

Mind Your Head



Study of Youth Mental Health in
Sligo, Leitrim and West Cavan

Strategic Planning Process: Part 1 of 2
Youth Mental Health Initiative
October 2014

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FOREWORD

I welcome this study on youth mental health and wellbeing in Sligo, Leitrim, west Cavan. These are challenging times for young people. We are aware of the impact of poor mental health in young people and how this can lead to problems in later life. We know that up to three-quarters of mental health problems have their onset in the 15-25 year age range.

The Youth Mental Health Initiative is a partnership of a range of agencies, both statutory and voluntary, which has taken as its remit the improvement of services in the local area. In times of recession, it is important that the various agencies co-operate to make best use of the limited resources available. This will help deliver a better service to young people in our area.

This report, produced by St. Angela's College on behalf of the Youth Mental Health Initiative, gives us a unique opportunity to improve our services according to the findings of the research and in partnership with other agencies. The key message from the report is that services need to be working more closely together for the benefit of young people.

As well as developing services, the research shows us that we need to support the family and friends of young people. The Headstrong sponsored report, *My World Survey: National Study on Youth Mental Health in Ireland*, showed that the 'one good adult' was an important protective factor in relation to a young person's positive mental health. I am pleased to note that Sligo / Leitrim / west Cavan is leading the provision of training in this regard in conjunction with Headstrong.

The *Mind Your Head* study finds that a trusted friend is important for young people. It informs us that, when external services are needed, they should be responsive and non-stigmatising. These findings will inform the future development of our service for young people in this area.

I wish the Youth Mental Health Initiative well in using the findings of this study in shaping our services to meet the needs of young people in Sligo, Leitrim and west Cavan.

Damien McCallion,
HSE Area Manager

INTRODUCTION

The Youth Mental Health Initiative was established in 2011 as a result of young people's concerns about the style and lack of services that promote and support positive mental health in Sligo, Leitrim and west Cavan. The Initiative aims to foster the positive mental health and wellbeing of young people in the region and involves a partnership between statutory and voluntary agencies, communities and young people in order to achieve this aim. The central action of the initiative is to develop an innovative, evidence-based approach for organising services and supports to enhance the mental health and well-being of young people.

A key component is to ensure that the work is informed by a reliable needs and resources analysis in relation to youth mental health. In bringing about change, the initiative also relies on knowledge and understanding of evidence-based best practice in relation to youth mental health. This study was commissioned with that requirement in mind.

It is fitting that the *Mind Your Head* study concentrated on seeking the views of young people in great depth. The fact that more than one thousand people participated in this research in one form or another is a testament to their willingness to take some responsibility for ensuring that services meet their needs. It is essential that young people and their families be involved in the planning and implementation of the work as it moves now to the next stage.

This study is the first part of an overall strategy of the Youth Mental Health Initiative. The second part will be the actual strategy which arises from the research findings and the ongoing work of the Youth Mental Health Initiative.

Mark O'Callaghan,
Chairperson
Principal Psychologist Manager,
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Youth Officer,
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Research Participants

On behalf of our colleagues on the Youth Mental Health Initiative, we acknowledge all the research participants who gave of their time to participate in this study. These were the young people themselves and their families, including service users. We also thank those who contributed to or facilitated the research process (e.g. school Principals / year heads / teachers / support staff; staff and student support services in third level colleges; youth workers; family support workers; mental health professionals; other service providers such as statutory and voluntary agencies, GPs).

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We acknowledge present and past members of the Youth Mental Initiative Steering Group and, in particular, the Research Sub-group.

Headstrong

Finally, we acknowledge Headstrong for their generous advice and support throughout the life of the Youth Mental Health Initiative and, in particular, in the preparation of this study.

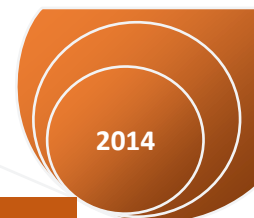
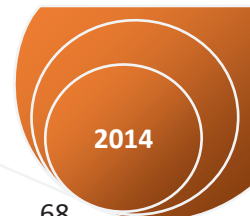


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Executive Summary

Introduction

In 2013, Youth Mental Health Initiative in Sligo / Leitrim / west Cavan (YMHI) through Mayo, Sligo and Leitrim ETB (formerly the VEC), commissioned an independent team of researchers from St. Angela's College, Sligo to carry out a regional consultation with young people and relevant stakeholders in relation to mental health needs and service provision. Specifically, the consultation sought to address the following aims:

1. To establish the current mental health needs of young people between the ages of 12 – 25 years in the Sligo / Leitrim / west Cavan area.
2. To identify the current resources for youth mental health care and the strengths and weaknesses of such resources.

Methodology

An agreed multi-method triangulated design was deployed for the purpose of the research, which enabled the research team to elicit the views of young people and identified regional key stakeholders. Data collection and analysis took place between July 2013 and January 2014.

Data were collected via:

- Anonymous surveys
- Individual in-depth interviews
- Focus group interviews
- Written submissions

A multi-pronged sampling strategy was used to generate the sample of 925 survey participants; 129 interview participants and 67 written submissions from individuals and groups. In total, 1,005 individuals' views were captured. Data sets were integrated at time of analysis and subsequently presented using a socio-ecological framework. The findings from both the literature review and the empirical phase were considered in unison to form the basis of the emerging practice principles and recommendations.

Key Findings

The findings that emanated from the young people and the stakeholders were remarkably similar. The quintessential attribute for a young person to possess to maintain their mental wellbeing is resilience. A young person's relationship with their parent(s) and family emerged as the other crucial factor in supporting their mental wellbeing. Young people's friends also played a vital role in their mental wellbeing status through serving as confidants, educators and, unfortunately, at times a source of pressure. Mental health stressors emanated from the young person themselves; their homes; educational

engage with services also emerged as an issue for young people under the age of consent.

Young people reported a desire for services/supports which guaranteed privacy in their local areas. Whilst the region has a range of support services (statutory and voluntary) available to support young people's mental wellbeing, the existence or focus of many were not widely known among the region's young population. The services that were known and accessed were in the main positively evaluated. Both stakeholders and young people perceived the value that technology could realise; in terms of access, support and education, if harnessed in a manner that young people relate to.



In summary, a range of mental health needs were identified and effective regional support structures /personnel/groups recognised. In addition, a number of deficits in the current support provision was highlighted which require consideration by key stakeholders.

In light of the findings generated and the exemplars of good practice to emerge from the review of the literature, the following

considerations are being advanced in respect of the strategic plan.

Intrapersonal Considerations

1. Consider promoting a framework such as *The 7 Cs: The Essential Building Blocks of Resilience* to guide parents in the development of their son's/daughter's resilience.
2. Consider promoting the current online Lifeskills programmes among adolescents and young people.
3. Consider promoting programmes such as the 'Hope and Optimism' course to teachers as a means of assisting them develop young people's self-esteem.
4. Review the curricular content of SPHE to evaluate if there is sufficient emphasis on developing the young person and to ascertain how this is objectively measured.

Interpersonal considerations

1. Evidence based on-line parenting interactive programmes should be introduced to target the greatest number of parents.
2. Evidence of the effectiveness of the region's current parenting programmes in relation to educating parents on the promotion of mental wellbeing and the

recognition of poor mental health should be ascertained empirically.

3. Promote the concept of “*five moments for initiating a mental wellbeing (or Mind your Head)*” conversation with parents (pre-school; pre-post-primary; midpoint post-primary; pre-third level/employment and pre-21 years or prior to gaining their financial independence).
4. All key stakeholders working with young people should create opportunities to engage with young people on a regular basis with the purpose of affording young people the opportunity to discuss their mental wellbeing.
5. An agreed decision making framework should be selected for universal utilisation in the region to support young people in:
 - a. Their selection of one good adult and/or selection of an individual they relate well to.
 - b. Their deliberations around disclosure.
 - c. Their appreciation of the range of therapies available.
6. The number of young people who engage in *Big Brother: Big Sister* and/or mentoring programmes should be increased by an agreed percentage on an annual basis.
7. The meaning of friendship should be a core element of the SPHE curriculum.

Community Considerations

1. All post-primary schools in the region should engage with the Home Youth Liaison Service to maximise the support that young people with specific needs can avail of.
2. The capacity of General Practitioners must be strengthened through CPD to further support them in caring for young people’s mental wellbeing.
3. Modules on mental health and therapeutic engagement should be an obligatory component of undergraduate curricula for all health and social-care professionals and educators.
4. Until CAMHS (Child and Adolescent Mental Health Services) is in a position to respond to all primary care referrals in an acceptable time period: they must;
 - a) Engage all young people in some form of intermediary mental health support while they are waiting to access specialist secondary supports.
 - b) Consider allocating each young person an intermediary support person whose remit is to maintain regular contact with the young person during the waiting period.
5. Consideration should be given to the replication of some of the evidence-based family and peer-support programmes currently available in other parts of Ireland.

6. Consideration must be given to the employment of a broader suite of therapies to complement pharmacological therapy in the management of young people's mental health needs.
7. The philosophy and potential value of "social prescribing" as a complementary or sole therapy must be promoted among all key stakeholders and young people.
8. Train and support a number of lay people in the region to serve as mental health champions in their local community with the remit of promoting mental wellbeing and directing young people who are exhibiting signs of mental distress to relevant supports/resources.
9. Utilise the current recreational/sporting groups that young people engage with as a conduit to the promotion of youth mental wellbeing through the provision of training to designated key personnel in these groups.
10. Consider how the SPHE curriculum delivery can be further supported by the region's statutory/ voluntary groups to capitalise on its effectiveness.
11. Consideration should be given to identifying and using publicly funded accommodation to provide young people with a venue to meet at least three times per week in their local community.
12. Create an informed awareness of the focus of the CRIB among young people in the region.

Organisational Considerations

1. Conduct a systemic review of the current provision of voluntary, statutory and community support groups/services in the region to ascertain:
 - a) Their individual focus in relation to the dimensions of the socio-ecological framework.
 - b) Their catchment area.
2. Following this exercise; duplication and deficits in focus may emerge which will assist in refocusing the activity of support groups/resources across the region to ensure that all young people in the region have equitable access to supports/resources that address their mental health needs.
3. An awareness campaign should be initiated to promote the regional online service directory of supports accessible (via the alive2thrive website) to stakeholders and young people.
4. Consideration should be given to the employment of psychiatric nurses to support CAMHS in the community.
5. Young people must be afforded the opportunity to be part of the decision making process in relation to their support plans. A tripartite (young person; parent and service provider) approach should be deployed with young people under 18 years where the Meitheal Model is not deployed or suitable.

6. A transition/bridging programme needs to be developed to support young people's transition from CAMHS to Adult services and from in-patient settings to home/school.
7. In keeping with the goals of the National Carer's Strategy (DoH, 2012), CAMHS should develop a programme to support parents of young people accessing their services.
8. Consideration should be given to the co-location of Primary Care and Mental Health Services to reduce perceived stigma associated with recognisable mental health establishments.
4. The delivery of specialist care and client assessments/consultations should be conducted on a rotational basis in a number of satellite centres in the region.
5. A debate on young people's age of consent, competency/capacity to consent and risk and protection issues must be initiated in the region.
6. Development of the individual child/young person should serve as the underlying philosophy of all curricula (early childhood to third level) and should be evidenced in curricula learning outcomes.

Policy Considerations

1. The Meitheal Model should be deployed more frequently to enhance interagency co-operation so that young people with mental health needs and their families receive support and help in an integrated and coordinated way that is easily accessible to them.
2. Technology should be harnessed to ensure all young people have equitable access to knowledge, support and mental health services in the region.
3. The region's model of service provision should be one of two hubs (Sligo and Carrick-on-Shannon) with outlying satellite venues to provide young people with equitable access to support and service provision.

Societal Considerations

1. Consideration should be given to broadening the categorisation of vulnerable groups to include young people under financial strain.
2. A youth-led media campaign should be conducted to promote:
 - a) The current online support and information resources available to young people aged 12-25 years regionally and nationally.
 - b) The existing national telephone information and support service "Walk in my Shoes" which is staffed by mental health nurses to provide accessible advice, guidance and support for young people and their families should be developed.



3. Consideration should be given to engaging more young people/educational organisations in the planning and delivery of stigma reduction programmes in the region in conjunction with *See Change* (the National Mental Health Stigma Reduction partnership).

*"I didn't think you could get
depression so young"*

(Parent)

***Better education in
schools/colleges on life skills including
relationships, friendships, sex, drugs,
alcohol, emotional awareness, money
and budgeting is required***

(Service Provider)

Chapter 1: Introduction

Introduction

Mental health is a prerequisite for normal growth and development and good mental health in youth provides a solid foundation for positive mental health into adulthood and old age. Mental health is perceived to be the primary health issue for young people (Headstrong and UCD, 2012). It is recognised that the majority of young people in Ireland have good mental health and are functioning well. However, it is equally recognised that young people's mental health status is influenced by a number of innate and external factors. The literature identifies factors that have the potential to impact on a young person's mental wellbeing in a positive or negative fashion into *protective* and *risk* factors. In recognition of same, it is incumbent on society and young people themselves to enhance the modifiable protective factors and minimise the risk factors where feasible.

Research Context

The Youth Mental Health Initiative was established in 2011 to foster the positive mental health and wellbeing of young people aged 12-25 years in Sligo, Leitrim and west Cavan. The initiative involves a partnership between a wide range of statutory and voluntary agencies, communities and young

people in order to achieve this aim. The primary objective of the initiative is to develop an innovative, evidence-based approach for organising services and supports to enhance the mental health and wellbeing of young people. The initiative has developed links with Headstrong, the National Centre for Youth Mental Health. This involved participation in the Headstrong Learning Network, as well as creating working relationships between Headstrong and the initiative in order to learn from international best practice in the area of youth mental health.

A key component of the initiative is to ensure that the work is informed by a reliable needs and resources analysis in relation to youth mental health. In bringing about change, the initiative also relies on knowledge and understanding of evidence-based best practice in relation to youth mental health.

Research Aims

It was within the above context that the following aims and objectives were set for exploration:

1. To establish the current mental health needs of young people between the ages of 12 – 25 years in the Sligo / Leitrim / west Cavan area.
2. To identify the current resources for youth mental health care and the strengths and weaknesses of such resources.



Research Objectives

1. Identification of a baseline of data of young people in respect of their mental health needs in Sligo / Leitrim / west Cavan (by reference to quantitative data in Headstrong and UCD’s *My World* survey).
2. Identification of the needs of the key stakeholders (young people, statutory services, community and voluntary sectors) in relation to service provision.
3. Identification of the existing range of service provision in Sligo / Leitrim / west Cavan in relation to youth mental health.
4. Identification of gaps in service provision in relation to youth mental health.
5. Comparison with best-practice guidelines.
6. Development of recommendations for the reconfiguration of existing services.
7. Identification of additional supports required.
8. Identification of design of any potential model of service and identification of methodology of costing same.
9. Identification of an agreed set of quantified objectives in terms of desired outcomes for young people and mental health in Sligo / Leitrim / west Cavan.

Conceptual Framework

A socio-ecological framework (see Figure 1 overleaf) served as the study’s conceptual framework. The framework recognises the interwoven relationship that exists between the young people and their environment.

The framework was deployed because it was considered sufficiently expansive and dynamic to capture the many varied influences on young people’s mental wellbeing from their own innate attributes to society’s valuing of mental health.

At the core of the framework is the young person, surrounded by multiple bands of influence representing the interpersonal, community, organisational, policy and societal dimensions that have the potential to impact on young people’s mental wellbeing in a positive or negative manner.



Figure 1: Social Ecological Framework

The Intrapersonal dimension refers to the innate challenges/attributes/knowledge and resources that young people possess that can impact on their mental wellbeing.

The Interpersonal dimension encapsulates the impact that young people's interactions (or lack of) with significant others (face to face or social media) can have on their mental wellbeing.

The Community dimension encapsulates the impact that young people's interaction with their families, schools/colleges, employers, primary health care practitioners/ place of residence and local facilities can have on their mental wellbeing.

The Organisational dimension captures the impact that young people's interactions with

secondary health services and voluntary groups can have on their mental wellbeing.

The Policy dimension refers to the impact that the existence and implementation (or lack) of various local and national policies can have on young people's mental wellbeing from a broad range of perspectives.

The Societal dimension encapsulates the openness and significance that Irish society places on mental wellbeing.

The framework treats the interaction between factors at the different levels with equal importance to the influence of factors within a single level. The philosophy underpinning the framework also mirrors a number of the principles underpinning the World Health Organisation's Mental Health Action Plan 2013-2020; namely those of

empowerment; a life course approach and a multi-sectorial approach. The deployment of the framework permeates all aspects of the study from the review of best practice to recommendations generated.

Structure of the Report

Chapter 2: presents a synthesis of the current literature in the area of youth mental health.

Chapter 3: summarises the methodological approach to the empirical phase of the project and provides details about data collection and analysis.

Chapter 4: provides a triangulation of the research findings.

Chapter 5: presents a number of principles for practice and recommendations in relation to supporting the mental health of young people in the region.



Some issues identified by young people in Comhairle na nÓg

Chapter 2: Literature Review

Introduction

The aim of this review is to provide a synthesis of the literature on youth mental health through the lens of a socio-ecological framework. Exemplars of good practice and their evidence base are included.

Context of Study

According to the CSO (2012), the population of Sligo is 65,393; made up of 32,435 males 32,958 females, i.e. 984 males to 1,000 females. The population of Leitrim is 31,798 with 16,144 males and 15,654 females, i.e. 1,031 males to 1,000 females. Leitrim is the most rural county in the country with almost 90% of the population living in a rural setting. Approximately 62% of people in Sligo live in a rural setting and, taking the full county of Cavan into consideration, approximately 65% live in a rural setting. Therefore, the counties linked with this study are predominantly rural.

In Sligo town, 52% of the population reported they were single and 36% married. This contrasts sharply to Leitrim county where 37% are single and 51% are married. This is probably explained by the higher levels of adolescents and young people reported living in Sligo. Across three age brackets (15-29 years), Sligo town had a much higher

percentage of young people than the national average. Over 75% of the population are in employment in the region. Most people work in professional services followed by industry, commerce/trade and in manufacturing industries.

Currently there are 26 Post-Primary schools and two Higher-Education Institutions in the region. The main recreational activities that young people in the region engage in are Gaelic football, soccer, water sports, music, dance and drama.

Defining Mental Health and Adolescent Mental Health

According to the WHO (2005), mental health is a state of wellbeing in which the individual recognises their own abilities and is able to cope with everyday stresses. Headstrong and University College Dublin (UCD) (2012) believe that optimal adolescent mental health is the capacity of an adolescent to achieve and maintain psychological functioning and wellbeing. Therefore, mental health is viewed as more than the absence of a mental disorder but rather as a continuum where, at one end the person experiences a sense of positive emotional health and wellbeing and, at the other end, the person feels unstable and unwell (Headstrong and UCD, 2012). The young person, their relationships and their role within their community can affect their

place on this continuum. Whelan and Layte (2006) agree and recognise that there have been many economic, cultural, societal and value changes in Ireland. These changes influence where the young person is placed on this continuum and in turn have influenced what it means to be an adolescent in contemporary Ireland. What is positive about the representation of the mental health continuum is the fluidity of the continuum which recognises that individuals can move on the continuum at different life junctures. In other words, the existence of stress and vulnerability in someone's life might move them in the direction of mental stress, whereas the provision of appropriate support and resources should shift their position in the direction of positive mental health again. It is recognised by Headstrong and UCD (2012) that the full implications of the current societal and economic changes on a person's mental wellbeing cannot be fully understood or appreciated at this juncture in time.

Mental Health Needs of the Young Person

Headstrong and UCD (2012) recognise that the majority of young people were found to be functioning well across a variety of mental health indicators with: 68% of adolescents reporting that they enjoyed family life; 93% indicating that they felt they were either at the top or middle of their class; 48% indicating that they coped well with problems and 46%

stating that they sometimes coped well. Therefore, it is important to point out that many young people are functioning well from a mental health perspective, even at a very transitional stage in their lives. However, it is also recognised that some young people's mental health is challenged and compromised. According to Cannon et al. (2013), one in three young people up to the age of thirteen in Ireland is likely to have experienced some type of mental disorder. This ratio will have increased to one in two by the age of twenty-four. These figures broadly concur with earlier studies by Lynch et al. (2006) and Martin et al. (2006). Equally pertinent is that approximately 75% of mental disorders emerge before the age of 25 years (Kim-Cohen et al., 2003; Kessler et al., 2005). Therefore, adolescence and young adulthood are critical periods that strongly influence the progress of mental health problems into adulthood (McGorry and Purcell, 2009).

Also, youth is a time of great experimentation and change for young people (Arnett and Eisenberg, 2007) with an increase in risk-taking behaviours such as smoking, drug and alcohol use, careless driving, unprotected sexual behaviour, delinquency and suicidal behaviour (Keren and Hasida, 2007; UNICEF, 2007). Regarding alcohol and drugs, a recent study has reported that high numbers of young adults in Ireland between the ages of 19 and 24 engaged in the misuse of alcohol and other substances and that one in five met

the diagnostic criteria for substance-use disorder into adulthood and later life (Lynch et al., 2006). These same researchers also found that over one in fifteen young people had engaged in deliberate self-harm and by the age of 24 years, up to one in five young people will have experienced suicidal ideation. According to the CSO (2012), Ireland has experienced major economic changes in the last few years. Unemployment has increased from 4% in 2006 to 14.2% in 2012. Many young people have experienced a drop in their standard of living, which may affect their mental health and wellbeing. Census figures also have shown an increase in the number of lone parents (CSO, 2006). Therefore, many of the extended family support systems, previously relied on are less available to young people today. Also, many parents are spending long periods commuting to and from work, are at home less often and are possibly less emotionally available to other family members after a day's work.

According to the Mental Health Foundation (2006), there appears to be broad agreement on the groups who are most vulnerable to experiencing mental health issues and on the factors that increase the risk. These include adolescents from poor socioeconomic backgrounds, minority ethnic communities, the Traveller community and young people placed in care. Other recognised vulnerabilities are work and relationship stress, family difficulties, the experience of

being in an abusive intimate relationship and having a bisexual or homosexual orientation (RSCI, 2013). Females are more vulnerable when it comes to deliberate self-harm with figures revealing that it is three times more prevalent among females than males (McMahon et al., 2010). Regarding suicide in Ireland, the mortality rate in the 15-24 age group is the fourth highest in the EU (National Office for Suicide Prevention, 2011) and the second highest among young men aged 15 to 19 years (Eurostat, 2009).

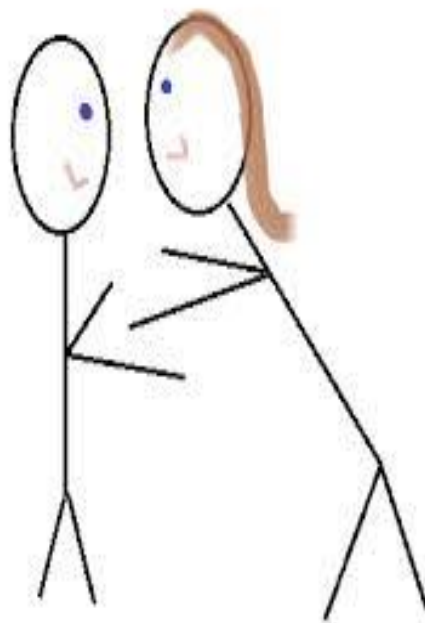


However, despite an obvious need for young people to avail of mental health supports and services, the utilisation of such services by young people is poor (Booth et al., 2004; Samargia et al., 2006). Therefore, people who may require the care of mental health services the most are not availing of timely help and support (McGorry, 2007). According to Illback et al. (2010), an integrated array of youth-focused and evidence-based prevention, early intervention and treatment services to ensure that young people can

source responsive support when needed is required. Aisbett et al. (2007) caution that this may be particularly problematic for young people living in rural areas who face significant barriers to addressing mental health issues: such as accessibility factors relating to a lack of transport, the need for young people to be dependent on other people for travel, the impact of stigma in terms of the negative attitudes within rural communities, fear of being seen going in to a mental health facility and the lack of anonymity. In a recent mental health study in County Mayo, the rural nature of the county (75% rural) and the low population density was acknowledged and posed an access challenge for young people in terms of mental health support and services (Mayo Youth Mental Health Initiative, 2012).

When asked who they would talk to about their problems, Sullivan et al. (2004) found that young people overwhelmingly reported a preference for talking to friends (38.7%); and then to family (15.1%). Interestingly and worryingly, very few reported that they would talk to a teacher (2.5%) or health service (3.9%). This theme of non-engagement or lack of/poor dialogue also emerged in the report conducted by Headstrong and UCD (2008), who surveyed over 1,000 adolescents, across Ireland (ages 12-18). They found that one in five felt that they had no-one to talk to about their problems, with over 25% specifically reporting that if they had problems with

depression, they had no-one to share this with. Nearly one in ten reported having serious problems but did not seek professional help. Disconcertingly, for the one in five that had spoken with a mental health professional, half reported that it had not been a helpful experience. Only 64% of the sample believed they had an adult they could trust who was always available to them and only 40% felt that they could cope well with their problems. One in three felt they were generally unhappy.



Therefore, while many young people cope very well with everyday life and its associated stresses, we must also be cognisant that many are challenged. Of equal concern is that, many who need timely and efficient support may

more likely talk to friends or family, who may not be in a position to offer this help at that time. Seeking out help among health care professionals or teachers appears to be limited. Therefore, people who are in distress in their lives, are finding themselves isolated when the necessary ingredients of support, advice and practical help are missing in their lives, leaving them vulnerable to engage in more maladaptive ways of coping.

Intrapersonal Dimension

Protective factors are referred to as a broad range of assets that may improve the likelihood of a person responding successfully to hazards (Headstrong and UCD, 2012). The Centre for Addiction and Mental Health (CAMH) (2012) in Canada, consider protective factors from an intrapersonal perspective to include: easy temperament; adequate nutrition; good physical health; attachment to family, above average intelligence; school achievement; problem solving skills; internal locus of control; social competence; social skills; good coping style; optimism, sense of purpose; moral beliefs; positive values; positive self-related cognitions; religious affiliation; history of competence and success. Headstrong and UCD (2012) adds characteristics such as talents, strengths, resilience and constructive interests. These internal protective factors are any factors that

reduce the impact of internal risk factors such as depression, anxiety or anger.

It is therefore incumbent on society to try to furnish young people with these attributes.

A nationwide intervention which has the capacity to influence the mental health of young people is SPHE (Social, Personal Health Education) which is a mandatory school subject taught to all primary and post-primary students in Ireland up to Junior Certificate. It is optional - depending on the school - to Leaving Certificate. The aim of SPHE is to promote positive mental health and general wellbeing in children and adolescents by improving self-esteem, self-confidence, personal skills and introducing them to the concept of informed decision making. It also envisages that by the effective teaching of SPHE, the child will be able to integrate more fully into the community thus providing a greater sense of wellbeing and functioning. A report on SPHE in primary schools conducted by the NCAA (Primary Curriculum Review, Phase 2, 2008) indicated that in general, teachers believe that by introducing this subject, children are "becoming more aware of others, more concerned for them, having greater respect for others and their property and displaying better manners and courtesy" (Primary Curriculum Review, Phase 2, 2008, p.113). However, they point out that it is difficult to assess the level of success, as SPHE's goal is complete child development

and therefore it may take years for the material taught to become obvious. The short time allocation given to such a broad subject is also an area of concern for the teachers. A more in-depth review of the effectiveness is needed to correctly evaluate its role in promoting strong personal development of primary school children. The effectiveness of SPHE at post-primary level has recently been subjected to empirical investigation by the Department of Education and Skills (2013). The research found that students perceive SPHE effective in relation to the recognition of bullying behaviour and understanding the effects of substance abuse on individuals, families and society. Further, there are a number of findings of concern to the promotion and maintenance of mental wellbeing which are disconcerting; namely in relation to students' perceptions of its effectiveness in relation to assisting them cope with change or loss, understanding feelings and emotions, developing a positive self-image and coping with peer pressure.

The research suggests that SPHE is effective at teaching adolescents the facts but isn't as effective at teaching or supporting the adolescents in developing life skills, e.g. coping skills which can be extremely important for mental wellbeing. In light of this research and until the recognised limitations are addressed, consideration must be given to how post-primary students are

supported in the areas where they perceive deficits in SPHE.



More recently, physical exercise is being actively promoted as a means to maintain/improve a person's mental health. However, the evidence base regarding exercise at this juncture is not sufficiently robust in relation to its impact on mental wellbeing. Ekeland et al. (2009) found that exercise had some positive short-term effects on self-esteem in young people. However, this finding was based more on the fact that there are no known negative effects of exercise and is therefore more likely to improve self-esteem. A recent systematic review of the effects of exercise on depression found inconclusive results regarding its actual effectiveness and found that it was no more effective when compared with psychological or pharmacological therapies (Cooney et al., 2013).

The literature confirms that having at least one caring adult in a young person's life can act as a buffer against stress and lead to positive psychological functioning (Bogard,

2005). This is referred to by Headstrong and UCD (2012) as 'one good adult' and their survey found that 71% of young people reported receiving support from one good adult in their lives which was used to help them when things were difficult. They concluded that the presence of one good adult: affected the young person's level of life satisfaction; built self-esteem; helped the young person to cope better; and promoted a sense of belonging. Of key relevance is the finding by Headstrong and UCD that the absence of one good adult is related to an increased likelihood of self-harm and suicide. Therefore where possible, young people should be encouraged to consider whether one good adult exists in their lives and who this person might be.

Another such initiative is the Big Brother Big Sister (BBBS) programme which facilitates a 'match' or friendship between an adult volunteer and a young person and supports them to meet weekly for a year or more. According to Big Brother Big Sister Ireland (2008), this was envisaged as a support for the young person facing difficulties in their lives. This rapidly expanding programme was evaluated by the Child and Family Research Centre, NUIG in 2011. Findings were generally positive with young people with a mentor being more hopeful, having a greater sense of efficacy, having a sense of being better supported and their parents rating their pro-social behaviour more positively than the

parents of non-mentored youth. More tentative findings were in relation to social acceptance, school liking, plans for school and college completion and reduced drug and alcohol intake. Interestingly, the findings suggested that the BBBS programme was particularly effective for young people from one-parent families. Headstrong and UCD has also accumulated evidence on positive youth development programmes which give direction to service providers on how the programmes can yield the most benefits.

Therefore, policy implications for youth development in Ireland include youth being supported in their own communities through prevention and early interventions, emphasis on the role of support networks beyond the immediate family, a 'whole' child approach which is child-centred and services that are tailored to the developmental, educational and health needs of the individual child.

Community Dimension

A sense of community may advance economic security, sense of connectedness, attachment to networks within the community and participation in church or other community groups.

According to Headstrong and UCD (2012), the family, school environment and the wider community play a big part in the mental health of any young person.

Parental Dimension

Likewise, parents are vital to the overall mental health of our young adults. According to Clarke et al. (2013), Irish parents are very aware of the association between positive youth mental health and the development of coping skills, confidence, communication skills and supportive peer and adult relations. Parents see first-hand the pressures that young people are under and the impact that this pressure has on their mental health and they are often the resource that the young person shares their problems with (Headstrong and UCD, 2012). Therefore, parents need to be aware of where to seek and attain help and support.

Parenting programmes are considered to have the potential to improve the mental health and wellbeing of children, improve family relationships; and benefit the community at large (Sanders, 2008). The challenge with parenting programmes is to ensure that they filtrate down to those in society that require them, not those who are confident in their parenting role. Sanders adds that a public health approach is required to ensure that more parents benefit and that a societal level impact is achieved. Therefore, those at risk, as well as the general populations of parents, are targeted to attempt to reach as many as possible.

Unfortunately, recent research has found that parents awareness of local/national mental

health organisations is limited with under 30% indicating awareness of such organisations and the majority (69.3%) stating that they were not aware of any (Clarke et al. 2013).

Another source of support is the internet with Clarke et al. (2013) revealing that over two thirds of parents (69.8%) stated that they were likely to seek help on the internet if their child was going through a tough time. In addition, 22.1% of parents stated they had used the internet to search for mental health information in the past month. These findings, coupled with the findings that 24.6% disagreed that they could help their child through a tough time and only 57.4% agreeing that they felt equipped to help their child if they had a mental health problem, indicates the need for mental health resources and training for parents and also the need for developing an online youth mental health resource to meet parents' needs. Clarke et al. (2013) believe that an online resource should include: information about local services available to support young people; reliable information on mental health issues; guidelines about what to do if a young person is experiencing mental health problems; guidelines about how to promote wellbeing in young people and develop their communication skills, self-efficacy and coping skills; and resources to support parents' own mental health, in particular, stress management skills.

School Dimension

Schools have the potential to offer: a sense of belonging; a positive school climate; pro-social peer group; required responsibility and helpfulness, opportunities for some success; recognition of achievement; and availability of opportunities at critical turning points or major life transitions. According to the DoES/HSE/DoHC (2013), promoting the mental health of our young people in schools is everyone's business and not just the sole responsibility of any one individual, team or subject department. Schools are considered to be in a unique position to promote emotional wellbeing when certain factors exist. These include, according to the DoES/HSE/DoHS (2013):

- Providing a positive school climate.
- Ensuring a sense of belonging.
- Actively implementing school mental health policies.
- Having support systems in place to proactively support young people and their families, should mental health difficulties arise.
- Working collaboratively to prevent early school leaving.
- Develop positive teacher-student and teacher-parent relationships.
- Supporting the development of positive relationships with peers.
- Fostering expectations of high achievement and providing opportunities for success.

- Using positive classroom management strategies.
- Focusing on social and emotional learning and the development of problem-solving skills through SPHE.
- Providing support for teachers, including professional development.
- Encouraging young people to participate in extra-curricular activities.

These same guidelines recommend the adoption of the National Educational Psychological Service (NEPS) three-tiered continuum of support model for the promotion of mental health (NEPS, 2010) which state that all young people's mental health needs exist along a continuum ranging from mild and/or transient to complex and/or enduring. The three levels of the continuum include: school support for all; school support for some; school support for a few.

School support for all focuses on promoting positive mental health for all school members through a process of prevention, effective mainstream teaching and early identification and intervention for any difficulties. School support for some concentrates on identifying the smaller number of at risk young people who are already showing early signs of mental health difficulties. School support for a few put in place interventions for those with more complex and enduring needs, which may include external agencies that complement the work of the school. To action the

aforementioned guidelines, the Mental Health Awareness Initiative which aims to raise awareness among post-primary teachers nationwide on the topic of youth mental health, was instigated in September 2013. The initiative involves a 'train the trainers' approach to the transfer of positive mental health messages from 'Lead Facilitators' to 'Mental Health Promoters' to 'Whole School Teams'.

Until this mental health initiative is rolled out across the country and found to be empirically effective, due cognisance of the role stigma plays in young people's decision to access any school services must be taken into account (Bowers et al., 2013). A greater proportion of younger people versus providers of care viewed stigma as the biggest obstacle in accessing such supports. Another obstacle was the perceived scarcity of school-based mental health resources. Therefore, young people's involvement is critical in any mental health initiatives in schools. Also, Bishop (2003) suggests that the development of peer support in schools is worth considering as young people are more likely to share openly with their friends. The evidence base in relation to peer support has been garnered by Headstrong and UCD. Research has shown that female adolescents perceive receiving more support from friends; whereas their male counterparts perceive more support from their fathers (Colarossi and Eccles, 2003).

Workplace Dimension

Similarly regarding the workplace, the Health and Safety Authority (HSA) (2008) asserts that work can have a positive or negative impact on the health of both the individual and society in general. Positive impacts include an increased sense of social inclusion, status and identity and the provision of a time structure in someone's life (Harnois and Gabriel, 2000). It may also offer a context in which mental health problems can be addressed and positive employee mental health and wellbeing promoted (Leka and Cox, 2008). Conversely, the risk of anxiety, depression and burnout is amplified in environments that are stressful and pressured. Therefore unsurprisingly, the HSA (2008) affirms that at any one time there are many thousands of workers in Ireland either out of work or underperforming with some form of mental disorder.

According to the European Agency for Safety and Health at Work (ENWHP) (2011), problems associated with poor mental health remain the fourth most frequent cause of incapacity at work. This is often manifested through increased absenteeism and early retirement, often due to stress and depression (McDaid, Curran and Knapp, 2005), with a cost of EUR 136 billion to the EU annually (ENWHP, 2011). Therefore, this is something worth focusing upon to reduce both the emotional and financial costs. The

HSA (2008) makes certain recommendations that include:

- Providing a guidance or code of practice on managing stress in small and micro-enterprises.
- Implementation of the recommendations of the 2005 Report of the Expert Group on Workplace Bullying.
- Promotion of awareness among employees and employers of the HSA's revised Code of Practice on the Prevention and Resolution of Bullying at Work.
- Support of employers with initiatives that minimises the risk of violence.
- Supports initiatives aimed at the reduction of stigma associated with mental illness.

The ENWHP (2011) add that there should be activities aimed at the individual that increases emotional resilience, promote self-esteem, coping and social skills and enhance relaxation abilities. There should be active involvement of workers in the identification of key risk and protective factors as well as commitment and involvement of management. Also, the process must be evaluated to determine whether the intervention/programme was effective in meeting defined objectives.

However, despite what might be perceived as the excellent potential in the workplace for intervening with people with mental health difficulties, a systematic review by van Oostrom et al. (2009), found that the

insufficient robustness of the research conducted in this area to date meant that no firm conclusions regarding its effectiveness can be concluded at this juncture in time.

Marginalised Groups Dimension

Likewise, good practice considerations with marginalised groups such as LGBT and Travellers must be recognised and actualised. According to Meyer (1995), the stress associated with being part of a minority group is termed 'minority stress' caused by alienation from social structures, norms and institutions. This can create mental health difficulties among members of such groups, such as elevated levels of suicidal behaviour and self-harm; increased risk for depression, anxiety and substance use; lack of social support at the time of coming out; elevated levels of alcohol consumption; and elevated use of recreational drugs (Meyer, 2003). Therefore, communities must be aware of LGBT mental health issues and gay specific stressors by not assuming that we live in a hetro-normative society; to understand LGBT's health issues; and to understand someone from an LGBT persuasion's discomfort discussing their sexuality. The recommendations from the publication *Supporting LGBT Lives* (Mayock, 2009) are explicit on how the various sectors in the community, from education to employment, should respond to and support LGBT persons

in a positive manner. The consequences of the absence of support to date are clearly evident in the report, the sample comprised of 40% young people.

Likewise, communities need to be conscious of the specific risk and protective factors relevant to Travellers. According to Loftus and Fitzpatrick (2012), the needs of young Travellers must be seen in the context of Traveller lives, recognition of Traveller culture and an appreciation of what Travellers want. Travellers need to be facilitated to be proud of their identity, have a sense of belonging and have the right to reach their full potential without hiding who they are. Suicide is six times higher for Traveller men than men in the general population – it accounts for 11% of deaths among Travellers (All Ireland Traveller Health Study Team, 2010), 65% of suicide deaths occurring among those aged 30 years or less (Walker, 2008). It is seen as a recent phenomenon among the Travelling community. According to Loftus and Fitzpatrick (2012), suicide is not something that is discussed openly in the Traveller community or within a lot of Traveller families. Therefore, when suicide does occur, young Travellers may feel that they have no one to share their thoughts or feelings with.

Therefore, the development of Traveller inclusive practice should involve: awareness of how many Travellers are living in your local community; awareness of their culture and

values; consider culture awareness training or an information session facilitated by a Traveller organisation; and encourage Traveller men and women to become volunteers in your area/service.

Urban/Rural Dimension

According to HRSA (2005), the impact of mental health disorders is greater in rural than in urban areas due to three main problems: accessibility, availability and acceptability of mental health services. Unique challenges therefore exist in relation to ensuring that young people living in rural communities have access to mental health supports and services in a manner that is acceptable to them. Key accessibility challenges include transportation to and from services and ability to pay for these services. Acceptability of receiving psychological services in rural areas is lowered due to increased stigma and decreased anonymity (HRSA, 2005). The level of stigma towards mental health services has been shown to be greater, the smaller the community is (Hoyt et al. 1997). Also, because of the interconnected nature of rural communities, there is less anonymity when seeking such services (Helbok, 2003). Ironically, despite the tight knit nature of rural communities, rural residents face increased burdens of isolation and loneliness because of the geographic separation, but also because of the high level

of stigma (Smalley et al. 2012). Therefore, cognisance must be taken of these factors when establishing a youth mental health service in an area and a balanced view taken when considering a centralised or rural outreach (Mayo Mental Health Initiative, 2012). Of note the Mental Health Commission in Western Australia (2012) in their publication *Mental Health 2020* recommend the use of technology in rural settings to increase access to mental health services including the continued expansion of tele-psychiatry and video conferencing as a means of linking persons living in rural areas with urban based psychiatrists. They are also promoting a confidential telephone service, Rurallink as a single point of contact for people in rural and remote areas to obtain information and advice from experienced community mental health staff. The Mental Health Commission of Australia perceives the value of promoting mental health issues in rural and remote regions in order to cultivate resilient communities.

Primary Care Dimension

The DoHC (2006) postulates that, when a person experiences a mental health problem, contact with their general practitioner (GP) is usually their first formal attempt to seek help. If the problem is identified and treated by the GP, or referred on to the local mental health service, then this can be key to a timely and

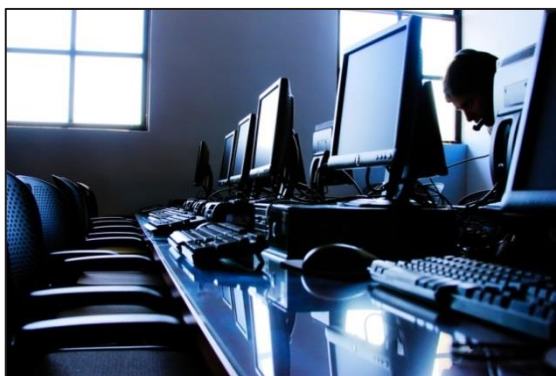
successful resolution of their mental health problem. According to Tylee et al. (2007), young people attend primary care regularly and therefore this service is ideally placed to address any possible mental health difficulties opportunistically. But these opportunities are not always availed of (Martinez et al. 2006). A recent survey by the Irish College of General Practitioners (ICGP) found that 68% of GPs indicated that they had no specific training in mental health (Coptly and Whitford, 2005). Therefore, this presents the challenge that if primary care is to have a pivotal role in the addressing mental health needs of the population, staff in primary care must feel better equipped to support people in this area. However, great efforts are being made to counter these challenges with the publication of such documents as 'Child and Adolescent Mental Health: Diagnosis and Management' (O'Keeffe et al. 2013) which focuses the attention of primary care on the challenging area of child and adolescent mental health and the unique requirements of this group. Recent Irish research found that there are many processes that would increase screening and treatment, thereby supporting young people's mental health in primary care to (Leahy et al. 2013). These include:

- Raising awareness
- Training
- More systematic and formalised assessment

- Youth-friendly practices such as communication skills and ensuring confidentiality.

Others include:

- Closer inter-agency collaboration and training for all healthcare professionals working in primary care.
- On-going motivational work with young people by:
 - Setting achievable treatment goals.
 - Supporting transition between child and adult mental health services.
 - Recognising primary care's longitudinal nature as a key asset in promoting treatment engagement.



Also, the social importance of mental health is widely recognised (Keenaghan et al., 2012). Rather than adhering to a purely medical perspective of care, social prescribing in primary care is a relatively recent concept and another care option, describing the use of a non-medical support to address the needs of people whose mental health is affected by

depression and anxiety. These authors recognise the diverse variety of forms that comes under the social prescribing umbrella such as bibliotherapy, exercise referral, self-help, CBT-based approaches, social support and more recently, -assisted CBT. However, Keenaghan et al. recognise the importance of training and support for GPs in the context of social prescribing to ensure its appropriate use, actualisation and evaluation.

Spiritual Dimension

Bronk et al. (2003) believe many individuals find their way to a sense of purpose through some kind of religious experience. According to Van Dyke and Elias (2007), religion is sometimes used as a coping mechanism for both youths and adults. They add that sources of religious support include a relationship with God, prayer, personal meditation, a belief system that fosters life meaning and social support systems found in religious congregations. Frank and Kendall (2001) note that many religions value optimism, thus motivating followers to reframe stressful life events in a more positive light. An association between religiosity and happiness, purpose and self-actualisation during late adolescence has been found by French and Joseph (1999). This research was supported further by that of Peterson and Seligman's in 2004 who found that adolescents with a strong sense of religion are more likely to associate with like-minded peers, thereby reducing peer pressure and exposure to risky situations. Attendance

at religious services, self-ranked religiosity and positive interpersonal religious experience were associated with lower levels of depressive symptoms (Pearce et al., 2003). A systematic review by Wong et al. (2006) observed that the majority of research (90%) carried out suggested that there was a correlation between adolescents with a greater level of religiosity or spirituality and better mental health. Cotton et al. (2005) found that adolescents with a higher level of spirituality, in particular existential wellbeing, had fewer depressive symptoms. Therefore the potential of religiosity/spirituality as a positive mental health intervention for young people should not be excluded in an ever-growing pluralist Irish society.

Organisational Dimension

According to the Department of Health and Children (2006), the provision of a comprehensive mental health approach involves a partnership and collaboration between many stakeholders, namely statutory and voluntary agencies, primary care, as well as the wider community. Headstrong is one such vital link in its role as the National Centre for Youth Mental Health. According to Headstrong and UCD (2012), their approach is to recognise and develop existing capacities within communities in Ireland, through three distinct and mutually supportive approaches: service development

(Jigsaw), advocacy and research. Jigsaw is considered to be a community-based solution which is guided and informed by young people to ensure that programmes are relevant, accessible and appropriate. Advocacy refers to young people being part of Jigsaw development and any other youth mental health initiative while up-to-date research deepens our understanding of young people's mental health needs. Headstrong and UCD contend that alignment to national and international policies regarding youth mental health, as well as the integration of clinical governance and regular evaluations, ensures the safety and quality of the service delivered to young people and communities.

Headstrong and UCD (2012) state that Jigsaw's core premise is that young people are embedded in multiple and intersecting systems (family, peers, schools, services, neighbourhood), but that these systems do not necessarily connect and function in ways that support them as they mature. Therefore, the Jigsaw model seeks to strengthen a community's capacity to support its young people by:

- Engaging young people in programme design and planning - increasing the likelihood that the result would be relevant.
- Being non-stigmatising and accessible.

- Building an integrated network across the community through training and support for providers.
- Making programmes that strengthen resilience more available.
- Identifying young people at risk of mental illness earlier and providing support.
- Ensuring that there are clearly defined pathways to support and treatment at all levels of need.
- Promoting awareness of mental health issues, while reducing the stigma associated with help-seeking.
- Encouraging communities to view their young people as valued contributors.

All of these principles attempt to ensure consistency in the approach towards youth mental health in the young person's community.

Likewise with Meitheal, the national practice model for all agencies working with children, young people and their families. According to the Child and Family Agency (2013), Meitheal attempts to ensure that an integrated working approach exists among all agencies working at the frontline with young people. Therefore, duplication of care should be avoided and multi-agency working will be greatly enhanced. This model of working was evaluated by Forkan and Landy (2011) when they evaluated the Identification of Need (ION) process, the forerunner to Meitheal, in Sligo/Leitrim and Donegal. They found much

evidence of success from the perspectives of high levels of engagement from a wide range of agencies in the statutory, voluntary and community sectors; high levels of uptake of ION training; a receptive response from parents; and an increase in the delivery of support services to families.

Mental Health Services Dimension

Another crucial area of the overall youth mental health care is the mental health services (MHS) and the way that they are provided to young people who need such support. The initiation and development of CAMHS teams was considered as the optimum means of supporting young people's mental health. However, the roll out of same has not been at the aspired pace.

The objectives, as set out by the DoHC (2006) to have 99 teams nationwide found that in 2011, only 63 of these teams had been established (HSE, 2011) with staffing on these teams at 38.1% of that recommended. Hence, waiting lists of 2,056 children and adolescents existed in 2012, with two thirds of these waiting more than three months.

Interestingly, the Independent Monitoring Group (IMG) (2012) of the Vision for Change document, details the focus to date on progressing CAMHS inpatient facilities while Sweeney (2013) acknowledges that Ireland

has not yet developed a strategic framework for CAMHS that would focus specifically on areas such as policy, organisation, management and specific CAMHS related goals. Other barriers to effective CAMHS services include young people's concern regarding stigma, their fear of being judged as a failure, lack of knowledge of how to access services, long waiting times, while enabling factors include, young people's ability to relate to the service environment, how they experience inclusion, as well as their relationship with staff (Buckley et al., 2012).

A review of CAMHS in Sligo/Leitrim in late 2013 has set out a change process for mental health services for children and young people in this area. Development of a more integrated model of service for CAMHS with greater involvement of service users and families in service planning and as partners in their own care are amongst the recommendations emerging from this process. The review also identified the need for a wide range of services, including other HSE services and community-based services and supports to work together to develop effective care pathways into and through CAMHS in order to support the development of effective services that can respond in a timely way to the needs of young people. Some of the high-level needs identified by

parents consulted as part of the CAMHS Review include:

- Need for shorter waiting times to access services.
- Need for consistency in doctors/health professionals to enable young people and parents to establish relationships.
- Effective communication between staff and parents to enable parents to be partners in their young people's care.
- Ensure that CAMHS and other community-based services are both as child-centred and adolescent-centred as possible.
- A single plan for care that everybody involved is clear about, including young people and parents. Parents wanted to be clear about expected outcomes and young people's progress towards planned outcomes.
- Transitions emerged as an area of concern for parents of young people using CAMHS – transition from child and adolescent services to adult services at age 18; transition to secondary school, transition from acute inpatient mental health services and transition to discharge from CAMHS were all identified as critical points from parents' perspectives. They wanted planned processes and support for the young person and the family to ensure that these transitions are

managed well (Personal Communication- Kate Ferguson, April 2014)

Mental Health Commission (2007) consider that ideally, a quality framework from a mental health perspective should revolve around the following eight themes:

- Provision of a holistic seamless service and the full continuum of care provided by a multi-disciplinary team.
- Respectful, empathic relationships between people using the Mental Health Services and those providing them.
- An empowering approach towards service delivery.
- A quality physical environment that promotes good health and upholds the security and safety of Service Users (SUs).
- Easy access to the service.
- Family/chosen advocate involvement and support.
- Staff skills, expertise and morale in existence.
- Systematic evaluation and review of MHS underpinned by best practice which will enable providers to deliver quality services.

Policy Dimension

Many factors impact on young people's mental health, thus policies and strategies that are linked to these factors are all relevant and important. Therefore, policies on matters such as education, social welfare and justice are equally as relevant to a young person's mental health as they will greatly impact on the protective and risk factors in someone's life.

Specifically regarding mental health, international policy has prompted the shift from an institutional to a community-based model of care. Relevant national policies and strategies include the national mental health policy document 'A Vision for Change' (DoHC, 2006) and the establishment of the HSE National Mental Health Clinical Programmes which focus on early intervention programme for first episode psychosis; eating disorders; and self-harm. The establishment of the new Child and Family Agency under the Department of Children and Youth Affairs in January 2014 will ensure that needs of children and families are met in our country. In March 2011, WHO Europe announced the development of a new mental health strategy for Europe (Callard and Rose, 2012). Its focus is mainly around four key areas: promoting wellbeing; preventing mental health problems; reducing stigma; and improving mental health formation.

A recent mental health strategy in England focuses upon early intervention and prevention (Parish, 2011). Priority areas include the early years, children, young people and families, access to psychological therapies and drug misuse. The emphasis in policies from a mental health perspective is ensuring that people with early signs of poor mental health are identified to prevent their condition becoming worse. Psychosocial approaches are increasingly being considered as 'gold standard'. A recent Mental Health Strategy for Scotland (The Scottish Government, 2011) and Wales (The Welsh Government, 2012) set out very similar aspirations and plans for achievement as that set out in England, Ireland (Vision for Change, Mental health Policy, 2006 and Reach Out – Suicide Prevention Strategy in Ireland, 2005) and indeed Europe.

The existence of these policies and strategies offer focus and aspirations for good mental health, prevention of mental illness and caring for those with mental illness. An example of the effects of such policies is in relation to the youth suicides in Australia which according to Morrell et al. (2007), began to rise in 1970 and reached their highest level in 1997, had by 2007 dropped dramatically. This reduction was attributed by many to Australia's National Youth Suicide Prevention Strategy which begun in 1999. This had included a strong public health campaign to promote help-

seeking and de-stigmatise mental illness (Hickie et al., 2007).

Societal Dimension

According to the WHO (2013), there is a discrepancy between two widely held positions regarding mental health. One is that mental health is an integral part and vital concern of individuals, communities and societies throughout the world. The other is the lack of mental health promotion, low levels of service availability and the ongoing problem of discrimination and stigma against those who have a mental health diagnosis. In addition, the financial cost is exemplified in a recent analysis by the World Economic Forum who estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to \$16 trillion (US dollars) over the next 20 years (Bloom et al., 2011).

Therefore, a very real argument exists to consider how these personal and financial costs can be reduced. However, for every such argument, there appears to be an equally forceful counter-argument, thus challenging the investments and attitudes of governments in the area of mental health. According to the WHO (2013), such debate is well influenced by the following:-

- Whilst mental disorders are a major cause of the overall disease burden, they are not a leading cause of mortality globally.
- Mental and physical health are core elements of individual welfare, other components of welfare such as income and consumption are equally important.
- Mental disorders reduce labour productivity and economic growth, the true impact of mental disorders on economic growth is not well known.
- Access to health is an essential human right, persons with a wide range of health conditions currently lack access to appropriate health care.
- Stigma is an ongoing difficulty in mental health care provision as well as the lack of advocacy for better services in mental health.

Therefore, the debate isn't clear cut in the direction of increased spending in this area until further clarity arises in the areas of disease burden, stigma and more comprehensive advocacy structures.

Challenge of Stigma

The biggest challenge to a positive attitude being held by any population is that of stigma (DoHC, 2006). According to *See Change* (2012), six in ten reported having no personal experience of mental health problems. However, they question whether this is

related to underreporting due to perceived stigma. Interestingly, seven in ten accept that anyone can develop a mental health problem with one in two agreeing that mental health issues are very common, but not well understood. Regarding the workplace, whereas two in three strongly agree that those with mental health problems should have the same rights as others, only 46% agree with this in respect of job rights, thus indicating that stigma is felt more keenly in the workplace. Also, whereas three in every four agree that mental health should be openly discussed, one in two agree that they would not want others to know if they had personal mental health problems. Worryingly, one in four agree that it would be hard to talk to someone with mental health problems. Of significant relevance is the fact that family and friends are considered to be as helpful as mental health professionals in dealing with mental health.

However, people stated that one in three of them would hide mental health problems from friends and one in ten wouldn't disclose issues to their family. One in three states that their family would hide the diagnosis from their wider community. Of particular relevance to this study, among 18-24 year old males, 53% said that they would not know what to do to help someone and 29% would delay seeking help for themselves for fear of someone knowing about it. Overall, since a similar study was carried out by the HSE in

2007, there has been some progress in lessening stigma, with 25% less people having less difficulty talking to someone about their mental health problems. However, further work has to be done in the workplace, among farmers and 18-24 year old males.

McGabhann et al. (2010), in an Irish study found that 95% of those with a chronic mental health issue reported some experience of unfair treatment because of their mental health problems, including making or keeping friends, being treated unfairly by family, being avoided by people who knew they had a mental health problem, being treated unfairly by mental health staff and being treated unfairly in their role as a parent.

Two types of stigma exist: the one that the person with the illness has towards themselves; and the one that society holds towards those with a mental illness. Boyd et al. (2014) talks about internalised stigma or self-stigma, all of which correlates with higher depression, lower self-esteem and greater symptom severity.

Mestdagh and Hansen (2014), in a review of qualitative literature on stigma as experienced by patients with schizophrenia receiving community mental health care, found the recipients of this care still experience stigma and discrimination.

Three major themes were identified from the 18 studies reviewed and need to be taken into

consideration when implementing an adequate community mental health care:

- a) The continuing existence of stigma inherent in the health care setting.
- b) The importance of relational aspects of stigma encounters in daily life.
- c) The significance of the behavioural aspects related to previous stigma experiences and beliefs among patients.

The involvement of service users in the planning and implementation of programmes to fight stigma and discrimination has been found to have a significant positive effects in terms of reducing stigma (Jouet et al., 2013). The challenge for further research is to understand how such service user involvement can be maintained over time.

One way of reducing the level of self and societal stigma is the implementation of life-skills programmes for those with chronic mental illness which attempts to enhance independent living and quality of life for those with the mental illness.

Examples of such programmes include: communication skills; financial awareness; domestic tasks; and personal self-care. However, in a systematic review by Tungpunkom et al. (2012), little evidence exists to suggest life-skills programmes are effective for people with chronic mental illness.



Likewise, mass media interventions are often perceived as effective interventions for reducing mental health related stigma. However, a recent systematic review by Clement et al. (2013) found that more high quality research is required to establish the effects of mass media interventions on the area of discrimination against those with mental health difficulties. The evidence to date is insufficiently robust. It is also noteworthy that the review found that there were no studies focusing upon the impact of media interventions on the attitudes of children and adolescents to mental health.

Conclusion

The aforementioned six dimensions need to be considered when implementing mental health strategies or practice in any region to promote or maintain young people’s mental health. These encompass domains that range from the intrapersonal resilience of any of our citizens and their individual wellbeing to the overall views and attitudes, often represented by the level of investment that our society

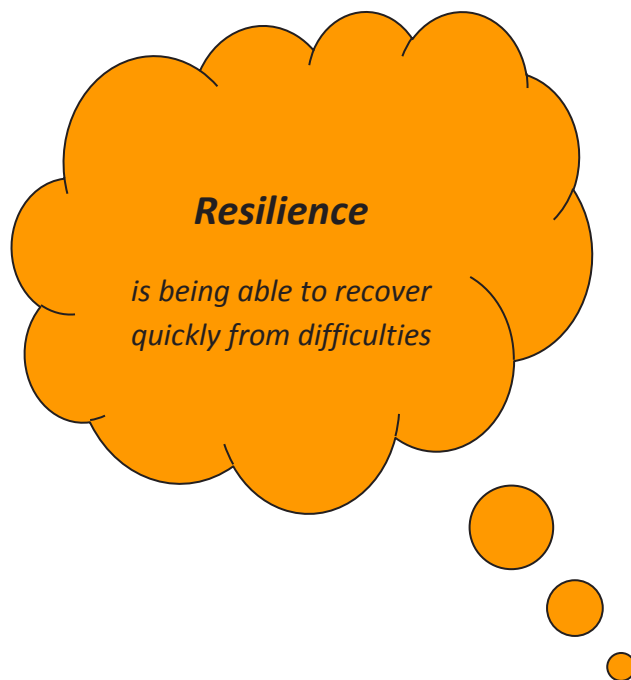
holds regarding mental health. To ensure that a comprehensive mental health approach is available, there must be evidence based interventions that address all of the six domains. Therefore, rather than assuming that any approach is successful in its aims, ongoing evaluations and research should back-up such claims to ensure that money is invested wisely, especially due to the fact that the argument for investment in mental health is often a complex one to make. Clear policies and strategies, updated at regular intervals



should ensure that services, both statutory and voluntary are positioned well to ensure mental health promotion as well as the provision of a comprehensive mental health service. It is now fully appreciated that mental health is not the responsibility of any one group or organisation but is *everyone’s business*. Therefore clarity is needed in such areas as parenting programme provision, schools and workplaces to ensure that token approaches to mental health care are not adopted but are guided by best practice from



national and international perspectives. Likewise, ongoing efforts to engage with marginalised groups, who have been shown to be at increased risk in our society is imperative. The overall approach of mental health care cannot only be reactive and treatment-orientated. Rather, the promotion of positive mental health should embrace all age groups in society.



Chapter 3: Methodology

Introduction

This chapter details the methodology used to achieve the aims set for exploration. A mixed methods research design was deployed with equal importance being attributed to each element – quantitative and qualitative. Implementation was concurrent. A multi-pronged sampling strategy was utilised to generate participants. Data were collected via the following mediums. Survey x2 (Adolescent(12-18yrs) and young people (>18-25years))

- a) Individual interviews
- b) Focus group interviews
- c) Written submissions

Data collection took place between July 2013 - January 2014. Integration of data sets occurred at time of analysis. A modified version of the socio-ecological framework served as the study's conceptual framework. The framework was considered sufficiently expansive and dynamic to capture the many varied influences on a young person's mental wellbeing. A number of strategies were instigated to publicise the study in the region namely:

- Development of a study specific title and logo- *Mind Your Head: A Youth mental health study*

- Development of a study specific Facebook page & website-
<https://www.facebook.com/MindYourHeadStudy>
<http://www.mindyourheadstudy.com/>
- Development of a promotional video which was posted on Youtube / Facebook page / Webpage
www.youtube.com/watch?v=q4kSWUhTgw (1315 hits up to March 18th 2014)
- Participation in radio interview: Ocean FM 2/9/2013
- Launch of research study: 3/9/2013.

Ethical approval for the study granted in April 2014.

Quantitative Phase

The quantitative phase of the study involved the development and administration of two study-specific surveys, involving adolescents aged 12-18 years and young people >18-25 years. Emergent data were subjected to descriptive statistical analysis.

Sampling and Recruitment of Adolescents (12-18 years)

The research team sought to recruit a sample of adolescents enrolled in post-primary schools representative of students enrolled in the 26 post-primary schools in the Sligo/Leitrim/west Cavan region. The aim was to initially generate a sample of schools that reflected the distribution of schools with



regard to county population density, gender composition, location (urban: rural), school type (secondary/vocational/community), DEIS, non-DEIS and subsequently engage in the purposeful selection of students from the selected schools. Fourteen schools (54%)

were purposefully selected to serve as the sampling frame. Seventy-eight per cent (n=11) of the said schools from across the region agreed to the research team accessing their student population (Tables 1 & 2).

Table 1: Geographical distribution of schools

Sligo	west Cavan	Leitrim
7	1	3

Table 2: Characteristics of post-primary schools

DEIS school	School type	Gender classification	Location
Yes	Vocational	Mixed	Cavan
	Secondary	Mixed	Sligo
	Secondary	Mixed	Sligo
	Secondary	Mixed	Sligo
	Secondary	Boys	Sligo
	Secondary	Mixed	Sligo
	Vocational	Mixed	Sligo
Yes	Vocational	Mixed	Sligo
	Vocational	Mixed	Leitrim
	Vocational	Mixed	Leitrim
	Community	Mixed	Leitrim

Adolescent Survey Instrument

The survey contained four sections comprising of forty one questions. The majority of questions were closed ended and only required the adolescent to rank and/or tick the appropriate responses. An opportunity to express in writing what they believed various individuals/ bodies could do to support adolescents’ mental health was also afforded to participants in the form of open questions.

Section 1 sought to ascertain a range of demographic information as detailed in Table 3.

Table 3: Focus of Section A questions: 12-18 questionnaire

Gender
Age
Year in school
Nationality
Number of children in family
Location of family home
Who they live with
Parents’ marital status
Who owns family home
Parents’ employment status
Location of parents’ employment
Adolescent physical and mental wellbeing
Family physical and mental wellbeing
Caring responsibilities

The second section of the survey sought to ascertain adolescents' understanding of good and poor mental health and who contributed to their comprehension. In order to ascertain the region's adolescents specific mental health needs, the findings from the My World Survey study were used to focus the content of five questions. Prospective participants were asked to rank the three leading issues which were sources of distress to them with regards to themselves; school; home; friends and their local community.

Section 3 sought to identify if the adolescents talked to someone when they were distressed; who was that individual; their appealing attributes; and the coping mechanisms the adolescents deployed when they were distressed.

The final section of the survey examined the supports adolescents perceive are available to them and what would facilitate or hinder their access to these supports.

The survey instrument was developed in conjunction with adolescents and piloted prior to use.

Data Collection Process

Each post-primary schools' principal was written to and met in person to explain the study aim and procedures. In consultation with the researchers, a year or selection of years from each school was chosen for participation to ensure that all post-primary

school years would be represented in the final sample. The following process was agreed for data collection.

1. Research packs containing: information sheets (parent and adolescent specific); parent consent form; adolescent assent form; questionnaire; and support services card were issued to each student in the selected year(s).
2. Parents were made aware of the research pack by a school-initiated text message.
3. A second text message, reminding parents of the survey were sent the day before planned data collection.
4. A research team member met selected students in person on the day of data collection to:
 - a) Explain study and address any queries
 - b) Show promotional video
 - c) Ensure consent forms were signed
 - d) Facilitate students to complete survey.
 - e) Scrutinise all surveys for any indication of suicidal ideation/mental distress with designated liaison school personnel.

The final sample achieved was 654 with all school years represented (Table 4).

Table 4: Categorisation of sample size by school year

School year	n
1 st year	129
2 nd year	181
3 rd year	83
Transition year	131
5 th year	69
6 th year	61

Sampling and Recruitment of Young Adults (> 18-25 years)

The aim was to recruit a sample of young adults across the region who were in third-level education; enrolled on national training courses/schemes; in employment (full/part time); unemployed; and members of marginalised groups where feasible.

A multi-pronged approach to recruiting this cohort of young people was deployed. The Presidents and equivalent of the two third level institutions and two Centres for Education in the region were contacted about the research study and permission sought to access their student/participant cohorts. Two colleges who run post-leaving certificate (PLC) programmes were also contacted with one agreeing to participate within the study time frame. Organisations, identified as potentially employing young adults in the region, (manufacturing; retail; restaurants) were contacted by letter and in person to gain consent to access young persons in their employment. The region hosts one prison and permission to access the young men in

custodial care was sought and received from the prison governor. A significant challenge that emerged was accessing young people who were under the age of 25 in full-time employment. For example, in one major manufacturing plant in the region, only two individuals are under the age of 25. The majority of young people were engaged in further education/training and in part-time employment. Young unemployed persons were recruited through snowball sampling. The achieved sample size was 280. The response rate was not amenable to quantification as the research team had to rely on gatekeepers to distribute questionnaires to young people who met the study criteria and therefore the exact number that were actually distributed by gatekeepers was difficult to determine.

Young Adult Survey Instrument

As per the adolescents' survey instrument the survey contained four sections comprising of forty five questions. The majority of questions were a form of closed ended questions and only required the young adult to rank and/or tick the appropriate responses. An opportunity to express in writing what they believed various individual/bodies could do to support young person's mental health was also afforded to participants. The focus of some of the questions differed from the adolescents' survey to reflect issues potentially pertinent to young people in the

targeted age bracket. Section 1 sought to ascertain a range of demographic information as detailed in Table 5.

Table 5: Focus of Section A questions 18-25 questionnaire

Gender
Age
Nationality
Marital status
Where they live
Who they live with
Sexual orientation
Location of home
Highest qualification to date
Employment status
Student status
Qualification at completion of course
Adolescent physical and mental wellbeing
Family physical and mental wellbeing
Caring responsibilities

The second section of the survey was similar in nature to that of the adolescents' survey but also included questions in relation to employment and unemployment and recognised the potential differences between young adults' family structure/relationships to that of adolescents.

The third and fourth sections of the survey were very similar in content and structure to that detailed previously with regards to the adolescent survey. The survey instrument was developed in conjunction with young people and was piloted prior to use.

Data Collection Process

All participants were furnished with a research pack which contained a letter of invitation; survey instrument; information sheet; services support card and a stamp addressed envelope (where appropriate). The survey instrument was distributed in person to the majority of all participants by members of the research team or designated gatekeepers. Where feasible, the completed survey instruments were also collected in person although participants were also given the option of returning their completed surveys by mail. Two participants chose to complete the survey online via Survey Monkey. Consent was assumed on return of completed survey.

Data Analysis of Surveys

The quantitative data generated from the surveys were analysed using SPSS (Version 21). Descriptive statistical analysis facilitated the meeting of the studies aims. The findings are presented in both tabular and written form. Percentages have been rounded to the nearest tenth. Some questions allowed participants to tick multiple response categories and, where appropriate, the analyses reflect this. The textual data from the open-ended survey questions were transcribed and analysed using the socio-ecological model framework.

Qualitative Phase

The qualitative phase involved the conduction of a series of one to one individual interviews; focus group interviews and the compilation of written submissions from individuals and groups.

Individual and focus group interviews

Nineteen, individual, one to one and fifteen focus group interviews were conducted across the region. In total, one hundred and twenty nine individuals participated in interviews.

Sampling and Recruitment of Interview Participants

The research team purposefully selected a range of persons to participate in the interviews-adolescents, young people, parents and various stakeholders who engage with young people and have an appreciation of issues that can potentially challenge and promote their mental health. The Youth Mental Health Initiative Research Advisory Group also guided the selection of participants for interview (Table 6 & 7 overleaf). Sampling continued until data saturation was achieved.

Interview Schedules

Semi-structured interview schedules were developed for both the individual and focus group interviews. They addressed the following areas broadly:

Positive mental health – identification of needs; existing and required resources and supports from an intrapersonal, interpersonal and wider community, organisational and societal perspective.

Mental Distress – identification of needs; existing and required resources and supports from an intrapersonal, interpersonal and wider community, organisational and societal perspective.

Mental ill-health - identification of needs; existing and required resources and supports from an intrapersonal, interpersonal and wider community, organisational and societal perspective.

The manner in which these broad topic areas were addressed was contingent on the individual and groups being interviewed.



Table 6: Characteristics of individual interview participants

Adolescents (n=5)	Parents (n=3)
Male, aged 12 years – Leitrim	Mother, whose daughter engages with mental health services (Sligo urban)
Female, aged 13 years – Sligo	
Female, aged 16 years – Leitrim	Mother, whose son engaged with mental health services (Sligo rural)
Male, aged 18 years with mental health issues- Sligo	Mother, son aged 13years – Leitrim Rural
Male, aged 18 years – Leitrim	
Young Adults (n=4)	Stakeholders (n=6)
Unemployed Male – Leitrim	Professional Counsellor – Sligo
Employed Female – Leitrim	Arts/Youth Theatre Group Leader – Sligo
Student Union President	Youth Leader/Manager who covers Sligo/Leitrim region
Female with Mental Health Issues – Leitrim	Family Support Worker – Leitrim
	Post-Primary Teacher – Sligo
	Student Support Services Officer – Third level Institution
	Mental Health Professional

Table 7: Focus group interview cohorts

Young people	Stakeholders
12-18 yrs	Youth Mental Health Initiative advisory group (n=25)
Female Adolescent Travellers group (n =6)	Post-Primary Teachers and Third Level Lecturers (n=5)
Youth Arts group (M=6; F=1) (n=7)	General Practitioners (n=7)
Comhairle (Leitrim) (M=5; F=3) (n=8)	Community Mental Health Teams x 3 (Sligo & Leitrim) (n=19)
>18-25 yrs	Parents (n=3)
Youth Theatre Group (Aged 22-25; M,5; F,1) (n=6)	
Young people on National training scheme (Aged: 18-23 years; F,6) (n=6)	
Unemployed young people (Aged: 18-24 M, 6) (n=6)	
Disabled adolescents and young adults (Aged 16-23; M,4; F,3)(n=7)	
Lesbian, Gay, Bisexual and Transgender group (Aged: 20-25 years, M,3; F, 3) (n=6)	

Data Collection Process

Interviews were conducted at a time and venue that suited participants. Participant informed consent was obtained prior to interviewing. Ground rules in relation to the conduction of the focus group with regard to confidentiality were established and agreed prior to the commencement of the focus group interviews. The duration of the individual interviews ranged from 30 minutes to 2 hours and 45 minutes, with the average duration being 90 minutes. The duration of the focus group interviews ranged from 40 minutes to 1 hour: 30 minutes with the average being one hour. A debriefing period was held where required following interviews.

All interviews were digitally recorded.

Data Analysis

All interviews were transcribed in full. Members of the research team reviewed all transcripts prior to analysis to remove any identifying information. The interviews were thematically analysed using the dimensions of the conceptual framework as a guiding framework.

The final phase of data analysis involved a synthesis phase, where the findings from the interviews were reviewed in tandem with the findings from the survey. This process of triangulation enhances the credibility of the findings.

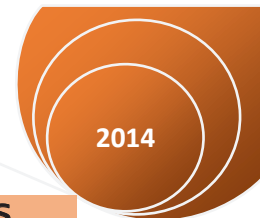
While the research team strived to value and acknowledge the contribution of each individual/group, the constraints of report writing require that the more prevalent issues are reported.

Written Submissions

A template for the written submissions was developed by the research team and located on the study specific webpage and on *Survey Monkey*. It comprised of seven questions:

1. What do you consider are the main needs of young people in relation to their mental health?
2. What supports/ resources are you aware of that already exist to meet their needs?
3. What are the strengths of these resources?
4. What are the limitations of these resources?
5. Are there additional supports/resources required in your local area to meet the mental health needs of young people?
6. What do you think might prevent young people from accessing these supports/ resources?
7. Open question inviting any additional information participants wished to contribute.

One hundred and eighty seven individuals; statutory organisations; voluntary groups and the general public were invited via letter, the



local press and radio advertisement to submit a written submission. Sixty seven written submissions were received (Table 8).

Table 8: Characteristics of written submission sample

(Note: Participants could select more than one identifying characteristic.)

Participants	n
Adolescents (12-18 years)	12
Young adults (>18-25 years)	7
Parent	10
Service user	2
Voluntary organisation	11
Service provider	28
Others (e.g. GPs, teachers, ex -service user, CAMHS)	10

Credibility of the Findings

The credibility of the data has been attained as a result of the following: prolonged engagement in the field, multiple but supporting modes of data collection; the perspective of multiple persons/cohorts on the topic; the maintenance of an audit trail and the inclusion in the report of multiple excerpts from the data generated, clearly indicating how the findings advanced were generated. The credence of the findings is further substantiated by concurring with previous research.

Ethical Considerations

Ethical approval was received from the Research Ethics committee of Sligo Regional Hospital in April 2013. A research protocol developed by the research team in conjunction with the research advisory group, ensured that the ethical rights of all participants were upheld in relation to autonomy; beneficence/mal-beneficence; confidentiality and privacy. It also detailed the supports available to any young person/parent and or guardian in relation to mental health. The written consent/assent of all guardians/participants to partake was ascertained. Consent was assumed on completion of the young adult surveys only.


Any perceived issues of concern emerging from the adolescents’ survey administered in the schools were highlighted to the schools prior to the researchers leaving the school premises. Participants who were interviewed had the freedom to stop the process at any time and make explicit what information they wanted to be utilised.

The research team developed a wallet size information card that contained the contact details of a range of support services in the region. This card was given to all participating young people. Data were stored in accordance with the Data Protection Act (2003).

Conclusion

The research sought to: establish the current mental health needs of young people between the ages of 12 – 25 years in the Sligo / Leitrim / west Cavan area and to identify the current resources for youth mental health care and the strengths and weaknesses of such resources. Ethical approval was received from Sligo Regional Hospital's Research Ethics Committee.

A mixed methods research design was utilised and involved the collection of data through surveys; individual interviews; focus group interviews and written submission. A multi-pronged sampling strategy achieved a sample of 925 survey participants; 129 interview participants and 67 written submissions from individuals and groups. Data sets were integrated at time of analysis using the lens of a socio-ecological model as a conceptual framework.



***“Positive self-love
or self-acceptance is
considered as one of the
most important
influences on mental
wellbeing”***

(Service Provider)

Chapter 4: Findings

Introduction

This chapter provides a synthesis of the findings generated from the multiple modes of data collection deployed, in an integrated manner. The findings will address the mental health needs of young people in the region, the needs of key stakeholders and young people in relation to service provision and perceived gaps in service provision to support the mental health of young people in the region.

The findings have been apportioned to one of the six core dimensions of the modified socio-ecological framework. However, it is recognised that some of the issues, such as stigma, could traverse all or some of the dimensions depending on an individual's perspective. The framework and the researchers respect this fluidity and have apportioned issues only to facilitate the presentation of the findings in a comprehensible manner.

The data analysis would suggest that the majority of young people who participated in the study are functioning well. They recognise their personal responsibility to mind their mental health and equally recognise what/who supports them in this activity and what resources/supports could assist them further. The stakeholders and young persons'

perspective on needs; services and supports were surprisingly similar.

Profile of Survey Participants

The profile of interview participants/groups is detailed in Table 6 and 7. Table 8 details the profile of the groups/individuals who submitted written submissions. Table 9 and 10 provide a précis of the two cohorts of survey participants (n=925). As detailed, three hundred and eighty five males and five hundred and forty nine females participated. The gender differential was more marked in the older cohort. All age groups were represented with the majority emanating from the 14-16 age group (n=341). The majority of participants were part of two parent families (81.9% n=758). Seventy six young adults (27.1%) were married. The Leaving Certificate was the highest level of education attained by approximately two-thirds of the young adult cohort.

A larger proportion of the young adult cohort reported being affected personally or through their family by health issues, with approaching twenty-five per cent declaring they had caring responsibilities. Approximately half of the 12-18 year old cohort reported that both of their parents were in employment. Seventy per cent of the young adult cohort were in employment; the majority being in part-time employment (n=167). Less than 28% of all participants reported that they lived in an urban area (27.4% n=254).

Table 9: Demographic data: 12-18 year old survey participants {%,(n)}

Gender	Which best describes your home set up?	Family Home status	Are you affected by any illness/disability?
			Yes No
Male 47.6% (311) Female 52.4% (343)	Two parent family: 80.2% (522) One parent family: 12.6% (82) One parent as a result of death of one parent: 3.7% (24) Foster family: 0 Blended Family: 2.5% (16) Living with Guardian: 0.2% (1) Other: 0.9% (6)	Owned by your parents: 79.2% (514) Rented from the council: 9.1% (59) Rented from a private landlord: 7.1% (46) Hostel style accommodation: 0 Traveller designated accommodation: 0 Foster home: 0 Don't know: 2.8% (18) Other: 1.8% (12)	Physical illness: 1.5% (9) Mental Illness: 1.9% (12) Physical Disability: 1.1% (7) Learning Difficulty: 7% (44)
Age profile 12: 10.1% (62) 13: 25.3% (155) 14: 18.4% (113) 15: 20.4% (125) 16: 16.8% (103) 17: 6.5% (40) 18: 2.4% (15)			98.5% (608) 98.1% (605) 98.9% (612) 93% (582)
Nationality Irish: 88.6% (526) British: 3.7% (22) USA: 0.8% (5) Other European: 5.6% (33) Other: 1.3% (8)	Parents Marital Status Unmarried: 6% (39) Married: 74.5% (486) Separated: 10% (65) Divorced: 4% (26) Widowed: 2.9% (19) Foster parents: 0 Parenting you by themselves: 2% (13) Other: 0.6% (4)	Employment status of parents Both employed: 49.9% (323) Father employed only: 18.9% (122) Mother employed only: 16.8% (109) Both unemployed: 8.8% (57) Don't know: 5.6% (36)	Is there illness/disability in family? Yes: 12.4% (80) No: 84% (541) Don't know: 3.6% (23)
Siblings Only Child: 6.9% (45) 2 or less: 53.4% (349) 3 or more: 39.8% (260)			Caring Duties Yes: 20.1% (30) No: 58.4% (87) Sometimes: 21.5% (32)
Home Location Town: 21.7% (141) Village: 21.4% (139) Countryside: 56.9% (369)		Location of Parents Employment Both Parents need to live away from home: 1.1% (7) One of my parents need to live away from home: 5.6% (36) No: 86.3% (559) Not relevant as parents not in employment: 7.1% (46)	Is there mental illness in family? Yes: 10.4% (66) No: 81.9% (520) Don't know: 7.7% (49)

Table 10: Demographic data: > 18-25 year old survey participants {%,(n)}

Gender	Where do you live?	Local area	Are you affected by a...		
			Yes	No	
Male: 26.4% (74) Female: 73.6% (206)	Family home: 53% (148) Own home: 3.2% (9) Rented accommodation: 18.3% (51) Digs: 1.4% (4) Student house/residence: 24% (67)	Town: 40.5% (113) Village: 25.1% (70) Countryside: 34.4% (96)	Physical illness	27% (74)	73% (200)
Age profile		Employment status	Mental illness	26.4% (73)	73.6% (203)
18: 13.2% (37) 19: 26.8% (38) 20: 19.6% (55) 21: 23.9% (67) 22: 12.5% (35) 23: 7.1% (20) 24: 5.7% (16) 25: 4.3% (12)	Whom do you live with? Family (Parents/siblings): 52.5% (146) Fellow students: 28.8% (80) Fellow tenants: 1.4% (4) Friends: 8.3% (23) Partner: 7.9% (22) Other: 1.1% (3)	Employed Full Time: 10.4% (29) Employed Part Time: 60.1% (167) Unemployed - job seeking: 14% (39) Unemployed - not currently job seeking: 15.1% (42) Other: 0.4% (1)	Physical disability	24.4% (67)	75.6% (208)
Nationality	Sexual orientation Straight: 97.1% (272) Lesbian: 0.7% (2) Bi-Sexual: 1.4% (4) Unsure: 0.7 (2)	Student Status Full time 3 rd level: 75.9% (192) Part time 3 rd level: 3.6% (9) P.L.C.: 7.5% (19) Training course: 0.4% (1) Not in education: 11.9% (30) Other: 0.8% (2)	Learning difficulty	26.9% (74)	73.1% (201)
Family Set up	Highest level education Junior Certificate: 3.6% (10) Leaving Certificate: 65.6% (183) P.L.C.: 7.9% (22) Certificate: 3.9% (11) Diploma: 2.5% (7) Degree: 9.7% (27) Higher/Post graduate diploma: 2.9 (8) Masters: 3.2% (9) / Other: 0.7% (2)	Qualification on completion Certificate: 9% (20) Diploma: 1.4% (3) Degree: 81.9% (181) Post grad/Higher diploma: 4.1% (9) Masters: 1.4% (3) PhD or equivalent: 1.8 (4) Other: 0.5% (1)	Do any of your family suffer from a...	Yes	No
Two parent family: 84.3% (236) One parent family: 13.6% (38) Foster family: 0.4 (1) Blended family: 1.1% (3) Other: 0.7% (2)			Physical illness	31.9% (87)	68.1% (186)
Married/living with partner			Mental illness	32.7% (89)	67.3% (183)
Yes: 27.1% (76) No: 72.9% (204)			Intellectual disability	27.8% (76)	72.2% (197)
			Learning difficulty	29.4% (80)	70.6% (192)
			Physical disability	72.4% (197)	27.6% (75)
			Caring Responsibilities		
			Yes: 24.5% (67) No: 65.2% (178) Sometimes: 10.3% (28)		

Intrapersonal Dimension

The Intrapersonal dimension refers to the innate attributes, knowledge and resources that young people possess, that can impact on their mental wellbeing. Both young people and stakeholders identified a wide range of intrapersonal mental health needs and resources, spanning from early childhood to early adulthood.

Positive Self-Image

The ability of young people to accept, love and recognise their self-worth emerged as the key to the development of their sense of wellbeing and the subsequent developments of inner resources to assist them cope with life stresses. Self-love or self-acceptance is considered one of the most profound influences on mental health. However, it is also considered one of the biggest struggles for young people. Young people and stakeholders recognised the value of love, self-love and the need to accept young people as unique individuals as the foundations required for positive mental health.

If you want to please someone else, you have to please yourself first. FG¹ 1 (Minority group).

I always felt loved at home and Mum always taught us to love ourselves, Participant 1 (Adolescent).

I think they need confidence and self-assurance. They need to believe in themselves and know that people care about them and are there for them no matter what. (SP² 18-25yrs)

¹ FG = Focus Group

² SP = Survey Participant

Young people need to develop a healthy and loving relationship with themselves first and foremost to prepare them to deal with all sorts of encounters with their peers and adults. (Stakeholder submission).

The consequences of not meeting young people's basic need for love led young people to seek other mechanisms to have this need fulfilled.

The sad thing is that a lot of the young people that I work with don't see themselves as loveable and have never felt loved and are now seeking love in relationships that often are unhealthy. Once they become pregnant, they no longer want the father to be around. The underlying subconscious need is that they only want someone to love them. Participant 2 (Stakeholder – Statutory).

Strong self-belief provides a strong footing for future aspirations.

I won't let anything hold me back from following my dreams. FG 1 (Minority group).

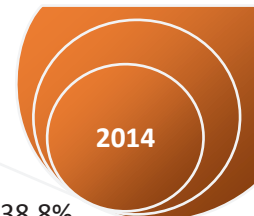
Being able to cope with all the things life throws at you...Confidence stuff like that, able to cope with stuff. FG 13 (Youth group).

Unfortunately, the repercussions to the young person of a poor sense of belief in self, emerged in the study in both the surveys and interviews.

She has a no faith in herself at the moment. She's a failure. She doesn't have any aspirations about a debs, or going to college or Leaving Cert, none of these are options for her. Participant 3 (Parent of teenage daughter).

I convinced myself that I was stupid and that I would fail every exam, there was no light at all. Participant 4 (Young adult).

Lack of self-confidence or confidence in one's own abilities was ranked as one of the three leading personal stressors by 26.1% (n = 157) of the teenage cohort and by a higher



proportion of the young adult cohort 37.1% (n = 101). Overall this stressor emerged as the third leading source of personal stress for survey participants.

Table 11: Personal stressor: Lack of confidence in own abilities

	%	n
12-18 yrs.	26.1.	157

Table 12: Personal stressor: Lack of self-confidence

	%	n
>18-25 yrs.	37.1	101

However, as the results above indicate, non-acceptance/ lack of confidence are not a source of stress for the majority of young people. Young people recognised that they need to accept themselves for who they were, their individuality and their limitations.

[Young people need]... the ability to accept individuality.....To know everyone is different..... need to believe in themselves and know that people care about them and are there for them no matter what.need to be yourself and try your best at everything you do. You can't do any more than your best...They need to understand that they are human. (SP 12-18).

Stakeholders believe that young people continually judge and compare themselves to each other, which impacts on how they view their own self-worth and value. This belief was endorsed by young people themselves with body image emerging as the cardinal personal stressor for both the teenage and young adult survey cohorts. It was ranked as

the leading personal stressor by 38.8% (n=233) of the teenage cohort and by 53.6% (n=147) of the young adult cohort. A statistical difference emerged between boys: girls in relation to this stressor with a greater proportion of girls reporting this as their top stressor (Chi square, $p < .05$).

Table 13: Personal stressor: Body image

	%	n
12-18 yrs.	38.8	233
>18-25 yrs.	53.6	147

The significance of this finding can be appreciated in light of the findings of a recent study by Jang and Lee (2013). They found that poor mental health was directly related to body image dissatisfaction, while it was indirectly related to BMI and self-esteem.

The impact of the media on young people's body image was highlighted by young people themselves as was maladaptive mechanisms deployed to cope with perceived poor body image.

I was always a big girl. Teenage girls are always swapping and sharing clothes – I could never do that. I pretended that I didn't care, I put on the tomboy image, but deep down, I hated myself. I was a great actress. Participant 4 (Young adult).

If they put on a bit of weight during their teenage years especially you know that around that 12, 13, 14 it has an awful effect on them. You know, even in boys now, my young fella put on a bit of weight round that age 12, 13. Now not very overweight but... he was putting on a bit of a belly and some of kids was teasing him in school. FG 14 (Parent).

Similar to requiring a *need for love* alluded to earlier, young person's non-acceptance of self, led some to engage in maladaptive activities such as sexual promiscuity to fulfil this need.

To get them to like me I had to sleep with them. If I don't sleep with them, they won't like me...I was taken advantage of a lot. I would have been known as a slut but nobody at the time understood what was going on in my mind. Participant 4 (Young Adult).

Young people as young as 11 or 12 are sexually active. It's very scary. The girls want to be accepted by the lads so they seem to succumb to what the boys say...the girls are nearly in competition with each other to see which of them is more popular with the boys. It's all down to how they value and accept themselves. Participant 5 (Stakeholder - Statutory).

The development of positive self-image starts in the home from an early age.

It's important to nurture from a young age that we look at the whole body not just the physical... that you build in resilience and then hopefully there'll be less problems down the road. FG 10 (Stakeholder).

A positive environment where children are taught and encouraged to identify, label and appropriately express thoughts and emotions was endorsed by both young people and stakeholders. Feeling safe, secure and loved as a child results in the teenager/young person engaging in healthier, positive future relationships.

Broadly speaking what young people need is skills for coping with life, relationships, communication skills, confidence building skills. (Stakeholder submission).

Young people need to be educated about their emotions, about relationships and self-esteem. (Stakeholder submission).

Young people need... knowledge on how to cope with emotions (SP 12-18).

Building confidence and self-esteem from a young age through offering positive affirmations and recognising the small things that all children/young people do well rather than focusing on the contrary was re-iterated as essential.

We need to find one small positive thing that we can say to a child as often as possible, even if it's just how well they buttoned their coat. Participant 12 (Stakeholder – Statutory).

I'd like to see the young people being given an opportunity to have some pride in themselves to have some, to be able to be proud of something. To be able to say 'I did that', 'I took part in something like that' and you know different things like that. FG 14 (Parent).

Being part of the team was great and when people came up afterwards and said you were brilliant and well done that made my day. It makes you feel very proud. Participant 6 (Young adult).

Often, young people only get recognition for misbehaviour which further reinforces a negative self-concept.

As teenagers we get judged on absolutely everything we do. People never forgive or let go of our past. (SP 12-18).

Some young people reported moving between hope and despair as they journey through adolescence/young adulthood.

When I had no job...It felt like I hadn't much future. FG 2 (Young adult – single parent).

I was not thinking positively ...like at the start of every day just thinking – oh today's going to be a bad day -just not being happy and not looking forward to the – to the rest of your life – that kinda thing. FG 3 (Youth Group).

These excerpts depict the deep sense of despair felt by some distressed young people:

He came to me and said I am worried about myself. I'm in a very bad place at the moment. I think I need help I am having these very dark thoughts and he went onto say he wasn't afraid of dying. I got him up for school – he was feeling very low and I... remember him sitting on a chair in the kitchen and he was black under the eyes.

Anyway, I dropped him to school and about an hour later they school rang...I knew something had happened... Mrs X (teacher) said he is safe. So when I got there he was a broken boy. He said to me that he had tried to hang himself with his tie in the cloakroom but it didn't happen, he wasn't able to do it. Participant 13 (Parent).

Interestingly, many stakeholders considered that the ages of 14-16 are the most challenging time for adolescents, in particular, it was perceived as the time when their problems started to emerge or began to escalate.

Second year was my absolute worst time, my parents had split up, I was drinking to blot stuff out. Participant 16 (Young Adult).

We have a surge of referrals for 14-16 year olds-that is our biggest population at the moment. Participant 5 (Stakeholder - Statutory).

The importance of building young people's resilience is perceived as paramount.

Although adjustments to the supports are probably needed I think a huge part of mental health is the person's own resilience, how they cope with their stresses and how they would react to major stresses. (SP 18-25).

Participants identified numerous supports available to young people of an academic; sporting and creative nature which provided

them with an opportunity to be able to express and disclose mental health needs/supports and become more resilient.

Focusing on young people's strengths, building resilience, giving them opportunities to flourish and develop, makes them stronger and more confident and gives them a greater ability to deal with the hard stuff themselves. Participant 5 (Stakeholder - Statutory).

Many young people themselves acknowledged that they needed to be encouraged and supported to participate in activities as they frequently did not know the potential long term benefits or were not in a position to make an informed decision themselves about engaging.

I was too much in my head, I had lost myself, I needed to get out and try different things. Participant 8 (Young adult).

My biggest one for that would be the importance/creation of how you feel yourself when you're doing a creative project – without really knowing it without having to label it. FG 5 (Youth group).

Knowledge of Mental Health

An appreciation of what constitutes good mental and poor mental health is a precursor to young people's ability to recognise what is 'normal' and what is possibly 'abnormal' and requires them to seek external support. The survey participants demonstrated a good appreciation of what constituted good and poor mental health as the word clouds in Figures 2 and 3 demonstrate.



Interestingly, their summation of poor mental health was not diagnosis focused but more symptom related. They also recognised that young people need to be aware that the issues challenging them are often not unique to them.

(Young people) need to be taught that all young people feel vulnerable at some point and that their situation is similar to so many others. (SP 18-25).

Their appreciation of what constituted mental health emanated chiefly from the home and educational sectors; with friends and the media lesser but still significant sources of knowledge. Friends were an important source for both cohorts of survey participants but slightly more so for the younger cohort where they emerged as their third leading source of knowledge/understanding and fourth for the young adult cohort (35.9%, n= 98)

Table 14: Sources of knowledge

12-18 yrs.	%	n
Parents/Home	66.6	401
Teachers/SPHE	65.6	379
Friends	30.5	176

Table 15: Sources of knowledge

>18-25 yrs.	%	n
Parents/Home	67.7	185
Teachers/Lecturers	56.4	154
Radio/TV	37.1	101

Health care professionals did not emerge as significant persons who shaped young people’s appreciation of mental health with only 28 young people in the 18-25 years cohort and 67 adolescents in the 12-18 years citing their GP. Participants rarely cited student health doctors/nurses.

Young people recognised that they needed to have a sound knowledge of mental health so that they were in a better position to appreciate what was normal and what wasn’t.

Better knowledge and understanding of mental illness/depression, how to spot the signs and how to cope with stressful situations in a healthy way. (SP 18-25).

More knowledge/reassurance that it’s normal to feel stress, that it can be motivating. (SP 18-25).

They need to know why they are feeling this way and they need to find the source as to where the problem come from. (SP 18-25).

When I look back I now see that the signs of depression were in me at a very young age. As a three/four year old, I used to go out and sit in the back of the dogs kennel for hours. Nobody could fit in to get me...my way of dealing was to run away and hide. Participant 4 (Young adult).

Young people were not alone in their desire and recognition of their need to be more knowledgeable about the signs of poor mental health - parents equally required knowledge.

Being a single parent of teenage girl is challenging at the best of times. As none of my friends or family have teenage children, I couldn’t go to them for advice. I thought that her behaviour was due to teenage hormones but in actual fact she was becoming depressed. Then when this (episode of mental distress) happened, I really had nowhere to go as her mother. It is

very isolating. Participant 3 (Parent of teenager daughter).

I still remember my mum saying "I didn't think you could get depression so young". (SP 18-25).

Young people were also very aware that it was just not knowledge about mental health per se that was required, but rather knowledge and possession of the requisite life skills to manage the daily issues that can potentially compromise an individual's mental health.

Better education in primary/secondary about life skills/knowledge including relationships, friendships, family relationships, sex, drugs, alcohol, emotional awareness, money and budgeting. (SP 18-25).

Views on the value of SPHE as a means of developing young people's life skills were mixed which concurs with the recent Department of Education and Skills (2013) research. Most participants believed that it is the qualities that the teacher/facilitator brings to the programme that is crucial. Some regarded a young teacher as being the most appropriate teacher/facilitator of the programme, more specifically in relating to and identifying with the issues affecting pupils.

Others suggested that an outside facilitator should facilitate this aspect of the curriculum. The format of delivering is usually class room with workshops been perceived as more appropriate. The mental wellbeing

component of the SPHE programme was perceived as disappointing.

In a lot of cases with the SPHE programme people will put lots of emphasis on healthy eating, they'll put lots of emphasis on exercise, they'll put lots of emphasis on physical health but the mental health part is often shied away from and isn't dealt with very well because again I think it takes adults who are comfortable with discussing their own mental health to be able to actually communicate effectively with young people about minding their heads, because very few of us even talk about it and if you think about it, you know, most adults, they'll say "I'm going for a walk and I'll do this and I've got to keep the heart healthy and I must keep that healthy". Very few people say "I need to look after my head". FG 10 (Stakeholder).

The youth participants' knowledge of specific youth supports/ resources such as Reachout; Spun Out or Headsup was very limited with references rarely made to them in the interviews or in the free text component of the surveys. Childline; the Samaritans and the GP encompassed the majority of the supports/resources that they referred to as a potential source of support.

A personal stressor for young people that was only acknowledged by the young people themselves via the surveys was the pressure they placed upon themselves in relation to examinations. It emerged as the second most significant personal stressor for almost half of the young adult cohort and over one third of the teenage cohort.



Table 16: Personal stressor: Examinations

	%	n
12-18 yrs.	33.6	202
>18-25 yrs.	49.3	135

It never ceases to amaze me about how public an exam the Leaving Cert is. ... I mean when you really think about it people aren't fully mature, yet it's the most public thing that...most people will ever likely do. and there's such... peer pressure, around like, "How many extra classes are you going to?" "Are you going to this revision school?" or "Are you doing this?" You know it's a huge amount of pressure for people who don't – you know, when you're 16 you don't have the resources...to deal with that level of stress. FG 8 (Stakeholder).

Developing young people's inner resources to cope with life stresses in a positive manner is a prerequisite to their ability to maintain their positive mental health.

Survey participants revealed a number of inner resources that they utilise to deal with stresses. It was apparent from the survey data responses that a number of participants were unable to articulate and/or recognise anything within themselves to assist them cope on a daily basis.

Table 17: Innate resources (12-18 years)

>12-18 yrs.*	n
Learnt coping skills	280
Ability to talk openly	180
Knowing that I have the inner strength to cope	229

*Participants could select more than one option.

Table 18: Innate resources (18-25 years)

>18-25 yrs.	n
Modelling parents	70
Ability to talk openly	180
Recognising that I have to confront issues	79

Both cohorts alluded to learnt coping skills and/or modelling parents so the importance of role modelling constructive coping strategies in the home environment cannot be underestimated. There is a need for parents and older siblings to model positivity, remain calm and in control and demonstrate adaptive ways of coping to help young people recognise the importance of these behavioural patterns in their own lives.

I see my mother and my older brother as very positive people, they are great role models at staying in control and that helps me to take stuff in my stride and do what I want to do without holding back. Participant 6 (Young Adult).

The ability of young people to be able to articulate issues of concern was also perceived as a positive resource. Other stakeholders consider this facility a very positive and necessary resource.

For me, young people don't hear their own voices anymore. They are at school all day surrounded by people, then they come home and are constantly bombarded by online chatting, Instagram, Snapchat. So they never get a chance to hear themselves. They need to give themselves some space to get in touch with themselves and who they really are and what they really want. Participant 9 (Parent).

Stakeholders also referred to a variety of other mediums that are now being deployed to allow young people express their feelings in a non-verbal format.

Young people need their own voice and I use drama, writing and painting for self-expression. For others forms of expression could be on a skateboard, my brother uses music. Even graffiti is something that comes from inside and can be very beautiful. Participant 10 (Young adult/Stakeholder - Voluntary)

Hobby, especially dancing and acting, because you can totally remove yourself. It's more important to express rather than actually just feel happy, like you can do drugs in a place that makes you feel happy, you're not addressing the initial issue. It's important, this is just from my experience and not just to focus on this thing that just makes you feel happy. FG 13 (Youth Group).

However, not all young people have the capacity or desire to articulate what is distressing them with some participants resorting to self-harm to cope with their difficulties.

No I wouldn't talk about it. Because it becomes reality when you talk about it. If you don't talk about it...it's just not there. FG 2 (Young adult – Single parent).

I wasn't able to talk to anyone and I had so much going on in my head and my stomach was in a knot, I needed to release that emotion and that feeling of hatred and anger that I held within myself (self-mutilation). Participant 11 (Young adult/Stakeholder - Education).

I do it (self-harm) because I don't know what else to do... I think about killing myself all the time but don't have the nerve to do it, so I cut myself instead, but I feel really stupid afterwards as it doesn't change anything Participant 16 (Young Adult).

I started missing school, spending more time on my X Box and became withdrawn from my friends. When I cut myself it feels like a release... the first time I cut myself, I thought I would never

do it again but the next week I couldn't stop. Participant 8 (Young adult)

Young people's ability to rationalise challenges/stresses was evident of positive coping skills.

I think that whatever is happening in your life/whatever you are dealing with won't last forever. Whenever I am down on myself I picture all the things my life will be like in ten years and think what I will do to make my life different. (SP 12-18).

Praying emerged as an innate coping strategy in both survey cohorts (12-18yrs; n=102; >18-25 years, n= 44) and in interviews with some specific cohorts.

We have a (strong) belief in religion and if the young person is feeling pressurised they go to the church or they go to a holy place and they talk to God. In our Travelling community, God is our light. FG 1 (Minority group).

Other self-initiated coping strategies shown in Figure 4 included listening to or playing music; blocking it out; and participating in exercise – the latter, which according to some stakeholders was underestimated in its capacity.

Being aware that walking and cycling are two forms of exercise that produce natural endorphins into the brain which gives us the feel good factor. Therefore when young people are worried about anything going for a walk can really help them to feel better about their worries and therefore more able to deal with those worries by coming up with solutions. Walking helps our brains to think outside the box and cycling in particular helps our creative juices to flow better. (Parent submission).

I just feel that the whole area of physical activity and its importance to good mental health often gets overlooked. (Stakeholder submission).

Figure 4: Coping methods used by adolescents and young adults



The most frequent coping strategy deployed was seeking help from families and friends.

The engagement in mal-adaptive forms of coping such as blocking it (issue) out, crying, getting angry, comfort eating and drinking alcohol were more prevalent in the older cohort of survey participants.

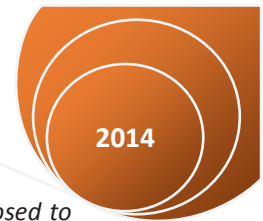
I'd have a joint, a cup of tea; a fag that just makes you relax. FG 4 (Unemployed Young adult).

In summary, in order to support young people in the maintenance and promotion of their mental wellbeing, strategies to foster their resilience, promote a positive self-image, provide them with accurate knowledge about mental health and teach them adaptive coping techniques is required. The instigation

of these strategies needs to take place from early childhood.

Interpersonal Dimension

The interpersonal dimension encapsulates the impact that young people’s interactions (face to face or social media) with significant others can have on their mental wellbeing. As alluded to in the previous section, an ability to articulate an issue, concerning a young person verbally or otherwise, is a requisite for the maintenance of mental well being. This section will explore who young people engage with; why they are selected and the consequences of engaging with another to support their mental health.



Young people need to learn from a young age that it's ok to talk. Participant 2 (Stakeholder - Statutory).

The value of the 'one good adult' and peer support were addressed in the literature review. The value of someone to talk to was recognised by stakeholders and by some young people themselves in this study.

Young people need a trusted adult to talk to. (Young adult submission).

I was at breaking point but I had three people I could talk to, I spoke to XX (lecturer) about my depression, I spoke to XX (Student support) about struggling to stay in college and I spoke to XX (Lecturer assistant) about everyday stuff. Participant 11 (Young adult/Stakeholder - Education)

When I have a problem, my mother is someone that has a real interest in me, she really listens to me, shows me she cares and that I am worthwhile. Participant 7 (Adolescent)

Having access to supportive adults in their life who will listen and support them, without catastrophising mental health difficulties. (Service user submission).

They need to be able to talk to people without being judged. When they do talk to someone they need to feel supported and listened to. - Not just when things are on top of them and all too much for them - it should be an ongoing thing. (Voluntary Organisation submission).

Other young people felt that it did not have to be an adult but someone who they could relate to; who would listen to them and not talk at them.

Young people need someone that they can relate to and feel like they are being understood no matter what they say. Having someone to talk to that is not an 'authority' figure like a doctor or a teacher, for example, can make a huge difference to a young person because they feel like they would be able to open up to someone

who is on the same level as them as opposed to someone who sees themselves in a higher position. It's important to feel like you're being listened to and also that you are being talked to and not talked at. (SP 18-25).

Some young people expressed the lack of emphasis that is put on listening, yet according to them, the importance of it cannot be over emphasised.

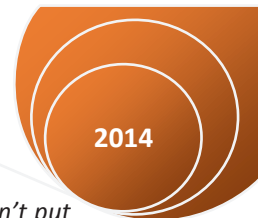
They have the confidence to talk to someone else and they have the ability to listen to someone... if someone comes to them, because out of all the Mental Health Workshops and things like that we've done, we've always been told – oh yeah "You can go talk to someone", but never have we been told that you can listen to people. FG 3 (Youth group).

However, despite this general recognition of the need to have someone to talk to, it emerged from the survey that a significant number of young people never or only 'sometimes' share their distress with another person.

Table 19: Talking to someone

	Yes % (n)	Never	Sometimes
12-18	43.3 (276)	11.1 (71)	45.5 (290)
>18-25	36.2 (98)	18.1 (49)	45.8 (124)

As can be appreciated, the older age cohort were more likely not to share their distress ever with another person. Approximately 45% of all survey participants chose only to share their distress sometimes with another. Although the participants were given an array of options (parents, teacher, chaplain, doctor, pet) to choose from in trying to identify who



they spoke to; parents, siblings and friends emerged as the key persons that young people selected and therefore by association play a significant role in supporting their mental health.

Someone in my family, someone you trust, your mother or your sister, could be your best friend. FG 1 (Minority group).

The older cohort selected friends more frequently than parents which possibly mirrors the fact that a number of them live away from their family home at this juncture in their lives.

Table 20: Sources of support (12-18 years)

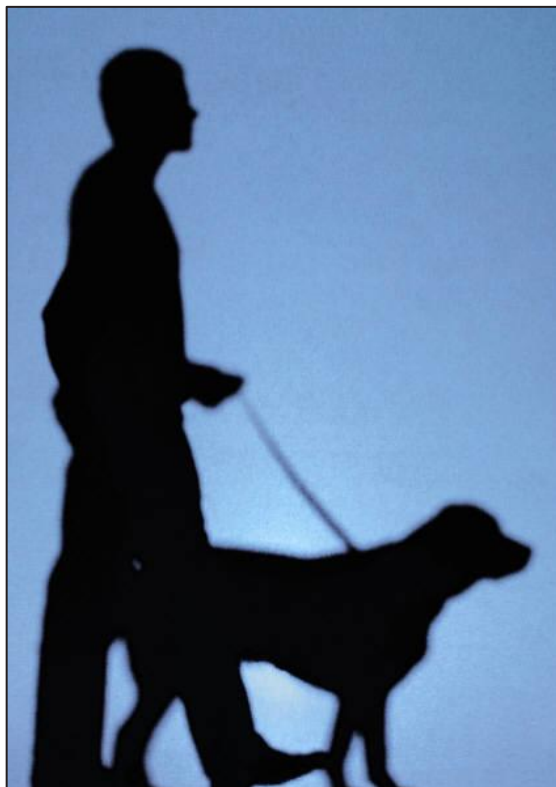
>12-18 yrs.	% (n)
Parents	74.8 (327)
Friends	59.5 (260)
Siblings	36.6 (160)

Table 21: Sources of support (18-25 years)

>18-25 yrs.	% (n)
Friends	80.7(206)
Parents	75.1 (193)
Siblings	49.8 (128)

A noteworthy finding is that the fifth most frequently selected option by the younger cohort was a pet animal. A qualitative comment from one of the participants may provide the rationale for an animal being selected over another human being or engaging with another, via technology.

I just talk to my dog because I know he can't put it on Facebook, Twitter or judge me as most people would. (SP 12-18).



Health professionals / chaplains / youth leaders / counsellor, etc. were selected very rarely as someone the young person would speak too. The GP was only selected by 1.2% of the 12-18 yr old cohort and by 1.6% of the older cohort.

Significant adults in young people's lives (parents/teachers/student officers) in this study were very aware of the need to give young people an invitation to talk and were open to such engagement at any time.

My daughter just has the normal teenage stuff going on...and I know she opens up to her friends a lot but whenever I get the opportunity to get her on a one to one and if she seems in chatty form, I always ask her how things are going...and with a little warmth and encouragement, she will open up and tell me everything that's happening

for her. I feel this is what keeps her grounded. Herself and her friends never stop talking and problem sharing but nothing ever gets resolved, they just seem to talk in circles. At least when she chats to me we can make a genuine attempt to address the important issues in her life. I think regular friends should never replace parents as the most important support in a child's life. Parents must start having these conversations-regular check ins with your children is your responsibility. Participant 9 (Parent).

I said to X (son) come and talk to me, don't keep it in, don't be afraid of it, it doesn't matter if it is day or night, you come and get me...and he always did come and tell me. Participant 13 (Parent).

I would always be looking out for them and if they seem a little different, I might call them back after class and say, you don't look yourself today, just open up the conversation, if something is bothering them and I ask them to meet me later for a chat. Participant 14 (Statutory – Education).

If a student comes to my door and I see that they are somewhat distressed and they see that I am busy, they might say, I can see that you are busy, I'll call back later. But I always say No, come ahead now because I know if they turn away from the door now, that might be the last time I'll see them. So for me it's very important to grab that opportunity with them. Participant 15 (Statutory – Education).

However, despite most young people relying heavily on their parents for support, there were also some who felt that their parents were the cause of their mental health problems, through not listening, belittling issues or providing insufficient time for discussion.

When I was feeling crap, my mum would say to me you'll get over it. Go out and do something. Participant 16 (Young Adult).

I often have chats with my mum, but sometimes she pushes me to talk when I don't want to and

this annoys me but when I'm in the mood to talk I can get loads off my chest and if I had a real problem, she would be the first one I would go to. Participant 7 (Teenager).

You couldn't go to them (parents) with a problem ...But they just annoy me more like....By just being stupid. FG 4 (Unemployed young adults).

Parents themselves acknowledged that they could be the actual cause of the young persons' mental ill-health.

I'm saying like people think "oh, the parents will do this and the parents will do that", but a lot of the time it can be parents or family members that are the abusers. FG 14 (Parent).

The young participants were replete with advice for parents on how to engage and support them. Frequently it centred on listening and talking to them and recognising that their age reduces their capacity to be deal with all of life's issues and the need to give their son/daughter a balanced life.

Parents should listen to what their child is saying more. (SP 12-18).

Talk to kids. Realise we are still young (and) cannot always cope with fights and secrets. Listen. Help us, give us advice. (SP 12-18).

Advice for parents, let your children enjoy their life, let them play as much as possible and have fresh air. Encourage them to take part in sport at a young age as exercise helps prevent a mental illness especially from a young age. Do not put pressure on them from school in the evening or any other life pressure from a young age. There should be a balance between play and other parts of life. I advise people to live a healthy lifestyle. Socialising, exercise and a balanced diet. If I was playing more and exercising from a young age, I would have never have developed a mental illness. (Young adult submission).



Equally parents recognised their need for support and advice on how to engage with their children in a meaningful manner and be vigilant of the signs of mental distress.

As parents, we are not geniuses so we need to be made aware of how to spot the signs of our child being low and how to deal with. For us we might think that low mood is normal teenage hormones but it could be depression. FG 2 (Young adult – Single parent).

There should be a course for parents to do as well to make them more aware of spotting the signs of their child being low and all that... because if no one is telling us... how are we supposed to deal with it. What I want for the future is something to be put in place so I know there is something there for my child when he starts to get distress(ed). FG 2 (Young adults – Single parent).

Nobody gets a handbook on parenting you know, so some people take to it and other people find it very challenging. FG 14 (Parent).

It was also recognised by both young people and stakeholders that some parents for various reasons are not in a position to be that supportive adult for their son/daughter.

It's difficult for them {parents} to relieve our stress because they are very stressed themselves. (SP 12-18)

They (parents) either have problems themselves and they can't deal with ... you know children's problems. FG 14 (Parent).

Similar to some parents, some young people are unable to engage at any meaningful level because of the lack of socialisation skills or guilt at burdening another with their issues.

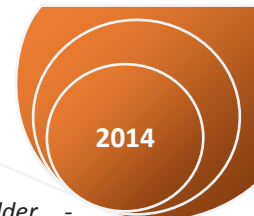
A lot of young people nowadays aren't very social because they are either uncomfortable with themselves or they don't know how to socialise properly. (SP 12-18).

I was thinking I don't matter, people won't miss me, I'm only a burden and nuisance to everyone. Especially when I was diagnosed with depression, I really felt guilty for all I had put my poor mother through. Participant 4 (Young adult).

The influence of peers sometimes means that parents regardless of their competence / openness / availability to engage with their son/daughter are precluded as peer pressure at times is the overriding influence in the lives of some young people.

It's not cool to talk to your parents and the influence of peers is huge, it seems to be the done thing (self-harm) if you have problems and it is learnt from other friends. Bracelets are becoming a sign for it. It also brings young people together. In the last year or more, it has become much more common especially among girls aged between 14 and 16 years. Unfortunately, in the more severe cases it becomes addictive, a compulsion where their hunch is to lash out on themselves. It appears to affect the deeper, quieter type of child. Participant 12 (Stakeholder – Statutory).

The centrality and dependence on family and friends as a means of support was very evident in the data.



There needs to be more support systems if I did not have a strong group of friends and family I would feel very alone as I would not feel comfortable approaching any others. (SP 18-25).

The interview data revealed that a positive response from their interaction with their selected person can have a lasting affirmative impact on the young person. Conversely the impact of a negative interaction was reported.

When I was a mess last year I went and talked to Miss XX in school and to XX a school counsellor... before I felt like no one liked me and I was isolated and I was going to commit suicide but they helped me really understand everything! (SP 12-18).

I remember one day I was very upset after my brother died, I remember my English Teacher was an angel, we talked for about 10 minutes.... To this day I have never forgotten my English teacher for that. Participant 10 (Young adult/Stakeholder - Voluntary).

All it takes is one person to take an interest in the young person for things to start to turn around for them. Participant 2 (Stakeholder - Statutory).

Teachers told me ... that I needed to cop onto myself for the way I was behaving ... there was one that called me a retard in 1st year in front of the class. I just went crazy ...but when I came out of hospital (Mental Health Services), she tried to come back and apologise to me... I had no respect for her after that. Participant 16 (Young Adult).

However, a small number of participants revealed distressing experiences of placing all their trust in one good adult and cautioned against espousing to such a concept or at a least exercise care in the selection of the one good adult:

The one good adult who I thought was the bees knees was the adult who did what he did to me so I am very wary of this one good adult thing because if you are looking for this one good adult you could find yourself a wolf in sheep's clothing.

Participant 10 (Young adult/Stakeholder - Voluntary).

When it comes to the one good adult it's a tricky one and young people need to be careful, sometimes the priest or the football coach were the good adults but in the end they weren't that good. Participant 2 (Stakeholder -Statutory)

The qualities of the person that both cohorts of young people chose to speak too were very similar as Table 22 details.

Table 22: Qualities of support person(s)

	12-18 yrs % (n)	>18-25 yrs % (n)
Trustworthy	61.9 (338)	59.3 (166)
Non-judgemental	51.6 (282)	43.7 (114)
Able to help/advice	47.5 (260) 45.2 (247)	37.9 (99)
Good listener	37 (202)	56.6 (147)

A number of reasons were identified which prevented young people engaging with others namely:

- Fear of being judged (60.4% of 12-18yr. old cohort & 53.9% of older cohort).
- Not being able to articulate the concerning issues (40.8% of >18-25 yr. old cohort)
- Fear of others finding out (51% of 12-18 yr.old cohort)
- Embarassment (49.8% of 12-18 yr. old cohort).

The qualitative data substantiated the aforementioned reasons for non-disclosure at times with that of being judged as a significant concern and ultimately a barrier to open discussion or disclosure.

Young people viewed disclosing mental health diagnoses or issues with great trepidation and fear. The need to “fit in” supersedes, at times the benefits they could accrue from disclosing and garnering the appropriate supports. Stoicism at time prevails as a coping strategy.

I made it this far without talking to people; I can just keep going. FG 3 (Youth Group).

XX didn't want her teachers to know she wanted things to go on as normal. She didn't want her name to go up on the board in the staff room as one of the pupils who require pastoral care. Participant 3 (Parent).

The students can be very reluctant initially to disclose their diagnosis, but it is something that we encourage. For example if a student is affected by panic attacks and presentations are part of their assessment, other creative approaches can be used to achieve learning outcomes. In terms of the college programmes, the benefits of disclosure definitely outweigh the costs. Students also express a sense of relief that people know and that they no longer have to hide behind their diagnosis. Participant 15 (Stakeholder - Statutory/Education)

Young people were also conscious that at times the person they may wish to talk to doesn't have the time, or that engaging with them on a personal level is not part of their remit. This is perceived to be particularly true for teachers.

The teachers can't talk to you. They don't have to... They're very busy. They have to tell us to go somewhere else because it's not their job. There's nothing they can do for you. Their only job with regard to you is when they're teaching

you. They won't be able to talk to you about personal things. FG 3 (Youth group).

Disclosing to peers must be perceived as particularly challenging for some young people as being excluded from a group or not being part of a group were perceived as stressors by some of the survey participants. Feeling excluded was perceived by 15.3% of young people in the 12-18 year old cohort and 26.8% in the >18-25 year old cohort. Not being part of a group was also identified as a stressor by 19.9% of the older cohort. Although the numbers are not significantly large for either of these stressors, they were the top two friends related stressors and demonstrate the importance to some young people of fitting in.

It takes a certain level of confidence and a lot of trust to talk to your friends ... there is a fear that they're not going to be accepted and scared that they are not going to fit in – and if you're the kind of person that doesn't have a lot of friends or doesn't have a lot of confidence or trust in their friends, then it's going to be harder to talk. It's like a vicious circle, you know, you have a mental illness and you want to talk about it to someone, but because of your mental illness you don't have friends, you don't have someone to talk to... and then, it kind of progresses. FG 3 (Youth Group).

Young people also provided exemplars of being the “friend” confided in and the repercussions that they have experienced as a consequence of trying to seek help for their friend. Such experiences are usually a consequence of a young people's failure to appreciate the meaning of true friendship.

I was concerned about two of my friends; I knew they were cutting their wrists. But they asked

me to keep it a secret. Then a few days later, my mum starting asking me stuff and I told her and she said that we would have to do something about it and I freaked out ...I am not supposed to tell anyone...but she insisted and my mum told their parents...that night they messaged me to thank me but since then they have stopped talking to me...I am so upset now...I asked them to meet up and talk about it but they won't...I heard that both of them are getting help and they would not be getting that help only for me. Participant 7 (Adolescent).

It took me a while to realise that a true friend is someone who listens to me when I need it and then I listen to them when they need it – it has to work both ways. Participant 11 (Young adult/Stakeholder - Education).

Young people also felt strongly that they need to be prepared and supported to deal with friends' mental health issues.

I think the (friends of a) person who is dealing with poor mental wellbeing,... should be given advice on how to help (them). In the last year, two of my close friends developed eating disorders and I was unsure of what to say or do. (SP 18-25)

Young participants and stakeholders all possessed mixed views on the value of social media as a means of establishing a connection with someone. Some felt there was a great possibility of misinterpreting information shared on a social media site compared to that shared in a face to face interaction. Others felt that it provided a medium for those who found face to face interactions challenging.

I think that young people should be encouraged to talk to a real life person as opposed to becoming too reliant on online forums/social media outlets etc. People can pick up things that are written in different ways, whereas if you are talking directly to someone, it is easier to tease things out. Also, I feel that young people should

be encouraged to talk. (Voluntary organisation submission).

Many young people considered it a powerful reservoir for information and support but were very conscious of the negative impact it could have on a vulnerable young person.

They just go onto their page and write what they think about them. ... Then of course there is always the chance that people will write up nasty stuff – you are leaving yourself wide open. I don't understand why they do it. Participant 7 (Adolescent).

People seem very influenced by the 'like' button so if they comment on something, they will get excited about the number of likes they get. Some people think their popularity depends on the number of likes that they get for a profile picture. If they are vulnerable, they would feel that nobody cares if they don't even like my stupid picture. Boys wouldn't bother with likes on their pages but it is definitely a big thing for the girls I know. Participant 17 (Adolescent).

The views of parents were equally mixed. Parents who engaged in various forms of social media recognised its potential to enhance the parent: child relationship. Others considered there was a *digital disconnect* between parents and children.

I find it quite positive because I am friends with them on Facebook so therefore I see things that they are tagged into from their friends. FG 14 (parent).

I'm only on it since. ... but in that year and a half the closeness you know I've gotten so much closer to my daughter ... as soon as I went on it with her, you know she kind of responded to me I suppose. FG 14 (parents).

I think from me looking at the social media, there is a complete disconnection between say adults and the children. FG 14 (Parent).

The impact of young people choosing to engage in gaming is impacting on their ability to engage in school and manage their emotions in particular, anger.

The gaming industry is a big one for the teenagers we work with. A new game will come out like Grand Theft Auto... and you won't see them for a week ... they're on that game round the clock, they don't stop to eat, sleep, anything. They just get caught up in the game and they'll just disappear underneath another blanket for a week. FG 11 (Teacher).

Helplines as a means of engaging with someone in an anonymous manner were viewed by a small number of interview participants with suspicion.

The helplines, I wouldn't use them, you wouldn't know who you'd be talking to ... they could tell you anything...FG 1 (Minority group).

If I was totally against the wall; I might use one ...FG 3 (Youth group).

In summary, some young people chose to interact with various individuals face to face or via other forms of social networking. The response of that interaction can be either affirming or disparaging. Other young people chose not to engage with another person at all or only occasionally when distressed. Reasons underpinning this decision include fear of being judged, fears of others finding out or embarrassment. It is apparent that the underpinning reasons need to be addressed so that all young people feel able to engage with another to support to their mental well being. The centrality and value of a positive parent/child relationship was highlighted.

There is a need to support significant others in young persons' lives with knowledge and therapeutic communication skills in order that they can respond to them appropriately. In essence:

(Young people) need to learn to talk to someone and feel able to express their feelings and emotions whereby they will be listened to, not judged and get any further help needed. (SP 18-25).

Community Dimension

The community dimension encapsulates the impact that young people's interaction with their families, schools/colleges, employers, primary health care practitioners/ place of residence and local facilities can have on their mental wellbeing.

Family

The functioning family was recognised by the majority of participants as the foundation for mental wellbeing. It facilitates the role modelling of productive coping skills, provides the young person with a safe and supportive space to transition into adulthood, facilitates open communication so young people feel able to raise issues of concern and enables the development of life skills. It was also apparent that a committed family provides young people with a sense of security and stability rather than how the family unit was structured.

Growing up in a family provides them with a good structure and gives them coping mechanisms to deal with stress. FG 8 (Stakeholder).

Supportive parents give their children the appropriate space and responsibility to be able to try new things. There needs to be a balance – a middle ground where the young person can be themselves and develop but ... know that they are safe. Participant 5 (Stakeholder – Statutory).

The environment they live in. This should be safe, supportive and an environment where they could develop and live a happy daily life. (Young adult submission).

My family have always been there and taught me things that I carry with me through life, like don't sit back and speak up for yourself. Participant 17 (Teenager).

When parents have a bad day, it's OK to think and say that I feel stressed today and to name how we are feeling rather than maybe acting out that stress through irritability or anger. Participant 5 (Stakeholder - Statutory).



A positive family environment that supports a child at all times even when they fail, was deemed to be very important. It was acknowledged that it was very challenging for parents to get the balance right: affording children with opportunities to develop new skills and engage in a variety of activities, to facilitate them achieve their potential and to ensure that non achievement does not spell “failure” for the young person and diminish their self-concept.

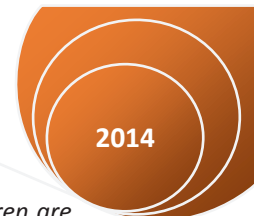
We see children who mightn't have a huge amount of supervision right through to children that are being timetabled with activities every single day and they are actually suffering massive stress because in some activities they actually expected to perform at a superb level and suddenly these activities that are supposed to be promoting the child's self-esteem are actually becoming a massive stress in the child's life...so as a whole... the word balance is critical one, where young people learn to cope with whatever life throws at them. FG 10 (Stakeholder).

It was also acknowledged that the arrival of social networking has encroached on the safe space that young people used to be guaranteed in their homes. It was believed that parents had a responsibility to recreate a safe space for their children by limiting their access to social networking.

With the arrival of social networking, the home may no longer be perceived as a safe place where young people can relax and separate themselves from the outside world. Social networking entices young people to 'stay connected' to the friends day and night. In the case of bullying, this makes it much more difficult for the young person to detach themselves from the intimidator. Participant 9 (Parent).

A very good tip for parents is to encourage their son/daughter to put their phone in the fruit bowl at 8 or 9 o'clock because if they are lying awake in bed at night they're not going to get sucked in. But parents need to be told that they have a right to tell their child to do that. Some parents don't realise that. Participant 5 (Stakeholder - Statutory).

Programmes such as the ‘Teen Between’, the ‘Rainbows programme’ and parenting programmes like ‘Positive Parenting’ and ‘Strengthening Families’ were viewed positively by stakeholders. These foster emotional wellbeing, building resilience and coping skills and promote the development



and maintenance of effective relationships/interactions between family members.

The parenting programmes now are very interactive and less judgemental. They look at the importance of effective communication and empowering parents in terms of setting boundaries. A good facilitator is essential. Participant 19 (Stakeholder - Statutory).

When my parents broke up I went to the Rainbows programme and it was a turning point for me because my facilitator was brilliant. Participant 6 (Young Adult).

Unfortunately, a dysfunctional family heightens a young person’s vulnerability and susceptibility from a mental health perspective.

If the foundations at home are rickety they are more vulnerable to mental health problems. If young people feel rejected by their parents and don’t receive that unconditional love, they become more vulnerable. Participant 2 (Stakeholder -Statutory).

The family are the most stressful part, they just make it worse...depress you out even more...FG 4 (Unemployed young adult).

I’m not living up there with mine anymore; defo would have mental health if I lived up there. I’d be in jail if I lived with my family, any one of them. FG 4 (Unemployed young adult).

Misuse of drugs; alcohol and fractured relationships can add additional stress to an already recognised stressful developmental stage. Young people are often placed in insufferable positions by parents.

They (young people) are not only grieving the parent that has left, they also feel pushed aside if their mother’s focus is on the new partner. This causes a lot of stress and can be a real crisis for them. Participant 2 (Stakeholder -Statutory).

When relationships break down, the children are often enmeshed in the middle of both parents’ differences. They are often asked to collude with either parent in an attempt to isolate or exclude the other parent. This can have a devastating effect on the young person. Participant 2 (Stakeholder -Statutory).

The majority of the survey participants reported no home generated stressors sufficiently burdensome to cause them distress. Those that were reported centred on conflict with and between parents, conflict with other family members, perceived overprotective parents and a lack or limited money as Table 23 demonstrates.

Table 23: Home generated stressors

	12-18yrs % (n)	>18-25yrs % (n)
Conflict with parents	95 (16)	-
Conflict between parents	10.1 (60)	20.7 (54)
Overprotective parents	13.4 (83)	-
Lack/limited money	14.1 (81)	32.8 (86)

In summary, the family and its environs has the potential to strengthen or diminish a young person’s mental wellbeing. Stakeholders believed that *universal skilled support for all parents* is required to support

parents in the development of healthy constructive safe home environments for their children with many effective programmes currently on offer to some parents/ families. A systematic review on parenting for mental health would suggest that universal parenting programmes could be more beneficial than targeted programmes over time as they reduce the potential for stigma and parents are in a better position to recognise problems before they reach clinical significance. However, it is recognised targeted programmes have a place as well as they also yield benefits (Stewart-Brown and Schrader-McMillan, 2011).

Educational Institutions

Another institution that is recognised as having a significant impact on young people's mental health is their educational environment. The school/college environment was the most prevalent source of stressors for both cohorts of survey participants. Young people reported that the school system in general is supportive of youth mental health, with some schools

hosting specifically targeted mental health events with support from external mental health speakers/facilitators.

The chaplaincy and



pastoral care teams make specific endeavours to support students' mental wellbeing.

Subjects outside the core subjects that were credited with indirectly supporting mental health, were music, art and P.E. However, not all schools offer music as a subject and art is often a subject that students cannot opt in certain situations. A reduction in hours allocated to P.E. is a feature of some schools, with others not in a position to offer P.E. to some cohorts of their student body at all. Transition year projects that promoted freedom of initiative and the integration of more holistic personal development projects were widely commended. School websites and newsletters were seen as the great medium for publicising and informing young people on mental health. However, some participants espoused the notion that young people have reservations about the amount of information that young people are receiving in schools:

It's like if you keep bombarding the young people with loads and loads of information they're just – get saturated with so much information. FG 3 (Youth Group).

The transition to the school/college environment was advanced by both cohorts of young participants as a very stressful time for them. Often the stress emanated from poor social skills or self-inflicted expectations of themselves in terms of being able to cope and being perceived as independent.

I will never forget that Sunday night, I suppose XXX was so large, coming from a class of 30 to



500 students was mad. You are a small fish in a big pond, you are literally a number on a system. It was such a culture shock for me coming from a small secondary school in the country. You don't want to say either that you are from the country because that becomes a label too...so I just kept thinking stick it out until Christmas, you just want to be independent, you don't want to rely on other people, it's your first taste of independence and you want to see it through. If I left I would have seen it as an admission of failure. Participant 18 (Young adult/Stakeholder Statutory - Education).

Social anxiety has a lot... to do with difficulty mixing with peers and social isolation. This can be particularly evident when they are moving from a small rural primary school to a larger urban secondary school. Participant 5 (Stakeholder - Statutory).

When I went into the secondary school, I felt like an outcast really. They wouldn't even bother talking to me. Participant 16 (Young Adult).

Poor/inappropriate recognition of students' emotional and behavioural issues can lead to negative consequences for the student.

Children with emotional and behavioural issues are often excluded from activities and are getting recognition of their negative behaviours which is wrong. Their whole self-perception is being damaged. Participant 5 (Stakeholder - Statutory).

For some young people the initial transition from primary school to post-primary is not very stressful but the second year when the 'honeymoon period' is over, emerges as challenging.

I have asked my clients over the years, when did they start going down the wrong road and 2nd year seems to be the most significant year. In first year, it's the honeymoon period, they are at the bottom of the pile they are sussing each other out, then by second year, cliques are beginning to form and the decision regarding which clique to go with can dictate what happens from there on in...if they go with the wrong crowd, then things can quickly start to

deteriorate. Participant 2 (Stakeholder - Statutory).

The separation from family, friends, boy/girlfriends and community for attending college is a source of great distress for some young people which has to be dealt with, in conjunction with striving to make new friends and getting to grips with their college programmes.

The survey identified a number of school/college related stressors that cause young people distress. The sources of distress demonstrate the differences between the post-primary school and the college student where the cost of college and need to work to address same emerged as significant stressors along with examinations.

Table 24: School generated stressors

>12-18 yrs.	% (n)
Homework	74.8 (327)
Exams	59.5 (260)
Poor time management skills	36.6 (160)

Table 25: Third level generated stressors

>18-25 yrs.	% (n)
Exams	67.9 (173)
Cost	41 (105)
Balancing work with college	30.9 (79)

The stressors clearly demonstrate that the perceived academic philosophy of the present educational system is a real threat to young people's mental wellbeing. Young people feel pressurised to succeed in their exams affording them with little free time to engage in activities.

I really need to work hard so I study 3-4 hours every night and about 5-6 hours on a Saturday. This means that really I go home, eat my dinner and go to my room. It can be really hard to fit in others things. Participant 7 (Adolescent).

Sometimes they might (say) "you're going to fail your Leaving Cert because you don't know this point", which leaves an imprint in your head ... stressing people out and put their mental health into bother. These expectations leaves us with less time for our interests. FG 3 (Youth Group).

I've not really found a way to properly handle the demands (of Leaving Certificate) yet, to be honest, I'm just treading water really... trying to get all the work done, it's like this exam is the most important thing ever so you're expected to drop everything else. FG 3 (Youth Group).

Some young people are unable to cope and opt to select another route to meet their educational needs.

A lot of it had to do with this pressure and worry around expectations of what you have to reach – and I ended up going through Youthreach educational system and it was one of the best things that ever happened to me. FG 5 (Youth group).

According to stakeholders there must be opportunities for all to succeed in the school/college environments.

It is important that there are opportunities for all young people to succeed regardless of academic ability (Stakeholder submission).

The School Completion Programme and the Leaving Cert Applied were highlighted as

avenues available to support pupils who may feel challenged by the standard curriculum and may be at risk of dropping out of school. The smaller number of students in these programmes enables the achievement of positive outcomes for the young person. The Home Youth Liaison Service was highly credited as being a wonderful support to young people, teachers and their families.

XXXX is on site in XXX School and she sits in on meeting with XX, her teachers and myself. They do weekend retreats, which were brilliant. XX really enjoyed them and really got involved in all the outdoor activities. It also gave her an opportunity to meet other friends which was great. I really wish there could be more of these positive opportunities for her. Participant 3 (Parent of teenage daughter).

Bullying as a school/college stressor did not emerge as one of the three leading causes of distress in the educational environment. However, it was identified as a stressor by sixteen per cent of the post-primary survey participants and by just over one per cent of the older cohort. Many references were made to it in the free comment section of the survey, usually offering suggestions on how it should be tackled, indicating that bullying is an issue in the post-primary school sector.

More help is needed for young people regarding cyber bullying. (SP 12-18).

Bullying policies should be fully implemented and teachers should not turn a blind eye to bullying that causes stresses. (SP 12-18).

Apply stricter punishment to bullying. (SP 12-18). Knuckle down on bullying. A lot of people get bullied in my school including me. I'm not as bad anymore but I told my mum and she came in. I think that people should be suspended or given

detention or something because they aren't getting the message now. (SP 12-18).

Have regular lectures and talks about mental health and bullying. Let them know they have someone to talk to in confidence. (SP 18-25).

The pervasive nature of bullying was alluded to in the interviews.

Bullying is everywhere, it's in every classroom, in every group, all types of students are perpetrators - the bright students, the outgoing friendly students, the quieter students. The victim's mental health is trying to deal with that and the perpetrators mental health is causing them the problem. It all goes back to mental health. Participant 11 (Young adult/Stakeholder - Education).

It is not in my nature but I would have bullied someone to be part of gang then I would go home and feel guilty about it... the lads would put pressure on me to be one of the lads, I am accused of being whipped because I am seen as being too kind to girls. Participant 6 (Young Adult).

Young people's experiences of teachers/guidance counsellors etc. were mixed with two ends of the continuum of support being alluded too. Some teachers appear to have a keen interest in the mental wellbeing of students while others avoid it for many reasons: ill-equipped to deal with any issues that arise; pressure to get the curriculum delivered; insufficient time or ever expanding workloads.

Some of our teachers are great promoting mental health among young people, especially out XX teacher, she puts stuff up on the school webpage, gives out information sheets, she would be very genuine about it and people would chat to her outside class. Participant 6 (Young Adult).

In our schools we've Guidance Counsellors and you can go to them and they would actually talk to you. FG 3 (Youth group).

In my training, there were no tools or guidelines or structure into how to look after students. In actual fact there was no talk about student wellbeing at all. It just focused on the classroom. Participant 14 (Stakeholder. Statutory - Education).

Teachers are under more pressure than ever before with increased demands and shrinking resources. As well for a lot of teachers, there is a great sense of fear...that they may say something that might make the situation worse for the young person, so they might feel it is better to say nothing at all, than the wrong thing. Participant 18 (Young adult/Stakeholder Statutory - Education).

I don't know how much more schools can do. They are bursting with responsibility for family life. Participant 5 (Stakeholder - Statutory).

In addition, some teachers seem to struggle to understand the meaning of students' behaviour and label them as troublesome rather than attempting to understand what this behaviour is communicating for the student.

I knew I was one to watch, I had got a reputation because of my flipping out but I couldn't help it but only one or two teachers seemed to care about what was going on inside me. Participant 16 (Young Adult).

Teachers are so busy and if a pupil misbehaves, the easiest way to deal with them is to stick them in detention, which doesn't work...after a few detentions, the person is suspended, so they are put out of school and at home and you hear his friends saying - he is at home on the X Box all day. Participant 14 (Stakeholder - Statutory - Education).

Mentoring programmes exist in many post-primary and third level institutions. Some participants reported them as a very positive support mechanism.

If I ever had a problem I would go to my mentor. I got on really well with her, I look up to her and she would advise me on everything from how to respond to that difficulty I was having in school to what to wear to the next disco. Participant 1 (Adolescent).

However, for others, despite their existence and the principles underlying, these programmes are often not very worthwhile.

I had a mentor in college but it didn't really work, I don't know how committed she was to being a mentor so in the end I didn't really bother with her. Participant 18 (Young adult/Stakeholder - Statutory - Education).

Teachers reported feeling more confident to engage with young people at this level when they were in receipt of preparatory training.

Mentoring ... we had to engage in training to take that on you know. So I suppose we have... knowledge of what we should and shouldn't be doing... FG 11 (Teacher).

Participants felt that teachers “could not be bystanders” when it came to mental health and believed that teachers needed to realise the importance of monitoring the mental wellbeing of students.

I think it's important that the students have a teacher or teachers that will pick up on the little signs that they might be giving out, they might not just be waving a red flag and saying I need help here...Participant 14 (Stakeholder – Statutory -- Education).

It is no surprise that the primary emphasis is placed on teaching, learning and assessment in schools. However, given that young people spend lengthy hours within the school, teachers need to be capable of detecting potential or actual mental distress and therefore mental health should be a component of the undergraduate curriculum

for teachers and/or part of Continuous Professional Development (CPD).

I think the teachers should do a course on how to spot issues like signs of depression and bullying. FG 2 (Young adults – Single Parent).

Whilst it was acknowledged that schools had some resources/ supports in place, students had issues surrounding timing, privacy and confidentiality which often served as barriers to engagement.

The support is sufficient when the person is diagnosed with a mental illness. I wish I had the right support at school before I developed the illness. The presence of someone who knows something about mental health at school would have been helpful as it would have reduced the time between the onset of the illness and the time where I got help. (Service user submission).

They've got an outside counsellor that comes in and you can talk to them if you want, but it is like kinda really obvious where you're going, because you've coloured cards to get out of class and like it's the one colour so, like, no matter what you do with your hand, they're going to aware of where you're going. I think that kinda puts people off. FG 3 (Youth Group).

If you were seen going to a chaplain, there would be rumours going around and that would make it all worse for you... probably lower your confidence even more. FG 3 (Youth Group).

Young people are equally conscious of the impact that diminishing school resources was having on supports/ services.

Our school counsellor is also the guidance counsellor and is now pulled back into teaching, nobody goes to him as a counsellor, we just wouldn't because he is also a teacher. Participant 6 (Young Adult).

Stakeholder participants felt strongly that schools needed additional resources in order to have the capacity and competence to deal

with student mental health issues. The need to ensure these resources are timely and part of a multi-sectorial service for young people's mental health is also considered a necessity.

There aren't enough supports in schools. These are the places where the vulnerable can be identified. There isn't enough communication happening between schools and outside bodies. This lack of interaction creates a taboo around mental health and means that students are reluctant to seek help. (Stakeholder submission).

I would also support an enhanced school directed programme with a multidisciplinary team and more school counselling like that available in Northern Ireland, I do not think this should be the domain of psychologists only, there are people trained in child and adolescent psychotherapy. Also I would like to see the Home School Liaison Service go into every school. (Stakeholder submission).

Not all schools allow the Home Youth Liaison team into the school which is interesting in itself...it might be that they feel that they can handle their own problems but these schools are some of the most reported for bullying. Participant 12 (Stakeholder - Statutory).

The findings would suggest that there are more supports available to students attending third level institutions. College health services are on campus and/or closely linked. Counselling is free to third level students or supplemented by the college funds. A strong focus on mental health awareness and positivity exists in Third Level colleges. Student Unions run many mental health promotions and activities throughout the academic year.

Students are always encourage(d) to open up and talk to people they trust, it is only through talking that things can get resolved. Participant 11 (Young adult/Stakeholder - Education).

In summary, the educational environs have the potential to support and or diminish a young person's mental health. Educators need to be aware of their role and responsibilities with regards to supporting students' mental health. The European Union Dataprev project (Wearne and Nind 2011) would suggest that the teaching interventions employed and a whole school approach has the potential to effect mental wellbeing positively. Educators need time to listen to their student population and should be able to identify signs of compromised health and be in a position to direct students in terms of specialist support when required.

Primary Health Care

A Vision for Change (DoHC, 2006) recognises the key role that Primary health care practitioners play in supporting persons with mental health needs in the community. The GP is the primary health care professional currently in the community dealing with the mental health needs of adolescents. A diverse range of views were expressed regarding the GP service. Some participants felt a great sense of support from their GP while others expressed converse experiences.

Our GP was fantastic, he knew our situation so well and was so supportive but there was only so much he could do and there was no place else for us to go with XX. Participant 13 (Parent).

I had mixed experiences with GPs. The first time I went I told him how I was feeling, I wasn't sleeping and my back was really bothering me

too. So he just said "here is a prescription for Lexapro and Valium"...I was thinking how could you say that to me, I'm obviously in a very vulnerable place. He totally disregarded me. For a professional to imply that what you expressed wasn't important was very upsetting so I withdrew then, after that negative first experience. Participant 10 (Young adult/Stakeholder - Voluntary).

I often waited for two hours to see the GP to go in there for 2-3 minutes and come out with a prescription Participant 11 (Young adult/Stakeholder - Education).

As alluded to earlier in the findings, young people's perception of what constitutes good/poor mental health was not derived from their GPs. This finding may arise from the fact that as the majority of young people are healthy they have limited opportunities to engage with their GP so GPs have not the opportunity to educate young people on mental health issues.

The perceived public stigma in relation to mental illness is a challenge to young people and their parents to openly engage with their GP about a mental health issue. This veil of secrecy disempowers the GP from engaging in a meaningful way with some young people about their mental health.

A lot of parents would be afraid to bring their child to a GP for a mental health service because they (young people) are tabooed for the rest of their days. FG 10 (stakeholder).

GPs aren't ideal in the sense that they lack a sense of confidentiality, the waiting room in small villages/ towns is a nightmare because you're guaranteed to meet a neighbour etc. who'll be wondering what's wrong with you. (Young adult submission).

However, young people considered that the normalising of the mental health conversation should begin in the GP consultation process from an early age.

From an early age and even in GP surgeries it should be part of the general check-up ... "How are you?" and "Are you stressed?" and so just making it normal...so that people don't think "God he is asking me about my mental health – is there something wrong with me?" FG 10 (Stakeholder).

Other stakeholders felt that as the GP was the first port of call for a young person in need, practices need to become more attractive to young people by being 'in sync' with their needs and expectations. General practitioners themselves recognise that attributes such as a GP's age; gender or location can factor into a young person's decision to engage with them.

General practitioner services... need to tune in better to what is relevant to people's needs of this age. Practices can make themselves more friendly to young people in a number of ways and may need help with this. (Parent submission).

Age of GP is a big problem but I also think what stops a lot of kids coming is because they fear that auld fella knows me since I was a baby or he knows my mother...I think that sort of is an obstacle to them actually coming forward. FG 9 (GP).

I think a lot of people come to me because I'm female in a male practice and they would see me as more maternal in a sense. FG 9 (GP).

I have been on that many tablets I feel like a guinea pig really. They will either change your tablets or put you on more tablets. It's just "how are you feeling", and I say "not great" and they say "right, try these." Participant 16 (Young Adult).

They think , if the doctor says, "Oh I have depression", the only way to cure this is by like

pills ...They don't think..."well, maybe if I just talked to someone it might just help as good". FG 3 (Youth group).

Once you start taking one, you might get hooked on it, like and you're on it for the rest of your life. FG 5 (Youth group).

The GPs identified a number of challenges they encounter in supporting young people's mental health; namely, the long waiting lists to access secondary/specialist services; restricted knowledge on the range of complimentary services in the region; the range of mental health conditions that young people can present with; time; the absence of psychiatric nurses in the community to support them in the care of those under 18s with a mental health issue; and the need to acquire parental consent to engage with young people under 18 years old. The latter has resulted in the non-development and/or breakdown of the therapeutic doctor/patient relationship at times.

Access to services from my point of view, it's quite difficult because there's a huge waiting list. FG 9 (GP).

I think a lot of GPs wouldn't know their services in the area ...100,000 people working in the health service in such a small country and we all ... don't really understand each other's role sometimes. We don't know not just locally but nationally and I think someone, probably the HSE has to do a better job mapping out what the services are and I think it would really help us. You know GPs are dealing with so many different issues in health care when you deal... with an adolescent mental health issue, it will be nice to have a map, like you know of community based (resources). FG 9 (GP).

I think as GPs we don't really... get enough training or we don't get enough ongoing training to deal with this (mental health issues) – I think

another issue that is huge in this nature is GPs are not trained for it at all (Facebook/social media with regards to bullying). So there is a whole self-help kind of area that we need guidance on...maybe therapy websites and maybe videos. FG 9 (GP).

Because the community psychiatric nurse will sometimes ring in (in relation to adults with a mental health problem) and say I think so and so needs to be sent in, you know, they'll see the ante being upped and you need to then once it is recognised. FG 9 (GP).

And the public health nurse knows what's going on, they know the communities. FG 9 (GP). Nurses are almost better than doctors and people feel more confident and comfortable with nurses because they are not the doctor. FG 9 (GP).

It is recognised that the presence of fully functioning primary care teams would enhance the current primary care provision.

I think if there was a true primary care service with social workers and psychologists/psychotherapist including family therapists available it would really help. (Stakeholder submission).

Young people perceived a number of limitations to the narrow range of therapies prescribed for them by GPs. There was a perception that GPs over relied on pharmacological therapies. There was also a perception that young people were not afforded an opportunity to engage in a meaningful way in the decision making process related to their therapeutic options and there was a perceived lack of consideration of other complementary strategies to support medication.

When I was put on medication, it wasn't a good experience. I didn't feel involved in the decision. When the doctor said here's a prescription for



Lexapro and some sleeping tablets, I said can we not talk about it for a minute. It just seemed to be the only solution and I felt that I hadn't much say in it at the time. Participant 10 (Young adult/Stakeholder - Voluntary).

Young people feared that once they commenced on medication that they would be on them for the remainder of their lives.

In summary, the GP remains the primary provider of care to young people with mental health needs in the community. Young people are seeking the deployment of more therapies to complement medication, or replace it, in the first instance, if appropriate. The latter is in keeping with the philosophy underpinning *social prescribing* and in keeping with the shared care model of care.

GPs encounter many challenges in supporting young people's mental health needs in the primary care setting, in the absence of established primary care teams and accessing secondary services for the under eighteens in a timely manner.

Employment

Both employment and unemployment can impact on a person's mental health. Various stressors were identified via the young adult survey in relation to employment/unemployment. The stressors in relation to employment need to be considered in context. Most of the employed

participants were also students and working in part-time positions.

Table 26: Employment generated stressors

Employment	% (n)
Work times	34.5 (85)
Too much work	24.1 (85)
Unrealistic expectations from managers/employers	27.8 (67)

Table 27: Unemployment generated stressors

Unemployment	% (n)
Fear of never getting permanent job	19.6 (51)
Life not under one's control	15.3 (40)
Having to move away for employment	14.9 (39)

Participants saw no future when they were unemployed and had a perception that some members of the public perceived a person without employment as valueless and/or lazy. Unemployed young people perceived they were under constant pressure to secure employment, regardless of the fact that frequently, no employment opportunities existed in their locality. Threats of reductions in their benefits as a consequence of not securing employment was a tangible stress.

People on the dole are getting pushed into – "Get a job, get a job, get a job –" – like there's no

jobs out there to get – so it's like "What else am I meant to do?" FG 5 (Youth group).

It was evident that parental unemployment was a source of distress for some young people and that a source of stress for parents was the uncertainty of future employment opportunities for their sons/ daughters.

Young people today are growing up in the midst of changing economic landscape, where they are faced with shrinking job prospects. This instils a sense of despair in young people and those that support them.

The Recession...that's why I worry about the kids – you don't know like- where they're going to end up after all of this. FG 2 (Young adults – single parent).

The uncertainty of the economic climate is causing a lot of stress for young people. Moving out of home/country is very stressful and sometimes not an option. (SP 18-25).

Young people were also aware of the negative impact a diagnosis of a mental health condition could have on their future employment prospects.

You can't put down mental illness or depression on it (application form) because you are limiting yourself, it has to be back trouble or a sore knee or something like that. FG 11 (Teacher).

Young people perceived that it is incumbent on Government bodies to prepare young people for the employment market, through the provision of programmes to upskill them, informing them of job opportunities etc. They also were replete with ideas on how to engage unemployed young people in community and voluntary work as they

perceived such activity as a necessity to give young people a sense of purpose; reduce isolation and facilitate socialisation and networking.

There needs to be a campaign towards voluntary work. ...need to make it 'cool'. (SP 18-25).

Young people also considered that employers had a role in maintaining and promoting their employees' mental wellbeing through positive reinforcement; respecting individual's contributions to the work environment; establishing support networks in the work environment and monitoring their employees' wellbeing on a regular basis.

In summary, employment can impact on an individual's mental wellbeing. It is recognised that longer durations of unemployment predict higher level of depressive symptoms among younger adults (Mossakowski, 2009). Recent British research, via the Prince Trust Macquarie Youth Index (2013), found that among the long term youth unemployed, twice as many of the unemployed youths compared to their peers have been prescribed anti-depressants; one in three have contemplated suicide and one in four have engaged in self-harm. Unemployment and its unique stressors need to be addressed in a proactive manner.

Place of Residence

A young person's place of residence can impact both negatively and positively on their

mental wellbeing. It dictates their access to both formal and informal supports and resources.

Young people need good environments to grow in where all their various needs can be met be they health needs (access to primary care), educational needs (timely psychological assessment and tuned in teachers) and a balanced family life. (Stakeholder submission).



Young people and service providers alike, acknowledged the contribution many private and voluntary services, for example, Foróige; Comhairle na nÓg; community based creative arts group; sporting organisations such as the GAA; musical and youth theatres made to their mental wellbeing. Their creative, person-centred approaches in working holistically with young people gained much recognition from participants in helping them on their journey and transition to adulthood. Their willingness to engage with young people and their flexibility of access and referral was highly valued by young people. These organisations promoted young people's mental wellbeing directly and/or indirectly.

I was elected onto the Comhairle council in Leitrim and we meet every 2-3 weeks and raise issues that are important to us at local level and decide on the best way to address them. We were discussing the SPHE Programme as part of that. I feel very involved and part of this organisation. Participant 17 (Adolescent).

'Branching Out' is an open, friendly safe space where people can communicate and share how they are feeling so that they don't feel alone. Participant 10 (Young adult/Stakeholder - Voluntary).

Lots of kids attend the CRIB and we would refer them there also and they find it really supportive. Their programmes are so relevant and are really pitched at the right level for them. Participant 12 (Stakeholder - Statutory).

'Branching out' are real champions and XX there has a great understanding of things that are important to young people. Participant 5 (Stakeholder - Statutory).

However, even though some young people were aware of the existence of 'The CRIB', many were unaware of its philosophy and purpose:

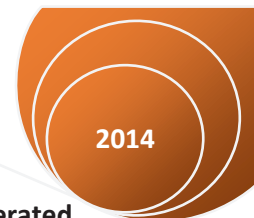
I know where the CRIB is and I know a couple of people who go there but I am not quite sure what goes on there. Participant 7 (Adolescent).

I have seen posters up in the school about the CRIB but that's about it, I don't know much more about it. Participant 14 (Stakeholder - Statutory - Education).

It's (The CRIB) for kids man, 12, 13 year olds go there...grungers with long hair, Emos and Rockers. FG 4 (Unemployed young adult).

Many stakeholders perceived that recreational organisations were an untapped resource and could be utilised further to promote young people's mental health.

I definitely feel that that's one true resource that sometimes is missed is the GAA clubs, soccer



clubs, rugby clubs who are working with youngsters – from when they’re 3, 4, right up into adulthood, rather than medicalising mental health difficulties, we need to normalise it more by tapping into these resources. FG 7 (Stakeholder).

People that run Foróige clubs (and) football coaches could be educated in mental health, so they could talk to the young people around their locality about mental health promotion and how to spot the signs of distress. FG 7 (Stakeholder).

Within some communities there are identified people that young people go to if they have a mental health issue. Through their involvement in mental health awareness campaigns, or as a result of their own personal life experiences, these individuals have inadvertently taken on this supportive role.

I suppose people would come to me because they know that I know about mental health and I can see that people are struggling from a distance. Participant 6 (Young Adult).

I could get a call at any time from people and I would just get up and go. Participant 4 (Young adult).

Some survey participants reported a number of stressors that caused them distress emanating from their locality. The majority of participants described their place of residence as the countryside or a village. The rural locality presented challenges for young people to engage in activities to support their mental health and to access mental health resources or services when required. References to isolation because of rural locality was a constant in the data.

Table 28: Place of residence generated stressors

Stressor	12-18 yrs % (n)	>18-25 yrs % (n)
Lack of venues for young people to meet	25.9 (153)	23.3 (60)
Lack of activities for young people to take part in	25 (148)	43.7 (112)
Lack of respect for young people’s opinion	18.8 (111)	-
Lack of public transport.	11.9 (70)	25.3 (65)

I live in a little village, it’s a good bit away to see all my friends... you’d be kinda isolated –You’d be left with your phone and Facebook and there is no transport. FG 3 (Youth group).

I live in the country so I don’t have supports available. (SP 12-18).

When you’re out in a place where there’s hardly anything to do or anywhere to go – so you’ve got more time to think. FG 3 (Youth group).

Accessing mental health services in a private capacity is particularly challenging for rural based young people where public transport is not an option. Cost was a further burden acknowledged by stakeholders for young people having to use public transport to access services.

In rural areas, you generally rely on your parents to give you a lift somewhere in the evening and that can be hard if you’d prefer to attend mental health services privately – sometimes you’re just

not ready to share your problems with your close family – sometimes, close family can be a source of the worry/ problem. (Young adult submission).

Congruently providing services to young people in rural locations is challenging for statutory and voluntary providers.

Service locations are not always easily accessed particularly to rural dwellers and due to public transport costs and times of buses etc. (Voluntary Organisation submission).

(Young people) in urban areas have very good access to well-run youth services, however the same cannot be said for young people from more rural communities (Stakeholder submission).

A lack of age-appropriate social activities and venues for young people to meet and engage with each other was perceived as significant obstacles to the maintenance and promotion of mental health by some young people. For many rural communities, the GAA is the only outlet for young people which further isolates those not interested in sport. Young participants felt that young people were frequently stereotyped by society and there was a need for smaller communities in particular to embrace diversity and individuality among their young population.

They should acknowledge that not all teenagers are dangerous hooligans. It annoys me that because of the way I look people stereotype me as a drug-filled, elderly-thieving teenager rather than be seen as the fairly respectable young adult I currently am. (SP 12-18).

Learn to embrace individuality and diversity particularly in smaller communities. (SP 18-25).

Young people acknowledged that groups such as Foróige existed in some areas and catered for those under the age of eighteen. The findings identified a particular need to create opportunities/activities other than the pub for those over the age of eighteen.

Organise activities/venues for young people between 15 and 18 because they are 'too old' for teenage discos and 'too young' to go to the nightclub. (SP 12-18).

A centre for young people where you can talk to similar aged people about stresses in an informal manner. (SP 18-25).

The value of developing role models in the community was also highlighted as a means of supporting young people.

What's needed is a few more good role models out there, someone that's young like me because they might not take an older person seriously enough. This person needs to be able to reach out to young people. But this should not be laid on one person, there should be few people in every community to spread it around because it can be a lot for one person to take on. Participant 6 (Young Adult).

Many stakeholders also recognised the challenges of a rural location and identified the need for 'outreach' centres to address young people's mental health needs.

Need to have outreach time/places for rural communities (Stakeholder submission).

Outreach services to isolated and rural areas are desperately needed. (Stakeholder submission).

There is a need for timely, easily accessible services that young people can access themselves, before a minor mental health issue becomes an extreme situation. (Service user submission).

In summary, a number of resources exist in the community to support young people's mental health. Many organisations, such as the GAA promote young people's mental health in an informal, unstructured manner. It is widely believed that such organisations are an untapped resource to assist maintain and promote mental health. The rural nature of the region presents challenges to both its young residents and service providers which need to be addressed.

Organisation

The organisational dimension encapsulates the impact that young people's interactions with secondary health services and voluntary groups can have on their mental wellbeing. The survey highlighted the issues that present as challenges and enablers to young people considering accessing a service to support their mental wellbeing. Gossip, fear of others finding out, fear of being judged and embarrassment were perceived as very real barriers for young people. Additional issues that emerged for the 12-18 year old cohort centred on the location of services in public areas and the need for parental consent. The reputation of the service was also important to them.

Young people living in the country, the stigma of being seen to be in attendance at these places where supports etc. are available. (Adolescent submission).

Some of the supports do not exist at this time (outside office working hours) - re statutory services, the service is run to suit the people working in it (the appointments are during

school hours, Monday to Friday). It is very difficult for a young person / family to maintain privacy when explaining absences from school etc. (Service user submission).

Organisations and voluntary groups had a good appreciation of the barriers to young people accessing services.

Lack of knowledge, lack of advertising of what is available, lack of education in post-primary re the conditions and what can be offered....stigma, peer pressure and being ridiculed. (Stakeholder submission).

Stigma - (not seen as cool to do or it's not what others may be doing). Transport issue. They don't know what's available. (Voluntary Organisation submission).

Not knowing they exist, afraid/embarrassed to admit they need them, being judged by their peers, not being able to recognise that their behaviour or how they are feeling is an issue. (Voluntary Organisation submission).

The factors that make a service more amenable to access according to the survey participants are detailed in Table 29 with privacy emerging as the cardinal enabler.

Exemplars of services that address these enablers were advanced.

Jigsaw is non-stigmatising, less threatening and more accessible. (Service user - Adolescent - submission).

Many service providers also perceived that their services were *accessible, available, approachable and well publicised*, so should be attractive to young people. Voluntary organisations' underpinning philosophies seem to acknowledge the benefit of empowering the young person in the relationship.



When young people come into us first there is a fear of not knowing the person or “what is going to happen if I do tell, will they tell my parents?” While ultimately, we have to do that, we really work hard with the young people to empower them and get them to do the telling. Participant 5 (Stakeholder - Statutory).

listening to me. I had counselling with her for 2 years and it was really, really great just getting out and been able to tell someone. They gave me all sorts of ways to manage my anger as well. I had great respect for them. Participant 16 (Young Adult).

Table 29: Factors that facilitate engagement with services

	12-18yrs % (n)	>18-25yrs % (n)
Privacy	59 (288)	67.9 (162)
No appointment necessary	36.7 (168)	57.3 (131)
Locally available	53.5 (272)	48.6 (171)
Multiple ways to contact	30.7 (143)	43.9 (97)
Parent consent not required	30.7 (150)	N/A

The support of the mental health team is that you can always count on them when you are getting sick or stressed in any way. The social worker can help in term of daily life. They can help with family problems. The occupational therapist can offer support in your life, at the moment I am attending Recovery Action Group which is run by the OT. (Young adult submission).

Unfortunately, I think you hear – you hear about the suicides and all of that... But you don’t hear about the people who have accessed services and done well. You know you don’t hear the – the flip side. FG 8 (Stakeholder).

When we arrived there (acute admission unit)... it was like a dream, for once I feel that someone is listening to me and really cares. He kept saying I have a really good feeling about this place. He ended up in the right place he developed great relationships with all members of the MDT and the person centred therapeutic DBT programme that he engaged yielded very positive outcomes for him. He is now living a full life, finishing secondary school and has ambition and hopes and dreams for the future. He is looking forward to so much now. Participant 13 (Parent).

Participants expressed conflicting views on their experiences with the secondary mental health services. Many had very positive life changing experiences. There was also an appreciation of the benefits to families and young people of engaging with mental health services. However, this positive aspect is frequently overshadowed by the reporting of worst case scenarios, namely suicide.

The first time I went there, I thought it was strange that someone was actually sitting down

Conversely, all experiences reported were not positive. Many related to policy issues which were not within the remit of the health care professionals such as long waiting times; availability; absence of a community psychiatric nursing service to support CAMHS; site of care delivery and an absence of a ‘safe place’ in the region for very vulnerable young adults, leaving families limited in the choice of health care facility they could seek help from in time of crisis.

There is no service where a young person could be kept 'safe' in Sligo, Leitrim, or west Cavan -



the nearest place is Galway and a lot of times you might have to wait weeks for a bed. (Parent submission).

When we were in crisis and XX (daughter overdosed) the only place we could go was A&E, and all they do is look after the physical side of things and observe her. Participant 3 (Parent).

We were desperate after he attempted the suicide as there was no place to go straight away only present in A & E or get a bed in St Columba's. No one would take responsibility for our son. Participant 13 (Parent).

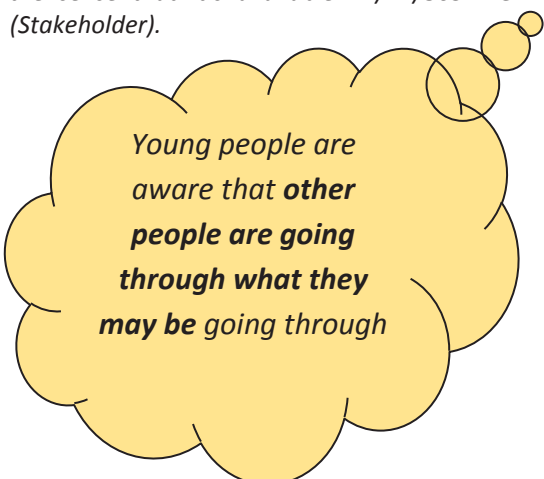
Malloway House is a great asset to the area but it's too small and cannot cope with the current needs. It was probably fine a few years ago but sadly it cannot meet the needs for today. (Parent submission).

When you leave this door (Malloway House) there is nothing else really out there, only hitting a brick wall every time. Participant 3 (Parent).

This is one of my main hobby horses, Mental illness does not stop at 5pm on a Friday and come back until 9am Monday morning. Services that are not hospital based are required that go right through the weekend, families in crisis need to know that there will be a response. FG 7 (Stakeholder).

Service providers recognised and concurred that issues such as those alluded to above, do have a negative impact on the young adults' journey through the secondary health services.

Our service needs to be more people friendly in the sense that it's available 24/7 /365. FG 7 (Stakeholder).



Young people are aware that *other people are going through what they may be going through*

The length of the referral time to secondary/specialist service was the cardinal stressor for many young people having to wait from 2-3 weeks to 2-3 months to 2-3 years. Often the only way this was circumvented was when the mental health issue reached crisis point. There was also a perception that there was a two-tier system in relation to access with those in a position to pay for services receiving access in a more prompt manner than those in receipt of a medical card.

That really bugged me, we had tried so many avenues for the 2-3 years that he was unwell, trying to manage him ourselves with the GP and then because it's an emergency we were seen that afternoon. Participant 13 (Parent).

Depends on if you've got a medical card. If you are on a Medical Card you are on a waiting list The amount of money it costs to see a Counsellor individually is unbelievable but if you're with the VHI or any of them you are seen straight away. FG 5 (Youth group).

Other issues alluded to are linked to care provision and are modifiable such as the duration of appointments – often considered too brief to facilitate any meaningful therapeutic relationship from developing; and the constancy of the health care provider the young person engages with.

You would be waiting for ages and you are in in 5 minutes and asked how you are and they would just write this down, "take these" (medication). You wouldn't be too bad going in – you would actually come out feeling worse. Participant 16 (Young Adult).

I was just brushed off and pushed under the carpet really Participant 8 (Young adult).

Trust is a big thing for me. It takes me a long time to trust someone, so if I see different doctors every time, that doesn't help. Participant 16 (Young Adult).

Some participants felt that greater emphasis needs to be placed on encouraging young people to re-engage with the secondary mental health services:

If young people disengage with CAMHS there needs to be more follow up on a personal level as to the underlining problem. It can't just be a matter of "well, they didn't show up for two appointments, so the case is closed". Participant 5 (Stakeholder - Statutory).

The actual or anticipated transition from CAMHS to Adult Mental Health Services and from the acute admission unit in Galway to home/ school emerged as an issue that is very stressful for both the young person and their families.

I hated it. It was totally different, such a shock to the system. Coming from them one day and then going to the other the next time... .. and then they were like: "what can we do for you?" I felt kind of crap and I started to drink again. In the child and adolescent service, I could tell them how bad I felt whereas here... you can't explain yourself in that 5 minute slot ... You just can't sum that up in 5 minutes. Participant 16 (Young Adult).

I am so afraid of what's going to happen when we have to move onto the adult services and if she relapses at the time or after she leaves here (CAMHS) Participant 3 (Parent).

One day I was being discharged from Merlin Park and on Monday I was expected to go back to school. Participant 8 (Young adult).

Once discharged, they are expected to re-engage in life and if they are not able to do that they have to stay at home which is not the best situation. It would be great to be able to refer them to another programme for a few weeks to help them to re-engage with everyday life. Participant 12 (Stakeholder - Statutory).

All who experienced the aforementioned transitions believed that the process should be conducted in a more staged approach and

supported with a structured transition programme where all stakeholders are involved. The need to harness post-primary schools' involvement was perceived as a necessity from both the school and the young persons' perspective.

You need to be let down gently, you are expected to get on with them (Adult Mental Health Services) straight away and that's not going to happen. You should be introduced more slowly to the adult service. Participant 16 (Young Adult).

The lack of service integration presented as another source of stress. Parents and young people find it 'soul destroying to have to tell their story over and over again'. Greater use of 'joined up' thinking and working for the benefits of the child was strongly suggested. The previously named ION process was highlighted as a support mechanism that worked well by facilitating the co-ordinated support from a number of agencies involved in the care of young people.

It really opens up the conversation and makes the world a far more supportive place for the young person. It's about working relationships and everyone working together. Participant 5 (Stakeholder. Statutory).

Participants expressed a strong desire for greater support services for parents:

There should be somewhere she (daughter) can go and somewhere I can go for support as her mother. Participant 3 (Parent of teenage daughter).

It would be great for parents to have contact with one another. Participant 12 (Stakeholder - Statutory).

Both parental and child consent was voiced as a barrier in many aspects of care. The addiction services were highly commended for their input with young people. However, in order to access the service, a GP referral and parental consent are both required. Many young people are silent drinkers and aware that they need help and support with their problem but are reluctant to engage with the addiction services as they need their parents' consent.

They wanted me to go to the addiction services when I was in school but I was like "no" because my parents had to give consent to go and I didn't want them knowing. They still don't know I go. Participant 16 (Young Adult).



The notion of confidentiality and consent were also alluded to as potential barriers within the services in particular from parents' viewpoint. The following excerpts illustrate a parent's confusion and worry about a possible disparity between how her daughter is presenting to the professional counsellors and to her as her mother.

When she started going to the counselling, the counsellor told me that she would let me know if she disclosed anything that might pose a risk to yourself or others and that was fine. So she was going every week and I worry sometimes because I really have no idea what goes on in those sessions. I know there are things that I don't need to know but there are also things that I think I should know and what I need to be looking out for at home. On the one hand, they say that I am the ultimate decision-maker when it comes to my daughter but, then on the other hand, I don't know what's going on. They kept pushing me to admit her but I felt that she didn't need it. so I was left confused, is she telling them stuff that I don't know about? It's all about the child which is great but they are nearly too focused on her. After she did the suicide attempt they told me after that she did show some indications but when I questioned them on why they didn't tell me, they said they didn't think it was serious enough. That sort of worried me. I think it is taking confidentiality a little too far. Participant 3 (Parent).

From a stakeholders' perspective:

We engage with the younger community and talk about confidentiality but, mum and dad will want to know how we will update them or involve them. Parental consent is really a grey area. FG 9 (GP).

I had a very mature level headed 17-year-old who came into me with full capacity, maturity, had depressive symptoms and anxiety symptoms and she was really engaged with CBT, so I referred her for CBT and I wrote specifically "this is direct referral, she does not want parents to know about this... this is her mobile number please ring her." They didn't contact me, so in the interim, she turned 18. A month later, by the time she's already 18 they saw her address on the letter, they wrote a letter to her mother and said "because she is minor can you please bring her". I rang her she wouldn't answer. I felt terrible that was just a real breakdown. There is that capacity /consent age issue. FG 9 (GP).

We can only make contact with the school with the parents' and young person's permission. If the young person gives permission, we can do some kind of joint care. Participant 12 (Stakeholder - Statutory).

It is clear that a dichotomy exists in relation to consent. A young person cannot access a service without their parents' consent but a young person's consent is required to share information about their progress with their parents and other key stakeholders once the young person is engaged with a service.

Stakeholders acknowledged that there are many different groups (statutory and voluntary) in existence in the region that are purporting to be supporting young people's mental health, with some emerging as a response to a crisis in a region. There was an identified need to explore how the current groups could work together so that young people are not receiving conflicting messages/information regarding their mental health and know which groups are reliable.

How can you get them to marry together that all have a similar message that is not conflicting or that young people know that it is good? FG 10 (Stakeholder).

I think in general there are good working relationships between community, voluntary and statutory sector and it's just finding something common to work on in respect of mental health. FG 10 (Stakeholder).

Stakeholders were keenly aware of the confusion that young people must encounter when they are trying to decide which 'online' site or group to access for support, as a consequence of the plethora of groups/website sites in existence. They were also conscious of the lack of regulation in relation to some groups. The development of

the region's local website 'Alive2thrive' was welcomed and perceived as an invaluable local on-line support.

Some stakeholders also acknowledged that they are not aware of all the services available in the region and that such knowledge would enable them to offer the young people they engage with on a daily basis, a range of options in relation to services.

I don't know half the services available and if I don't know it, I mean how can we expect young people to really... but it is really helpful when I know a service ... and I can say to a young person look this is a really good service... they are more likely to get in touch with that place. FG 10 (Stakeholder).

In summary, both statutory and voluntary organisations are supporting young people to address their mental health needs in an empowering manner. However, a number of issues require addressing at policy and practice level to address the acknowledged deficits in service provision. The core focus of all the services/groups in relation to mental health in the region needs to be identified and streamlined.

Policy

The policy dimension refers to the impact that the existence and implementation (or lack of) of various local and national policies, can have on young people's mental wellbeing from a broad range of perspectives. All cohorts of participants made suggestions for supporting

the mental health of young people, which would require policy changes in the health, education, ICT and social welfare sectors and/or additional resources to be attributed to support the full implementation of current policy.

Participants believed that young people have a vital role in policy making and currently they are not provided with a sizeable platform to do so.

I personally don't think there's enough of a platform given for young people and...if anyone in authority wants to be taken seriously they should definitely give the younger groups a big(ger) platform. FG 5 (Youth group).

The day has gone when they say a child should be seen and not heard like you know. They...have to have a little voice like. Even at a young age. FG 14 (Parent).

Participants widely acknowledged the need to have mental health as a curricular theme that traverses all of young people's engagement with the education sector: pre-school to third level. Indeed some stakeholders believe the concept of mental health should be introduced at the prenatal level.

To me this starts in the womb, if parents have knowledge on how we work mentally, then that's the starting point for education. Participant 19 (Stakeholder - Statutory).

Young people need to be supported to manage their emotions and know how to manage stressful situations; this needs to be done in the school setting, at a very early age and not just dipped in and out of occasionally, but structured and delivered nationwide. (Voluntary Organisation submission).

The efficacy of SPHE as it is currently constructed and developed was widely discussed. Participants consider that it requires review in its current format, in order that young people acquire the necessary knowledge and life skills to support their mental wellbeing.

Rather than SPHE being a talking shop, it should give young people real skills...CBT, coping skills, anxiety management...nearly like a subject. FG 5 (Youth group).

Some teaching professionals acknowledged their lack of confidence and limited education to engage with the subject of mental health in a meaningful way. Many recognised their need for CPD and openly admitted to 'not knowing everything'.

There isn't enough on the influence that teachers can have on young people. We do certainly learn how to teach, we learn about our subjects and how to care about young people in general but as teacherswe need to be more aware of mental health and wellbeing. Participant 11 (Young adult/Stakeholder - Education).

Young people perceived there was a greater need for technology to be deployed to provide support to their mental health in their locality; to educate them on mental health and to engage young people in a conversation about mental health in a medium they are very familiar with.

We have a huge resource that isn't actually used by this, which is the Internet and for young people, it's what they're familiar with. It's the way that they access information a lot of the time. And we should really be using (it) to increase awareness. And even as a resource for therapeutic interactions, they may not want to come to see someone face to face. They may

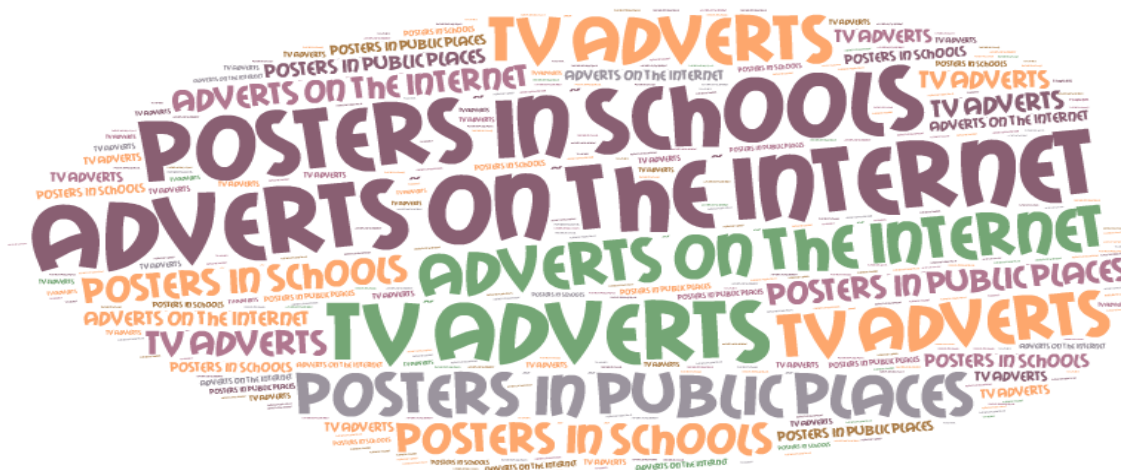


want to ask questions and have a simple answer.
FG 7 (Stakeholder).

Consultations could be done using Skype that would take a lot of pressure off people.
Participant 12 (Stakeholder - Statutory).

Figure 5 indicates the mediums by which the survey participants perceived the message around mental health should be promoted to their age group.

Figure 4: Mediums for Mental Health Information



Stakeholders also perceived the need to have information in venues which are accessed by young people. They also perceived the need for services both at local and national level to agree the message that should be promoted.

In order for health services to be recovery, community based as espoused in Vision for Change (DoHC, 2006), additional resources and commitment is required to ensure that it is implemented in full, across the region.

Reduced funding by government is also impacting negatively on those services in existence. (Stakeholder submission).

There should be linking of the Community Services... Counsellors... Primary Care Workers... Health Promotion linking together working hand in glove, there wouldn't be as much gaps in services, there wouldn't be as many new people falling through the cracks. FG 10 (Stakeholder).

It was acknowledged that many new initiatives such as the 'Meitheal' Model (previously known as the 'ION' model) have progressed the 'roll out' of the policy in a more person centred, community focused manner.

Financial strain as a particular stressor for mental health emerged in the 2012 *See Change* survey, where it emerged that 77% of those who described their own financial situations to be under severe strain, claim experience of a mental health problem either personally or through others. As a consequence, *See Change's* stigma-reduction activities will now recognise those under financial strain as a new target group.



Stressors related to unemployment and a lack of money permeated the survey data as Table 30 demonstrates.

Table 30: Income related stressors

Age Group	Stressor	% (n)
12-18	Lack of/Limited Money	14.1% (83)
12-18	Unemployment	4.6% (27)
18-25	Lack of/Limited Money	32.8% (86)
18-25	Unemployment	11.5% (30)
18-25	Insufficient pay	12.1% (29)
18-25	Cost of going to work	11.6% (28)
18-25	Lack of Money	31.7% (87)
18-25	Cost of attending College	41% (105)
18-25	Uncertain about employment opportunities	20.1% (55)

When I was thirteen I couldn't wait to leave home and go to college but now that I'm 16, I'm thinking...how will I manage, how will my parents manage financially and that. Participant 7 (Adolescent).

As alluded to earlier, long term unemployment can have a negative impact on individuals' mental health and by default; that of their families and their communities and

therefore, there is a need for the Department of Social Protection to be conscious of the impact that their policies may have on their recipients mental wellbeing.

In summary, policy makers need to give consideration as to how modified or new policies can impact on young people's mental health, directly or indirectly. All policies should aim to improve young people's mental health in a positive manner. Young people need to have a voice in policy development and evaluation.

Society

The societal dimension encapsulates the openness and significance that Irish society places on mental wellbeing.

At least four of my friends are suffering with mental health issues. Each of them felt pressure from wider groups to be ashamed so I think much more work needs to be done to combat this. Pieta House has really opened my awareness. Young people's suicide rates scream "HELP". (SP 18-25).

The stigma attached to poor mental health pervaded all forms of data collection. It was acknowledged by both young participants and stakeholders. Young people were very conscious of the stigma that is still attached to poor mental health in Ireland. Perceived public stigma is preventing young people accessing services and disclosing mental health diagnoses, heightening their already vulnerable state. Young people believe that

the stigma originates from misperceptions and ignorance around mental health.

The reasons mental health carries a negative connotation is because of the taboo – the stigma... and it's because of this taboo that... most people... would feel very apprehensive in approaching someone because they say "Listen, you know,... if I do admit I want... to get help it means I'm crazy. FG 5 (Youth group).

I have never told anyone that I suffer from depression and nor do I want to, due to the stigma that is attached. It was mentioned in a class on mental health recently that a patient the lecturer was caring for was suffering a depressive episode and confessed that they wanted to press the accelerator and crash their car.... my classmates started laughing! I don't feel that people understand or are considerate of those that are having mental health issues. (Young adult submission).

Stigma attached to mental health can sometimes make it difficult for young people to make contact and avail of service. (Stakeholder submission).

I find that there is a stigma surrounding people's mental health. If you fall and cut your arm you put a plaster on it, you have an assortment of aid for that one cut. I see no such quick fix for a person's mental health. My understanding of the stigma of mental health is that many people are quick to judge, yet slow to understand young people "oh it's just a phase", "They'll grow out of it" sometimes it is, but often it's not a phase. I believe that simple communication and knowledge is key in helping everybody's mental health. (SP 18-25).

Young people were very conscious of the *veil of secrecy* surrounding, in particular, poor mental health and that there was a need to engage young people in discussions about mental health from an early age.

People aren't told about mental health early enough. There is a stigma about it as it's almost kept secret until mid to late teens. (SP 18-25).

The interviews with marginalised groups reflected emotions, reactions, concerns and anger expressed by the participants while they are trying to continue successfully on the road to adulthood. Many felt society had 'let them down' and were placing too much pressure on them and had unrealistic expectations of them. Some members of marginalised groups spoke of being discriminated by society, others spoke of being stigmatised by society and many blamed society for the state of their mental health.

Members of marginalised groups such as Travellers, who do not conform to the norm for their particular group are extremely vulnerable from a mental health perspective, as a consequence of the double life they are forced to lead.

That are leading a double life that's hiding the fact that they are gay or lesbian do you know what I'm on about...And this is what's causing this suicide. FG 1 (Minority group).

Members of marginalised groups (e.g. L.G.B.T) with a mental health condition experience what is referred to in the literature as 'double stigma' which augments their mental health vulnerabilities and further challenges society's conceptualisation of normality.

There's a taboo on mental health and on sexuality – if you combine them... FG 5 (Youth group).

Young people believed that the only mechanism to reduce the stigma attached to mental illness is through openness and creating new attitudes, not trying to change the one society currently possesses.

There needs to be more openness towards mental health, that is, it shouldn't be forgotten about and a no-go area. It needs to be highlighted and positive to talk. (SP 18-25).

As a society we need to start young – it's not about changing attitudes, it's about creating attitudes. Participant 11 (Young adult/Stakeholder - Education).

Young people alluded to potential discrimination if they divulged their mental health status to employers. Perceived discrimination is also recognised to preclude people from disclosing their mental health issues to families and friends. A recent Amnesty International Ireland (AI) commissioned research study found, that perceived unfair treatment as a result of a mental health problem was experienced by the majority of the study participants.

The majority of participants reported experiencing distress due to their perception being discriminated against because of their mental health problem (MacGabhann, 2010). Hence, discrimination is a very real problem in Ireland today. See *Change* the National Mental Health Stigma Reduction partnership, explored the Irish public's attitudes towards mental health problems in 2010 and 2012. Notable positive differences in the 2012 survey included, a self-reported increased

awareness and understanding of mental health; stigma and support services and an increased willingness to seek professional help. Conversely, there is a greater reluctance to disclose information about a mental health problem in a personal and professional relationship. In addition, there is a more negative perception of peers' reaction to a person's mental health disclosure which was alluded to by young survey participants.

In summary, society's perceived perception of mental health has a potent influence on the engagement of young people with supports/resources to maintain and enhance their mental wellbeing.

Conclusion

The triangulated data has been deployed to highlight the perceived current mental health needs of young people in the region; the existing range of supports/resources to address the identified needs and the perceived deficits in support provision. In addition, a number of stakeholders generated proposals to address the identified mental health needs and gaps in service provision are dispersed throughout the chapter in alignment with the socio-ecological framework.

Chapter 5: Guiding Principles and Considerations for Strategic Plan

Guiding Principles

The research evidence generated underpins the guiding principles and considerations for the strategic plan being advanced for the future delivery of youth Mental Health Services in the region. The principles being advanced are in alignment with the principles detailed in both national and international mental health care policies. The model of service delivery for youth mental health in the Sligo/Leitrim/west Cavan region should be:-

- ✓ Person/relationship centred and empathetic.
- ✓ Community driven and focused.
- ✓ Evidence based, accountable and outcome focused.
- ✓ Empowering for young people/ families and communities.
- ✓ Inclusive and responsive to diversity.
- ✓ Integrated, streamlined and flexible.
- ✓ Stigma minimising.
- ✓ Supportive to all stakeholders (Young person; families; care providers).
- ✓ Supporting and recognising the community as its own best resource by acknowledging local knowledge and develop community capacity to improve mental wellness.

Furthermore it should:

- ✓ Promote mental health across the life span in homes; schools; communities and workplaces, to prevent mental illness and suicide, when possible.
- ✓ Foster optimal mental health through capacity building from the individual to societal level.
- ✓ Recognise and minimise risk to attain optimal mental health.
- ✓ Provide accessible and equitable service and support provision.
- ✓ Have a universal wellness to recovery focus.
- ✓ Foster partnership and collaboration between young people; carers and service providers.
- ✓ Facilitate choice, opportunity and responsibility.
- ✓ Utilise technology to foster collaboration; increase access to service and engage young people in managing their mental wellbeing and illness.

The following recommendations are being advanced for consideration. It is recognised that for the recommendations to be operationalised additional and/or refocused, resources (finance, time and personnel) will be required. It is also the contention of the research team that a project manager or equivalent should be appointed to monitor and evaluate the implementation of the recommendations.

Considerations for Strategic Plan

Intrapersonal	<p>Consider promoting a framework such as <i>The 7 Cs: The Essential Building Blocks of Resilience</i> to guide parents in the development of their son's/daughter's resilience.</p> <p>Consider promoting the currently available 'online' Lifeskills programmes among adolescents and young people.</p> <p>Consider promoting programmes such as the 'Hope and Optimism' course to teachers as a means of assisting them develop young people's self-esteem.</p> <p>Review the curricular content of SPHE, to evaluate if there is sufficient emphasis on developing the young person and to ascertain how this is objectively measured.</p>
Interpersonal	<p>Evidence-based 'on-line' parenting interactive programmes should be introduced to target the greatest number of parents.</p> <p>The effectiveness of the outcomes of the region's current parenting programmes in relation to educating parents on the promotion of mental wellbeing and the recognition of poor mental health, should be ascertained empirically.</p> <p>Promote the concept of "<i>five moments for initiating a mental wellbeing (or Mind your head</i>") conversation with parents (Pre-school; pre post-primary; midpoint post-primary; pre-third level/ employment and pre-21 years or prior to gaining their financial independence).</p> <p>All key stakeholders working with young people should create opportunities to engage with young people on a regular basis, with the purpose of affording young people the opportunity to discuss their mental wellbeing.</p> <p>An agreed decision making framework should be selected for universal utilisation in the region to support young people in:</p> <ol style="list-style-type: none"> Their selection of one good adult and/or selection of an individual they relate to well. Their deliberations around disclosure. Their appreciation of the range of therapies.



	<p>The number of young people who engage in <i>Big Brother Big Sister</i> and/or mentoring programmes should be increased by an agreed percentage on an annual basis.</p> <p>The meaning of friendship should be a core element of the SPHE curriculum.</p>
<p>Community</p>	<p>All post-primary schools in the region should engage with the Home Youth Liaison Service to maximise the support that young people with specific needs can avail of.</p> <p>The capacity of General Practitioners must be strengthened through CPD, to further support them in caring for young people’s mental wellbeing.</p> <p>Modules on mental health and therapeutic engagement should be an obligatory component of the undergraduate curricula for all health and social care professionals and educators.</p> <p>Until CAMHS is in a position to respond to all primary care referrals in an acceptable time period they must:</p> <ol style="list-style-type: none"> a) Engage all young people in some form of intermediary mental health support while they are waiting to access specialist secondary supports. b) Consider allocating each young person an intermediary support person whose remit is to maintain regular contact with the young person during the waiting period. <p>Consideration should be given to the replication of some of the evidence based family and peer support programmes currently available in other parts of Ireland.</p> <p>Consideration must be given to the employment of a broader suite of therapies to complement pharmacological therapies in the management of young people’s mental health needs.</p> <p>The philosophy and potential value of “social prescribing” as a complementary or sole therapy must be promoted among all key stakeholders and young people.</p> <p>Train and support a number of lay people in the region to serve as mental</p>

health champions in their local community with the remit of promoting mental wellbeing and directing young people who are exhibiting signs of mental distress to relevant supports/resources.

Utilise the current recreational/sporting groups that young people engage with as a conduit to the promotion of youth mental wellbeing through the provision of training to designated key personnel in these groups.

Consider how the SPHE curriculum delivery can be further supported by the regions statutory/ voluntary groups to capitalise on its effectiveness.

Consideration should be given to identifying and utilising local communities, publically funded accommodation, to provide young people with a venue to meet a minimum of three times per week.

Create an informed awareness of the focus of the CRIB among young people in the region.

Organisational

Conduct a systemic review of the current provision of voluntary statutory and community support groups/services in the region to ascertain;

- a) Their individual focus in relation to the dimensions of the socio-ecological framework.
- b) Their catchment area.

Following this exercise; duplication and deficits in focus may emerge which will assist in refocusing the activity of support groups/resources across the region to ensure that all young people in the region have equitable access to supports/ resources that address their mental health needs.

An awareness campaign should be initiated to promote the regional 'online' service directory of supports accessible (via the 'alive2thrive' website) to stakeholders and young people.

Consideration should be given to the employment of psychiatric nurses to support CAMHS in the community.

Young people must be afforded the opportunity to be part of the decision

making process in relation to their support plans. A tripartite (young person; parent and service provider) approach should be deployed with young people < 18yrs where the Meitheal Model is not deployed or suitable.

A transition/bridging programme needs to be developed to support young people's transition from CAMHS to adult services and from in-patient settings to home/school.

In keeping with the goals of the National Carer's Strategy (DoH, 2012), CAMHS should develop a programme to support parents of young people accessing their services.

Consideration should be given to co-location of Primary Care and Mental Health Services to reduce perceived stigma associated with recognisable mental health establishments.

Policy

The Meitheal Model should be deployed more frequently to enhance interagency co-operation, so that young people with mental health needs and their families receive support and help in an integrated and coordinated way that is easily accessible to them.

Technology should be harnessed to ensure all young people have equitable access to knowledge; support and mental health services in the region.

The region's model of service provision should be one of two hubs (Sligo and Carrick-on-Shannon), with outlying satellite venues to provide young people with equitable access to support and service provision.

The delivery of specialist client assessments/consultations should be conducted on a rotational basis in a number of satellite centres in the region.

A debate on young people's age of consent, competency/capacity to consent, risk and protection issues must be initiated in the region.

Development of the individual child/young person should serve as the underlying philosophy of all curricula (early childhood to third level) and should be evidenced in curricula learning outcomes.

Society

Consideration should be given to broadening the categorisation of vulnerable groups to include young people under financial strain.

A 'youth led' media campaign should be conducted to promote:

- a) The current online support and information resources available to young people aged 12-25 years regionally and nationally.
- b) The existing national telephone information and support service "Walk in My Shoes" which is staffed by mental health nurses to provide accessible advice, guidance and support for young people and their families.

Consideration should be given to engaging more young people/educational organisations in the planning and delivery of stigma reduction programmes in the region in conjunction with *See Change*.

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Appendix A: Table of Available Youth Mental Health Services in Sligo/Leitrim/west Cavan Area

SERVICE	DESCRIPTION OF SERVICE
Accord, 1st Floor Social Services Centre, Charles Street, Sligo	Accord is a nationwide agency supporting marriage and relationships. Their aim is to help couples prepare for, achieve and sustain their marriage and family relationships by offering support and assist them in times of difficulty or crisis. Other services offered include Marriage and Relationship Counselling, Marriage Preparation, School Programmes, Martial Sex Therapy, Fertility and Wellbeing Programme.
Adult Mental Health Services, Sligo/Leitrim and west Cavan, Clarion Road, Sligo	Is provided on a Consultant Psychiatrist led multidisciplinary basis and is underpinned by the principles and philosophy of the recovery model of care. This service provides both in-patient and community care for people of 18 years and upwards who are experiencing mental health difficulties that require psychiatric assessment intervention and treatment. Referrals are made by local GPs. The service covers Sligo, Leitrim, South Donegal and west Cavan.
Al-Anon, Co Sligo	Al-Anon offers understanding and support for families and friends of problem drinkers in an anonymous environment, whether the alcoholic is still drinking or not. At Al-Anon group meetings, members receive comfort and understanding and learn to cope with their problems through the exchange of experience, strength and hope.
Alcohol Forum, Unit B9, Enterprise Fund Business Park, Ballyraine, Letterkenny, Co. Donegal, Co. Sligo, Co. Leitrim	The service is a non-governmental organisation in the North West of Ireland, established to work in partnership with all sectors inclusive of Health, Justice, Community and Education to reduce harmful drinking and its consequences to the individual, the family and the community. Specific services include: To inform; educate and raise awareness on the impact of harmful and hazardous alcohol consumption and appropriate consumption; Implementation of evidence based action to prevent the health risks and socio-economic problems associated with harmful and hazardous alcohol consumption; Promoting community mobilization as an effective approach in tackling alcohol related harm within the local communities to address family support; To conduct research into the area of alcohol, its affects and consequences on the individual, the family and the community.
Alcoholics Anonymous (AA), Co Sligo and Co Leitrim	AA is a fellowship of men and women who share their experiences, strength and hope with each other so that they may solve their common problem and help others to recover from alcoholism.

SERVICE	DESCRIPTION OF SERVICE
<p>Alive2thrive.ie</p>	<p>A website promoting positive mental health in Sligo and Leitrim, where you will find services, resources, tips and general information.</p>
<p>Avalon Centre, Chapel Street, Sligo</p>	<p>The aim of the centre is to provide a facility offering opportunities for personal, social, cultural and educational development; and which responds to diverse needs. They also offer opportunities for recreation and play in a safe and healthy environment and to offer the support necessary to help improve the quality of life, especially for those most disadvantaged and marginalized.</p> <p>Specific services include: Community based programmes for young and old, Drop in activity youth club for 7-12 and 13-16 year olds, Special Youth Project for children at risk for early school leaving, After school autism specific adventure programmes, Autism Specific Community Access Computer programme, Range of evening based activities (dance, football, music), Social Day centre for older people, Dance and samba workshop for people with special needs, Summer Camp for 8-16 year olds and those with learning disabilities, After School Homework Support Programme, Youth Club Supports, Summer Camps, Youth Activity Programmes e.g., Hip-Hop Dancing, Singing, Bingo.</p>
<p>AWARE - Markievicz House, Barrack St, Sligo</p>	<p>Is a national, voluntary organisation working to bring vital emotional support and information to individuals and family members who are affected by depression. This is offered through the use of a helpline and a support group at Markievicz House, Sligo.</p>
<p>Bee Park Resource Centre, New Line, Manorhamilton, Co Leitrim</p>	<p>Bee Park Resource Centre is a facility in the centre of Manorhamilton offering an environment from which the following services are delivered through tenant organizations: North Connaught Youth Services, Sean Mac Dermot Boxing Club, Tiny Toppers Pre-school play group, Tiny hearts Crèche and Playschool, Manorhamilton Enterprise Forum, ETB, North Leitrim Men's Group, North Leitrim Women's Centre, Simon Community North West, National Learning Network, Youth Café.</p>
<p>Branching out – Youth arts group</p>	<p>Branching Out is a youth arts group in Sligo which aims to support young people in exploration of their own creativity. Branching Out's new space The Nest is an open free space for artistic creation exploration. Development in the building is still in process and the creative projects are ongoing.</p>
<p>Carer's Association, Castle House, Castle Street, Sligo</p>	<p>This is a national, voluntary body of family carers in the home. Specific services include: drop-in resource centre; national care line; in-home respite service; private care services; support groups; counselling; training; advocacy and lobbying; pamper and fun days.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Carer's Development Officer, St John's Hospital, Sligo</p>	<p>Provides a dedicated support service for carers based on their needs and choices. The service provides advice information and support to carers. The service will assist you by providing advice, information and support to help you in your caring role.</p>
<p>Carrick-on-Shannon Education Centre, Marymount, Carrick-on-Shannon, Co. Leitrim</p>	<p>Provides training, development and support for teachers and the wider school community through professional development and support for Teachers, School Management, Special Needs Assistants, Parents, Board of Management and other relevant partners, Develops projects and programmes as identified nationally, regionally or locally. Provides a resource and meeting centre for the local school community, Engagement with other Education Centres, relevant bodies and organisations.</p>
<p>Child and Adolescent Mental Health Service (CAMHS), Malloway House, The Mall, Sligo</p>	<p>The CAMHS is a community based team which covers Sligo, Leitrim, South Donegal and west Cavan. Referrals are made through local GPs for young people who are experiencing mental health difficulties and require psychiatric assessment up to the age of 18 years. The service includes, but is not limited to: Emotional and Behavioural Disorders in childhood and adolescence; Difficulties resulting from abuse and other traumas; Eating Disorders; Developmental disorders e.g., ADHD; Psychiatric conditions in childhood and adolescence e.g., depression, phobias.</p>
<p>Citizen's Information Centres - Leitrim (Carrick-on-Shannon; Drumshambo; Manorhamilton)</p>	<p>The Citizens Information Board is the statutory body which supports the provision of information, advice and advocacy on a broad range of public and social services. Specific services include: Providing Information on Birth; Family and Relationships; Consumer Affairs; Death and Bereavement; Education and Training; Employment and Housing; Health; Money and Tax; Social Welfare; Travel and Recreation; Clinic; Referral for MABS; and Information Website.</p>
<p>CLASP - Community of Lough Arrow Social Project, Gleann Community Centre, Drumnacool, Co. Sligo</p>	<p>CLASP is a community development project based in East County Sligo. It focuses on the needs of older people and the young people in the community. It assists older people to remain living independently in their own homes/communities. Services Offered include: Meals on Wheels; Home Improvement; Facilitate 5 active age clubs; Co-ordinate social and educational activities; Youth Clubs; Educational/Recreational courses; Youth Summer camps; Provides rural transport service to older or younger people; Manage FAS employment scheme; Community education programmes; Rural scheme</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Community Psychology Service for Children and Adolescents, Markievicz house, Barrack Street, Sligo</p>	<p>employment project; and Men's Shed.</p> <p>This is a countrywide primary care service for children and adolescents under the age of 18 years which provide individual assessment, intervention and training to parents, community groups and other health professionals, consultation to other health professionals and service development initiatives.</p>
<p>Counsellor for Special Needs, Nazareth House, Church Hill, Sligo.</p>	<p>Main services include: Practical and emotional support to families; Information on disability; Information on benefits and allowances; Guidance on developmental intervention that supports individuals' needs; Joint working with relevant professionals in Early Intervention and Multi-Disciplinary teams; Co-ordinator of Multi-Disciplinary Team Reviews; Guidance and support at transition periods and key stages of development; Support groups such as Parent & Toddler Support Group, Sibling Support Group, Social and Recreational Saturday clubs</p>
<p>Cranmore Community Co-operative, 11 Devin's Drive, Cranmore, Sligo</p>	<p>The Cranmore Community Co-Operative aims to transform the social, economic and physical landscape of the area through collaborative long term strategic planning, investment of resources and urban regeneration. The co-operative run many activities and programmes such as Counselling service for adults, Drugs Task Force Outreach Worker, Youth drop-in service, Various programmes for adults and youth e.g., Computer classes, Dancing, Keep-Fit, Photography.</p>
<p>Cura, Charles Street, Sligo</p>	<p>Based in Sligo, this is a voluntary organisation which offers support and help to those who are faced with a crisis pregnancy. Other services include: crisis pregnancy counselling; Free pregnancy testing; Information on social welfare and other rights and entitlements; Linking clients with other support services; Support with accommodation if required; Post abortion counselling and support; Crisis pregnancy counselling to baby's father and other family members; School awareness programme.</p>
<p>Diversity Sligo, Globe House, Chapel Hill, Sligo</p>	<p>Supports asylum seekers and refugees in their inclusion into Irish society by offering the following services: Advocacy; Asylum Applications Assistance; Information Services; Integration; Mental Health Services; Recreation; Support Group; and Training.</p>
<p>Dochas Clubhouse, Millbrook, JFK Parade, Sligo</p>	<p>This is a HSE funded resource for individuals experiencing mental ill health based in Sligo. It strives to enable its members to access employment, educational and social opportunities in the community whilst providing a safe and respectful environment to assist individual members in their recovery. This is done in the following ways: Develop personal goal plan;</p>

SERVICE	DESCRIPTION OF SERVICE
	<p>Encourage participation in running of the clubhouse; Focus on strengths; talents and abilities of each member; Provide benefit and entitlement guidance; Liaise with other appropriate agencies; Provide daily well balanced meal; and Assist in job seeking.</p>
<p>DVAS - Domestic Violence Advocacy Service</p>	<p>DVAS provide a range of services to women who are experiencing domestic violence and abuse from intimate partners and other adult family members. The core purpose of our service is to support women to access safety for themselves and their children. DVAS have a helpline and also provide support, information and advocacy through a one to one support service. Services offered include: Helpline; Support; Information; One to One Meetings; Court Accompaniment; and Advocacy.</p>
<p>Eating Disorders Therapist, Markievicz House, Barrack Street, Sligo</p>	<p>Once the community-based mental health services receive and screen referrals from GPs, the Eating Disorders Practitioners provide assessment and treatment to individuals with eating disorders. In Sligo, Leitrim and Donegal Eating Disorder therapists Mary Harron Adult Eating Disorders Practitioner and Aisling Lafferty, Child and Adolescent Eating Disorders Practitioner, offer assessment and treatment with the aim of early intervention in an attempt to prevent the person's eating disorder becoming more severe. Treatment focuses on helping the individual to change some of their thoughts and behaviours regarding their weight, body image and eating. The treatment provided is a cognitive behavioural approach which can help to change how a person thinks and what they do in order to improve their emotional health and wellbeing.</p>
<p>Employment Response North West, 1 Custom House Quay, Sligo</p>	<p>Employment Response North West, provides a Supported Employment Service in Sligo, Leitrim and Donegal that can help people with mental health issues or concerns to find, secure and maintain paid employment in the open labour market. They specifically support people in the following ways: Assistance in the identification of skills; Skills are matched with potential jobs; Suitable potential Employers are identified and approached; Integration into the workplace is facilitated; and Support is provided on the job - the Fading of the Support is organised so as to allow the new employee to continue to work independently.</p>
<p>Family Therapy Service (HSE), Markievicz House, Barrack Street, Sligo</p>	<p>Offers counselling and support to families couples and individuals who are experiencing personal and/or relationship problems and are seeking help to resolve them. They provide a supportive, therapeutic environment where people can explore their problems and find solutions. The service is non-denominational, non-racist and gender sensitive. There is no charge.</p>
<p>Family Resource Centres (Ballymote, Tubbercurry, Sligo, Enniscrone (West Sligo FRC), Breffni</p>	<p>Aims to improve the functioning of the family unit by serving all families in a warm caring and open environment. This is done by providing support information and support programmes to ameliorate against the impacts of poverty</p>

SERVICE	DESCRIPTION OF SERVICE
<p>(Carrick on Shannon) and Mohill)</p>	<p>marginalisation and exclusion.</p> <p>Examples of services provided in many of the centres include Parent and Toddler Group, Childcare (Crèche, Pre-School and After School), Spiritual meditation group weekly, Holistic Therapy programme for people living with addictions, Family access provision, FETAC Accredited courses including self-advocacy, computers and communications, Counselling-Bereavement and Family Therapy, Summer Camp during July, Interest groups (Art, Women’s, Weight Watchers, Youth and Lone Parents), Senior Adult System (65+), Youth Café, Men’s Shed, Saol Nua social programme for people with disabilities, Rainbow Programmes, Teen Between Counselling Service, Narcotics Anonymous weekly, Breastfeeding support group monthly, Weight Management and Nutrition weekly, Attention Deficit Disorder Support Groups.</p>
<p>Family Welfare Conference Service, Teach Laignhe, Humbert St., Tubbercurry, Co. Sligo</p>	<p>Family Welfare Conference (FWC) is a structured, family led, decision making meeting, where as wide a range of family members as possible come together to formulate a safe family plan in the best interests of the child. Essentially it is a method of family intervention that enables families to provide their own solutions to the difficulties they face.</p>
<p>Foróige, The CRIB, Rockwood Parade, Sligo</p>	<p>The CRIB in Sligo town is a multifaceted service providing a range of programmes and supports to enable the healthy development of all young people aged 12-18yrs. The CRIB provides targeted group and individual programmes, parental support, Drop-In service, Mind-Full of Health Service, Music Generation rehearsal space and houses the Network For Teaching Entrepreneurship Programme co-ordinator for the west/northwest area.</p>
<p>Foróige, Big Brother Big Sister Programme (BBBS), Rockwood Parade, Sligo</p>	<p>This internationally recognised evidence based mentoring programme is based at the CRIB and open to young people throughout county Sligo. Big Brothers Big Sisters of Ireland (BBBS) is an internationally proven youth mentoring programme that connects an in-need young person to an adult volunteer mentor to facilitate a positive transition from adolescence into adulthood. Young people aged 10 to 18 years can be referred to the programme from throughout Sligo town and county . It is the belief of BBBS that all young people need and deserve support to enable them to develop as people and succeed in their transition from adolescence into adulthood. The involvement of a volunteer mentor in the life of a vulnerable young person through BBBS acts as a powerful natural development support and connects the participants to their communities in a very real way.</p>
<p>Foróige Club Development, Foróige, Rockwood, Parade Sligo</p>	<p>Foróige Clubs enable young people to experience democracy at first hand through the election of their own club committee and the management and operation of the club in co-operation with their Volunteer adult leaders. These clubs operate in local communities for young people aged 12-18 years. Foróige Junior Clubs are for young people aged 10-12 yrs and while</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Foróige Youth Drug and Alcohol Education & Prevention Projects Sligo – Foróige Volunteer, Foróige Office, Humbert St., Tubbercurry / Leitrim – Foróige Office, Leitrim Rd., Carrick on Shannon, Co. Leitrim</p>	<p>they also operate with adult leaders the young people work in a huddle as opposed to a formal meetings.</p> <p>This project is funded through the North West Regional Drugs and Alcohol Task Force through Mayo, Sligo and Leitrim ETB. The overall aim of the project is to promote healthier lifestyle choices amongst all young people aged 10-17yrs, specifically young people at risk of/ or using drugs or alcohol, by equipping them with the knowledge, skills and attitudes to enable them to make positive informed decisions. The project is outreach and has a countywide brief in both counties. Both group and individual programmes are facilitated in line with best practice.</p>
<p>Foróige South Leitrim Neighbourhood Youth Project Hilldrum House Leitrim Rd., Carrick on Shannon, Co. Leitrim</p>	<p>The South Leitrim Neighbourhood Youth Project is a community based family support project open to all young people and families throughout the south Leitrim area. In particular, the project works with young people aged 10-18 who are at risk of or currently experiencing personal, educational, family or social difficulties. The project provides a range of one to one and groupwork interventions in an outreach capacity.</p>
<p>Foróige, Comhairle na nÓg, Rockwood Parade, Sligo</p>	<p>Comhairle na nÓg Shiligh is a joint partnership between Foróige, Sligo County Council and Mayo, Sligo and Leitrim ETB. The overarching aim of this work is to work with the Comhairle na nÓg Shiligh to facilitate them as the official structure for the participation of young people in strategy and policy development in the county, and, to increase the participation of young people in local decision making. A yearly AGM is open to all young people in county Sligo to participate in round table discussion on youth issues and the election process.</p>
<p>GA - Gambler's Anonymous, Sligo</p>	<p>Gamblers Anonymous (GA) is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from a gambling problem. Based at St Participant 6 (Young Adult)'s Family Life Centre, Sligo.</p>
<p>Girls' Brigade (Sligo and LEITRIM)</p>	<p>The Girls' Brigade is an International Uniformed Youth Organisation for girls of all ages, denominations, backgrounds and abilities. The Girls' Brigade Ireland operates in 33 companies around the country, offering a varied programme of activities designed to educate, challenge and inspire young people in a safe, fun and sociable environment.</p>
<p>GRASP Life Foundation, Co Sligo</p>	<p>The Grasp Life Foundation provide outreach counselling services; a 24x7 crisis helpline and bereavement support meeting in St Michael's resource centre, Sligo. Grasp Life go into schools and workplaces when requested to speak on the topics of suicide, depression and mental health issues.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>GROW Leitrim - St Patricks Hospital, Carrick-on-Shannon, Co. Leitrim</p> <p>Sligo - St Participant 6 (Young Adult)s Family Centre, Sligo</p>	<p>GROW is a mental health organization which helps people who have suffered or are suffering from mental health problems. Members are helped to recover from all forms of mental breakdown, or indeed to prevent such happening. Specific services offered include: A place to talk in confidence if you're experiencing mental health problems or difficult life events (Bereavement/loss of relationship/Fed up); Opportunity to meet people who feel and think like you; Offers programme of recovery and prevention; Gives support and help to people to combat day-to-day stresses of modern living.</p>
<p>Home Youth Liaison Service, (covers Leitrim and Sligo)</p> <p>Sligo - 13 Mailcoach Road, Sligo</p> <p>Leitrim – Carrick on Shannon, Co Leitrim</p>	<p>Home Youth Liaison Service, Sligo and Leitrim, aims to provide a sympathetic, confidential, non-judgemental and personal support to young people and their families with the objective of enhancing the young person's future personal and social development and wellbeing. It also aims to provide a link between family, school and professional services (both in the government sector and the voluntary sector). Specific services include: One to one support in Primary and Post Primary schools; In School programmes; Residential Weekends; Summer Breaks; Facilitate out of school education; and Out of hours Youth Support for Social work.</p>
<p>HSE Alcohol & Substance Misuse Counselling Service, Sligo and Leitrim (HSE), Charter House, Old Market Street, Sligo</p>	<p>To reduce the impact that alcohol and substance misuse has on the lives of individuals and concerned people. Specific services include: Comprehensive Assessment; Care planned counselling; Motivational Interviewing; Some group work; Shared care liaison work with General Practitioners; Referral to residential treatment; Support services for concerned persons of alcohol/drug users.</p>
<p>Leitrim Development Company, Drumshambo, Co Leitrim</p>	<p>Recognising our shared commitment and diverse experience, they strive to stimulate social, local, economic and rural development throughout Co. Leitrim, for the benefit of all, particularly the marginalised, empowering them to engage with development opportunities that respond to their needs.</p> <p>Specific services include: Day Service for Older People (Twice a Week); Befriending Service for older people; youth projects with young people; Cross-Border Projects; Back to Education Courses; Exercise classes for women; first aid classes; Internet café; Assist with CV writing and interview skills; Support local voluntary groups (setting up; planning and applying for funding) and much more, see website for more details.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Leitrim Sports Partnership, Leitrim County Council, Áras an Chontae, Carrick on Shannon, Co. Leitrim</p>	<p>Leitrim Sports Partnership aims to increase the number of people involved in sport or physical activity in Leitrim.</p> <p>Specific services include: Promote sport and physical activity among adults and children with disabilities and raise awareness on the benefits of their participation; Information provided on local activities; sports directory and identifying needs and resources to form basis of local planning; Range of national programmes available to encourage participation; Disability Forum; Active Age Sport and Dance; Community Fitness (2014); Link to Be Active (Unemployed); and 10k and 5k mini-marathons.</p>
<p>Liaison Psychiatry Service, Sligo Regional Hospital, Sligo</p>	<p>Based in Sligo Regional Hospital Accident and Emergency Department. A 24 hour on call service comprising of a Non Consultant Hospital Doctor and 2 Nurse Practitioners providing a comprehensive assessment to inform a care plan.</p>
<p>Lifestart Sligo and Leitrim</p>	<p>Lifestart educates parents on how their children grow and the Lifestart Growing Child programme helps parents to support their child's physical, intellectual, emotional and social development and to ensure that their children are 'school ready' at an appropriate age and are able to take full advantage of preschool and formal learning.</p> <p>Specific services include: Delivery of the Growing Child Programme (0-5years); home based programme to support parents in their role as primary educators; Childcare facilities 0-6years; Parent and Toddler Groups; The Toy Box Project – Home based weekly support to Traveller parents and their pre-school children who are not currently accessing pre-school services; Training for parents as requested; Parenting support on child development (Growing child programme/sessional interventions/Spirals); Programme for young parents; First time parents (children aged 0-3yrs); Families with additional support needs (children 0-5).</p>
<p>Living Links Sligo and Leitrim</p>	<p>Living Links provides practical help, information and support to persons bereaved by suicide. Specific services include: Trained individuals offer a confidential listening ear service and information to families and those who have experienced a death by suicide; information and practical support concerning the funeral; inquest; entitlements; how to deal with children or neighbours; and home visits on request.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>MABS (Money, Advice and Budgeting Service) Leitrim - Swanlinbar Road, Ballinamore, Co. Leitrim</p> <p>Sligo - Cadbury House, Fish Quay, Sligo</p>	<p>State-funded, free, confidential and independent service for people with debt and money management problems.</p> <p>Specific services include: Give caring and high quality advice on money matters; Help clients to deal with debt problems; Assist clients to manage their money on their own; Refer clients to other services if they wish; Provide support suited to client's needs.</p>
<p>Mayo, Sligo and Leitrim Education and Training Board (ETB)</p> <p>Quay Street, Sligo / St. George's Terrace, Carrick-on-Shannon, Co. Leitrim</p>	<p>The ETB (formerly known as the VEC) operates post-primary schools, PLC colleges and alternative education centres in the region, as well as a range of adult education and training services.</p> <p>In addition, the ETB is responsible for the support, coordination, administration and assessment of youth services. This includes coordinating the Youth Mental Health Initiative in the region.</p>
<p>Skreen/Dromard Community Centre, Carrownaboll, Skreen, Co. Sligo</p>	<p>Skreen/Dromard Community Centre aims to create a safe secure meeting place for both the young and old generations of the local communities as well as an increased sense of community.</p> <p>Specific services include: Playschool; Hall Rental; Adult education classes (computer, arts and crafts); Action Kids Groups; Kids Support Activities (basketball, tag rugby, soccer, badminton); Adult Sports (circuit training, soccer, badminton); Speech and Drama/ Music Classes; Programmes for the older adult (exercise); Walking; Pilates; Hip-Hop; Irish Dancing and Athletics.</p>
<p>MCR Community Centre, Mail Coach Road, Sligo</p>	<p>MCR Community Centre aims to initiate and support measures to improve the social, cultural and economic development of the community area in partnership and co-operation with various statutory and voluntary agencies and bodies.</p> <p>Specific services include: Playgroup for children 3-5 years; After school service for children 7-12 (Homework support, arts, crafts, sport); and Active Age Group.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Mental Health Associations - Sligo, Easkey, Ballymote, Breffni, Manorchamilton, Mental Health Associations, Development Officer Sligo Leitrim, JFK House, JFK Parade, Sligo</p>	<p>These associations promote positive mental health and are active in assisting to meet the mental health needs of people in Sligo, Leitrim and west Cavan. These are all branches of the national organization Mental Health Ireland.</p> <p>Specific services include: Information boards on positive mental health; Donations to people in need in the catchment area; Support education initiatives on mental health in local schools (e.g. annual public speaking competition to reduce stigma); Organises social activities for people with mental health difficulties; Welcomes new volunteers.</p>
<p>Mental Health Promotion/ Suicide Prevention Officer, HSE West, JFK House, JFK Parade, Sligo</p>	<p>The Mental Health Promotion / Suicide Resource Officer HSE provides information, support and training to communities in Sligo and Leitrim to promote mental health and prevent suicide. The Resource Officer co-ordinates and delivers a number of training programmes in the area including: ASIST (Applied Suicide Intervention Skills Training); SafeTALK; Stress Control and Positive Mental Health workshops. The Resource Officer works in partnership with the statutory and voluntary sector and community groups, including the National Office for Suicide Prevention, the Mental Health Services, Foróige, National Educational Psychologists, Schools and Colleges, Mental Health Ireland, Grow, Console and the Family Resource Centres to improve mental health at a community level and to prevent suicide.</p>
<p>Merville Youth and Community Centre, Maugheraboy, Co. Sligo</p>	<p>The aim of Merville Youth and Community centre is to promote inclusive community participation in the economic, social and cultural development of the Merville and Maugheraboy Areas of Sligo town.</p> <p>Specific services include: Child Care Services; Active Age group; Hall Rental for classes including Circuits; Bokwa; Social Dancing for older adults; Zumba; Kung Fu for adults and Kids; Soccer Club for kids.</p>
<p>Mohill Family Support Centre, Mohill, Co Leitrim</p>	<p>The centre works to help individuals and families improve the quality of their lives. The centre is managed by a board of volunteers from the local community and has a small staff. Their focus is to help local people achieve what they themselves see as priorities for their lives.</p> <p>Specific services include: Counselling service; Art therapy; Rainbows programme; Parent and Toddler Groups in Mohill and Ballinamore; Youth club and youth café, Outreach development worker visiting Ballinamore and Carrigallen; Personal Enhancement Programme for 12 weeks, one morning per week; Women's and Men's Groups; Carers Support Programme; Practical Assistance to Community Groups; Family Mediation; Positive Parenting; Senior Alert Scheme; Knitting Group; Active Age Group; ION Programmes; Strengthening Families programme; Information Days; Summer Camps.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Narcotic's Anonymous, Leitrim</p>	<p>Narcotics Anonymous (NA) is a non-profit fellowship of men and women for whom drugs had become a major problem. We are recovering addicts who meet regularly to help each other stay clean.</p>
<p>NEPS - National Educational Psychological Service, Sligo/Leitrim/west Cavan, Unit 3-6, Bulleah Building, Finisklin, Sligo.</p>	<p>Main activities include: Psychological service to schools, assessment and consultancy.</p>
<p>No Name Club, Gillooley Hall, Sligo and Tubbercurry, Co Sligo</p>	<p>No Name Club enables young people to organise and enjoy positive alternatives to alcohol and drug-centred activities, building self-confidence and increasing awareness of the effects of alcohol and drugs, helping young people make informed choices when they are older.</p>
<p>North Connaught Youth and Community Service, Hill Road, Drumshambo, Co Leitrim</p>	<p>Works with and for 7 - 18 years across the county in partnership with young people, volunteers and other organisations. We are committed to pioneering and sustaining quality youth work which enables young people to maximise their potential through their voluntary participation and offers them opportunities for learning, achievement and support.</p> <p>Specific services include: Group work and one to one work with young people aged 10 – 18 years throughout Leitrim through clubs, cafes and projects, Teen Between support service, Specific projects in Base Cafe Drumshambo, also drop-in support and training to volunteers, Issue based workshops with young people in communities and schools.</p>
<p>North Connaught Youth and Community Service, Rockwood Parade, Sligo</p>	<p>North Connaught Youth Service Sligo works with and for 7 - 18 years across the county in partnership with young people, volunteers and other organisations. We are committed to pioneering and sustaining quality youth work which enables young people to maximise their potential through their voluntary participation and offers them opportunities for learning, achievement and support. Also runs Sligo Youth Information Centre, Rockwood Parade, Sligo, which provides free, comprehensive and confidential service to young people.</p> <p>Specific services include: Youth Information Service; Youth Work through clubs; cafes and projects; Youth Club Development; Teen Between Support Service; Garda Youth Diversion Projects; Youth Exchange; Child Protection Training; Youth Club Volunteer Training; In School Programmes such as, Life Choice, Cyber Safety; Babysitting Programme; Comhairle na nÓg.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>North Leitrim Resource Centre, New Line, Manorhamilton, Co Leitrim</p>	<p>North Leitrim Resource Centre is a community resource sponsored by the Sligo/Leitrim Council of Trade Unions and is a member of the Congress of Trade Unions Network.</p> <p>Specific services include: Community Employment Scheme; Training and Work experience for unemployed; Secretarial Support for Community Groups; Promotion for community events.</p>
<p>Northside Community Partnership, Northside CDP, Resource Centre, Forthill, Sligo</p>	<p>The Sligo Northside Community Partnership aims to make a positive difference in the lives of people in the North Ward, primarily through the provision of different courses and activities and also to provide a vibrant focus for all sectors of the community with emphasis on their social economic and educational needs.</p> <p>Specific services include: Childcare; Pre-School & Afterschool Youth Clubs and Summer; Substance Misuse Project Women’s Training and Development; Community Steps Training Programme.</p>
<p>Northwest LGBT Pride Ireland</p>	<p>Based in Sligo is a support for lesbian gay bisexual and transgender people in the North West where groups offer facilitated support through activities networking events and other projects.</p>
<p>North West Regional Drugs and Alcohol Task Force, Sligo and Leitrim</p>	<p>NWRDTF is responsible for tackling the issues associated with illicit drug use and underage drinking in the North West region with reference to the NDS pillars; Supply Reduction, Education and Prevention, Treatment, Rehabilitation and Research. Their aim is to reduce the negative impact of drug misuse and underage drinking upon the individual and society in the region through coordinated and targeted actions at regional and local levels.</p> <p>Specific services include: To raise awareness levels of drug misuse and underage drinking in the North West; To proactively encourage and facilitate effective communication between relevant agencies dealing with issues of drug misuse and underage drinking at appropriate levels; To inform the public of Task Force actions on an ongoing basis; To undertake evidence based actions positively impacting upon drug misuse and underage drinking.</p>
<p>North West Simon Community, Bee Park Resource Centre, Newline, Manorhamilton, Co. Leitrim</p>	<p>North West Simon Community was formed in June 2005 with a vision that every person in the North West Region having a place that they can call home.</p> <p>Specific services include: Develop a Settlement and Tenancy Sustainment Service in each county in the region, Aim to prevent homelessness by building on the work that has already been undertaken by voluntary and statutory agencies in working with people who are homeless, Work with clients on the local authority housing list whose needs cannot be</p>

SERVICE	DESCRIPTION OF SERVICE
	<p>currently met by the authority, Work with people who may be a risk of losing their home or those who are experiencing difficulties, Purchase accommodation in conjunction with Simon Communities of Ireland Housing Association and councils.</p>
OUTWEST	<p>OUTWEST is a social and support group for Gay men, Lesbian women and Bisexual people in the West of Ireland. They hold social meetings every second month and discos and other events several times a year.</p>
Some On line resources	<p>Spunout.ie Reachout.com Aware.ie Grow.ie Headstrong.ie Bodywhys.ie Teenbetween.ie Mymindmatters.ie – specifically for 3rd level students Headsup.ie Alive2thrive.ie</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Rape Crisis and Sexual Abuse Counselling Centre Sligo, Leitrim and west Cavan.</p>	<p>The service provides a safe space for survivors of child sexual abuse, rape, sexual assault and sexual harassment. A place where adults and young people can explore and access help with issues resulting from their experiences. They believe that everyone has the inner capacity and resources to move towards change and wellbeing.</p> <p>The service is free and confidential. Specific services include: Crisis counselling; Ongoing face to face counselling; Free phone helpline; Support; advocacy and information for survivors; Group Therapy; Relationship Counselling; Counselling support for family/friends of survivors; Hospital; Court; GP; Garda accompaniment; Education; Training; and awareness-raising; Lobbying and influencing policy on relevant issues; Networking and information sharing with other organisations.</p>
<p>Regional Counselling Service, 68, John Street, Sligo</p>	<p>This service provides counselling/therapy to individuals and families in cases of complicated grief, abuse, sexual abuse and trauma.</p>
<p>Rennafix Group</p>	<p>This service assists with the promotion of positive mental health through Outdoor Activities, Connecting People and 'Having a Laugh'. They do this through the creation of events that showcase life-enhancing activities and generate a sense of mischiefousness and joy. They subsidise community groups and those seeking counselling and/or therapy to take part in outdoor and life enhancing activities by fund-raising through festivals and events which are also wellbeing orientated.</p>
<p>Samaritans, 3 The Mall, Sligo</p>	<p>Samaritans offers support and someone to talk to through a variety of mediums: telephone, email, letter and face-to-face and also works in the local community, workplaces, schools and prisons.</p> <p>Specific services include: Telephone Helpline, Email Support, Face-to-Face support.</p>
<p>Scouting Ireland (Sligo, Leitrim, west Cavan)</p>	<p>Scouting Ireland is a multi-denominational, co-educational; youth based association with a membership close to 40,000 across the island of Ireland. It is affiliated to the World Organisation of the Scout Movement.</p>
<p>Shack Youth Café, Bee Park Resource Centre, Newline, Manorhamilton, Co. Leitrim</p>	<p>The Shack Youth Cafe is a Drop In centre for young people of post-primary age. Run by a committee made up entirely of volunteers the Shack offers a safe environment for young people to hang out, meet their friends and have some fun.</p> <p>Specific services include: The Shack has a number of computers with Internet access, a pool table, DJ decks, games consoles and lots of other things for the young people to use, The nightly charge is €2 after which everything is free to use. All volunteer leaders are fully trained and Garda vetted.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>SHINE (recover.ie)</p>	<p>Shine is the national organisation dedicated to upholding the rights and addressing the needs of all those affected by enduring mental illness including, but not exclusively, schizophrenia, schizo-affective disorder and bi-polar disorder, through the promotion and provision of high-quality services and working to ensure the continual enhancement of the quality of life of the people it serves.</p>
<p>Sligo Cancer Support Centre, 44 Wine Street, Sligo</p>	<p>The centre offers support and practical help to people with cancer, their families, friends and bereaved in total confidentiality. Drop in for a cup of tea, meet someone who has had cancer diagnosis and is still living life to the full. Sharing experiences widens horizons and opens out new and better ways to deal with difficulties. There is no need to try and solve them alone.</p> <p>Specific services include: ‘Journey towards Wellness’ workshop facilitated by a psychotherapist exploring fears and giving support, Workshop on self-care, Support Groups for Adults, Support groups for children and young adults, 1:1 counselling and psychotherapy, Support for those who have lost a loved one to cancer, Complementary therapies: aromatic massage; foot relax therapy; meditation/relaxation; Art therapy; Yoga. Specialist aftercare services; Bioenergy Healing; Biodynamic Psychotherapy and Massage; Reiki.</p>
<p>Sligo Citizen’s Information Centre, Unit 3 & 4, Bridgewater House, Rockwood Parade, Sligo</p>	<p>The Citizens Information Board is the statutory body which supports the provision of information, advice and advocacy on a broad range of public and social services. Specific services include: Providing Information on Birth; Family and Relationships; Consumer Affairs; Death and Bereavement; Education and Training; Employment and Housing; Health; Money and Tax; Social Welfare; Travel and Recreation; Clinic; Referral for MABS; Information Website; Outreach Service.</p>
<p>Sligo Education Centre, Sligo I.T. Campus, Ballinode, Co. Sligo</p>	<p>Provide continuing professional development and support for Teachers, School Management, Special Needs Assistants, Parents, Boards of Management and other relevant partners through the development and delivery of projects and programmes to meet the national, regional and local school community needs e.g. In-service Project Maths for all post-primary teachers, literacy and numeracy initiatives to support teachers and parents, SNA courses, courses on Special Needs, Bullying and Cyber Bullying, support to teachers and parents of infant children in Aistear the Early Childhood Curriculum Framework, training in Incredible Years to both teachers and parents, support and training to school communities on Child Protection, offer support to any educational initiative locally.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Sligo Leader Partnership Company Limited, Cleveragh Road, Sligo</p>	<p>Is responsible for delivering programmes which are aimed at developing and improving the quality of life for the people of Sligo.</p> <p>Specific services offered include: Support for Migrant Workers and Refugees; Rural Men/Women Support Programme; Traveller Community Development programme; Community Action for the Elderly; County Community Forum Supports; Rural Transport Initiative; Development Youth Work; Traveller Youth Development; Traveller Interagency Working Group; Young People with Additional Needs Programme; Tus (for unemployed offers 20 hours work per week).</p>
<p>Sligo Sport and Recreation Partnership, ETB Offices, Riverside, Sligo</p>	<p>Our aim is to support increased participation in sport and active recreation throughout County Sligo. Our goal is having more people, more active, more often.</p> <p>Specific services include: Education and Training at local level; including generic training courses in areas such as Code of Ethics; First Aid and Active Leadership; Walking groups for people with mental health difficulties; Gym group for people with mental health difficulties; Many more programmes (see website for details).</p>
<p>Sligo Traveller Support Group 1a/2a St Annes, Cranmore Road, Sligo</p>	<p>They run programmes and provide family support in Tubbercurry, Ballymote, Sligo, Gurteen, Enniscrone:</p> <p>Primary Health Care Programme; Fully accredited Counselling Service for adults and young people; one-to-one and group (psychotherapy and addictions); Mediation Service; Homework Club accommodated next door in 2a St. Anne's, primary and secondary school students; Support for young people at risk of early school leaving; Support and work with Youth Groups from disadvantaged areas; Men Groups; Boxing Clubs; STSG Football Club (mix of Travellers and foreign nationals); Women's Groups; Weekly Walkers Group; Advocacy Service; Delivery of Traveller Awareness Training Sessions; Art Therapy programme; Staff trained in Strengthening Families programme; Staff trained with ION services; Various training and recreational courses for adults; Venue for family access visits.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>SMILY – Sligo</p>	<p>This youth group is for young LGBT people aged 14 - 23 years old. It's a safe space to come in and chill out, get to know some people and have a chat about anything that's on your mind. Or online at http://www.belongto.org.</p>
<p>St. Michael's (Family Life Centre), Church Hill, Sligo and Carrick on Shannon, Co Leitrim, Family Life Centres</p>	<p>Promotes the wellbeing of individuals and families through educational courses, seminars, support groups and counselling in a compassionate and confidential setting. They will value the uniqueness of each individual, irrespective of gender, marital status, sexual orientation, religious beliefs, age, disability, race and membership of the Travelling community.</p>
<p>St. Vincent de Paul, Sligo and Leitrim</p>	<p>St. Vincent de Paul provides support and friendship to families, elderly and individuals combating social isolation and offering a support service. They provide information and support on housing and hostel accommodation. When members call, you can expect kindness, courtesy and respect and acceptance of you as a person.</p> <p>Specific services offered: Person to person contact with people who need support; Family visitation; Support for older people in the community; Prison visitation service; Information and supports on housing and hostel accommodation; Financial advisory service; Train and support volunteer networks; Network of charity shops; Helping people access a range of social services.</p>
<p>STOP Suicide, Bee Park Resource Centre, Newline, Manorhamilton, Co. Leitrim</p>	<p>STOP Suicide was founded in 2004 by families who were bereaved by suicide. We are a community, voluntary body that works to prevent suicide by informing educating and promoting positive suicide prevention policies throughout the West of Ireland. Specific services include: Provide a counselling service to those that are in distress or feeling suicidal; to those who have been bereaved by suicide; Promote awareness of the problem of suicide & suicidal behaviour in the general public by holding information evenings & workshops by communication of relevant material through the media; ensure the public are better informed about suicide prevention; facilitate a bereavement support group to those who have been bereaved by suicide.</p>
<p>Tenancy Support Unit, Housing Section, Sligo County Council, Quay Street, Sligo</p>	<p>Main services include: Provision of support and referral in relation to housing tenancy issues, rent arrears, estate management.</p>

SERVICE	DESCRIPTION OF SERVICE
<p>Tusla, Child and Family Agency, Markievicz House, Barrack Street, Sligo</p>	<p>Statutory service provided to children and their families. Anyone can refer members of public, family members or other statutory services, voluntary / community based services.</p> <p>Main activities and services include: Child Welfare; Child Protection; Children in Care.</p>
<p>Youth Reach Sligo, Unit 10, Cleveragh Business Park, Sligo</p>	<p>Youthreach is the Department of Education and Science’s official education training and work experiences programme for early school leavers aged 16-20 years. It is administered and managed locally by the ETB. Specific services include: Promote personal development and self-confidence of young learners and empower them with decision making skills; Enable young learners to recognise and respond positively to their talents and learning difficulties; Help learners adapt to change and appreciate the need for life-long learning; Provide a safe and healthy environment and promote safety in the workplace; Courses offered: Leaving Certificate Applied; Junior Certificate Programme; General Learning, FE/CTC Levels 3 and 4.</p>

Appendix B: Sample Information Sheet

INFORMATION ABOUT THE STUDY (Parents) – focus groups

Invitation

You are invited to take part in a research study which is seeking to gain a better understanding of the mental health needs and supports available to adolescents and young adults in Counties Sligo, Leitrim and west Cavan. This study has been reviewed and approved by the Research Ethics Committee at Sligo Regional Hospital and has been funded by Co. Sligo VEC on behalf of the Youth Mental Health Initiative for Sligo / Leitrim / west Cavan.

Purpose of the study

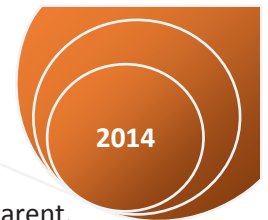
The study wishes to find out what young people in the area consider is good mental health and poor mental health. It will also explore what distresses them; what supports they are aware of to assist them maintain their mental health or help them when they cannot cope with something. It also wishes to find out what type of services young people would like in their area to help them with their mental health needs.

The study will involve up to 500 young people (aged 12-18years and 18-25 years) and up to 80 other stakeholders i.e. parents, teachers, youth leaders, community development workers, health professionals and representatives from sporting and arts organisations. We are conducting 1:1 interviews, focus group interviews, inviting written submissions and inviting young people to complete a questionnaire.

It is important that you understand what the research is for and what you will be asked to do. Please take time to visit our website www.mindyourheadstudy.com and read the following information or follow us on Facebook at <https://www.facebook.com/MindYourHeadStudy?fref=ts>. It is your decision whether to take part or not.

Why have you been chosen and what will taking part involve?

You have been chosen because you are a parent of a young person living in Sligo/Leitrim/west Cavan. You are invited to take part in a group interview. The interview will consist of you speaking as part of a group to two members of the research team about your thoughts on the mental health needs and supports available to young people in their school, community, college or workplace.



During the interview they will listen to your thoughts, feelings and experiences of being a parent. They will ask some questions, which you are free to answer in whatever way you choose. There are no right or wrong answers.

Due to the sensitive nature of the topic, you may experience various emotions before, during, or after the interview. As researchers, we will endeavour to support you during such an eventuality.

How often and how long will you be interviewed for?

The interview may last an hour or more. If you chose to take part, a member of the research team will organise a time and location suitable for the group. The interviews will be digitally-recorded as it would not be possible to remember or write all of the group's contribution during the interview.

What will happen to the information once collected?

Once the interview is over, the information on the recording will be transcribed onto paper so we can read it and begin the process of looking at the information for common meanings between all the people involved in the study. Once the information is analysed, recommendations will be made as to how services can be developed to meet the mental health needs of adolescents/young adults in this region. The findings will be published in a report for Sligo VEC. However, it is important to note that no participants will be identified in this report.

Where will the information be stored and for how long?

All information will be stored in keeping with the Data Protection Act, 2003. The recordings will be stored in a locked press in the researcher's workplace. The recordings will then be transferred to a password protected computer. Printed transcripts of the interviews will also be stored in a locked press. At no stage will your name appear on the interview recording or the transcript. Each recording and written transcript will be given a number for identification purposes. The members of the research team will be the only people who will know who took part. The information will be deleted/destroyed after the completion of the study.

Who will have access to the information?

The only people who will have access to the information are the research team and the person who types up the recordings, who has signed a confidentiality clause.

Are there any negative consequences if you choose to participate?

Talking about your thoughts, feelings and experiences of being a parent may be painful and emotional for you. We are aware that there is the possibility that you may become upset or find certain things difficult to talk about. We are also conscious that for some people, talking about mental health may bring to the surface previous events or experiences. Our intention is not to heighten your emotions in any way. If you get upset during the interview, the researcher will stop the interview and give you time to consider if you wish to proceed. Alternatively, you may withdraw from the interview and re-join later or withdraw from the study altogether. If you choose to continue we will respect your wishes and proceed sensitively. At all times your wellbeing will take priority over the research study.

If following the interview, you feel that you need support we would encourage you to contact your GP in the first instance or Mr Mark O' Callaghan, Principal Psychologist Manager, HSE West (071-9155100), who will signpost you in the direction of the most appropriate support service. We have also enclosed a card which provides you with the contact details of key sources of support in the area.

Are there any consequences if you choose not to be part of the study or if you want to opt out during the study?

You are free to withdraw your consent. This means you can opt out before the interview. You can also refuse to answer any question(s) during the interview.

What should you do if you want to drop out of the study?

If you wish to drop out before the study, you can let a member of the research team know by letter, e-mail or phone. You can also tell the researcher in person before the interview. If you choose to opt out there will be no obligation on you to give a reason or explain your decision and all information about you will be withdrawn from the study.

Will people know you took part in the study?

The research team will not be informing anyone that you participated in the study. As your name will not appear on the recording or transcript there will be no means of identifying you with the study.



Will you benefit from participating?

There is no guarantee that you personally will receive any direct benefit from the research in the immediate future, but the findings of the study will produce information that could influence the future development of services for adolescents and young adults in your area. However, being asked to take part in the research may serve as an opening for you to reflect on your mental health needs which may be beneficial to you.

How can you participate?

If you are interested in participating, you can contact Dympna on **089 2013504**. We appreciate you taking the time to read this and hope you will consider participating.

Who are the research team?

Most of the research team work as nurse lecturers in St. Angela's College, Sligo. Denis works as a nurse manager in Sligo/Leitrim Mental Health Services. We are undertaking the research for the Co. Sligo VEC.

If you wish to contact any member of the research team you can call them on

089 2013504 or e-mail them on research@mindyourheadstudy.com

Ms Ursula Gilrane-McGarry

Dr Michele Glacken

Dr Dympna Walsh-Gallagher; Mr Denis O'Brien; Mr Tom O Grady



Appendix C: Sample Consent Form

PARENT'S CONSENT FORM

Outline explanation

In this study, we want to learn more about the mental health needs and supports available to adolescents and young adults living in Sligo, Leitrim and west Cavan. We would like your son/daughter to complete a questionnaire which will ask them questions about their understanding of what mental health means to them; what causes them stress/distress; their knowledge of the support services available to them to help them when they feel their mental health is compromised and what they would like to be available to support their mental health.

I have read the above and the information leaflet.

I understand that it is my decision whether my son/daughter takes part or not and that if he/she does take part they can withdraw from the study at any time and they don't have to explain why they changed their mind.

I as a parent have been provided with enough information and been given the contact details of the researchers to answer any queries I may have.

I give consent for my son/daughter to complete the questionnaire.

I understand that if the researcher has any concerns about anything my son/daughter wrote in the questionnaire regarding risk to them or someone else, other professionals or myself may be informed of this.

This is to certify that I (print name) , give consent for

my son/daughter (print name) to be included in this study.

Signature of parent Date

Signature of researcher..... Date



Appendix D: Sample Assent Form

ASSENT FORM (Individual Interviews)

Please read and sign if you wish to take part in the study.

I (print name), have agreed to be in a research study which wants to find out what are the mental health needs of young people in the Sligo/Leitrim/west Cavan area and what supports young people know about and want in the future.

1. I have read the information about the research and have discussed it with my parent(s)/guardian(s).
2. I understand that I will participate in an interview which will explore issues related to young people’s mental health.
3. I am aware that there are no right or wrong answers or views.
4. The researchers will make recommendations about the best mental health supports for young people. Therefore, I will answer and give my opinions in the interview in relation to this topic.
5. I know that this study might not help me personally but, may help other young people in the future.
6. I know that I don’t have to take part in the interview. No one will be annoyed if I decide to leave the interview at any time.
7. I have been promised that no-body will be able to identify me from the recordings of the interview. However, if I say something that is of concern to the researcher regarding risk to myself or someone else, I am aware that my parent(s)/guardian(s) or other professionals within my community may be informed of this.
8. I know that I can ask questions now or at any time later on.

I am happy to be interviewed in an interview as part of this study

Young person’s signature

Researcher’s signature

Date and time

Appendix E: Sample From Questionnaire

As stated in the methodology chapter the questionnaire contained four sections comprising of between 41 (adolescent questionnaire) to 45 (young adult survey) questions. The majority of questions were a form of closed ended questions and only required the participants to rank and/or tick the appropriate responses. An opportunity to express in writing what they believed various individual/ bodies could do to support participants mental health was also afforded. The focus of some of the questions differed from the adolescents' to the young adult survey to reflect issues potentially pertinent to young people in the targeted age bracket. The main difference being questions regarding Employment status and Sexual Orientation included in the young adults survey but was deemed inappropriate/unnecessary for the adolescent survey.

Section 1 sought to ascertain a range of demographic information in both surveys and the results have been shown above.

The second section of the survey sought to ascertain participants understanding of good and poor mental health and who contributed to their comprehension. Five core questions were asked regarding where their stress came from in relation to; School/College, Home, Within Themselves, Friends, Community and in the older survey Unemployment and Places of Work were added. Participants were asked to rank the three leading issues which were sources of distress to them.

An example of question from section2;

Other young people have identified the following issues as causes of stress emanating FROM RELATIONSHIPS WITH FRIENDS. If any of them cause you stress, please choose up to three of them and rate 1 to the biggest cause of stress, 2 to the next and then 3 to your final one.

- | | |
|---|--------------------------|
| No close friend(s) | <input type="checkbox"/> |
| Not being part of a group/gang | <input type="checkbox"/> |
| Feeling excluded from a group/gang | <input type="checkbox"/> |
| Pressure to conform to 'macho' image if a young man | <input type="checkbox"/> |
| Pressure to conform to a 'girly' image if a young woman | <input type="checkbox"/> |
| Pressure to take part in activities such as drinking/drugs etc. | <input type="checkbox"/> |
| Pressure to be in a relationship | <input type="checkbox"/> |



- Bullying
- Social media
- Relationship 'breakups'
- Pressure to be sexually active
- No stress coming from friends
- Other (please specify)

Section 3 sought to identify if the adolescents talked to someone when they were distressed; who was that individual; their appealing attributes and the coping mechanisms the adolescents deployed when they were distressed.

An example of a question from Section 3;

What is it about the person that makes you choose them to talk to? (Rank the attributes that influence you most - that is rate 1 to the attribute about the person that persuades you most to talk to them and so on)

- Their non-judgemental attitude
- Availability
- Easy to contact
- Trustworthiness
- Know they will be able to help
- Good listener
- Able to give advice
- Sound reputation
- Their status
- Other (please specify)

The final section of the survey examined the supports adolescents perceive are available to them and what would facilitate or hinder their access to these supports.



An example of a question from Section 4;

What is it WITHIN YOU that helps you cope with stress and maintain good mental health?

- Modelling how parent(s) deal with stress
- Modelling how partner deal with stress
- Ability to talk openly about issues that are upsetting me
- Recognising that I have to confront issues as they arise.
- Feeling in control of my life
- Sense of purpose to my life
- Awareness that I have to look after my 'mental health'
- Past experience of coping successfully
- My faith/belief in higher power
- Nothing that I know of
- Other (please specify)

Youth Mental Health Initiative