ways to address them.
- Encouraging expression of young men's emotions and views through a supportive / advocacy approach.
- An understanding of masculinity and its impact on the mental health of young men.
- A proactive approach that focuses on developing young men's confidence and self-esteem.



- Creating suitable learning environments in which young men feel safe and valued.
- Not being afraid to make mistakes or to blame oneself if things go wrong.
- Practitioners' / service providers' dedication to building important relationships with young men.
- Appreciation of qualities that young men look for in a practitioner - support and acceptance, humour, respect and trust.

In summary, young men are less likely to seek help for a mental health problem, more likely to turn to alcohol and substance misuse as coping strategies, and less likely to approach key informants for support (Russell et al, 2004; Ellis et al, 2013). Young men also appear to use the Internet and technology as a way to seek help for mental health issues in preference to more conventional health services (Ellis et al, 2013). There are a number of issues to consider when attempting to engage young men in mental health, such as the contradictory nature of masculinity and a lack of access to mentors and role models. Those who provide a service to young men need to explore their own masculinity and what it means to be male. They also need to share their own feelings and emotions with young men to help break down barriers around stigma. A sense of humour, honesty, trust and good listening skills are necessary to engage young men.

3.6 ISSUES AND CHALLENGES CONCERNING YOUNG MEN AND MENTAL HEALTH

The barriers young men face concerning help-seeking for mental health issues are examined in this section. These barriers range from stigma around mental health at an individual level to attitudes in society in relation to mental health more generally.

Gulliver et al (2010) conducted a systematic review of both the qualitative and quantitative literature on the perceived barriers and aids to help-seeking for mental health problems in adolescents and young adults. Databases were searched in September and October 2009 using search terms like 'help-seeking', 'barriers' and 'mental health'. A thematic analysis was undertaken on the results reported in quantitative and qualitative literature.

The most important barriers to help-seeking, as perceived by young people, were embarrassment, problems recognising symptoms, a penchant for self-reliance and stigma. Social support, encouragement from others, and positive past experiences were perceived as aids. Some limitations include the choice of databases, which could influence the coverage of potential journals to be included, and the search strategy may not have obtained all the relevant articles. The key terms used in the search may not have captured all published research on facilitators and barriers for young people. Only one researcher coded the barriers and facilitators into themes, raising questions around bias. The review did, however, provide a useful insight into what young people perceive as facilitators in relation to their mental health.

The factors that affect help-seeking among young people for mental health problems were explored by Rickwood et al (2005). They aimed to consider why young people, particularly males, avoid seeking help when they are in mental distress or are experiencing suicidal ideation, and to determine the factors that inhibit help-seeking. A range of studies were undertaken in Australia using both quantitative (questionnaires) and qualitative (focus

groups) approaches. Males were more likely to seek help from family. However, there was no gender difference in the low rate of professional help-seeking. Boys were found to be socialised to seek less help from all sources across the mid-adolescent years. The study revealed that boys tend not to build up supportive friendships or seek professional help to compensate for their reduced dependence on family. A lack of ability to recognise, describe and identify emotions, and the ability to handle them in an effective and non-defensive manner were also highlighted as barriers to help-seeking.

In the university sample, it was found that young men were particularly poor at identifying their emotional state or having the required vocabulary to explain it. The different university and high school samples showed that young people's help-seeking intentions tend to decline as thoughts of suicide increase. Negative attitudes towards professional help-seeking was another barrier that was identified. These attitudes came from negative past experiences, and also pessimistic beliefs about seeking professional help. Fear of stigma was a barrier that was highlighted with young men - particularly in rural areas - stressing the importance of discretion and confidentiality concerning mental health services. A number of limitations are evident in this study. Firstly, the research focused on periods of clear need, when a mental health problem had become apparent. This needs to be extended to the roles of informal help sources in terms of prevention and early intervention. Also, ongoing research is needed to further validate the measures of help-seeking. The study contributes to a better understanding of the measurement of help-seeking intentions and behaviour.

Scheerder et al (2010) investigated Community Facilitators' (CFs; i.e. pharmacists, clergy, teachers and policemen) attitudes towards depression, and compared them to those of nurses and mental health professionals. Data were collected in nine European Alliance Against Depression (EAAD) countries from 2003-2007. A standard EAAD questionnaire was constructed using existing instruments of EAAD partner countries. CFs and nurses had a more negative attitude towards patients with depression, and had a more limited knowledge of depression symptoms than mental health professionals. These findings are particularly significant when considering the barriers to help-seeking in young men as reported by Rickwood et al (2005).

The limitations in this study were predominantly methodological. Firstly, the study group was a convenience sample (non-random), making generalisability of results difficult. Secondly, the professional groups targeted in each country differed, along with cultural attitudes towards mental illness. Thirdly, data could not be obtained or controlled for other potentially interesting participants' characteristics, such as familiarity with mental illness, educational level or personal experience. Also, the questionnaire excluded items that are not as clinically orientated, such as stigma towards patients with depression.

In summary, there are a variety of issues and challenges concerning young men's capacity to seek help for a mental health issue. These range from embarrassment and stigma, to problems recognising symptoms. Boys and young men generally tend not to have the same supportive friendships or the ability to identify and handle emotions as young women (Rickwood et al, 2005). Consideration also has to be given to limitations or barriers at a service provision level to reach out to young men. For example, one study found that some service providers and professionals had a negative attitude towards patients with depression, and had a limited knowledge of depression symptoms (Scheerder et al, 2010).

3.7 RESEARCH AND POLICY CONTEXT

There are a number of research reports and policy documents, both national and international, that serve as an important backdrop to the current study. This section reviews the wider research and policy context that relates to young men and mental health.

Within an Irish context, the report 'Getting Inside Men's Health' (Richardson, 2004) was the first Department of Health funded study on men's health in Ireland. It provided insights into many of the key issues concerning men's health. Consistent with the findings highlighted in the previous section, Richardson (2004) reported that the majority of men do not manage emotional or mental health issues appropriately, and that men who have such issues try to distract themselves from their problems or keep problems to themselves. It also revealed that men with mental health problems turn to their partner for social support or to a close female acquaintance. This is consistent with the wider literature in this area. The report made a number of recommendations, most notably:

- The development of a national policy for men's health in Ireland (R1).
- The mainstreaming of gender in health (R2).
- The adoption of a holistic approach to men's health at both a policy and health service delivery level (R4).
- The expansion of boys' health on the primary and secondary school curricula; placing a more explicit focus on the relationship between masculinities and health (R8).
- Challenging the stigma associated with seeking help for depression (R21).

'Reach Out' - the National Strategy for Action on Suicide Prevention in Ireland - was published in 2005 against a backdrop of a growing number of people taking their own lives through suicide. The strategy comprised four main policy approaches: general population approach; targeted approach; responding to suicide; and information and research. In relation to young men and suicide prevention, the strategy highlighted the need to develop services and initiatives that would help young men to cope with changing roles in society, and to involve them in the progression of policy and services that affect them. It identified a number of actions in an attempt to combat the high rates of suicide among young men, including:

- The need for a comprehensive review of all the relevant research and service initiatives for men's health, both nationally and internationally (20.1).
- The preparation of a detailed service plan for the development of pilot mental health promotion and support initiatives for young men (20.2).
- The need to develop, with voluntary organisations, methods of creating partnership approaches to providing support for young men in the community through the voluntary sector (20.3).

Ireland's National Mental Health Policy, 'Vision for Change' (2006), was developed to address the need to have mental health services in the country that would be fit for purpose and of a standard comparable to other developed nations. A number of recommendations were made for the general population and, also, for more targeted groups. Some of these recommendations included: engagement with the general community to promote positive mental health; the creation of a health promoting college network to help students in crisis; and the development of Community Mental Health Teams (CMHT) providing consultation and assistance to primary care providers in the management and referral of those with mental health problems.

The policy also identified a number of recommendations to help reduce the incidence of suicide in Ireland, most notably:

- The development of evidenced-based programmes to tackle stigma (R4.2).
- The encouragement of education and promotion of positive mental health within the general community (R11.1).
- The coordination and collaboration of statutory, voluntary and research sectors to ensure that suicide prevention initiatives are effective (R15.7.3).
- Having agreed guidelines for engaging those deemed to be at high risk of suicidal behaviour (R15.7.1).

The findings from the Getting Inside Men's Health report informed the development of the Irish National Men's Health Policy (Department of Health and Children, 2009) which was developed in response to a need for a specific focus on men's health as identified in the National Health Strategy 'Quality and Fairness' 2001. A number of key principles underpinned the policy, namely: the need to adopt a gender-mainstreaming, social determinants and community development approach; having an explicit focus on health promotion and prevention; approaching men's health from an inter-sectoral and inter-departmental perspective; adopting a strengths perspective; and supporting men to become advocates for their own health. The policy stressed the need to move away from a curative medical model of health that focused on tackling the symptoms of ill-health. A mental health continuum was proposed that offered a more holistic comprehension of mental health, and which paved the way for help to be sought before a mental health issue reached a crisis point.

The policy made a number of recommendations that are relevant to the current study, namely:

- The promotion of a positive and holistic focus on men's health that supports men to adopt greater ownership of their own health (R6.1).
- The development of gender-competent health information for distribution through media that are appropriate for men (R6.2).
- The development of training protocols and courses on men's health that are suited to the needs of those working in the health industry, and that provide a range of innovative methodologies (R7.2).
- The provision of a clear and prominent focus on the creation of healthy and positive masculinities among boys through policy and practice within schools (R9.2.1).

The Young Men and Suicide Project (Richardson et al, 2013) aimed to promote an array of possible means to promote positive mental health among young men on the island of Ireland and to evaluate the efficacy of these approaches. The project was developed to help combat the growing numbers of young men who die by suicide in Ireland. It made a number of recommendations that are relevant in the current context, including:

- Developing and promoting positive models of mental health that are specifically targeted at boys and young men (R1).
- Adopting a whole of government, joined-up approach, to young men's mental health (R2).
- Planning programmes and services for and with young men, and working on building trust through the creation of male-friendly, non-threatening environments (R3).
- Expanding interventions that combat substance and alcohol misuse in young men (R5).
- Challenging traditional masculine ideology that is associated with impaired help-seeking behaviour in young men (R6).



- Incorporating role models and marketing into suicide prevention work with young men (R7).
- Having a more explicit focus on peer support and mentoring in suicide prevention work with young men (R8).
- Developing a one day training programme for all frontline staff on how to effectively engage with young men (R10).

In 2013, Ireland's first national public health policy 'Healthy Ireland' was published. The vision of Healthy Ireland is one where everyone in Ireland can enjoy physical and mental health and wellbeing to their full potential, and where wellbeing is supported and valued by everyone in society. It aims to protect society from threats to wellbeing and health, and to increase the number of people who are healthy at all stages of life. One of the actions in the policy is to set up a health and wellbeing programme in the Department of Health, within existing resources, to lead the coordination and monitoring of implementation of the policy (A1.3). It also recommends action to merge mental health promotion programmes with interventions that tackle social problems and broader determinants as part of a multi-agency approach - with particular attention on areas with high levels of socio-economic deprivation (A2.13). The policy advocates action to further improve and support existing partnerships, initiatives and strategies that aim to help older people to manage, maintain or improve their mental wellbeing (A3.5). There are also a number of actions recommended in the area of monitoring and evaluation, namely to produce a dissemination and data reporting plan for health and wellbeing indicators (for use by health and other sectors), and to publish annual health and wellbeing profiles at county level (A6.5).

From an international perspective, the Australian National Male Health Policy (2008) provides a framework for improving male health across Australia, with a focus on taking action on a number of different fronts. These include achieving optimal health outcomes for males, having a focus on preventive health for males, and building a strong evidence base on male health. Priority groups for the policy include males with a disability (including mental illness) and socially isolated males. It highlights a number of action areas, most notably:

- Identifying where men can be vulnerable to depression and risk behaviours such as self-harm (A3.3).
- Developing practical and positive health promotion material that reinforces messages that taking care of personal health is a sign of strength, and takes account of transitional stages in the lives of men (3.4).
- Improving access to health care for males, and health promotion initiatives aimed at improving the mental health and wellbeing of adolescents and young males through school programmes, community activities, and developing health promotion material (A3.5).

In England, the first ever set of guidelines attending to the mental health needs of men and boys was launched by the Men's Health Forum and Mind in 2011. The report 'Delivering Male' (Wilkins and Kemple, 2011) aimed to remedy the fact that there was no national men's mental health strategy to mirror the one that was established for women. The report offers comprehensive guidelines that were developed through widespread consultation and provides best practice advice on various areas such as:

- Stigma.
- Inter-agency working in the early years.
- Promoting services.
- The role of third parties.
- Treating men as individuals.
- Joined-up approach.
- Professional training and an improved knowledge-base.



It identified five key areas of interest and action, including: accounting for male views and experiences; identifying and supporting men in mental distress; supporting male in-patients; helping men and boys to maintain and improve mental health; and supporting men and boys with diagnosed mental health problems living in the community.

In summary, this research and policy context serves as an important backdrop from which to build from in terms of the key objectives identified in the current study. In particular, it provides a roadmap in terms of the key priorities and approaches that should inform the design of a training package on young men and mental health.

3.8 PRINCIPLES AND EVIDENCE OF BEST PRACTICE

Many service providers may have difficulty in engaging and working with young men on matters of mental health. This section looks at some of the key principles and best practice when working with young men.

Ireland's National Men's Health Policy (Department of Health and Children, 2009) outlines a number of key principles of best practice when working with men. These principles should be adhered to when engaging in work of a health promotion nature and include:

- Adopting a positive approach to men's health.
- Making services and programmes easily accessible.
- Using opportunistic and innovative ways to market men's health work and making initial contact.
- Finding a 'hook' and a 'way in' that will appeal to men.
- Adopting a hands-on approach and making sure there is a clear focus to the work.

The Young Men and Suicide Project (Richardson et al, 2013) highlighted the need for a focus on:

- 'Mind health' or 'mental fitness', not mental health.
- Challenging traditional masculine ideology that is associated with impaired help-seeking behaviour in young men.
- Developing a one day training programme for all frontline staff on how to effectively engage with young men.
- Developing and promoting positive models of mental health that are specifically targeted at boys and young men.

- Consultation with and involvement of young men in programme development and delivery.
- Targeting programmes to those young men most in need.
- The potential of peer support and mentoring.
- Consideration for the utilisation of role models or 'champions' around the issue of mental health.

The same report also put forward suggestions for promoting mental health with young men, for example: talking rather than telling; having an open, respectful, two-way communication; marketing and campaigning with role models that young men look up to; encouraging disclosure and help-seeking; and tying mental health in with the concept of physical health.

3.9 INTERVENTIONS, INITIATIVES AND PROGRAMMES

This section reviews various interventions, initiatives and programmes, both national and international, that have attempted to address the issue of young men and mental health. These have been categorised as either 'prevention' or 'early intervention', and sub-categorised in terms of the type of intervention, for example, sport and physical activity, use of technology, and education. The country of origin of each intervention and programme is also provided. A summary of all interventions, initiatives and programmes that have been reviewed is provided in Appendix B. This section seeks to ascertain whether there are common threads within these interventions and programmes and, where appropriate, to summarise and synthesise what these are. Finally, conclusions will be drawn from these initiatives in an attempt to understand best practice approaches when seeking to engage young men around mental health and wellbeing issues.

Many of the programmes for young men that centre on sport and physical activity are informal and easily accessible to young men from diverse socio-economic and cultural backgrounds. An evaluation of 'It's a Goal' revealed that it was crucial for men to work on their issues in a relaxing atmosphere - using language and behaviour they feel comfortable with. The outreach activities and awareness events in the 'Premier League' health programme helped to reach men who did not engage with traditional health promotion activities. Consistent with best practice, 'Reach Out Central' (ROC) was developed in consultation with young men, and helps to engage young men at source. It is important that young men are involved in the design of mental health services and interventions that target them. This was the case in the 'Mind Yourself', 'Tradies Tune-up' and 'WorkOut' programmes. The 'MAC-UK' programme is youth-led, and gives them a significant influence in the development and implementation of project activities. Humour and honest discussion - in language that men can relate to - is significant in mental health work, as demonstrated in the 'Man Therapy' campaign. This also has a targeted approach, for example, young men in rural areas.

The role of sport and physical activity as a 'hook' to engage young men in mental health cannot be underestimated; especially if programmes that involve sport and physical activity are targeted at particular cohorts of young men, for example, those in rural areas who may not have access to facilities and services. Peer mentors and role models appear to have a positive influence on a given programme, in that they help to break down barriers, for example, around help-seeking in 'Boxercise' and the male role models in 'STRIDE'. Burns et al (2013) revealed that many young men use technology and the Internet for information on mental health, but stressed that solutions to mental health issues should be tailored to vulnerable populations of young men. A market research campaign revealed that many men use the Internet as a source of information, again, highlighting the significant influence and future role of technology in mental health work.

The 'Life Care Skills Project' and 'Mind Yourself' programmes reiterate the need to go to where men are in order to do mental health work, and that adopting a strengths-based approach that is solution-focused is more likely to be successful. It is important to make young men feel comfortable in an environment or programme which provides a diverse range of activities and services that are confidential, such as the 'Topaz Wellbeing Centre' which acts as a drop-in centre that is easily accessible to young men. All the programmes identify the need to respect young men and to build trust with them in a suitable environment.

In addition to the data collated for this review, information about unpublished and non-evaluated mental health and wellbeing interventions targeting young men were also provided to the authors via their professional networks. These interventions are 'talk therapies', and there is anecdotal evidence that they have been effective in engaging young men around their mental health and wellbeing. Consistent with other interventions reported here, interventions delivered as part of the Men's Development Health Programme and Men's Action Network actively reached out to individual young men who, otherwise, would not have engaged with services. Details of these interventions are outlined in Appendix C.

3.10 MENTORING AND PEER-LED INITIATIVES

Young adult men who are struggling with mental health issues can sometimes feel powerless and isolated due to the stigma around mental health disorders. This isolation can result in negative outcomes such as withdrawal from the community, cutting ties with family and friends, and dropping-out of college or school. This section looks at mentoring as a way to help young men with mental health issues. According to Blaber and Glazebrook (2007), mentoring describes various programmes and/or relationships, formal or informal, which aim to develop the skills or wellbeing of a young person with help or input from another person who has greater experience and knowledge. Mentoring can occur naturally or be planned; when a relationship is created intentionally to aid a young person who may, otherwise, not have the access he or she needs to the support and wisdom of a caring person. Formal or planned mentoring can be:

- a) Traditional - one adult to one young person.
- b) Group - one adult working with a small number of young people.
- c) Team - several adults working with small numbers of young people.
- d) E-mentoring - via the Internet and email. Mentoring can also be performed by peers, where caring youth mentor other youth.

Peer-led initiatives have the potential to help young men who are in crisis. South Shore Mental Health in Massachusetts has a programme called Transition Resources and Community Supports (TRACS) that assists young adults aged 16-25 years who have psychological ill health and substance use disorders. TRACS aims to aid the rebuilding of hope, meaning and purpose in the lives of young adult service users (Butman, 2009).

Young adult peer mentors were hired and incorporated into the team at TRACS. The peer mentors offer their own personal experiences of living and rising above mental health issues to support and help young adults who come to the programme. Services include monthly social events and peer support groups, along with resource workshops and support for caregivers and families. About 50 young people are served by TRACS in any six month period. Young adults set goals in a range of domains, for example, education, wellness and employment.



4 FINDINGS FROM FOCUS GROUPS AND INTERVIEWS

4.1 INTRODUCTION

This section presents an overview of the key themes to emerge from analysis of the focus groups and interviews. These include:

- Mental health issues affecting young men.
- Meeting the challenges of stigma associated with mental health.
- Gender, masculinity and help-seeking.
- Finding the right language for mental health.
- The paucity of services for young men in relation to mental health.
- Communication, technology and social media.
- Barriers to and opportunities for engaging young men.
- Strategies and approaches to mental health promotion with young men.
- Training requirements for service providers.

The service providers also discussed what they felt had worked with young men from their perspective. A synthesis of the key themes to emerge is presented with due regard to the literature. The implication of these findings for the development of the training programme for service providers is presented in Section 5 of this report.

4.2 MENTAL HEALTH ISSUES AFFECTING YOUNG MEN

The majority of participants felt that many of the mental health issues that young men experience today are complex in nature, and are correlated in some way or another to a variety of risk factors such as substance misuse and socio-economic disadvantage. Some of the participants questioned whether substance misuse is the cause of mental health issues or the effect of mental health issues, as Muriel (Training and Education Group) noted: *"It's a catch twenty two. It's hard to know that one"*. Tina (Probation Group) cited her experience of working with incarcerated young men, many of whom have various substance addictions and mental health issues and wondered which came first:

"Was it the addiction that caused the depression, or the depression that caused the addiction?"

The participants felt that substance misuse was becoming more prevalent as an issue, particularly amongst young men. Many of the participants felt that this is partly due to adverse socio-economic conditions, for example, unemployment, which means that a lot of young men do not have a daily routine and fall into bad habits. Miguel (Chaplaincy Group) felt that many young men don't talk about their feelings and emotions unless they have consumed alcohol, and believed that this behaviour typically stems from a family history of alcohol use:

“... their fathers needed it... it does go back generations. It goes back a long time”.

Manuel (Young Man) believed that unemployment, in particular, causes many young men to become disillusioned with life, which also affects their confidence:

“I think your confidence is affected because you see everyone else seemingly living very purposeful lives... it's like the world is passing you by”.

For some of the participants, depression and anxiety were seen as the prevailing mental health issues that many young men experience, and they speculated as to the reasons for these issues: “... hereditary... their environment... lifestyle issues” (Peter, Sports Group). One group of participants (Chaplains) witnessed this depression and anxiety amongst young male students, particularly around exam times. All groups felt that social anxiety, in particular, is a significant issue for young men, and that it affects various aspects of their lives and can, potentially, be all-consuming. Mandy (Mental Health Worker Group) noted: “they get panicky... avoid going places... isolating themselves”. Most groups felt that depression is becoming more prevalent amongst young men and, rather than confronting it, they believed many young men choose to ignore it and to isolate themselves.

Participants in the Sports Group and Probation Group felt that, in some cases, young men are not aware that they have a mental health issue, and that those that are might choose to ignore and bury it, as Liam (Sports Group) suggested: “their head's in the sand”. Martin (Sports Group) felt that young men with mental health issues are not always aware that they have a mental health issue; possibly due to a “lack of education or information”. He felt that they [young men] would typically postpone help-seeking until it has “gone too far”.

Participants in the Sports Groups believed that many young men are under pressure from themselves and their parents to be successful, and that it is a struggle for many young men to meet competing demands in their lives, as Peter (Sports Group) asserted: “competing... training and... studying at the same time”. Kevin (Sports Organisations Group) believed that most of the pressures young men experience come from their parents who, he felt, expect their sons to be “high achievers”. He believed that many parents are “living their dreams through their children”. Conversely, Patrick (Sports Group) felt that most of the pressures on young men come from themselves “rather than external forces”, and that these internal pressures increase the prevalence of mental health issues in young men.

In the Sports Group, participants believed that bullying was a significant issue for many young men, and felt that it is more prevalent in today's society because of the increased range of bullying methods. They also felt that bullying operates within a wider culture of silence and is, according to Jake (Sports Organisations Group), “the great unspoken”. Kevin (Sports Organisations Group) believed that many young men are “probably not as aware of it” [bullying] as they should be.

A consistent theme to emerge from all the focus groups was that there is a lack of education and knowledge about mental health in society and, particularly, among young men, and that the words ‘mental health’ have negative connotations. Max (Youth Worker Group) felt that many young men equate “mental health with mental illness” and cited an occasion where young men, having been told of the World Health Organisation definition of mental health, were surprised about such a positive definition of mental health. Participants in the Primary Care

and Young Men Groups felt that many of the mental health issues that young men experience are not unique, and believed that they are similar to the mental health issues of the general population:

“... it’s probably the same five or six problems that most people have... issues are generally the same, like problems at home with family... in college... in work”.

Greg (Primary Care Group) believed that many of the mental health problems that young men experience today are no different to the mental health problems young men experienced in previous years. A number of participants felt that young men take longer than young women to mature emotionally, as Chrissie (Mental Health Worker Group) noted: *“they are actually like adolescents”*. She believed that this could lead to risk-taking behaviour around substance abuse etc. Some participants believed that a lack of emotional maturity means that many young men are not able to express themselves in emotional terms and that this can lead to mental health issues.

4.3 MEETING THE CHALLENGES OF STIGMA ASSOCIATED WITH MENTAL HEALTH

The majority of participants felt that stigma in relation to mental health is an issue in society, and one that *“still rears its ugly head all the time”* (Bidly, Training and Education Group). Some participants believed that the issue of stigma is worse for young men. Many believed that fear of stigma concerning mental health for young men results, in many cases, in a lack of help-seeking behaviour. As Manuel (Young Man) noted:

“I would think that there is still an element that would stop people from going for help or opening up to others... for lads especially”.

Beatrice (Probation Group) cited an example of a young man with whom she was in contact who had mental health issues, but had concerns around confronting these issues:

“... he doesn’t want to sit in the waiting room with other mad people... I have to sit in there with all these mad people”.

Some participants felt that opening up about mental health issues in Ireland is socially unacceptable, and that some young men need different language, or a *“more acceptable”* label, to describe how they feel. Roisin (Primary Care Group) noted: *“It’s ok to be stressed. It’s not ok to be depressed”*. Walter (Mental Health Worker Group) believed that stigma originating from oneself *“is a big issue”*. Some participants felt that stigma for young men is directly correlated with peer influences, and that many young men are concerned about bullying and being *“picked on”* if they are seen to be attending a mental health service. Manuel (Young Man) believed that stigma is not as prevalent in Irish society as it was in previous years: *“It’s not... as bad as it was twenty or thirty years ago”*.

4.4 GENDER, MASCULINITY AND HELP-SEEKING

The majority of participants felt that many young men adopt and conform to what are seen as more negative forms of masculinity which, they felt, pigeon-holed many young men into behaving within a constrained and narrow ‘gender script’. This, in turn, was seen to be adversely affecting young men’s mental health. In her work with young men and young women, Nancy (Youth Worker Group) witnessed this gender script and these gender roles:



“Girls are encouraged to talk to each other, to talk about their feelings... Men, on the other hand, are told to ‘get on with it’ and, instead, talk about soccer and cars and stuff”.

The majority of participants believed that ‘gender scripting’ began early in life: *“It starts when you’re baptised”* (Roisin, Primary Care Group). Some participants, particularly those in the Primary Care, Training and Education Groups, suggested that pigeon-holing young men into specific gender roles results, in many cases, in a reluctance to broach the topic of mental health. Niamh (Youth Worker Group) noted: *“Girls would be way more open to it and will talk openly about it”*. Participants in the Mental Health, Training and Education Groups felt that there are significant gender differences when it comes to knowledge around mental health and wellbeing.

The vast majority of participants felt that cultural and societal influences that are associated with such ‘gender scripting’ need to be challenged at the earliest possible stage in education - in primary school - in order to give boys the environment and knowledge to express themselves: *“Get them when they are young”* (Daisy, Probation Group). Participants in the Primary Care, Chaplaincy and Mental Health Groups thought that efforts to challenge gender roles and gender stereotyping in schools are wholly inadequate, thereby, placing boys and young men at a disadvantage when it comes to achieving optimum mental health. Sandra (Probation Group) believed this to be the case with the young men with whom she works:

“There is still that gender stuff going on from back when they were little... boys are still told don’t cry”.

Participants, in particular, those in the Youth Worker, Training and Education, and Primary Care Groups, believed that adhering to a certain form of masculinity and gender roles is strongly influenced by cultural norms, and that these norms are embedded in and reinforced by many institutions in Ireland. Jennie (Youth Worker Group) felt that this resulted in reluctance among many young men to demonstrate emotional or mental health vulnerabilities: *“It’s a lot harder for young men to say they are depressed”*. Participants, especially in the Training and Education and Primary Care Groups, felt that there was a prevailing cultural stereotype that many young men adhered to, and that society judges young men who do not adhere to this stereotype. Roisin (Primary Care Group) suggested: *“There are so many judgements”*. Greg (Primary Care Group) believed that this cultural stereotype is limiting and does not consider individual differences:

“I do think in Ireland there is... almost a script for the grand fella, if you’re into football... have a job... or doing a course... and you are heterosexual”.

Roisin (Primary Care Group) felt that cultural stereotypes concerning gender are not as pronounced for young girls or for women as *“the boundaries...are...a little bit more woolly than the men’s ones”*. She also believed that the mental health of the majority of young men *“would benefit hugely”* if society could *“knock down some of those barriers”*. The same participant highlighted a case where gender stereotyping had permeated a school in which she did some work - wherein the girls were chosen to do a mindfulness programme, whilst the boys were chosen to do a programme on anger management:

“There is something about the nice mindfulness and the girls getting it... and those angry men or boys who need to learn skills to reduce down their big feelings... it’s just being told you’re a boy, you are angry; you’re a girl, you are worried”.

The majority of participants felt that many young men conformed to a hegemonic or dominant form of masculinity, and that this is characterised by competitiveness, risk-taking, toughness, courage and stoicism. It was felt that the pressure on young men to strive for this more dominant or exalted type of masculinity affects their help-seeking behaviour. Eliza (Chaplaincy Group) felt that many young men use avoidance and stoicism as coping methods if they have mental health issues: *“Push it under the carpet and not deal with it”*. She believed that young men need to confront their issues or *“it [is] going to explode at some other time in some other way”*. In her work with young men, Tina (Probation Group) felt that many young men adhere to hegemonic masculinity as a means of *“self-preservation”* and survival in a male-dominated environment and believed that, for many young men, they never know anything different:

“A lot of the men are the strong silent type. They are brought up not to talk about their problems, so they don’t go to doctors. They don’t go to their family. They don’t talk to people about how they are feeling”.

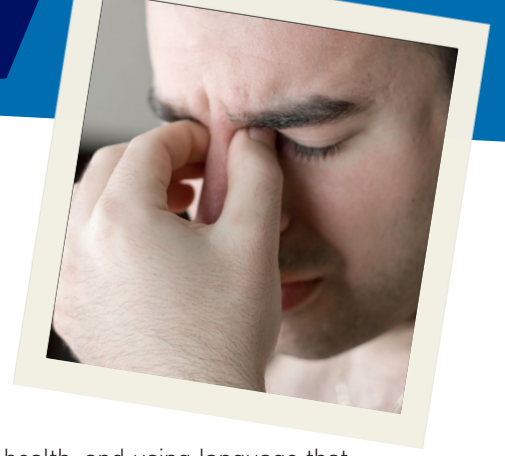
Manuel (Young Man) believed that many of his peers felt pressurised to *“be the tough guy and not talk about anything”* and felt that this negatively affects their openness to seek help during times of difficulty or crisis. He felt that many young men try to deal with their mental health issues by themselves, and exhaust all options other than *“talk to somebody about it”*. Participants in the Youth Worker and Primary Care Groups felt that this, more dominant cultural construction of masculinity, needs to be reframed into, as Greg (Primary Care Group) suggested, a more *“strengths-focused”* approach. This approach, he suggested, would be one where young men are enabled and supported to know, for example, that it takes courage and bravery to seek help.

Max (Youth Worker Group) felt that there are misconceptions regarding masculinity in society and that, as a concept, it is perceived as something inherently negative. He believed that all of the key stakeholders within society need to *“address the positives of masculinity”* and that the positives of masculinity need to become the norm. The same participant felt that service providers, who seek to engage with young men, need to have a holistic knowledge of masculinity and what it entails. He believed that, at a very fundamental level, service providers themselves need to reflect upon and explore their own gendered identity; otherwise *“they should forget about it, and go away and do something else”*.

4.5 IT’S NOT WHAT YOU SAY, IT’S HOW YOU SAY IT - FINDING THE RIGHT LANGUAGE FOR ‘MENTAL HEALTH’

Participants, particularly those in the Youth Worker, Primary Care and Mental Health Groups, felt that many young men do not have the required language to express themselves where mental health is concerned, and believed that it is necessary to equip boys, at the earliest possible stage, with the language to be able to do this. In her work with young men, Nancy (Youth Worker Group) found that *“language is the main problem”*, and that many young men have a limited vocabulary to be able to express themselves: *“They could only tell us if they were happy or angry. Nothing in between”*.

Participants in the Youth Worker, Sports, Chaplaincy and Young Men Groups believed that it is important that service providers have the capacity and skills to use appropriate language themselves, in order for work in this area to have a positive impact. After all, *“words are very important”* (Joseph, Chaplaincy Group). Jenny (Youth



Worker Group) felt that trying to link other illnesses like addiction to mental health, and using language that makes this link explicit, could have a negative effect when working with young men in this area as "... they would say: 'are you alright? Go away would you?'" Manuel (Young Man) believed that the key to engaging young men in mental health is getting the environment and the language right:

"If the right person gets them on their own, and says the right words in the right way, then everything will come flooding out".

Participants in the Chaplaincy and Primary Care Groups felt that the language relating to mental health itself should change, and that it should have a "softness" about it. Darren (Chaplaincy Group) felt that 'mental' is a "bad word", and that it is necessary to "reinvent the language". Roisin (Primary Care Group) felt that there are misconceptions about mental health, and that many young men equate it with mental illness and psychiatric problems. She believed that the phrase 'mental health' "should be dropped completely":

"We are flogging a dead horse with the mental health bit... and hoping... that people will come around".

The same participant believed that children should be given the appropriate language in their early school years, as they are more likely to be open to work in the area of mental health: "Kids will engage with stuff... will take to it".

4.6 PAUCITY OF SERVICES FOR YOUNG MEN IN RELATION TO MENTAL HEALTH

Participants in the Youth Worker, Sports and Probation Groups felt that there is a lack of information in society where mental health services are concerned. They felt that many service providers for young men do not know where to refer young men with mental health issues, as Beatrice (Probation Group) enquired: "Where do you send them? What do you do?" Daisy (Probation Group) believed that there are some good mental health services available to young men, but felt that they are "best kept secrets... it's a question of finding out where they are". Conversely, Nancy (Youth Worker Group) felt that there is an abundance of information on mental health services - almost an "information overload" - which, perhaps paradoxically, contributes to the same problem.

The majority of participants felt that not only is there a lack of information around services for young men, but there is a paucity of services, and the services that are available are not efficient or effective. Sandra (Probation Group) felt that mental health services are not of sufficient quality - even in times of affluence in Ireland:

"Even during the later years of the boom, the services were still shocking... they were pouring money all over the place, [yet] there were still no services".

Participants in the Youth Worker and Sports Groups felt that services, in general, are not available or accessible to young men with mental health issues, and that this further exacerbates their problems. James (Youth Worker Group) believed that services for young men are, in many cases, not accessible when they are most needed. He cited the absence of an out-of-hours service in his own area of work as an example of this:

"At 5.00pm the lock is put on the door and that's it. Nothing on weekends or evenings... the suicide assistant nurse is only there nine to five, five days a week... it used to be 24 hours".

The participants believed that many mental health professionals and GPs do not want to work with young men with mental health issues despite being, as Jake (Sports Organisations Group) lamented, *“paid to deal with those problems”*. Jennie (Youth Worker Group) suggested that many services do not want to work with young men who have medical cards:

“Doctors, themselves, are not prepared to deal with mental health... especially if you have a medical card... you would have no faith that it’s going to be addressed”.

Participants in the Chaplaincy and Probation Officer Groups highlighted what they felt were inefficiencies in the health service, and the ambivalence towards young men with mental health issues. Tim (Chaplaincy Group) cited the case of a young man with whom he worked who suffered from suicidal ideation and had previously attempted suicide. He reflected on his attempts to get this young man admitted:

“It was pure hell to get him dealt with... they didn’t want to see him... they could be threatening to kill themselves... I used to be able to bring them to the mental hospital or counsellor. Now, no way. It’s just impossible to get them admitted or to get them seen”.

Participants in the probation group highlighted what they believed to be inefficiencies in the probation service and also the GP service. The participants cited many occasions where young men with mental health issues were shuffled from one department to another, as Tina (Probation Group) highlighted: *“between addiction and mental health”*. She felt that this made it difficult for them [probation officers] to do their job efficiently:

“We have to... find some way of working with him while trying to work with the services, which are very limited”.

Sandra (Probation Group) believed that the probation service needs to re-evaluate its priorities when it comes to mental health, and that it needs to make the transition from *“management of risk”* and *“offending behaviour”* to positive mental health and wellbeing. Perceived inefficiencies in the GP service was a recurring theme in the Probation Group. Participants felt that GPs had *“huge workloads”*, and that they are more likely to *“give him a script”* rather than have a lengthy consultation with a young man. Kieran (Probation Group) believed that GPs are not willing to use exercise referral as an alternative treatment to medication, and felt that many GPs have become disillusioned with the scale of the challenge in dealing with mental health issues among young men:

“... sure look, he is never going to change. I’ll give him a script. Why should I bother making an effort?”

Manuel (Young Man) felt that there is a lack of facilities for many young men in Ireland. This is particularly true for young men who don’t consume alcohol or who might want an alternative to alcohol consumption. He felt that if there were alternative options - that were affordable for young men - then some would be happy to avail of these options:

“If there was somewhere you could go, and pay two or three euro, and sit down with your friends for the night in a safe environment, I think that... would be taken up”.

The same participant felt that alternative options would be desirable for some young men, but also questioned whether, in the wider context of a pop culture, there would be a demand for them: *“I suppose Irish people have a reputation for drinking for a reason”*.



Participants, in particular those in the Youth Worker, Chaplaincy, Mental Health and Primary Care Groups, felt that there is an overall siloing of services, and a lack of collaboration and networking between service providers for young men. Mandy (Mental Health Worker Group) believed that service providers are “*not willing to collaborate*” with mental health workers - to the detriment of young men. Darren (Chaplaincy Group) believed that improved mental health outcomes for young men requires close collaboration and information sharing:

“It’s about inter-agency sharing... about the GPs... all of us sharing procedures... what is the best practice... sharing our experiences”.

Participants in the Primary Care Group felt that there is a lack of information sharing, both nationally and internationally, concerning young men and mental health. They felt that, instead of service providers looking for best practice, they, as Roisin (Primary Care Group) suggested, “*reinvent the wheel all the time*”. Greg (Primary Care Group) expressed frustration at what he felt was a lack of seeking out best practice in Ireland:

“It’s absolutely farcical... there are other countries with much more resources, who have thought about this stuff twenty years ago”.

The same participant expressed a desire to learn about the experiences of service providers outside of the health sector “*from different epistemologies*” (such as those working in the community sector) and that, in general, there should be a lot more collaboration and networking which, he felt, was “*important for links*”.

4.7 COMMUNICATION, TECHNOLOGY AND SOCIAL MEDIA

Participants, particularly those in the Sports, Chaplaincy, Training and Education, Mental Health and Young Men Groups, felt that young men increasingly access health information via technology. They felt that social media and technology have the potential for both positive and negative effects on the mental health of young men. In his work with college students, Stan (Chaplaincy Group) felt that cyber-bullying is a big issue, and that this phenomenon means that it is more difficult to avoid bullying. He believed that many people are reluctant to question the use of technology as “*we don’t want to confront technology, we say everything is good*”.

Respondents, particularly those in the Training and Education and Young Men Groups, believed that young men spend a disproportionate amount of their time using technology and social media - to the detriment of their mental health and social lives. In his work with young men, Josh (Training and Education Group) highlighted that more young men are suffering from depression as a result of negative experiences using technology and social media. He felt that technology provides young men with a “*platform*” to ridicule their peers, and this contributes to mental health issues and social isolation:

“It’s giving them a pathway of not going out and interacting. It’s a way of hiding yourself away”.

Manuel (Young Man) believed that technology and social media have, in many cases, had a negative influence on young men. He felt that many of his peers have friends on social media who are not real friends “*unless you can hold a conversation with them face-to-face*”. The same participant felt that there is little privacy on

social media, and that many young men might be excluded from certain activities by their friends - which can then be witnessed on social media: *"You mightn't be involved in something, and then you see all your friends are involved"*. Conversely, Jason (Young Man) felt that the negative effects of technology and social media are more of a problem for young women, and did not believe that young men are as *"sensitive or naive"* to online comments from their peers:

"I think women would be more inclined to let out their inner jealousy online than do it face-to-face... I think fellas would be affected more by real... bullying rather than... psychological [bullying]".

Members of the Chaplaincy, Training and Education, Mental Health and Young Men Groups believed that there were positive aspects to technology and social media, and that the positive aspects are often overlooked when evaluating the role of social media on mental health. Joseph (Chaplaincy Group) felt that social media could be used *"to affirm the good and the achievement"*. He felt that if there was a digital forum for young men to provide positive affirmations, that it *"could be a powerful force amongst their own peer group"*. Manuel (Young Man) felt that social media *"can be a good release"* for many young men with mental health issues. This respondent also believed that there are many resources available online that have the potential to make a positive contribution to mental health. Jason (Young Man) felt that technology and social media is unfairly blamed for many of the ills within society:

"It can be over-played... saying that all our problems are because of technology and the media... you can go too far... blaming... technology".

Chrissie (Mental Health Worker Group) believed that technology is a useful tool for learning about mental health and for the promotion of mental health issues. She revealed that she often advises young men to use technology such as Apps for information, and argued that if, for example, young men receive regular information and positive tips on mental health on their phones *"they would actually feel better"*.

4.8 BARRIERS TO AND OPPORTUNITIES FOR ENGAGING YOUNG MEN

Participants, in particular those in the Youth Worker, Primary Care and Young Men Groups, felt that young men are difficult to engage in mental health issues - as Niamh (Youth Worker Group) noted: *"You have to probe and probe"*. She felt that there are various barriers that prevent young men from engaging with mental health service providers. Roisin (Primary Care Group) felt that the initial engagement with young men (i.e. *"getting them in in the first place"*) is the primary difficulty. Chrissie (Mental Health Worker Group) acknowledged her own lack of clarity in relation to engaging young men, but felt that it *"depends on age"* and *"how you engage them"*. Manuel (Young Man) felt that more young men are willing to engage in mental health, but highlighted what he felt are barriers to engagement - with a particular focus on a young man's home environment:

"... the family home... their fathers... mightn't ever have shown any sort of emotion like a sensitive side... if a young man was particularly hard to get through to... the first thing you would have to think of is the father".

Nancy (Youth Worker Group) believed that many of the young men with whom she works *"lack the motivation"* to engage. She felt that in some cases this lack of motivation is rooted in a fundamental denial of the problem within the family home: *"There's nothing wrong with him. His mental health is fine"*. Greg (Primary Care Group)



felt that it is difficult for many young men to initiate engagement in mental health, and felt that the onus is on service providers to “reach out... we haven’t yet prioritised reaching out to young men”. Leonard (GP) felt that young men are “waiting to be engaged”. Participants in the Youth Worker Group felt that it is up to service providers to persevere in their attempts to engage young men, because it is “the time you least expect it when you will help somebody” (James, Youth Worker Group).

Participants in the Primary Care and Youth Worker Groups believed that it is a myth that young men do not want to engage or talk, and that they [young men] will engage - provided the environment is conducive to doing so. James (Youth Worker Group) highlighted his experience:

“... this thing that young men don’t want to talk is a load of crap. It’s not my experience at all... I can think of maybe twice that young fellas have turned around to me and said ‘I don’t want to talk about it’... they do”.

The majority of participants believed that, for young men with mental health issues, it is important to provide them with a sense of connection and belonging. They also felt that it is imperative that young men are able to trust service providers in order to sustain engagement. Liam (Sports Group) felt that if a young man has mental health issues, then a key concern is how much information he should divulge. He felt that it “became a trust issue” which, he believed, was a “massive part of it”. Max (Youth Worker Group) felt that providing an environment conducive for young men to engage is about “building relationships” and “rapport”. He believed that service providers have to take the initiative with young men, need to trust young men before looking for their trust, and ought “to give a bit of yourself”.

Participants in the Training and Education Group believed that young men should be given time and space to engage if that is what they wish to do. They felt that it is important for service providers to demonstrate restraint and patience with young men, and to always be ready and open for potential engagements with young men. Josh (Training and Education Group) believed that it is important to adopt a “non-judgemental” attitude “without preaching” when attempting to engage young men, and cited informal occasions when young men do engage: “Sitting in the back of the bus... is the best place where they open up”. The same participant did say, however, that poor attendance rates by young men are counter-productive and undermine the potential for engagement, as “they haven’t got time to build up that trust”.

Rick (Young Man) believed that it is important that young men are assured of confidentiality and a safe space, and felt that young men are more likely to engage with someone nearer their own age - “someone younger and more in-tune with what’s going on with younger people”. The same participant felt that many young men will not engage with an authority figure, someone who is well-known to them, or in formal settings, rather:

“... someone... not as polished, where you can see they haven’t been... perfect all their lives and have done things wrong where they can tell you that”.

Manuel (Young Man) suggested that it would be pointless to try and force young men to engage, and that not all men need to engage in mental health, as “somebody might be absolutely doing fine and be happy”.

Participants in the Chaplaincy and Primary Care Groups believed that young men need to feel a sense of connection and belonging to other people and, also, to the institutions in society. In his work with young men, Greg (Primary Care Group) believed that those [young men] who have their own hopes, aspirations and values

are more likely to be mentally healthy. He felt that young men need purpose in life, confidence in their own abilities, and to be connected to others:

“You need community, and being linked in with communities... to be part of something and to be visible and valued... [so that] your life is meaningful”.

In his work with young male students, Darren (Chaplaincy Group) highlighted that there is a high level of drop-out in colleges, particularly in first year, and felt that this is partly due to a disconnect that many of these young men feel with the college. He believed that helping young men to connect with college *“would be hugely important”*. He cited an example of an initiative that happened in his own college, where young men were made to feel welcome and connected at an induction for First Year Students. Later, he was able to *“recognise them as First Years and maybe spend a bit more time connecting with them”*.

The majority of participants felt that sport is an ideal way to engage young men in relation to mental health issues. Section 4.9 (Strategies and Approaches to Mental Health Promotion with Young Men) looks at the role of sport in the mental health of young men in more detail. Greg (Primary Care Group) believed that there is a need for more gender-specific programmes, so that young men can *“engage us, as opposed to us doing the things to engage young men”*. He suggested that young men can be engaged in mental health by utilising a pre-existing event and *“piggy-backing on something they actually want”*.

4.9 STRATEGIES AND APPROACHES TO MENTAL HEALTH PROMOTION WITH YOUNG MEN

Overall, participants cited a dearth of mental health programmes for young people and, in particular, the absence of any age or gender specific programmes that target young men. The majority of participants were unaware of any specific mental health programmes for young men, but did make reference to some programmes and one-off activities they did with their own organisations - that they believed were of some benefit to the young men with whom they worked. Jake (Sports Organisations Group) cited a programme that he rolled-out with transition year students that is intended to help them prepare for exams and get tips on *“how they should go about relaxing”*. Peter (Sports Group) revealed that he does *“wellness scores... once a month”* with his players, and tries to convey to young men that a good wellness score can help to improve their physical performance.

Participants in the Youth Worker and Training and Education Groups conducted talks relating to mental health, and also recruited people from outside their organisations to give talks. Gerard (Youth Worker Group) revealed that he did *“one-off awareness talks in schools around mental health”* to try to highlight the positive aspects of mental health. Josh (Training and Education Group) cited an example of a representative from a mental health organisation who gave a talk on mental health and drug awareness to the young people with whom he works.

Fred (Youth Worker Group) highlighted another example of a person who was recruited from outside the organisation to deliver a programme to the young men with whom he works. The programme centred upon building model cars and then racing them, whilst *“incorporating awareness”* of mental health. He believed that it was a successful programme and *“they did enjoy that... they really did”*. Roisin (Primary Care Group) highlighted a stress control programme that was run in her area. It was not, specifically, targeted towards young men, although low numbers would attend - *“maybe 4 out of 40 would fall into that category”*. She revealed that



the programme was a “very CBT type approach”, although it has not yet been evaluated. Manuel (Young Man) cited the work of a Youth Café in his locality that he felt is conducive to good mental health, and said: “I know they do some good work there”.

Notwithstanding the efforts of some individuals and organisations, overall current efforts to promote mental health among young men would appear to be ad hoc and very limited. Whilst service providers are well-intentioned, and have considerable goodwill to tackle the issue of mental health in young men, they are constrained by the absence of any meaningful support or evidence-based programmes in this area.

The majority of participants felt that the promotion of positive mental health should be done at the earliest possible stage in schools, and that innovative ideas and programmes are needed to engage young men in mental health. Chrissie (Mental Health Worker Group) felt that many young men do not know how to express their feelings, and that they need to be taught to do so in their early school years:

“... make it ok from school-going age upwards... we need to steer boys at a younger age into being more open and naming their feelings... I think that’s really important”.

Participants in the Sport, Chaplaincy, Primary Care, Mental Health Worker and Young Men Groups believed that it is necessary to promote a holistic approach to mental health; one which incorporates other domains of health. Kevin (Sports Group) believed that promoting mental health could be incorporated into “training and nutrition... without specifically referring to positive mental health”. Roisin (Primary Care Group) felt that promoting a holistic approach to health would be appealing to young men rather than focusing specifically on mental health:

“I prefer that notion of we look after ourselves physically, we can look after ourselves psychologically... slip that in as part of looking after yourself, rather than come to a class on mental health”.

Walter (Mental Health Worker Group) believed that a more simple and informal approach to promoting positive mental health works best, and that service providers do not need to over-complicate the issue. He felt, instead, that the focus should be on a more holistic approach (“It’s about the basics... diet, sleep, exercise”) and that the majority of young men will respond to an approach like that.

Most participants highlighted what they felt was the crucial role of sport in promoting positive mental health. They believed that many young men are already engaged with particular sports, and that implementing a mental health component into sport, without specifically referring to it [mental health], would provide ideal opportunities for successful work in this area. Ursula (Training and Education Group) argued that sport is a significant component of her work with young men, and that it [sport] allows young men to show a different side to themselves: “You see a different dimension to them”.

Roisin (Primary Care Group) felt that young men are more likely to engage in mental health when doing an activity of some sort “that’s skill-based”. She believed that sports psychology can play a significant role in engaging young men - especially if there is a link made between psychology and sports performance: “Use it as an opportunity. Put out the stuff we are talking about”. Participants in the Primary Care and Mental Health Workers Groups believed that service providers need to go to where men are. As Roisin (Primary Care Group) suggested: “Base ourselves in sports venues... that is the best way”.

Susan (Sports Organisations Group) felt that it is necessary to adopt a subtle approach when attempting to do mental health work around sport with young men, and believed that particular attention should be paid to the use of language relating to mental health. She stated that *“phrased as ‘mental health’, they are running for the hills”*, but combining sport and mental health could be a *“good thing”*. Patrick (Sports Group) felt that the best opportunity to combine mental health and sports is at the start of the season, when there is more flexibility in the schedule. He suggested that it needs to be done *“away from the group setting”* - as he felt that there is an element of bravado amongst groups of young men. James (Youth Worker Group) felt that a sporting environment is, in the main, *“non-threatening”*, and believed that most young men would be receptive to the idea of positive mental health if it is done *“in a meaningful way”* and with the full backing and support of everyone at the club:

“If it comes from the club it has a distributional message. Therefore, it’s coming from the one source that everyone looks up to”.

Darren (Chaplaincy Group) believed that sport and physical activity are ideal vehicles to do work in mental health because many young men are already engaged in and doing an activity. He cited the Men’s Shed phenomenon, where men work side-by-side *“hammering and sawing and talking”*. He believed that *“the doing”* element is very important, and that *“the talking comes anyway... it’s the doing that enables that”*.

The majority of participants felt that there are opportunities to promote positive mental health to young men, and believed that innovative initiatives are required, along with input from role models, peers, and young men themselves. Jake (Sports Organisations Group) believed that young men are now more open to discussing mental health, and that this bodes well for work in this area. He revealed that many sports clubs are beginning to recognise the importance of positive mental health, and *“there’s been a major sea-change”*. James (Youth Worker Group) highlighted some initiatives that he felt are effective in getting a positive mental health message across to young men. He cited the case of a golfer who did nine holes of mental health with some young men, and felt that it was enjoyed and well-received by them. He believed that many of the young men would not have benefited as much had it been in a classroom setting:

“... they would have learnt what they would have from three hours in the classroom, but in a real constructive and fun way”.

Max (Youth Worker Group) believed that it is imperative that young men take ownership of a programme or initiative, and are given some *“responsibility and empowerment”* to create ideas and initiatives. He also felt that young men should be included in any potential programme from the start, because he believed that *“finding out what they [young men] are interested in”* is paramount for any programme to be successful. Greg (Primary Care Group) felt that there is not enough work being done in schools around the area of mental health, and believed that opportunities to do so are often spurned:

“We are continuously, every year, missing a trick. This kind of stuff shouldn’t be starting at eighteen. This should be part of the culture and the language from junior infants... I feel we don’t do enough with the schools... I would love to do more with the schools around promoting wellness”.

Participants in the Youth Worker, GP and Young Men Groups felt that young men would be more open to mental health work if role models are involved (*“examples of people who have come through major diversity”*) as well as young men’s peers - who can relate better to them. Manuel (Young Man) believed that many young men

typically do not cope well with bereavement, and felt that it has a particular adverse effect on their mental health. He suggested that young men could benefit from work in this area, and suggested that hypothetical role playing could help young men to cope with bereavement:

“A role playing kind of thing, where someone has a problem and comes to someone else and talks to them... just so people can kind of get an idea... it’s just you need to get used to it... that’s the best way to address the problem”.

Participants in the Chaplain and Sports Groups believed that it is important for young men to have mentors, and regular access to peers in whom they can confide. Darren (Chaplaincy Group) felt that many young men would remain in college - especially during their first year - if they had access to a mentor who could facilitate their attempts to connect with the college. He felt that somebody who would meet the student *“two or three times... during that first year”* is required. The same participant believed that a mentor could help with a student’s transition from secondary school to a third level institute; especially with college assignments and *“how to study, all those sort of things”*. Some participants felt that mentors could help to prevent young men from succumbing to peer pressure to behave in particular ways by saying, as Joseph (Chaplaincy Group) suggested: *“No, we are not doing this”*.

Peter (Sports Group) believed that young men, upon entering a senior sports environment, would greatly benefit from having access to a mentor or mentorship group *“like a senior player or... a selector who is responsible for five or six players”*. He felt that, at times, young men do not have the *“skills or tools”* to approach management or senior players with an issue they may have. The same participant believed that having a friend or parent to provide advice and positive affirmation would be beneficial to the mental health of young men.

Roisin (Primary Care Group) cautioned against a one-size-fits-all approach, and felt that it would be negligent to assume that a single approach in the area of young men and mental health could be the solution to everything: *“I don’t think there is ever one panacea or a single approach”*.

4.10 TRAINING REQUIREMENTS FOR SERVICE PROVIDERS

The majority of participants expressed a desire to learn more about and better understand young men’s lives, to be able to recognise signs of mental distress in young men, and to be more competent and confident in engaging with young men. One participant expressed the desire to know what buttons to press and how to *“ask the right questions and to probe a bit more without being seen to be intruding”* (Sandra, Probation Group). Patrick (Sports Group) expressed concern about his own capacity to manage someone with a mental health issue - what advice to give, what steps to take, questions in relation to appropriate referral, and *“what happens after disclosure”*. Patricia (Training and Education Group) also expressed concern around disclosure, and worried about taking the wrong approach to young men who may be vulnerable:

“He could go off and kill himself you know, that’s the worry that would be at the back of our minds”.

Mandy (Mental Health Worker Group) expressed a desire to find out *“what interests them [young men]”* and to learn more about their psyche. Manuel (Young Man) believed that many service providers do not know what interests or engages young men, and felt that many service providers do not know enough about mental health in general:



“The service providers need to have... expertise in all the possible problems, mental health problems that these people could be having”.

Participants, particularly those in the Primary Care and Youth Worker Groups, felt that it is important to tailor any potential training on engaging young men - as different service providers have different needs. For, as Roisin (Primary Care Group) noted: *“It would be tough to do one set thing”*. James (Youth Worker Group) revealed that there are many volunteers in his place of work, and that it would be difficult to recruit volunteers for training who might only be volunteering for two or three hours a week:

“What will work for a volunteer who might engage for three hours a week is not what a youth worker doing 40 hours a week one-to-one needs... it should be tailored to who is getting it”.

The majority of participants felt that any potential training should be done in small groups, and that it should be delivered by professionals with experience of engaging young men in mental health. They felt that it should be backed up by appropriate and accessible reading and training materials on best practice - *“a sheet of very simple guidelines... nothing too big or complicated”* (Sarah, Sports Organisations Group). Darren (Chaplaincy Group) felt that smaller groups would offer potential for a better and more meaningful training experience: *“Deeper learning”* where the *“really sensitive stuff”* is shared. Walter (Mental Health Worker Group) expressed a desire for *“training workshops”* where hand-outs are distributed and participants can be referred to online resources.

Some groups, in particular the Youth Worker and Sports Groups, believed that understanding how to combat negative mental health thoughts is necessary to help young men with mental health issues. They also made reference to knowing the basics of Cognitive Behavioural Therapy (CBT), as Jake (Sports Organisations Group) noted: *“It has to be part of it... be relevant to the time and what is expected”*. Peter (Sports Group) believed that any training should be *“task oriented”* and involve the use of case studies. Leonard (GP) felt that role models for young men should be involved in training, and that those who were involved in the original Engage training should be a part of the Engaging Young Men training.

A number of participants, particularly those in the Young Men, GP and Sports Groups, felt that training which targets young men and mental health should be a compulsory part of any coaching course. They also felt that successful completion of any coaching course should be dependent upon undertaking a young men and mental health module. Liam (Sports Group) believed that all managers, coaches and other personnel ought to have skills and training in this area - as it is a crucial part of the sporting environment. He felt that mental health is *“lagging behind”* despite it being, in his view, *“probably the most important area in life”*. Rick (Young Man) felt that training in mental health would, eventually, become a compulsory part of the coaching curriculum. He believed that mental health issues are becoming more prominent in society, and that people are increasingly more aware of mental health:

“It probably will be part of the curriculum when they are being trained to be coaches and stuff... they have to, because it’s so popular now...”

Participants in the GP, Youth Worker and Primary Care Groups suggested various formats for any potential training in this area. Leonard (GP) felt that the existing ‘Engage’ format should be used. Max (Youth Worker



Group) suggested following the 'Jigsaw' format - which adopts twelve different modules over twelve weeks. He stressed, however, that any training with service providers should have an explicit focus on masculinities and mental health. Kieran (Probation Group) felt that training relating to young men and mental health should follow the ASIST (Applied Suicide Intervention Skills Training) model. This involves role playing and takes place over two days. The majority of participants stressed that *"there needs to be follow on... a refresher to get people to buy into it"*.

The majority of participants felt that a 'Train the Trainers' model should be adopted. Roisin (Primary Care Group) felt that this approach would have the added advantage of enabling trainers to sympathise and empathise more with service providers:

"The training package nearly has to start off with train the trainers... they need to understand how do we understand psychological wellbeing... there is something about being experiential, putting ourselves in the shoes of you know... to really appreciate their perspectives instead of making judgements from our perspectives".

The majority of participants expressed enthusiasm for training in the area of young men and mental health, and expressed a desire for society to see that talking about mental health is no different to talking about physical health or some other area of life. Daisy (Probation Group) believed that the ultimate aim for training in this area, and for society in general, is to normalise talk and behaviour in mental health:

"The ideal for me would be it would be almost like normal behaviour, where if you were talking to somebody about mental wellbeing, it is almost like you are talking to them about their diet".

5 CONCLUSION

The main aim of this research was to identify the training needs of a wide variety of service providers for young men, seek feedback on how the training might be delivered most appropriately, and shape the content, focus and structure of a training package. This research also sought to gain an insight into:

1. The mental health issues young men face - from the perspective of diverse service providers.
2. The challenges service providers encounter when attempting to engage young men in relation to their mental health.
3. Factors which might encourage young men to engage in mental health programmes and activities.

A variety of themes emerged from the data which highlighted the significance of mental health issues, the barriers young men and service providers encounter, and the needs of young men and service providers where the promotion of mental health is concerned. The findings suggest that young men face a myriad of mental health issues, from depression to social anxiety, and that these issues are often connected to the misuse of substances. Moreover, it is apparent that an adverse socio-economic environment (for example, unemployment) plays a significant role in the mental health of many young men who lack routine and purpose in life. Stigma in relation to mental health is still a prevalent issue for young men, and affects their help-seeking behaviour. Stigma is seen to be directly related to peer influences, and these influences further negate notions of help-seeking.

The findings indicate that many young men feel pressured to conform to negative forms of masculinity, and that these pigeon-hole them into behaving within a narrow and constrained gender-script. The negative forms of masculinity that many young men adhere to are characterised by competitiveness, risk-taking and stoicism, which negatively impact upon their help-seeking behaviour. It became evident in this research that it is necessary to reframe masculinity into a more strengths-focused approach, and that this needs to begin as early as possible in the education system.

The relevance of language in relation to mental health is clearly supported by the findings. These reveal that many young men do not have an adequate vocabulary to accurately express their feelings and emotions. It is equally important for service providers to use the appropriate language when navigating the issue of mental health. Furthermore, the findings reveal that the word 'mental' deters young men from engaging in mental health initiatives, and that this word should be avoided. Providing young men and boys with the correct language and vocabulary to express their mental health is required in their formative years.

The paucity of services for young men, as well as a lack of information on services that are available, is a prominent theme throughout this research. Many respondents felt that mental health services are not of sufficient quality, and never were - even in times of affluence. Some participants argued that hospital services portray ambivalence towards young men with mental health issues, and choose pharmacotherapy as the primary method of treatment, despite having other options. Many respondents believed that there is a lack of collaboration and shared learning between service providers, as well as a lack of knowledge of international best practice in relation to young men and mental health.

The findings suggest that young men regularly use technology and social media for information and socialising; often to the detriment of their social lives. Social media, in particular, can be a forum for cyber-bullying and harassment, which can negatively affect the mental health of young men. Conversely, social media could be used to promote positive mental health, and could provide a platform for young men to express their feelings and emotions. It became apparent that young men do engage in mental health services if the environment is conducive to do so. An appropriate environment consists of the right format for mental health exploration along with suitable personnel. Young men need to be offered a safe environment, to which they feel a sense of connection and belonging, and wherein trust and confidentiality are sacred. The findings suggest that young men engage in mental health in informal settings when least expected, for example, in a sports setting.

Numerous attempts to engage young men in mental health focused pursuits are cited. However, many of these are not evidence-based, though well intentioned. The relevance of sport and 'doing' activities are deemed to be of paramount importance when attempting to engage young men with mental health issues. Consistent with previous findings, the promotion of positive mental health needs to be done in the formative years of young men lives in conjunction with other domains of health. Positive mentors and role models are seen to have a significant role in future work in relation to young men and mental health. It is evident that there is a need for more gender-specific training and, also, a need for training in relation to awareness of the specific issues that young men encounter today. The findings suggest that there is a need for a greater understanding of what interests young men, and how to approach them using appropriate language. It is apparent that potential training should be tailored to a variety of service providers and to volunteers as well. The training should take the form of workshops that are facilitated by professionals with considerable experience of engaging young men. Case studies and role playing should also be part of the training, which should take a day or two to complete. The training that is provided must have a follow-up and a refresher component, in order to be up-to-date with any new developments in relation to young men and mental health.

It was suggested that service providers should be offered a holistic understanding of masculinity at the training, as well as an opportunity to explore their own masculinity / develop their own emotional intelligence before delivering programmes to young men. It was felt that this would help them to develop empathy with the world of young men.

5.1 RECOMMENDATIONS FOR TRAINING

Cultural influences in relation to mental health have become ingrained in Irish society throughout the generations. Traditionally, fathers and grandfathers were reluctant to broach the topic of mental health; instead, portraying an image of stoicism in times of mental distress. Misunderstandings, misconceptions and stigma in relation to mental health have compounded the difficulties that people have when coping with mental health issues.

In Ireland today, it is still taboo to talk about mental health and suicide - particularly for young men. It is essential that work is done at the earliest possible stage to ensure future generations are more comfortable with talking about mental health. A key component of 'A Vision for Change' is that the principle of recovery should be entrenched in mental health services. This necessitates a cultural shift by services. It means that services should centre on helping a person to improve their wellbeing, and that each person should have a stake in their own care and recovery. The following recommendations build upon this premise, by collectively seeking to change Irish culture in relation to mental health, with a specific focus on young men.

The following are the recommendations arising from this mapping exercise ...

- R1 Current services that provide for the mental health needs of the population should prioritise the needs of young men. Specifically, these services need to become more:
- Effective with respect to how they engage young men.
 - Accessible to young men.
 - Collaborative with other services, so that together they may appropriately meet the needs of young men.
- R2 Training should include key generic components, but should also be flexible and adaptable so that it can be tailored to the needs of specific groups within the community, including:
- Parents.
 - Those working with boys in the formative years e.g. childcare workers.
 - Teachers.
 - Any service provider who works directly with young men.
 - Volunteers who work with young men, for example, sports coaches.
- R3 Trainers who deliver training in this area should undergo the training themselves, so that they can have an understanding of, and empathise with, those they work with. Trainers should also have experience of engaging young men.
- R4 The training should be delivered in small groups using experiential methodologies (e.g. case studies and role playing), so that participants get an opportunity to: (a) explore the content of the training from a personal perspective, and (b) experience and deal with scenarios that mirror real life situations.
- R5 Training for teachers, service providers and volunteers who work with young men should apply a gender lens to mental health that includes:
- An educational component on young men and mental health in terms of signs, symptoms and coping strategies.
 - A significant component on masculinity, wherein participants get an opportunity to explore their gendered identities and the concept of 'hegemonic masculinity'.
 - The development of emotional intelligence amongst participants via experiential learning methodologies - so that they can develop emotional intelligence among boys and reframe the normal gender script into a more strengths-focused approach.
 - A component on language and communication - to equip service providers with a vocabulary that is appropriate for working with young men in this area.
 - The importance of building relationships with young men - by developing trust and offering a confidential space, a safe environment will be created which is conducive to engagement.
 - The importance of supporting young men to find a purpose in their life and to be confident in their abilities.

- The potential for piggy-backing on other 'doing' activities. Mental wellness activities can be incorporated into something which young men are already engaged with e.g. sport and physical activity. In such non-threatening environments, talking can often come after doing.
- The use of technology and social media to ensure service providers have an understanding of how it can be used to engage young men.

R6 Training should be supplemented by innovative and accessible resource materials that contain concise guidelines for action.

R7 The timescale for the training should be adaptable, in order to meet the training requirements and time constraints of the participants.

R8 Post-training, participants should be offered opportunities for follow-up / refresher training, so that they can be supported in their work and kept up-to-date with the latest research and developments in relation to young men and mental health.

R9 The training should be incorporated into the formal certification of those who work with young men.

R10 The effectiveness of training for service providers on engaging young men would be strengthened by the development of additional training for parents and those who work with boys in the formative years. Such training should focus on the development of emotional intelligence and positive masculinities among boys.

REFERENCES

Adinkrah, M. (2010). Better dead than dishonoured: masculinity and male suicidal behaviour in contemporary Ghana. *Social Science and Medicine*, 74 (4):474-48.

Begley, M., Chambers, D., Corcoran, P., & Gallagher, J. (2010). The male perspective: young men's outlook on life. *Suicide Prevention Office*, 1-50.

beyondblue (2010a). *Beyond Barriers*. 07/07/2014, <http://www.beyondblue.org.au/about-us/programs/mens-program/program-activities/beyond-barriers>

beyondblue (2014b). 'Soften the Fck Up'. 07/07/2014, <http://www.beyondblue.org.au/about-us/programs/mens-program/program-activities/soften-the-fck-up>

Big Lottery Fund (2012). Engaging men in your project: a good practice guide, 1-8.

Blaber, D., & Glazebrook, D. (2007). A guide to supporting effective programs for mentoring young people, 1-80.

Blisker, D., & White, J. (2011). The silent epidemic of male suicide. *British Columbia Medical Journal*, 53 (10): 529-534.

Burns, A., Goodall, E., & Moore, T. (2008). A study of suicides in Londonderry, Northern Ireland, for the year period spanning 2000-2005. *Journal of Forensic and Legal Medicine*, 15: 148-157.

Burns, J.M., Webb, M., Durkin, L.A., & Hickie, I.B. (2010). Reach Out Central: A serious game designed to engage young men to improve mental health and wellbeing. *Medical Journal of Australia*, 192 (11): S27-S30.

Burns, J.M., Davenport, T.A., Christensen, H., Luscombe, G.M., Mendoza, J.A., Bresnan, A., Blanchard, M.E., & Hickie, I.B. (2013). Game On: exploring the impact of technologies on young men's mental health and wellbeing. *Young and Well Cooperative Research Centre*, 1-71.

Butman, M. (2009). Peer mentoring: real recovery for young adults. *Summer 2009*, 23 (2): 28-31.

Caldwell, T.M., Jorm, A.F., & Dear, K.B.G. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. *Medical Journal of Australia*, 181 (7): S10-S14.

Carson J Spencer Foundation (2013). *Man Therapy: therapy the way a man would do it*. 12/08/2014, <http://carsonjspencer.org/programs/man-therapy/>

Central Statistics Office (2011). *Women and men in Ireland 2010*. 07/07/2014, <http://www.cso.ie/en/newsandevents/pressreleases/2011pressreleases/womenandmeninireland2010/>

Central Statistics Office (2014). *Vital statistics: fourth quarter and yearly summary 2013*. 13/07/2014, http://www.cso.ie/en/media/csoie/releasespublications/documents/vitalstats/2013/vstats_q42013.pdf

- Chandra, A., & Minkovitz, C.S. (2006). Stigma starts early: gender differences in teen willingness to use mental health services. *Journal of Adolescent Health, 38*, 754: e1-754.
- Cleary, A. (2011). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine, 1-38*.
- Connell, R.W. (1995). *Masculinities*. Cambridge, Polity Press.
- Connell, R.W., & Messerschmidt, J.W. (2005). Hegemonic masculinity: rethinking the concept. *Gender & Society, 19*: 828-859.
- Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. *Plos One, 8* (10): 1-6.
- Department of Health and Children (2009). *National Men's Health Policy 2008-2013: Working with Men in Ireland to Achieve Optimum Health and Wellbeing*, 1-168.
- Ellis, L.A., Collin, P., Hurley, P.J., Davenport, T.A., Burns, J.M., & Hickie, I.B. (2013). Young men's attitudes and behaviour in relation to mental health and technology: implications for the development of online mental health services. *Biomed Central Psychiatry, 13* (119): 1-10.
- Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science & Medicine, 62*: 2246-2257.
- Flood, M., Kegan Gardiner, J., Pease, B., & Pringle, K. (2007). *International Encyclopaedia of Men and Masculinities*. London: Routledge.
- Gatab, T.A., & Pirhayti, S. (2012). The effect of the selected exercise on male students' happiness and mental health. *Procedia - Social and Behavioural Sciences, 46*: 2702-2705.
- Griffin, E., Arensman, E., Wall, A., Corcoran, P., & Perry, I.J. (2012). National report of deliberate self-harm Ireland: annual report 2012. *National Suicide Research Foundation, 1-60*.
- Gulliver, A., Griffiths, K.M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *Biomed Central Psychiatry, 10* (113): 1-9.
- Harland, K. (2000). Men and masculinity: an ethnographic study into the construction of masculine identities in inner city Belfast. PhD submitted to the University of Ulster.
- Harland, K. (2008). Masculinity and mental health: key issues in promoting mental health. *Health Promotion Agency for Northern Ireland, 1-15*.
- Harland, K. (2009). Acting tough: young men, masculinity and the development of practice in Northern Ireland. *Nowhere Man Press 2009, 1-9*.

Hawton, K., Bergen, H., Kapur, N., Cooper, J., Steeg, S., & Ness, J. (2012). Repetition of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. *Journal of Child Psychology and Psychiatry*, 53 (12): 1212-1219.

Headstrong (2012). My world survey: national study of youth mental health in Ireland, 1-158.

Hope, A., Dring, C., & Dring, J. (2005). College Lifestyle and Attitudinal (CLAN) Survey. *Health Promotion Unit, Department of Health and Children*, 1-49.

Houle, J., Mishara, B.L., & Chagnon, F. (2008). An empirical test of a mediation model of the impact of the traditional male gender role on suicidal behaviour in men. *Journal of Affective Disorders*, 107 (103): 37-43.

Johal, A., Shelupanov, A., & Norman, W. (2012). Invisible men: engaging more men in social projects. *Big Lottery Fund*, 1-69.

Kilmartin, C. (2005). Depression in men: communication, diagnosis and therapy. *Journal of Men's Health and Gender*, 2 (1): 95-99.

Landstedt, E., Gadin, K.G., & Asplund, K. (2009). Understanding adolescent mental health: the influence of social processes, doing gender and gendered power relations. *Sociology of Health & Illness*, 31 (7): 962-978.

Lester, D. (2008). Suicide and culture. *Official Journal of World Association of Cultural Psychiatry*, 3 (2): 51-68.

Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behaviour*, 38 (2): 177-190.

Mac an Ghail, M., & Haywood, C. (2010). Understanding boys': thinking through boys, masculinity and suicide. *Social Science and Medicine*, 74 (4): 482-489.

Madge, N., Hewitt, A., Hawton, K., Jan de Wilde, E., Corcoran, P., Fekete, S., Van Heeringen, K., De Leo, D., & Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the child and adolescent self-harm in Europe (case) study. *The Journal of Child Psychology and Psychiatry*, 49 (6): 667-677.

Maxwell, M., Oskarsson, H., Palmer, A., Pull, C., Realo, A., Reisch, T., Schmidtke, A., Perez Sola, V., Wittenburg, L., & Hegerl, U. (2009). Gender issues in suicide rates, trends and methods among youths aged 15-24 in 15 European countries. *Journal of Affective Disorders*, 113 (3): 216-226.

McGale, N., McArdle, S., & Gaffney, P. (2011). Exploring the effectiveness of an integrated exercise / CBT intervention for young men's mental health. *British Journal of Health Psychology*, 16 (3): 457-471.

McMahon, E.M., Reulbach, U., Keeley, H., Perry, I.J., & Arensman, E. (2010). Bullying victimisation, self-harm and associated factors in Irish adolescent boys. *Social Science and Medicine*, 71 (7): 1300-1307.

- McMahon, E.M., Corcoran, P., Keeley, H., Perry, I.J., & Arensman, E. (2013). Adolescents exposed to suicidal behaviour of others: prevalence of self-harm and associated psychological, lifestyle, and life event factors. *Suicide and Life-Threatening Behaviour: Journal of the American Association of Suicidology*, 43 (6):634-645.
- Mengage (2011). *OzHelp Foundation: tradies tune-up program*. 07/07/2014, <http://www.mengage.org.au/Work-Effectively/Effective-Male-Health-Promotion/Tradies-Tune-Up-Program.aspx>
- Moller-Leimkuhler, A.M. (2003). The gender gap in suicide and premature death or: why are men so vulnerable? *European Archives of Psychiatry and Neuroscience*, 253 (1): 1-8.
- National Office for Suicide Prevention (2014a). Annual Report 2013. 16/10/2014, http://www.nosp.ie/annual_report_2013.pdf
- National Office for Suicide Prevention (2014b). The prevalence and impact of bullying linked to social media on the mental health and suicidal behaviour among young people, 1-83.
- Oliffe, J.L., Ogradniczuk, J.S., Bottorff, J.L., Johnson, J.L., & Hoyak, K. (2010). 'You feel like you can't live anymore': suicide from the perspectives of men who experience depression. *Social Science & Medicine*, 74 (4): 506-514.
- Oliffe, J.L., & Phillips, M.J. (2008). Men, depression and masculinities: a review and recommendations. *Journal of Medical Humanities*, 5 (3): 194-202.
- Ozawa-de Silva, C. (2008). Too lonely to die alone: Internet suicide pacts and existential suffering in Japan. *Culture, Medicine and Psychiatry*, 32 (4): 516-551.
- Patel, V., Flisher, A.J., Hetrick, S., & McCorry, P. (2007). Mental health of young people: a global public-health challenge. *Lancet*, 369 (9569): 1302-1313.
- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M.R., & Rahman, A. (2007). No health without mental health. *Lancet*, 370 (9590): 859-877.
- Richardson, N. (2004). Getting Inside Men's Health. *Health Promotion Department, Health Service Executive*, 1-151.
- Richardson, N., Clarke, N., & Fowler, C. (2013). *Young Men and Suicide Project: A Report on the All-Ireland Young Men and Suicide Project*, 1-120.
- Rickwood, D., Deane, F.P., Wilson, C.J., Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, 4 (3): 1-34.
- Russell, V., Gaffney, P., Collins, K., Bergin, A., & Bedford, D. (2004). Problems experienced by young men and attitudes to help-seeking in a rural Irish community. *Irish Journal of Psychological Medicine*, 21 (1): 6-11.
- Scheerder, G., Van Audenhove, C., Arensman, E., Bernik, B., Giupponi, G., Horel, A.C., Maxwell, M., Sisask, M., Szekeley, A., Varnik, A., & Hegerl, U. (2010). Community and health professionals' attitude toward depression: a pilot study in nine EAAD countries. *International Journal of Social Psychiatry*, 57 (4): 387-401.

Sibinga, E.M.S., Perry-Parish, C., Chung, C., Johnson, S.B., Smith, M., & Ellen, J.M. (2013). School-based mindfulness instruction for urban male youth: a small randomized controlled trial. *Preventative Medicine*, 57 (6): 799-801.

Sloan, C., Gough, B., & Conner, M. (2010). Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology & Health*, 25 (7): 783-803.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, CA: Sage.

Strauss A., & Corbin J. *Basics of Qualitative Research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications; 1998.

Suicide Prevention Australia (2010). Youth suicide prevention, 1-29.

Toprak, S., Cetin, I., Guven, T., Can, G., & Demircan, C. (2011). Self-harm, suicidal ideation and suicide attempts among college students. *Psychiatry Research*, 187 (1-2): 140-144.

Varnik, A., Kolves, K., Allik, J., Arensman, E., Aromaa, E., van Audehove, C., Bouleau, J.H., van der Feltz-Cornelis, C.M., Giupponi, G., Gusmao, R., Kopp, M., Marusic, A., Maxwell, M., Oskarsson, H., Palmer, A., Pull, C., Realo, A., Reisch, T., Schmidtke, A., Perez Sola, V., Wittenburg, L., & Hegerl, U. (2009). Gender issues in suicide rates, trends and methods among youths aged 15-24 in 15 European countries. *Journal of Affective Disorders*, 113 (3): 216-226.

Wilkins, D., & Kemple, M. (2011). *Delivering Male: effective practice in male mental health*. National Mental Health Development Unit, 1-121.

White, A., Zwolinsky, S., Pringle, A., McKenna, J., Daly-Smith, A., Robertson, S., & Berry, R. (2012). Premier League Health: A national programme of men's health promotion delivered in / by professional football clubs, Final Report 2012. *Centre for Men's Health and Centre for Active Lifestyles, Leeds Metropolitan University*, 1-98.

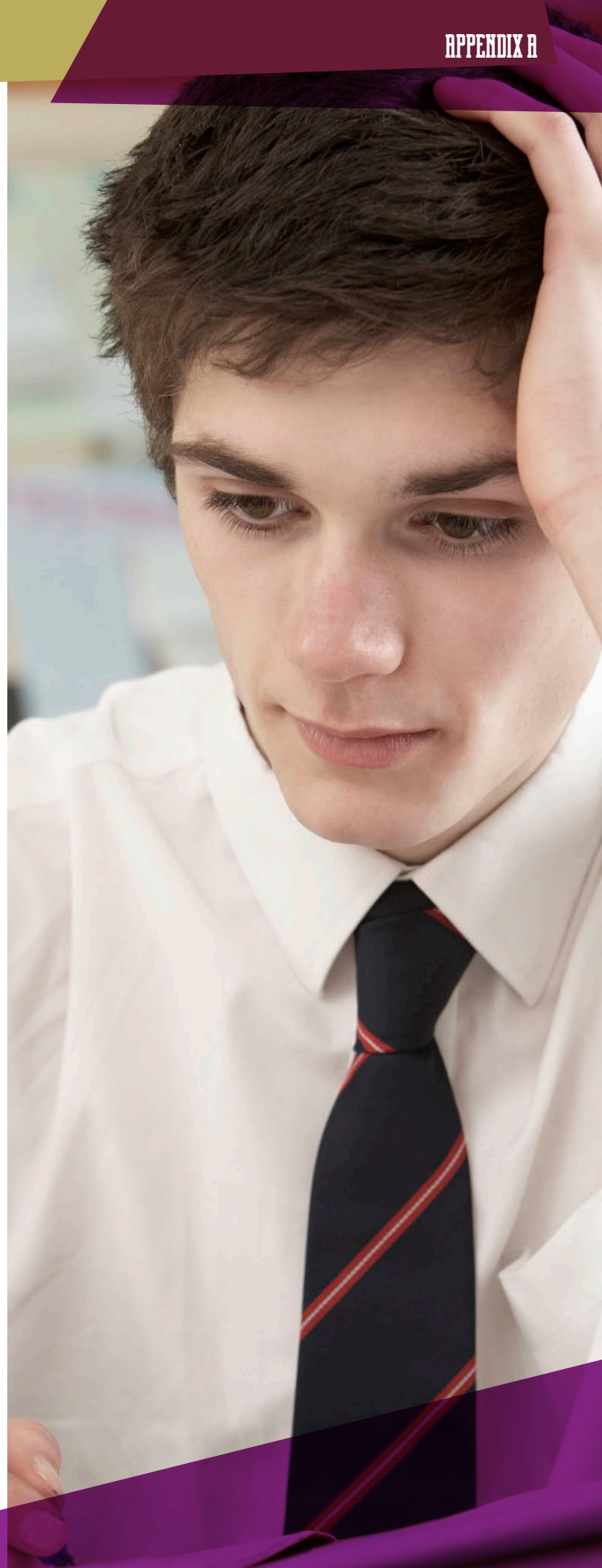
World Health Organisation, (2002). *Gender disparities in mental health*. 15/03/2014, http://www.who.int/mental_health/media/en/242.pdf?ua=1

World Health Organisation, (2010). *Investing in mental health*. 15/03/2014, http://www.who.int/mental_health/media/investing_mnh.pdf

APPENDIX A:

FOCUS GROUP AND INTERVIEW TOPIC GUIDE

1. What is the nature and extent of respondents' engagement and/or contact with young men at present?
2. Does this engagement include a mental health component and/or is there potential for doing this in the future?
3. What are the perceived mental health and wellbeing needs of young men?
4. What are the main challenges and barriers that respondents experience / might experience when seeking to engage with young men, generally, and on mental health issues, specifically?
5. Are there any approaches / programmes in this field that work well?
6. What support / information / resources / skills would make their efforts to engage young men easier?
7. What would be the most appropriate mechanism / timescale / format for delivering this training support?



APPENDIX B: INTERVENTIONS INITIATIVES AND PROGRAMMES

PREVENTION INITIATIVES

SPORT AND EXERCISE

Alive and Kicking Goals [Australia] - as cited by Richardson et al, 2008

www.healthinfolnet.ecu.edu.au/key-resources/programs-projects?pid=1261

This project aims to reduce suicide among indigenous youth through the use of football and peer education. The project encompasses community development, leadership development, youth health, sport, music and education. Using peer mentors, the teams meet after practice each week to discuss suicide, self-harm, and their plans and dreams for the programme. While there has been no evaluation of the programme, Suicide Prevention Australia's Youth Suicide Prevention Position Statement highlights the programme as being of worth.

Coach the Coach [Australia] - as cited by Richardson et al, 2008

www.beyondblue.org.au/resources/research/research-projects/research-projects/evaluation-of-coach-the-coach-project

Coach the Coach (CTC) is a training programme for coaches to recognise mental health symptoms among those that they coach. The programme utilises a football team structure to reach young men in rural towns. The aim of the programme is to increase an individual's ability to recognise mental health conditions, and to encourage self-help seeking and professional help-seeking behaviours; thereby impacting on suicide rates. The programme is aimed at young men aged 15-30 years, and is delivered through a medium that these young men already recognise, respect and listen to. The programme is partnered with the School of Rural Health Research in the University of Melbourne. CTC was undertaken in two phases: an initial phase involving one football league, and a second involving four football / netball leagues. The second phase included 10 mental health information sessions held at locations throughout the project area. It is a 12 hour mental health 'First Aid' course with the following content:

- Listening non-judgementally.
- Assessing the risk of suicide or harm.
- Encouraging participants to get appropriate professional help.
- Giving reassurance and information.
- Encouraging self-help strategies.

There were pre and post measures of club leaders' ability to: (i) recognise depression and mental health problems; (ii) be aware of supported treatment options; and (iii) respond with confidence to mental health problems. The evaluation concluded that rural football clubs appear to be appropriate sites for the promotion of mental health awareness. However, the benefit to players was less obvious - indicating that further research is required. The programme is highlighted within the Suicide Prevention Australia's Youth Suicide Prevention Position Statement.

Premier League Health [United Kingdom]

Premier League Health (PLH) was a three year, men's health promotion programme, delivered through professional football clubs. Premier League football clubs submitted proposals to run men's health programmes that met local needs identified in concurrence with partner agencies (White et al, 2012). Men were recruited using a range of techniques targeting those aged 18-35 years, although all adult men were eligible to attend. PLH activities included health checks and awareness raising activities, combined with a programme of regular weekly exercise classes designed to improve health and wellbeing. Everton Football Club: Men's Health Checks was one such club. This was a project run over three years, with a part-time wellbeing advisor to oversee the health and wellbeing of all programme participants and to deliver the men's health sessions (MENGAGE, 2014). Health checks were conducted around various themes, for example, smoking cessation, alcohol and drug misuse, and mental health. The project achieved a positive impact on men's health and fitness, which included an increase in self-efficacy and social capital.

White et al (2012) delivered a final report on the Premier League Health programme and used the RE-AIM framework to evaluate it. Data were collected through self-report questionnaires completed by participants who engaged with the interventions. The findings showed that football-based awareness raising events and outreach activities were significant for reaching men who are indifferent to traditional health promotion activities. Interventions that included socially supportive environments, aided a sense of belonging and a fun and enjoyable atmosphere. This experience supported the maintenance of newly acquired health behaviours for many men.

Exercise Intervention [Iran]

The effect of a selected exercise programme on male students' happiness and mental health was explored by Gatab and Pirhayti (2012). The study took place in Payame Noor University in Babol, Iran. Eighty male students were selected voluntarily, and were divided into two groups. The experimental group contained 40 students, and took the form of soccer that ran for eight weeks - with two sessions a week, each lasting 60 - 90 minutes. The other 40 students made up the control group. The Oxford Happiness Questionnaire was used to measure happiness, while the General Health Questionnaire (GHQ) was used to quantify a range of mental health measures. The GHQ used had twenty eight articles and four subscales; namely, physical symptoms, anxiety symptoms, social functioning and depression symptoms. Data Analysis was conducted using SPSS; specifically, dependent and independent t-tests. There was a significant improvement of physical symptoms, social functioning, level of depression and happiness in the experimental group, while there were no significant changes observed in the control group. Overall, the findings demonstrated that regular physical activity can increase happiness and general health in students. A number of limitations can be noted. It doesn't mention whether the students were randomly assigned to either the experimental or control group, and the use of questionnaires may lead to recall bias.

It's a Goal! [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.itsagoal.org.uk

'It's a Goal!' began in 2004, and the programme was based in football stadiums - a setting where many men already feel comfortable. The programme consists of eleven two hourly sessions ('matches') which concentrate on motivation, assertiveness, stress management, problem solving, confidence building, self-esteem etc. The project users ('players') sign contracts (as footballers would) that set out basic ground rules covering attendance, behaviour, confidentiality etc. They then set short and long term goals for themselves, and address their issues using analogy and metaphor drawn from football scenarios. Alongside the programme (the 'season') is an unstructured drop-in group called the 'Supporters Club'.

Thus far, they have run successful programmes at: Macclesfield Town, Manchester United, Stockport County, Plymouth Argyle, Burnley, and Stoke City. In May 2010, the programme was launched in the Scottish Borders, and they are currently planning launches at nine further clubs in the North West of England. The results so far are encouraging. Around two thirds of those who start the programme complete it. A high percentage of participants find or return to employment, and the overwhelming majority report an increase in confidence and self-esteem. What is seen by the players as crucial, is being able to work on their issues in a relaxing atmosphere - using language and behaviour which they feel comfortable with. Previous research has identified the absence of these factors as being instrumental in turning significant numbers away from seeking help.

STRIDE [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.digm.org

STRIDE is a Greater Manchester young men's (11-19 years) dance project, developed by Dance Initiative Greater Manchester (DIGM), in partnership with professional dance group Company Chamelon. It is a free activity, with its participants coming from diverse socio-economic and cultural backgrounds. STRIDE challenges stereotypes around young men and dance, and promotes positive role models in communities.

Via evidence gathered across 2009 and 2010 projects, they believe STRIDE improves:

- Physical fitness and wellbeing - through regular dance sessions that challenge strength, stamina, cardiovascular health, agility and flexibility.
- Mental health - through opportunities to develop creative ideas, for self-expression, and engagement with others in a positive environment.
- Confidence and self-esteem - through challenging participants to step out of their comfort zone, and supporting achievement through performance.
- Life skills - through providing opportunities to value the importance of team work, goal setting, commitment and time management.

DIGM works across Greater Manchester's ten boroughs in partnership with local authorities, communities, educators and artists. STRIDE is supported by six professional dance artists, who act as positive male role models for the boys. Creativity is at the centre of the project. For example, the pilot project ('Rites') asked participants to explore the stepping stones of a man's life, with themes including growth, peer pressure and support.

Initially, extensive outreach is undertaken, with 24 hours of high quality dance being offered over four or more locations in each participating district. District-based groups are formed following 'Try Outs' - where young men can demonstrate their openness and commitment to the project. Some STRIDE participants now look to pursue further opportunities in their dance development, such as entering pre-vocational professional training, and taking on supported facilitation roles with younger community groups.

USE OF TECHNOLOGIES

Reach Out Central [Australia] - ReachOut.com, 2007

<http://au.reachout.com/reachoutcentral>

Burns et al (2010) describe the concept, development and appraisal of Reach Out Central (ROC), which is a web-based 'serious' game designed to improve the mental health and wellbeing of young people aged 16 to 25 - particularly men. ROC was developed over a three year period, from 2003 to 2006, in consultation with young people, and September 2007 saw the launch of ROC. A conventional and viral awareness campaign was designed to appeal to and engage young men and 'gamers' in particular. Advertisements were posted on six gaming, social and community, and entertainment websites. Magazines deemed to be popular with young men were targeted, as they were specifically male youth-oriented. The campaign was also advertised in print and popular press, and was engaged nationally by radio stations, newspapers and television.

An independent online appraisal was conducted between August 2007 and February 2008 to examine mental wellbeing, help seeking, and stigma in ROC players. It involved 266 young people. The findings signified that ROC was successful in educating, attracting, and engaging young people. While young women reported greater life satisfaction and a reduction in mental distress, there were no significant changes observed in young men. While ROC was successful in attracting young men, it did not keep them engaged with the service - highlighting the need for further research.

A report in Australia - 'Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing (Burns et al, 2013) - revealed that almost 50% of young men aged 16 to 25 said that coping with stress was their biggest issue, while less than one in four would recommend professional support - either face-to-face or online. Utilising the Internet to find information on mental health, substance abuse problems or alcohol was acceptable to 43% of young men. The report also revealed that those with moderate to very high mental distress spent more time on the Internet than those with no or low mental distress. Two thirds of the young men surveyed were more likely to talk about problems on the Internet, whilst almost all respondents were highly satisfied with the information they received.

Like ROC, this report shows that young men can be engaged using technology and the Internet, while it stresses the need for the involvement of young men in the design of e-mental health services. It also recommends that technology solutions should be customised to vulnerable populations, including indigenous and unemployed young men, and stresses the importance of existing services being responsive throughout the day and night.

WorkOut [Ireland] - Young Men and Suicide Project, 2013

www.workoutapp.ie

The 'Young Men and Suicide Project' pilot intervention in the Republic of Ireland focused upon the development of an online mental fitness programme for young men called 'WorkOut'. Although, initially, targeting young men in the Republic of Ireland, this programme is now available to young men in Northern Ireland, and further afield as well - although the sources of further help suggested on the site have an island of Ireland focus.

The WorkOut programme was modelled on an application which was originally developed by the Inspire Foundation in Australia; working collaboratively with the Australian Brain and Mind Research Institute. The materials within it were chosen because of the strong evidence base which indicated that they can have a positive impact upon the mental health of young men.

The core objectives of WorkOut are to:

- Use the Internet to promote help seeking amongst young men by ...
 - Challenging stereotypical attitudes of mental health.
 - Providing them with the language and tools to take positive action.
- Promote social connectedness.
- Promote mental health literacy.
- Challenge thoughts that impede help-seeking behaviour.

WorkOut is free and easy to access. It is based upon a series of brief online interventions (called 'Missions') which utilise the principles of Cognitive Behavioural Therapy. During WorkOut, young men are invited to:

- Register for an account.
- Take a comprehensive test to assess their strengths and weaknesses.
- Undertake a series of practical Missions to improve their mental fitness.
- Use online reports to check (at any time) how they are improving.

The WorkOut programme addresses four main areas:

- Being Practical
- Building Confidence
- Taking Control
- Being a Team Player

The programme offers young men a standalone programme that they can access in their own time and engage with on their own terms. They can choose as many, or as few, Missions as they wish to within each of the main areas focused upon. It is anticipated that the website, and its content, will be added to / amended over time as new needs or issues arise.

Campaign Against Living Miserably [United Kingdom] - Powell, as cited by Wilkins and Kemple, 2011

www.thecalmzone.net/about-calm/what-is-calm

CALM, which stands for 'Campaign Against Living Miserably', targets young men aged 15-35 years. The campaign offers help, information and advice via a free, anonymous, and confidential phone line and web service. It was set up because suicide was, and is again, the biggest killer of men under 35 years of age in the UK. CALM was launched as a pilot by the Department of Health (DoH) in December 1997. In 2004, the DoH announced the end of the pilot. However, those involved on the ground felt that it was important to continue this service and CALM, the charity, was launched in 2006.

Currently, there are two local areas that CALM actively promotes in: Merseyside and East Lancashire. They do so with the support of the regions' Primary Care Trusts. Callers from within these 'CALMzones' are able to get signposting information to local agencies that can offer specialist support on a range of lifestyle issues. CALM believes that the way services are shaped, packaged, and the methods used to promote them, are as important as how good they are when it comes to successfully engaging with men. They receive over 80% of their calls from men.

The campaign is now firmly established as a credible brand that young men relate to. It is promoted by nightclubs, festivals and musicians, and has the backing of big male brands. In the Merseyside CALMzone, they have seen a sustained reduction in the suicide rate amongst men aged 15-34 years; measuring 39% over the eight years of figures available.

Beyond Barriers [Australia] - beyondblue, 2010a

www.beyondblue.org.au/about-us/programs/mens-program/program-activities/beyond-barriers

In response to higher suicide rates among men, and the lower rates of help-seeking behaviour and barriers to help-seeking such as stigma, the Australian Department of Health and Ageing contracted beyondblue to develop a comprehensive strategy, including a multi-platform campaign, which would target a range of Australian male population groups. The strategy is being independently evaluated. The Beyond Barriers Strategy aims to encourage men to take action against depression and anxiety by reducing stigma and barriers which prevent them from seeking support. The strategy is comprised of a suite of projects. The major piece of work is the 'Man Therapy' campaign.

EDUCATION

Incolink - Life Care Skills Project [Australia] - as cited by Richardson et al, 2008

www.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~Appendices-appendix-a~project16

The Life Care Skills Project aims to prevent suicide amongst young people in the building and construction industry. The programme raises awareness of suicide and its risk factors, and promotes positive life skills to support apprentices with the daily challenges of work and life. Incolink offers its training to all first year construction apprentices. The programme aims to reduce risk factors associated with suicide (such as relationship break-up, financial problems, gambling, and drug and alcohol abuse), while building resilience and other protective factors. The programme focuses on providing information to apprentices through technical and further education providers, trade unions and employer associations, and to employers and employees on building sites. The programme is tailored to the specific needs of young men - including their learning styles - and in terms of delivery of the programme to maximise effectiveness and attendance. The programme was evaluated, and has shown effectiveness in increasing awareness and knowledge of risk factors, increasing skills and knowledge of protective factors, and in promoting help seeking behaviour.

EARLY INTERVENTION INITIATIVES

SPORT AND EXERCISE

Boxercise [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.mindincroydon.org.uk/active-minds.asp

Boxercise is a partnership between Mind in Croydon and the former world champion boxer, Duke McKenzie. Under Duke's instruction, people with mental distress learn boxing techniques to help improve both their physical and mental wellbeing. The scheme aims to help people recover their confidence and self-belief in a different way to the usual mental health support. Although Boxercise is designed for both men and women, it has particularly good outcomes for men. Rather than addressing just the thoughts and emotions that go with mental distress, Boxercise helps people to recover the most basic of things - a feeling of self-worth. It can also be a positive way to manage emotions; a form of anger management. The project has four main aims: to improve self-esteem and mental wellbeing; to improve health and fitness; to help people lead healthier lives, and to improve social inclusion. The project brings the group together and facilitates bonding and friendship.

Back of the Net [Ireland] - McGale et al, 2011

Back of the Net (BTN) is an integrated exercise and Cognitive Behavioural Therapy intervention for young men's mental health. Trials show that the BTN programme was effective in reducing depressive symptoms in young men. The BTN programme is of further interest, as it is designed to address help seeking barriers specific to men - thereby, giving men a safe means to seek support without embarrassment. BTN consists of a ten week programme with two exercise sessions per week. Each session is integrated with themes which are delivered through a Cognitive Behavioural Therapy (CBT) approach. Further work has employed the use of online CBT techniques. The programme has been evaluated using a control trial methodology, and has shown effectiveness in reducing depressive symptoms in young men.

USE OF TECHNOLOGIES**Mindfulness Based Stress Reduction [United States of America]**

Sibinga et al (2013) explored the effects of a school-based Mindfulness Based Stress Reduction (MBSR) programme for young males in Baltimore, Maryland. All 7th and 8th grade boys (n = 44) at a small, application-based, tuition-free, middle school were recruited to take part in the study with parental consent. Using a computer-generated scheme, participants were randomly assigned to MBSR or an active control programme. All participants and school staff were blind to programme allocation prior to the project. Both programmes were incorporated into the school day, and consisted of 12 (weekly) fifty minute sessions. The control programme, 'Healthy Topics', consisted of age appropriate health information. Data were collected at baseline, post-intervention, and at three month follow-up on mental functioning, sleep, and salivary cortisol - a physiologic measure of stress.

The findings showed that MBSR boys had less anxiety ($p = 0.01$), rumination ($p = 0.02$), and demonstrated a trend for less adverse coping ($p = 0.06$) than Healthy Topics boys. Cortisol levels increased when comparing baseline with post-programme during the academic terms for Healthy Topics participants, but remained constant for MBSR participants. A number of limitations were evident in the study. These were, mainly, design related. Firstly, the small sample size and active control condition restricted the ability to sense distinctions between groups. Secondly, the generalisability of the findings may have been limited due to the single study location. The study did, however, have an active control group, and evaluation of mental and physical domains. These were its strengths.

MoodGYM [Australia] - as cited by Richardson et al, 2013

www.moodgym.anu.edu.au/welcome

MoodGYM is an online Cognitive Behavioural Therapy (CBT) self-administered intervention, designed to teach CBT skills to people who are vulnerable to depression. It comprises five interactive modules: pleasant activities; cognitive restructuring; problem-solving; assertiveness training; and downloadable relaxation sessions. The modules are made available sequentially on a weekly basis. All interactive exercises are stored in a personalised workbook and, at the conclusion of each module, an individualised feedback form is available for printing-off. The programme has, after randomised control trials with six and twelve month follow-ups, shown effectiveness in reducing symptoms of depression and dysfunctional thoughts. However, online programmes, which are delivered with therapist guidance, may be more effective in terms of retaining the participant through the whole CBT programme.

Man Therapy [United States of America and Australia] - The Carson J Spencer Foundation, 2013

www.mantherapy.org | www.mantherapy.org.au

'Man Therapy' is a website that was developed in the United States of America for men aged 18 to 54. It was part of a multi-agency effort that aims to help men with any problem that they may encounter in life. Man Therapy was launched in Australia ahead of Men's Health Week in 2013, after 12 months of research and an international collaboration with the Colorado Office for Suicide Prevention (in order to adapt Man Therapy for an Australian audience). The site aims to specifically reach: young men aged 18-24; fathers aged 25-54; men living and working in urban growth areas; men living and working in regional and remote areas; men who are unemployed; and men who are misusing alcohol or drugs. The Man Therapy campaign is based around a fictional doctor who uses humour and honest discussion to guide men through the website, and provide them with the instructions and tools needed to take action against depression and anxiety (beyondblue, 2014).

Man Therapy provides men with three key pieces of learning:

- Know the signs.
- Know the range of treatment options.
- Develop an action plan.

Following the launch of Man Therapy in Australia in June 2013, beyondblue commissioned Ipsos Social Research Institute to evaluate the campaign's effectiveness in reaching the target audience and raising awareness. A market research project was conducted into men's help-seeking behaviour - to build upon what was already known in this area. The research revealed that men had a number of key sources that they used when seeking help. These included family and friends, GPs, and telephone support services. It also included the Internet - hence, Man Therapy. A number of approaches to reaching men were identified:

- Take the mental health language out of the communication, at least at the start.
- Demonstrate role models of hope and recovery.
- Make connections between physical symptoms and emotional issues.
- Coach the people around men, including men themselves, on recognising the signs.
- Target men who have a range of risk factors, and who are the least likely to seek support.
- Meet men where they are through the use of humour to initiate conversations.
- Targeted media - using the Internet as the main vehicle.

COMMUNITY - FORMAL AND INFORMAL

Menzone [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.mindinbradford.org.uk/galleryone.htm

Menzone is the men-only drop-in session at Mind in Bradford, which is held every Wednesday evening from 5.00pm to 9.00pm. It caters for men from all backgrounds who have mental health difficulties. The aim is to create an atmosphere that allows men to share their experiences and coping strategies, so allowing them to learn about various ways of coping and improving their mental wellbeing. The drop-in is generally unstructured, with many discussions focused on improving self-esteem and having a positive mental attitude. Menzone has weekly meditation sessions, and also operates an anxiety support group. There are weekly football sessions which help keep the men engaged, while other activities include trips away and sports such as snooker and bowling.

MAC-UK [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.mac-uk.org

MAC-UK was established in 2008 to engage some of the United Kingdom's (UK's) most challenging young men through an innovative 'street therapy' approach, with the aim of promoting wellbeing amongst this group. MAC-UK works with 14-30 year olds with mental health and social care needs, and acts as a bridge to access appropriate mainstream services when required. It also trains existing service providers (e.g. youth clubs and the police) in a youth-led approach, and builds their understanding of young men's mental health needs. MAC-UK aims to empower its young men to re-engage with the community, and to realise positive aspirations for their future.

MAC-UK:

1. Works with young men in their own environment, and gives them a stake in the development and implementation of project activities.
2. Provides training to other service providers - to help them respond to the needs and aspirations of young adults.
3. Shares its findings and approach with key stakeholders - in order to influence practice more widely.
4. Monitors and evaluates its work with the support of University College London.

Each project is youth-led, with all decisions made and activities co-led by the young men. The project lasts for two years, and is framed around activities chosen by the young men such as music, gigs, football, street art and gym. The aim of these activities is to build rapport with staff in an informal, youth-led environment, so that subsequent mental health work can take place. Activities are held three days per week, and 'life skills' workshops take place twice a month. The activity times and days change on a regular basis to fit around the needs of the young men, as do the activities themselves - in order to keep the project fresh and prevent boredom and drop-out. One-to-one 'street therapy' sessions are offered on a daily basis to support young men to attend the main activities. These enable young men to interact with a therapist in whichever environment, and at whatever pace, they feel comfortable.

Topaz Wellbeing Centre [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.togmind.org

Tameside, Oldham and Glossop Mind changed from a traditional Day Centre to a Wellbeing Centre in April 2008. The Wellbeing Centre focuses on prevention, recovery, social inclusion and holistic intervention, and the mission statement is: 'To be an organisation of excellence with an ever-changing and diverse range of activities and services that promote physical and psychological wellbeing, stimulate recovery, and lead to social inclusion within mainstream society'.

The Topaz Wellbeing Centre offers a variety of services such as courses, counselling, drop-ins run by external agencies, an information centre, a problem solving service, and a one-to-one service. All of the resources are open to anyone living in Tameside and Glossop over the age of 16 years, are self-referral, and do not require an 'assessment'. The building is an open access environment, allowing men to access the services in an easy way. The centre's door is unlocked between 10.00am and 4.00pm each weekday, so anyone can walk in off the street to ask for support.

One of the roles of the café is to be a 'neutral normal' space where men can come and have a coffee without intrusion. This, therefore, breaks down the stigma associated with doing something about your wellbeing. The variety of services allows people, particularly men, to find something that works for them - rather than fitting men to services. Volunteering is central to the centre, and it could not operate without these volunteers. This allows people to give back their time, improve their own skills, and feel valued. It also provides an opportunity to not just be the receiver of services, but also be the giver of services.

SOS Men's Group [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.southendmind.org.uk/pages/reason

The SOS Men's Group began in February 2009. The concept was born out of Southend Mind's Racial Equality Accessing Support Opportunities Now (REASON) project. REASON is a community development service to improve access to mental health services for Black and Minority Ethnic (BME) communities. REASON staff identified a need for BME men to have somewhere to meet and socialise and, more importantly, to be informed about appropriate services that are available in the local area. The men came from the 'hidden' communities in the Southend-on-Sea area; many of whom had turned to substance abuse through depression, and were found loitering around parks and streets with nowhere to go. Mind workers approached these men directly in these settings, in order to recruit members of the group. Many of the men initially identified were suffering from variants of Post Traumatic Stress Disorder or Adjustment Disorder due to coming to the UK from war-torn or chaotic countries. Due to their culture, it was important to recognise the need for a 'men only' group as, in many of their birth countries, it is not considered appropriate for women and men to socialise together. A variety of men from different cultural backgrounds began to attend the meetings.

In the 18 month period after the group began, weekly attendance was reported to have grown to between 12 to 20 men from diverse backgrounds. The group received Information Technology classes from a member of the local Adult Education Centre. Speakers from a wide range of sectors were also invited to input to the programme, including: housing / benefit workers; social workers; police; drug and alcohol services; counsellors; health practitioners; art teachers; fitness coaches; immigration services; and English language tutors.

Soften the Fck Up [Australia] - beyondblue, 2014b

www.softenthefckup.com.au

Launched in July 2011, 'Soften the Fck Up' is a campaign designed to challenge what it means to be a man. It aims to encourage what it describes as 'tough conversations' around male mental health and how men go about getting help. The campaign was developed by Spur Projects, and beyondblue is a partner and supporter. On a set date, at a set time, people gather in a range of venues across the country to have a drink and a chat. There are two rules: (1) you must meet at least one new person, and (2) you must share at least one 'fck-up' you've made. 'Fck-up night' is an opportunity to celebrate and own the 'fck-ups' that everyone is deemed to have made in life.

TALK THERAPIES

The Bradford Reducing Anger and Violent Emotions (BRAVE) Project [United Kingdom] - as cited by Wilkins and Kemple, 2011

www.brave-project.org/aboutus.html

BRAVE is a gender specific, male focussed, strengths and resilience model. BRAVE believes heart-centred therapeutic interventions are most effective. The project offers one-to-one counselling, open and rolling therapeutic group work, and health 'MOTs' for men. The programme extends an invitation to responsibility without shaming. Key features include:

- Dignity and respect - see the man not just the behaviour.
- Identify (together) a man's needs - one-to-one counselling / group work / signposting.
- Work relationally, building trust and supportive relationships.
- Education - recognising anger / rage signals, time outs, ability to self-soothe.
- 'Heart listening' - validate men's histories.
- Continuity - 'holding and containing' men using a mix of therapeutic, educative, solution-focused and CBT interventions.
- Emphasis on the importance of the 'check in' - therapy, recovery and healing.
- A solid core of 'old timers' are welcome, and they mentor new men.
- Wealth of resources, but no fixed programme - all men must get the basics.
- A solid belief and faith in the ability of men to change.
- Professional clinical responsibility to work with risk to self and others and suicide.

The reported benefits of the project include: helping to change abusive / risky behaviour, attitudes and beliefs; fostering healthier relationships (with family, partners, children and friends); improving emotional health and wellbeing; reducing self-harm, risky behaviour and suicidal intentions; improving self-esteem, confidence and resilience; prompting recovery and healing from past experiences; learning how to regulate powerful emotions such as rage, sadness and fear; and recognising that it is a sign of strength to ask for help.

INTERVENTIONS TARGETING FATHERS

Boston Daddy Day Care (United Kingdom) - as cited by Wilkins and Kemple, 2011

Boston's Children's Services Team Management identified a need to increase the engagement of all male carers with their children under five years of age. A Father's Engagement Worker from Lincolnshire Young Men's Christian Association (YMCA) was, therefore, commissioned to work with all male carers through Sure Start's Children's Centres. The uptake of the Dad's Support Service was initially slow. However, the introduction of a six week pilot Daddy Day Care Saturday Club (10.00am - 12.00pm) led to the service gaining a higher profile within the Boston community. This resulted in the generation of a higher number of referrals from the multi-agencies involved with safeguarding, and an increase in parents' positive engagement with their children. The service offers support to all male carers on accommodation, mental health, parenting, behavioural, employment and childcare issues in their homes or via the Children's Centres.

Upon evaluation, it was obvious that the service has positively benefited male carers. It has enabled participants to develop their father / child relationship by providing an opportunity for them to engage with their children on a one-to-one basis through the activities on offer at the club. It has also allowed them to socialise with other dads. The Daddy Day Care Club has now restarted (with many new dads bringing their babies who are just weeks old) in an effort to help men engage with their children as well as giving mum a break from child care. The Dad's Support Service has become a vibrant and positive service for all male carers and family men in the surrounding Boston Community

EDUCATION

Mind Yourself [Ireland] - as cited by Richardson et al, 2013

www.mindyourself.ie

The Mind Yourself programme is a school-based problem solving brief intervention aimed at adolescents. Essential elements of the programme include:

- A holistic life-skills approach, encompassing coping and problem-solving skills.
- A strengths-based approach, which focuses on hope, optimism and is solution-focused.
- A whole population approach to working with young people. This way, those who are most 'at risk' - but may never come into contact with services - are more likely to be reached.
- A community-based approach that is founded upon consulting with young people on their needs.
- A firm grounding in strategies to enhance problem-solving skills, emphasise optimism, and promote resilience among adolescents.
- The provision of information on resources and services available to young people.
- An empirical evaluation of the programme - so as to measure its effects on helplessness and hopelessness. Levels of depression, self-esteem, problem-solving strategies, and coping methods are also assessed.

Two sessions, approximately 90 minutes each, are delivered to adolescents in groups of 15 or less (ages 15-17) in school settings. There was randomised pre and post group study, with experimental and control groups. Results show that the programme was effective in creating significant positive changes in terms of problem solving and emotional resilience. Other results indicate positive, but non-significant, changes in depressive symptoms (greatest reduction in boys) and self-harm thoughts.

OzHelp Foundation: Tradies Tune-Up Programme [Australia] - Mengage, 2011

www.ozhelp.org.au/site/ozhelp_in_act.php

The Tradies Tune-Up programme is a series of health checks focusing upon men in construction, mining and trades. It aimed to achieve an increase in the awareness of workers as to their current state of physical and mental health and, also, an increase in help seeking and education for health issues. The tune-up is generally run at locations where tradesman and workers frequent, including hardware stores, mining sites, and other locations. The Tradies Tune-Up programme has been developed to raise awareness of personal preventative health amongst workers in the construction industry, and offers a vital link to discovering better health and wellbeing. Tests conducted include cholesterol and blood pressure checks along with depression and stress awareness indicators. The programme was evaluated in 2010, and showed that it was successful in engaging and reaching this population due to easy access, the credible and confidential nature of the programme, the immediate access to intervention if and when needed, and also the low cost of the programme.



APPENDIX C

UNPUBLISHED AND NON EVALUATED INTERVENTIONS

MEN'S DEVELOPMENT NETWORK: MEN'S DEVELOPMENT HEALTH PROGRAMME

The Men's Development Health Programme has been funded since 2002 by the Department of Health and Children and the Health Service Executive, and is ongoing. The target group for the health programme is, primarily, men of all ages who experience disadvantage due to the effects of unemployment, marginalisation, poverty, and men's conditioning.

The purpose of this work is to:

- Build confidence, self-esteem and self-respect in men.
- Empower men to build good relationships with themselves, each other, partners, families, women, children, community and society.
- Train men to develop leadership, facilitation and co-operation skills.
- Encourage men to take responsibility.

To date, Men's Development Groups exist nationally (approximately 20), engaging almost 160 men at regular meetings.

The procedure for creating these groups is:

- The initial contact with men is personal i.e. not via media or posters etc. Word-of-mouth among men enables the groups to grow. The Men's Development Network (MDN) uses their existing networks (Community Development Projects, Family Resource Centres, County and City Partnerships, County Development Boards) to make this initial contact.
- Individual men are invited to join a Men's Development Group.
- MDN works with these groups, using experiential facilitative methodologies.

MDN's Men's Health Programme is, primarily, a 'talking' intervention. Arising from MDN's experience in the field of developing emotional intelligence among men, they have developed the '7 Questions Training'. This supports service providers to engage more effectively with men. This training underpins what MDN terms: 'a new conversation with men'. Certain aspects of the Men's Health Programme have been evaluated and written as reports, but these are not, currently, available online. Further information on the Men's Development Health Programme is available at: www.mens-network.net/mens-development-health-programme

See also: Carroll, P., Grace, B., Richardson, N. 'What works in relation to engaging and working with boys and men, particularly around mental health and wellbeing on the island of Ireland'. Dublin: Men's Health Forum in Ireland on behalf of the Centre for Men's Health, Leeds [unpublished report]. Contact pcarroll@wit.ie for a copy upon publication.

MEN'S ACTION NETWORK: THE REAL LIFE EXPERIENCES OF MEN AND THEIR HOLISTIC HEALTH

www.man-ni.org/resources/michaelspeech.pdf

Men's Action Network (MAN) began in Derry in 1994 in response to what was seen as the paucity of male-specific health services. MAN meets once a week, and provides a safe space for men looking for support. In 1996, MAN constituted as a charity, with the mission to support and promote male health and wellbeing. To meet the needs of men, MAN offers a telephone helpline, one-to-one support and counselling, health programmes, community projects, facilitated self-help support, advocacy work and outreach programmes. MAN challenges what it regards as myths around negative forms of masculinity and gendered stereotypical thinking. It seeks to create 'safe spaces' to engage with men, and outlines a number of key factors which can help to achieve this:

- Ensure that the physical environment in which the interaction takes place is welcoming, comfortable and male-friendly.
- Be self-aware of how working with men makes you feel, any gendered perceptions you may have of yourself as a worker, and your attitudes towards men in general. There should be no conflict between the needs of the men you work with and your own agenda(s).
- Remember that the worker needs to have an adequate awareness of how men think / act / are, and the life / health / societal issues that males face.
- Offer confidentiality, empathy, trust, a non-judgemental approach, and lots of time to assist men to find an emotional language which will help to support them.

MAN outlines some of the challenges that service providers may encounter:

1. Listen - in a community development model, it is necessary to listen, to hear, and to respond to what men want.
2. Resource Implications - working within tight budgetary constraints, there can be a conflict between the awareness of wanting / needing to do the work and having resources to do it in an adequate way. This can mean that sometimes it's preferable not to attempt work with men as, if attempted, it would get done in a piecemeal manner. MAN believes that service providers need to recognise the longer-term benefits of actively seeking out and engaging men, and to build this work into their organisations' strategies, policies and budget from the outset.
3. The Nature of Engagement - there is a need to develop safe spaces and best practice models for working with men. Innovative and unique ways of getting messages to men are required.
4. Awareness of the Gender Dimensions of the Work - service providers need to have a sound awareness of the key issues / gender dimensions of the work. There is also a need to have specific individuals (preferably men) in positions where they are tasked with actively and genuinely engaging men.
5. Men's Health versus Women's Health - men's and women's health should be complementary and not in conflict with each another. The major challenge to those who provide resources is the need to avoid creating a conflict situation or environment of competition - which will, ultimately, be detrimental to both men's and women's health.
6. Policies and Strategies - MAN believes that, in the first instance, most people identify as either male or female, and then as single, married, gay, lesbian, disabled etc. afterwards. It is necessary for service providers to look for gaps where males or females are excluded, and to see gender mainstreaming of policies as a means to help to address this.

See: Lynch, M. (2009). 'The Real Life Experiences of Men and their Holistic Health'. Nowhere Man Press, 1-10.



THE 'ENGAGING YOUNG MEN PROJECT' IS AN INITIATIVE OF THE MEN'S HEALTH FORUM IN IRELAND.
THIS REPORT HAS BEEN FUNDED BY THE HSE'S NATIONAL OFFICE FOR SUICIDE PREVENTION

