Thomas Coram Research Unit
Institute of Education, University of London

EVALUATION OF MENTAL HEALTH PROMOTION PILOTS TO REDUCE SUICIDE AMONGST YOUNG MEN

FINAL REPORT

Chris Oliver and Pamela Storey

February 2006

TABLE OF CONTENTS

1. INTRODUCTION 3
BACKGROUND 3
STRUCTURE OF THE REPORT 4
2. PILOT PROJECT DESCRIPTIONS 5
BEDFORDSHIRE BREAKOUT PROJECT 5
Funding 5
Project structure 5
Approach and focus 5
Project aims 5
CAMDEN – 'SORT OUT STRESS!' PROJECT 6
Funding 6
Project structure 6
Approach and focus 6
Project aims 6
MANCHESTER PROMOTING MENTAL HEALTH FOR YOUNG MEN 7
Funding 7
Project structure 8
Approach and focus 8
Project aims 8
3. RESEARCH AIMS AND METHODS 10
STRATEGIC AIMS OF NIMHE INITIATIVE 10
EVALUATION AIMS 10
EVALUATION FRAMEWORK 11
EVALUATION METHODS 11
Bedfordshire 'Breakout' Project 11
Camden 'Sort out Stress!' Project 12
Manchester Promoting Mental Health for Young Men 13
LIMITATIONS 13
4. PROVIDING TRAINING IN MENTAL HEALTH PROMOTION 14
TARGET GROUP AND OBJECTIVES 14
DEVELOPMENT OF TRAINING MATERIALS AND COURSES 15
Identifying training needs 15
Course content 16
Recruitment 17
Implementation 18
OUTCOME EVALUATION 18
Knowledge and skills 19
Meeting diverse training needs 20
Therapeutic and social models of mental health promotion 22
Expert and participative models of training 23
Sustainability 24
5. DEVELOPING PROMOTIONAL MATERIALS AND EVENTS 26
FOCUS GROUPS WITH YOUNG MEN TO IDENTIFY AND TEST MATERIALS 26
DISSEMINATING HEALTH PROMOTION MATERIALS 27
OUTCOME EVALUATION 28
6. INVOLVING YOUNG MEN 29
FOCUS GROUPS WITH YOUNG MEN 29
OUTCOME EVALUATION 32
7. MULTI-AGENCY CO-OPERATION 34
ROLE CLARIFICATION 34
ENGAGING WITH YOUNG MEN 34
INFLUENCING THE DEVELOPMENT OF THE PROJECT 35
HOW DO PILOT OBJECTIVES 'FIT' WITH PARTICIPATING AGENCIES' OBJECTIVES? 36
BUILDING LASTING PARTNERSHIPS 37
8. EMERGING MESSAGES FROM THE PILOT PROJECTS 39
KEY THEMES OR PRINCIPLES OF GENERAL RELEVANCE TO HEALTH PROMOTION INITIATIVES TARGETED AT YOUNG MEN 39
WORKING DIRECTLY WITH YOUNG MEN 40

WORKING WITH NON-MENTAL HEALTH PROFESSIONALS 41
IMPROVING YOUNG MEN'S ACCESS TO HEALTH (INCLUDING MENTAL HEALTH) SERVICES 42
WORKING IN PARTNERSHIP..42
POLICY IMPLICATIONS AND RECOMMENDATIONS FOR THE DEVELOPMENT OF A MENTAL HEALTH STRATEGY TO REDUCE SUICIDE AMONG YOUNG MEN. 43
REFERENCES 45

1. INTRODUCTION

In September 2004, the National Institute for Mental Health in England (NIMHE) commissioned the Thomas Coram Research Unit (TCRU) at the Institute of Education, University of London to undertake an external evaluation of three pilot mental health promotion projects targeted at young men. Each pilot project, based in Camden, Bedford and Manchester respectively, was funded by NIMHE for a twelve month period (2004-2005) to develop and deliver a mental health promotion programme that sought to enhance the mental health and well-being of young men. It was anticipated that the lessons learned from these three projects would inform the development of a national mental health strategy to reduce the risk and incidence of suicide among young men.

Background

In *Saving Lives: Our Healthier Nation* (Department of Health, 1999), the government set a target to reduce the death rate from suicide and undetermined injury by at least a fifth by 2010. Subsequently, a national suicide prevention strategy for England was launched in 2002 in support of this objective (Department of Health, 2002), and is now embodied in the Department of Health Public Service Agreement target and in *National Standards, Local Action* (Department of Health, 2004). These policy developments reflect growing concern about the suicide rate for young men, which has doubled in the last thirty years of the twentieth century and reached a peak in 1998 when it accounted for one fifth of all young adult male deaths (Brock and Griffiths, 2003). Despite a recent fall in the rate, young men under the age of thirty five remain a relatively high risk group with suicide accounting for around 20% of all deaths (Griffiths et al, 2005).

Improving mental health services and reducing access to methods of completing suicide play a part in any strategy to reduce the risk of suicide. Health promotion initiatives that aim to reduce risk factors and to enhance the protective factors for good mental health, may also have an important part to play. Hitherto, a wide range of possible approaches to mental health promotion for young men has been implemented, from individually-based education programmes to strategies of strengthening networks of support between young men and their families, friends, and professionals with whom they come into contact (Eppi-Centre, 2002).

Nevertheless, there is evidence and growing recognition (Men's Health Forum, 2000) that strategies to prevent suicide need to focus on more than public awareness to encourage the earlier recognition of signs of emotional and psychological distress. Offering relevant factual information about services relies on the expectation that young men will choose to access those services at times of risk. Consequently, effective interventions for mental health promotion need to address barriers to improving the mental health of young men and reducing suicide rates. Such initiatives also need to encourage young men to seek help and to ensure that services are able to respond appropriately.

The need to overcome young men's reluctance to seek help is crucial. Around three quarters of all suicides are of people who have had no contact with specialist mental health services in the year before their death. Indeed, around half have had no contact with any health services over the preceding year (Appleby, 2000). There is evidence that the majority of young men

experiencing emotional problems do not consult even their general practitioner and are even less likely to approach mental health services, with this behaviour attributed to norms of masculinity that make health (and help) seeking problematic for many young men (Men's Health Forum, 2000). The stigma associated with mental ill health may also discourage young people generally from seeking help in times of stress (Crisp et al, 2000).

Structure of the report

The report offers a brief description of the structure, aims and approaches of the three pilot projects (chapter 2), followed by a presentation of the aims and research methods used in the current study in the context of the strategic objectives of NIMHE (chapter 3). Subsequently, the report describes the training in mental health promotion provided by each of the three pilot projects and assesses their impact (chapter 4). One pilot project (Camden) included the development of promotional materials and events in its programme of work and these are reviewed and evaluated in Chapter 5. The next chapter discusses the ways in which the pilots involved young men in the development of their work (chapter 6). This is followed by an investigation of the role and effectiveness of multi-agency co-operation in the development of health promotion work targeted at young men (chapter 7). Chapter 8 identifies key lessons learned as a result of the evaluation of the three pilot projects, and discusses their policy development implications.

2. PILOT PROJECT DESCRIPTIONS

This section of the report provides information on the funding, project structure, aims, and approach and focus of the three pilot projects.

Bedfordshire Breakout Project

Funding

Bedfordshire PCT obtained £40,000 from NIMHE over a 12-month period from September 2004, to deliver a mental health promotion project for young men. Grant-aid from NIMHE was supplemented by a further £35,000 jointly contributed by five key partner agencies: Campaign Against Living Miserably (CALM)[1], Bedfordshire Drugs Action Team (BDAT), Bedfordshire Social Services, Connexions, and Bedford/Heartlands Joint Commissioning Team.

Project structure

The Bedfordshire scheme was a sole-worker project. It was established as a partnership initiative between Heartlands PCT, Bedford PCT, Connexions, Bedfordshire Youth Service, Bedfordshire Drugs Action Team, Bedfordshire Race Equality Council, and Social Services.

Approach and focus

The project focused its activities on young men aged 13-19 years and favoured a preventive approach to addressing the mental health and well-being of young men. The view was that this could be best achieved by working in partnership with agencies that work directly with young people in both the voluntary and statutory sectors.

Project aims

The project had three key aims:

- to develop and deliver training to enable professionals who come into contact with young men to better understand the factors that promote and demote mental well-being; to identify symptoms of distress; to make referrals to appropriate sources of support; and to review and develop services to make them more accessible to young men.

- to establish a small grants scheme to encourage the development of local and innovative initiatives that would contribute to the promotion of men's mental health.

[1] CALM was involved in the preparation of the original bid, but subsequently withdrew following loss of funding from the Department of Health.

to undertake an ongoing programme of research and consultation with young men using existing and emerging youth fora to inform project planning and decision-making.

Camden – 'Sort out Stress!' Project

Funding

The Camden Primary Care Trust established a local Suicide Prevention Steering Group and obtained £30000 funding from NIMHE over a 12-month period from September 2004, to deliver a mental health promotion project for young men. Grant-aid from NIMHE was supplemented by further funding of £101,000 from the Neighbourhood Renewal Fund (NRF) over two years from April 2004. A further £35,000 a year was received from local Health Action Zone funding.

Project structure

The project established a team of two part-time clinical psychologists, two full-time assistant psychologists, a part-time project leader and with input from the Primary Care Mental Health Development Coordinator for Camden.

Approach and focus

The project focused on developing a range of targeted and locally relevant mental health promotion materials and training courses aimed at non-mental health staff working with young men and also materials for working directly with young men. The project aimed to focus its activities on young men aged 15-35 years in community settings, which included agencies dealing with vulnerable young men e.g., the homeless and the unemployed. Additionally, the project sought to address community attitudes to, and awareness of, mental health problems among young men.

Project aims

The project identified the following key aims:

to increase young men's understanding and awareness of their emotional and psychological distress.
to encourage young men to seek help with their problems through their peer group, local community resources and through primary care services, mental health services and voluntary agencies.

In order to achieve these strategic aims, the project targeted three key groups: young men, non-mental health staff working with young men, and providers of statutory and non-statutory mental health services in Camden. Specific aims in relation to each target group were as follows:

Young men

to make young men better informed about emotional and psychological problems
to make it easier for young men to acknowledge these problems to themselves and others
to increase willingness to access help
to make young men more aware of where to access help
to enable young men to make better use of their own resources
to enable young men to encourage help-seeking behaviour by troubled members of their peer group

Non-mental health staff working with young people

to increase knowledge and awareness of emotional and mental health problems in young people
to increase knowledge and awareness of how and where to direct young men to access help

Providers of statutory and non-statutory mental health services in Camden

to raise awareness of the challenges of engaging with distressed young men
to ensure that services become more user-friendly and accessible to young men

The project sought to achieve these aims by:

organizing a high profile event to launch a website and a commissioned film, accompanied by extensive press, radio and TV publicity
training local community group leaders, youth workers, staff in employment centres and school counsellors to enhance their knowledge and awareness of mental health problems, and sources of help
working with young men to develop culturally sensitive and relevant training materials
disseminating information booklets to young men throughout the borough

Two elements of the proposed programme of work were deferred to a later stage in the project's development and were therefore not included in the evaluation. These were a) the provision of feedback to statutory mental health services on young men's attitudes to service use with a view to encouraging more user-friendly and accessible service provision, and b) a brief, school-based intervention informed by cognitive behaviour therapy (CBT) targeted at vulnerable male adolescents (age 15-16 years) with high scores on measures of hopelessness and impulsive behaviour.

Manchester Promoting Mental Health for Young Men

Funding

Manchester Public Health Development Service obtained £31,000 from NIMHE over a 12-month period from September 2004 to deliver a mental health promotion project for young

men. Additional Neighbourhood Renewal Funding of £78,430 through the Health Inequalities Partnership enabled the pilot to run from 2004 until 2007.

Project structure

The Manchester pilot is a sole-worker project. The project worker was appointed in mid August 2004 and reported directly to a manager working for Manchester Public Health Development Service. An officer from CALM, with whom the project worker was initially based, also offered day-to-day support for the first three months of the project worker's appointment.

The project was established as a partnership initiative. A Steering Group for the project was formed, representing the Self Harm Team from Manchester Mental Health & Social Care Trust, National Institute for Mental Health (NIMHE) North West, 42nd Street, Manchester Drugs Service, Manchester University Centre for Suicide Prevention, Manchester Joint Health Unit and Campaign Against Living Miserably (CALM).

Approach and focus

The project recognised that working with young men in Manchester would need to take account of the high level of social disadvantage experienced throughout wide areas of the city. These included high levels of unemployment, low educational attainment, and drug and alcohol use, all factors likely to indicate poor mental health. The project therefore aimed to focus its activities on young men aged 15-35 years who might be particularly vulnerable to suicide and mental health problems, the unemployed, those with drug or alcohol problems and those involved with the criminal justice system. It aimed to develop a programme that would be applicable across the wide 15-35 age range, recognising that there is less experience in engaging the 25-35 age group and less familiarity with their needs.

Project aims

In the original application for funding, the project identified its main focus to be planned interventions and activities with groups of young men in a range of settings. The project had the following aims:

- to offer training to young men with a view to increasing their resilience and improving access to support when needed.
- to offer activities and identify alternative approaches to improving mental health (eg sports, arts activities, self-management, learning, diet).
- to work with men to develop longer term action informed by their experience.
- to undertake training and development work with partner organisations in a range of settings, including a Manchester forum of organisations working with young men.

By October 2004, the project decided to meet these aims by focusing on the following three objectives:

- developing and delivering a training course aimed at young men age 15-19 years.

holding focus groups aimed at 25-35 year olds.
establishing a forum for professionals working with young men.

However, the volume of work involved in developing training courses was reported as restricting the time available for setting up young men's focus groups and a city-wide network for people working with young men. Work on these two latter objectives was therefore deferred and may be undertaken at a later stage.

3. RESEARCH AIMS AND METHODS

Strategic aims of NIMHE initiative

Overall, the strategic aims of the three pilot programmes as identified by NIMHE were to:

identify and act on the barriers which prevent or discourage young men from using services and from seeking help at times of suicide risk;

improve promotion of health and well-being by improving knowledge and skills in key individuals who work with young men, identifying good practice and producing practical resources for use by a wide range of service providers;

increase awareness in young men of health promoting issues and lifestyle factors including change in behaviour to encourage sensible drinking and reduce drug misuse; and

involve young men in the development of pilot programmes.

The first two aims might be described as intervening at the level of service providers to improve young men's *access* to services (Aim 1), and assist service providers to respond appropriately (Aim 2). The identification and dissemination of *practice knowledge and skills* is also emphasised.

The second two aims promote intervention at the level of young men themselves, and seek to raise their *awareness* of health issues, reduce risky *behaviour*, and to enhance their *participation* in the development of services. Clearly, these aims are not necessarily mutually exclusive; involving young men in the development of services, for example, might also be expected to inform work related to other strategic objectives.

Evaluation aims

The overall aim of the evaluation was to explore the lessons that might be learned from an analysis of the implementation of the pilot projects. The evaluation was designed to assist in identifying:

factors that help or hinder initiatives in reaching their objectives;
models of good practice so that the research might inform the development of other mental health promotion initiatives; and
policy implications pertinent to the development of a mental health strategy to reduce suicide among young men.

More specifically, the evaluation aimed to:

identify the aims and objectives of pilot projects.
offer a focused account of their implementation.

explore key lessons learned.

Evaluation framework

Each of the pilot projects addressed NIMHE's strategic aims in different ways, and not all projects gave equal attention to all four aims. The evaluation framework therefore aimed to identify cross-cutting themes, while also allowing for specific issues to emerge in relation to individual projects.

The evaluation also sought to acknowledge the exploratory and developmental dimensions of the pilot projects. Consequently, a collaborative approach was adopted, whereby research methods appropriate to the aims and implementation plans of each project were developed. At the same time, common methods were developed as far as the implementation plans of individual projects would allow.

Accordingly, interim evaluations were undertaken of pilot projects at three and six months. The six-month interim report presented a preliminary account of the progress of the pilot projects. The current report builds on this earlier work, and offers a comprehensive account of project implementation, together with an assessment of the extent to which projects achieved their objectives.

Evaluation methods

The research methods used to evaluate the three pilot projects comprised a number of common components: the local evaluator met with Project Directors and, where appropriate, their line managers and other team members, at regular intervals to monitor projects' progress. Information was also obtained from project documentation, semi-structured interviews by telephone or face-to-face, and from questionnaire surveys of participants according to the work programmes of specific pilot projects. These core methods were adapted to the needs of specific pilot projects, where appropriate. Detailed information on the research methods employed in relation to each of the three projects is presented below:

Bedfordshire 'Breakout' Project

Data were collected in two key phases. In the first stage, five meetings were held with the Project Co-ordinator and her line manager (the Health Promotion Team Leader), between October 2004 and June 2005 to document and explore issues that emerged during the initial stages of the project's development. Semi-structured telephone interviews were also conducted with five partner agencies (social services, Connexions, Bedford Primary Care Trust, the youth service, and *mentality*[2]), the Project Co-ordinator and her line manager between December 2004 and February, 2005. Project documentation provided an additional source of data.

[2] *mentality* is a specialist consultancy with charitable status that provides research, development and training in the field of mental health promotion.

Partner agencies were selected for interview on the basis of their involvement with, or knowledge about, the initial development of the project. With the exception of *mentality*, each partner agency was represented on the project's Steering Group. Telephone interviews lasted a minimum of fifteen minutes and a maximum of thirty minutes.

In the second stage, the evaluation focused on participants' satisfaction with the training course delivered by *mentality*, and progress in implementing a planned initiative with young men concerning mental health issues (called Project Action Plans).

Pre-training course interviews (n=6) were conducted by telephone with selected agencies participating in the training programme to explore their expectations of the course, training needs, self-assessed levels of knowledge about and confidence in dealing with issues of mental health, and the anticipated impact of the training programme on the work of their organisation. Agencies were selected for interview on the basis of the diversity of their client groups (e.g. general school populations, as well as young people that might be perceived to be more or less 'at risk', such as through unemployment or homelessness).

A post-training questionnaire survey of all training participants (n=30) was completed to assess their satisfaction with the course, its impact on their knowledge of mental health issues pertaining to young men, and their confidence in responding to young men's concerns. Sixteen participants responded, a response rate of just over 50%. Subsequently, telephone interviews were completed with a sub-sample of participants (n=6), selected to reflect the spectrum of reported satisfaction with the training course, and to further investigate progress in implementing Project Action Plans.

Camden 'Sort out Stress!' Project

Data were obtained from regular meetings held with the two Project Directors and the four members of the project team (two assistant psychologists and two clinical psychologists), between October 2004 and October 2005. Information in the earlier stages of the project was also obtained from project documentation and telephone interviews with partner agencies (including two youth centre managers, a detached youth worker and a key worker at a centre for homeless and vulnerable young people). The partner agencies were selected for interview on the basis of their involvement with, or knowledge about, the development of the project during its initial six months and with those where training sessions were conducted. Telephone interviews lasted a minimum of twenty minutes and a maximum of forty minutes.

During the second stage of the project, pre- and post-training questionnaires, similar to those used for the Bedfordshire project, were completed by staff undertaking training at two locations. Follow-up interviews were also conducted with managers at three centres. In addition, the pilot project team collected evaluation data from participants in training sessions (n=52) for non-health staff professionals. Young men taking part in training sessions were invited to evaluate orally at the end of each session.

The pilot team also provided information on the dissemination of the project materials (ie. distribution of the booklet and visits made to the project website).

Manchester Promoting Mental Health for Young Men

Data were obtained from regular meetings held with the project worker and his manager, from Manchester Public Health Development Service, between October 2004 and September 2005. Three of these meetings were also attended by a Steering Group member representing Manchester University Centre for Suicide Prevention and two meetings by the Manchester Co-ordinator of CALM. Information was also obtained from project documentation, and interviews (some by telephone, some face-to-face) with nine partner agencies including members of the Steering Group and partners directly involved in the pilot courses run by the project. The evaluator also attended two meetings of the steering group.

In consultation with the project worker, project manager and members of the steering group, the evaluator offered pre- and post-training questionnaires for self-completion by young men at each session. The session questionnaires were designed to assess participants' level of interest in, and views about, the material delivered in each session. In addition, the evaluator observed one session at three of the four training courses. Group interviews were also conducted with participants at all four pilot courses and a total of 27 young men took part in these group evaluation sessions.

Limitations

The collaborative aspect of the evaluation framework may be expected to raise questions concerning the independence of the evaluation. In order to manage boundaries between the roles of external evaluator and advisor, the evaluators aimed for transparency in the presentation of the data; occasions when guidance was sought or advice given are clearly identified in the report.

More seriously, a number of provisos also need to be made regarding the nature of the evidence obtained and, accordingly, the claims that can be made concerning the impact of pilot projects. The evaluation employed qualitative methods, although some quantitative measures were also utilised (for example, in self-report measurements of knowledge, confidence and awareness, or the number of times a website was visited. However, it is beyond the scope of the evaluation to measure the impact of publicity and other resources on young men's behaviour. The small scale of the intervention in each of the three projects limits the extent to which enhanced awareness of young men's mental health needs translated into improved professional practice in direct work with young men.

A further factor concerns the time-frame of the evaluation, which ran coterminously with the implementation of the pilot projects (i.e. over twelve months). Two of the three project obtained additional funding that resulted in these undertaking their work over a longer period than that of the evaluation. The current report reviews the achievements of the pilot projects at a specific point in time, and it is possible that further outcomes will emerge at a later stage.

4. PROVIDING TRAINING IN MENTAL HEALTH PROMOTION

Each of the three pilot projects selected training as a method for raising awareness of issues pertaining to young men's mental health. The development and delivery of these training programmes illustrate both the potential advantages and limitations of this approach to mental health promotion with young men. The evaluation highlights lessons that can be learned from the *process* of implementation (a process evaluation), as well as providing an assessment of the extent to which training courses were successful in meeting their stated objectives (an outcome evaluation).

Target group and objectives

The process and outcome evaluations of the pilot projects highlighted the importance of achieving clarity concerning at *whom* proposed training courses should be targeted, and to what *purpose*. Two pilot projects (Bedfordshire and Camden) targeted professionals who work with young men as a means of disseminating knowledge and raising awareness of mental health issues. In particular, the Bedfordshire project targeted non-mental health professionals from a wide variety of service settings in the voluntary and statutory sectors, including education, social services, youth services, counselling, and drug and alcohol agencies. The Camden project sought to engage with non-mental health professionals across a range of settings, and also with young men themselves by providing training sessions in statutory and voluntary settings. By contrast, the Manchester project targeted its training programme directly at young men perceived to be at high risk of mental ill-health, the unemployed and offenders.

The rationale identified for targeting training at non-mental health professionals varied. In Bedfordshire, non-health professionals in a wide range of settings were selected with the objective of developing an infrastructure of knowledge and skills in mental health promotion work. Importance was attached to facilitating networking between agencies in order to create a web of support for young people who might be better supported before reaching a stage of crisis:

'I would hope young people would feel more 'held' in the therapeutic sense and better supported to deal with vulnerable times in their lives.'
(Jane, steering group member)

A related objective was to establish a member of staff within participating agencies who might offer advice and support to their colleagues on mental health issues as they related to young men:

'The idea is that these champions will be in place to carry forward the work.'
(Susan, steering group member)

Both the Camden and Bedfordshire projects anticipated that training would raise awareness of, and knowledge about, mental health issues so that front-line staff might be enabled to identify and to respond to such problems appropriately, or to refer young men to specialist mental health services.

By working directly with young men, the Manchester project sought to work directly with groups of vulnerable young men in order to enhance their 'resilience' to mental health problems, promote individual personal health development and well-being, and to offer a variety of tools for dealing with stress and stressful situations, including signposting to local services.

Development of training materials and courses

Identifying training needs

An important issue concerned the extent to which the training provided had been developed to match projects' stated objectives and the training needs of participants. In this respect, each project adopted a different approach. The Bedfordshire project, for example, drew upon external sources of expertise as a means of developing an appropriate training course. Following an initial period of consultation with the project co-ordinator and her manager, independent consultants (*mentality* and the Men's Health Forum) developed and delivered a mental health promotion training course, comprising four 'learning sets'. Each learning set was delivered over one day at six-weekly intervals.

By contrast, the Camden and Manchester projects adopted a more developmental approach, devising training courses and materials by undertaking a literature review and by consulting with partner agencies. In Camden, project staff also consulted with young men via focus and reference groups. The review completed by the Camden project was more extensive, involving a search across Medline, Psychinfo EMBASE, CINAHL and HealthPromis, hand searches in salient journals, and through contacts with professionals working in mental health promotion. The team identified a lack of journal-based evidence on mental health training for non-mental health professionals. A range of mental health and suicide prevention packages targeted at young men were identified but because most had been produced by commercial enterprises (and therefore needed to be purchased), the detailed content was not readily available to project staff for review.

Consultations with partner agencies also emerged as a valuable means for identifying the training needs of potential training course participants. In Manchester, for example, the project worker established contacts within partner agencies such as African Caribbean Mental Health, the Black Health Agency and voluntary organisations providing mental health support to young people, such as 42nd Street and YASP (Young Adult Advice & Support Project), to identify the main problems that young men faced in terms of their mental health, and in accessing and using voluntary and statutory services. As a result of these consultations, the project worker tailored the proposed training programme to address likely barriers to participation in the pilot by both staff and young men. The term 'mental health' was dropped from the title of the proposed training course. 'Personal Health Development and Well Being' was perceived as a less stigmatising title and more acceptable to agencies with whom the pilot was intending to work. Among those consulted in Camden were organisations working with young gay men, a Bangladeshi youth group, several community Neighbourhood Renewal Fund projects, services working with the homeless and with Jobcentres.

Course content

Variations in the target audience and objectives of training courses produced a number of key differences in the duration, orientation and in the training methods employed by pilot projects. In Bedfordshire, for example, the course content aimed to address questions of both theory and practice in mental health promotion with young men. Three of the four 'learning sets' were designed to focus on the self-development of participants via the use of reflective diaries, engaging in direct work with young men, and observing behaviour at work. After the third day, participants were expected to devise their own Project Action Plan as a means of identifying how mental health promotion work with young men might be progressed in their own organisation. The original course programme was as follows:

> Day 1: warm up; masculinity and mental health in its broadest sense (led by a trainer from Men's Health Forum); gender and mental health (led by mentality); discussion; introduction of the idea and purpose of the learning diaries.
>
> Day 2: Cognitive Behaviour Therapy and preventive work with school-age children on depression; generic approaches to problem-solving skills and strategies; empowering front-line staff working with young men; empowering young men; identifying strategies for addressing a practical problem in the workplace.
>
> Day 3: Feedback. Case studies.
>
> Day 4: Discussion of Project Action Plans.

In contrast, the Camden project offered a single-session workshop that was adapted to the needs of each agency. This was supplemented, where requested, with a follow-up consolidation session within three months of the initial event. The session covered young men's reluctance to seek help, the ways that young men express distress, the identification of a language of positive mental health to which young men would relate, the identification of signs and symptoms of mental illness and role playing to develop skills to interact with young men experiencing problems.

The Manchester course, directed at young men perceived to be at high risk of mental health problems, comprised a combination of formal sessions based on concepts derived from the field of counselling and alternative health, combined with practical sessions and activities. Like the Bedfordshire initiative, the course was designed as an on-going programme, extending over several weeks duration. Initially, the thirty-hour course was designed to be delivered over a period of 6-12 weeks comprising five three-hour sessions and relying on support from partners to assist at the sessions and to supply mentors to work with participants between the formal sessions. However, early on it became clear that partners would not be able to provide that level of support, so the course was reduced to four 'learning sets', designed for delivery at four weekly sessions of three hours duration, followed by a residential event at the end of the course. The learning sets focussed on the self-development of participants, using folders of worksheets, CDs and video presentations, plus guest speakers. Diaries and Action Plans were designed for participants, working individually, to complete between sessions. The original course outline was as follows:

> Session 1: This was designed to introduce ideas from CALM and to identify what factors contribute to young men feeling miserable. It looked at the changing role of

men over recent decades and aimed to raise awareness of other cultural aspects of self-help.

Session 2: Maslow's hierarchy of needs and an introduction to positive thinking. This session was designed to introduce young men to the concept of human needs and the order in which these needed to be attained, offering participants the opportunity to identify their own needs and place them in a hierarchical scale. It considered how to turn negative thoughts into positive thoughts.

Session 3: Emotional Literacy and an introduction to body language. This session demonstrated how negative emotions could be adjusted and used positively and how body language hinders or assists overall communications. It also considered alternative life choices.

Session 4: Introduction to Self-Affirmations and Self-Actualisation. This session set personal goals and action plans for self improvement.

The formal content of each session was designed to be followed by an activity offered by an outside speaker on meditation, reflexology, aromatherapy, acupuncture, capoeira (a form of dance), yoga, or counselling. Co-facilitators from agencies hosting the groups and the Black Health Agency provided additional support in helping to plan course material, developing group discussions during sessions and generally assisting with the running of sessions.

In Camden, the young men's training sessions were designed to be brief, one-off events that aimed to challenge ideas about mental health and mental health services, to reduce stigma and raise awareness of young men's own abilities to deal with problems. The sessions were structured around group work, with the project's booklet and film providing points for discussion.

Recruitment

Consultations with partner agencies offered a valuable means for projects to recruit potential participants to training courses. The Camden project, for example, used existing and new contacts with local agencies in order to engage the interest of staff in training courses. In turn, these staff contacts assisted in helping with the recruitment of young men to focus groups and training sessions. However, the project team reported that they were surprised by the degree of persistence required in building relationships with agencies to ensure participation. Numerous telephone calls, followed by face- to-face meetings were required to enable partners to agree to hosting training sessions.

In Manchester, the project worker followed a number of leads with partner agencies to promote the course. Two pilot courses were arranged with E2E (an education to employment programme for young people), one at a centre for young men on the Intensive Supervision and Surveillance Programme (ISSP) and one via the local Adult Education Service together with the Probation Service. The project also produced an innovative flyer to appeal to potential participants and this was reproduced in a high quality format.

The Bedfordshire project undertook a targeted recruitment programme, making contact with key agencies in different parts of the county. Thirty places were made available on the training programme. An application pack for course participants was developed, which included information on the training programme, data on relevant NHS priorities, an introduction to the project, a programme schedule, and information on the proposed learning

sets. The pack also included information on the follow-up work that agencies were expected to undertake with young men following completion of the training course (known as the Project Action Plan). All thirty places were filled by individuals representing a wide range of agencies and geographical locations. Extensive outreach work undertaken by the project co-ordinator enabled her to receive positive feedback that the training programme was meeting an identified need, and helped to ensure that the course was well-attended but not over-subscribed.

All three projects incorporated incentives to encourage participation, particularly by young men, with varying levels of success. The Camden project offered mobile phone tokens to young men taking part in the focus, reference and training groups. No incentives were offered to staff. Attendance at the first two courses for young men in Manchester was compulsory and some participants expressed no clear idea what the course was about. Subsequently, participants were better informed by the project worker or their contact in the host agency and exercised choice about attendance. Additionally, the project offered mobile phone tokens, gym passes, and an outdoor pursuits residential weekend to young men attending the course sessions. The Bedfordshire project provided incentives to staff and made available £150 per day to cover the cost of supply teachers, and a £500 grant for developing direct work with young men around issues of mental health promotion. In particular, the availability of funds to cover the costs of substitute teachers was highlighted as an effective method for encouraging the participation of schools in the training programme.

Implementation

As might be expected, several changes were made to training courses once the implementation programme began. In the Bedfordshire project, participants were expected to organise focus groups with young men between sessions three and four in order to develop a Project Action Plan to inform their organisation's future work with young men. Initially, and in view of the workload involved in organising focus groups, it was decided that each participating agency would arrange a single focus group of up to six young men (rather than three or four, as originally envisaged). Subsequently, the Project Co-ordinator expressed concern regarding the time required to co-ordinate focus groups and to transcribe focus group tapes for participants. On the advice of the training providers, it was decided to defer the development of Project Action Plans until after the end of the training course. Three focus groups with young men were hosted by the Men's Health Forum and the findings fed back to course participants on the final day of the course.

In Manchester, two initial pilot courses were conducted during the first six months of the project. After the interim evaluation, the course was modified to offer more opportunities for discussion and group work and less directive teaching and guest speakers.

Outcome evaluation

Overall, a number of key themes emerged in data obtained from the evaluation of training courses delivered by pilot projects. These concern the following categories: knowledge and skills; social and therapeutic models of mental health promotion; expert and facilitative models of training; and sustainability.

In terms of participation, the vast majority of the thirty individuals who joined the Bedfordshire training programme attended each of the four sessions. In Manchester, a total of 43 young men attended the four courses, of whom 60% attended three or more sessions. Around 55% of participants were White, 10% Pakistani, 15% Black (mainly Black African and Black British) and the remainder of mixed ethnic group. By the end of September 2005, eight training sessions had been undertaken with eighty-four staff members in Camden. Three sessions had been also been conducted with young men, a total of twenty-six having taken part.

Knowledge and skills

In the Bedfordshire project, a key theme concerned the extent to which the training offered had achieved an appropriate balance between imparting information and offering guidance in the use of practical skills in working around mental health issues with young men.

Data obtained from pre-course interviews with the project co-ordinator, five course members and the questionnaire survey of course participants (n=20) indicated a general expectation that the training programme would be experiential in orientation, as well as enabling participants to acquire wider knowledge about young men's mental health and sources of referral. Post-course survey findings (n=16) showed less satisfaction with the practical aspects of the course than with the presentation of information. Several participants described the number of reports and articles circulated to participants as 'overwhelming'. Given that almost all of the participating agencies already worked directly with young men, the acquisition of generic skills in this respect was not identified as an area requiring particular input. Participants generally reported that more attention could have been given to the development of practical strategies for addressing mental health problems with young men through the use of case studies and the sharing of experiences between members of the group.

Overall, it was felt that a clearer framework might have been beneficial. With hindsight, it was thought that more detailed preparation of the course content, in consultation with steering group members and potential participants, had been required. This suggests that commissioning external providers of training in mental health promotion can be efficient in terms of time and resources, and allow projects to draw upon expert sources of help. The potential disadvantages concern a possible lack of influence over course content and direction, and insufficient attention given to identifying training needs.

Nevertheless, self-report assessments of confidence in advising colleagues on mental health issues pertaining to young men, and of greater awareness of sources of referral represented positive outcomes of the training course. In the post-course survey, respondents were asked to identify, on a scale of 1-10, how confident they felt in advising colleagues on mental health issues as they pertain to young men. Just over half (n=9) of those responding (n=16) reported a relatively high level of confidence (between 8-10 points). Respondents were also asked whether, as a result of the course, they were more aware of different agencies where they could refer young men. The majority (n=11) responded in the affirmative, citing both statutory and voluntary sector sources of help and advice. Likewise, staff attending the Camden training sessions who said that they were not confident about responding to mental health problems reported increased confidence after attending.

As part of the development of training sessions, the Camden project team invested several months consulting non-health professionals to gain an understanding of the issues they faced in dealing with mental health problems with the young men attending the centres they operated. Staff identified early discussions with the project team to inform the development of the pilot training programme as helpful in clarifying their own training needs. The partners felt that they had been given the opportunity to influence the way the teaching materials were developed and that the project workers had on the whole, listened to their specific needs as non-mental health professionals working in a range of environments with young men.

Meeting diverse training needs

In relation to the training offered to non-mental health professionals, the wide variety of agencies that participated emerged as having diverse levels of awareness and experience of mental health issues and consequently of training need. Some agencies were reported as more likely to work with 'at risk' young men than others; and in this case there was a more marked concern to address specific issues in young men's mental health (such as depression and self-harm) as well as more general issues. In Manchester, for example, staff running youth groups within community centres perceived mental health issues amongst young men attending their centres as minimal. A youth centre manager in Camden with over twenty years service, commented on the infrequent occurrence of serious incidents – 'only a handful over twenty years'. He was pleased that his advice, to make the training wider to cover how to approach young men who might have problems had been understood by the project team.

I think it needs to be bigger and broader than assessing suicide risk because it is wider than that. The training should include ways of approaching people, teaching people how to approach young men. You can't say 'I think you've got a mental health problem.' It's about people spotting that things might be wrong because young men don't tell you and then how to approach them 'Oh you look a bit run down, you've been a bit down for a while.'
(Mike, youth worker)

Workers at the local job centre, however, reported that the mental health problems that they were most likely to face were depression and aggression. Some organisations also had more experience of drug- or alcohol-related problems in young men than others. Only one out of ten job centre workers who undertook the training, for example, raised drug and alcohol problems as issues faced in daily work with young men. Others, such as workers at a centre providing support to homeless young men, sex workers, asylum seekers, those with the dual diagnosis of mental health, and drug or alcohol misuse problems, were more familiar with these issues. In their pre- training questionnaires, this group identified more acute problems, such as paranoia and schizophrenia, in their regular contact with young men. They also expressed more confidence in dealing with mental health issues when these occurred and a higher level of understanding of mental health issues than workers in less challenging community settings. However, staff at a centre for homeless young men who were also often asylum seekers, identified a need for specific training on Post Traumatic Stress Disorder (PTSD). Whilst staff at the centre were well informed and experienced through their ongoing work, most lacked formal training. They anticipated that the training offered would empower staff to make informal assessments with confidence and offer information and referral.

Overall, of the 52 responses received to the training evaluation, almost 80% (41 of 52) reported that the training had provided new information for them on what services were

available for young men locally. Two-thirds (35 out of 52) reported that the training had increased their confidence in working with young men. Staff working at centre for the homeless, for example, praised the training session they attended as an affirming experience, validating what they already knew and practised. 'I knew that, but I didn't know I knew it' commented a member of staff at the hostel. The mental health promotion worker at the centre also reported that the course had made everyone realise that they were more competent than they had realised. However, those staff working with homeless young men seeking asylum were among those who expressed a lack of satisfaction with the training offered. They expressed disappointment that the session had not provided more information on referral to mental health services. Their expectation of the training was that it would provide more information on local provision so that opportunities for getting young men into services more quickly would be enhanced.

Data obtained from interviews with the Manchester project worker, staff at the agencies hosting the courses (n=5), young men attending the sessions (n=22) together with the results of training course and session evaluation questionnaires from young men (n=31) indicated that the courses fulfilled a number of its objectives. For the hosting agencies, collaboration with the pilot was seen as a desirable addition to the mainstream work they undertook with young men, specifically in offering knowledge and awareness about mental health. They were not aware of other course or suitable teaching material which they could use with the young men with whom they worked. They perceived the course as fitting well with other work around physical health and bullying that they undertook with young men.

A recurring theme in the evaluation by the young men who participated in the Manchester project was that the sessions had offered a unique experience to hear about mental health issues for the first time and the opportunity to discuss topics never previously aired.

It was fantastic. It was the first time, it's the first time I've experienced that type of lesson.
(E2E group)

We don't normally do things like this in our normal life, drug takers and that. We don't usually mix with people and get on to this. We usually just sit and take drugs so this has all been…… It's good to sit here and talk and that.
(Probation group)

Learning about stress management, goal setting and action planning as well as relaxation techniques and life skills were specifically identified as valuable components of the course.

Going for walks and that, doing hobbies, listening to music and that.
If you were in a bad mood, it told you what to do about it.
He gave us something to put on the wall, things to do when you're stressed out, talk to someone and take your mind off it.
(E2E group)

The older group of offenders stressed that they were already aware of some of the techniques discussed in the sessions, not through any previous formal instruction, but from their own experience. It was valuable to understand why those techniques worked and to hear about other ways of coping with stress, feeling down and difficult situations. The group felt that the course had given them an insight and understanding into some of the coping strategies that they had already developed. They viewed the validation of those techniques positively.

I phone people up when I'm feeling down. I've done that before the course, but not consciously. It had not sunk in.
It does make you think a lot more when you've done something like this. This self-awareness about what you're doing.
(Probation group)

However some course participants, particularly the youngest men, expressed more mixed views about their need for the course and were less convinced of its relevance to their lives. For them, the issues around suicide and mental health were not issues that they themselves would ever be likely to face.

I think this course should be for people who really have got problems.
(E2E group)

Another assessed the course as *'a load of crap'*, finding the material boring. He expressed the view that people should be able to deal with feelings and maintain well-being without assistance.

Therapeutic and social models of mental health promotion

The evidence obtained from training course participants suggests that courses engaged with varying degrees of success in striking a balance between a focus on 'mental health promotion' and 'mental illness'. In the Bedfordshire project, for example, in post-course interviews and questionnaire survey findings, participants raised concerns about a possible over-emphasis on ill-health, and insufficient attention being given to preventive approaches, and practical ways of making services more accessible to young men. The course programme offered general problem-solving skills that were intended to support participants' work with young men. Information on a specific therapeutic model (Cognitive Behaviour Therapy) was also provided as a guide to their practice. Findings suggested that agencies offering counselling to young people were already aware of the CBT model of working, and tended to assess this aspect of the course as less relevant to their needs. Others generally found discussions about CBT interesting, but not necessarily helpful in supporting them to know *when* and *how* to apply such a model in their work with young men. Some anxiety was also expressed about managing the limitations of personal knowledge and skills in this respect, and deciding when to refer young men to more expert sources of help.

A significant part of the Camden sessions was devoted to empowering non-mental health staff to approach young men exhibiting stress and to improve knowledge of self-help and problem-solving skills. Whilst these components were well received by most groups, particularly those working in community setting and with lower risk young men, those working in centres supporting more vulnerable young people expressed a need for sessions to focus on specific conditions, such as PTSD or schizophrenia. They also required a greater emphasis on referral options.

Expert and participative models of training

A further theme concerns the extent to which the training methods adopted by trainers was well-received by course participants. The Bedfordshire project's training course was generally perceived by participants as more didactic than participative in orientation. Post-course survey findings indicated that, in any future developments, less emphasis should be given to presentations and the circulation of policy documents and published articles. A general preference was expressed for a more inter-active and varied mode of delivery. This finding suggests that the course would have benefited from a more thorough exploration of the expectations and training needs of participants in advance.

Compared with the Bedfordshire project, the Camden training sessions were designed to be more participative in orientation. For example, handouts on signs and symptoms were provided for reference rather than for discussion and explanation during the session. This fitted well with the expectations of most groups who said that they enjoyed the discussion and that the session gave them space to think about the issues in their day-to-day work with young men.

We are usually too overwhelmed by the day to day events of the hostel, so there's no time to discuss wider issues as a team, because of the 'in the face' nature of the work here. People had the chance to talk [in the session].
(Rose, hostel worker)

A participant in one session with a group of detached youth workers described a valuable lesson they had received whilst undertaking a role playing exercise on calming an angry young man. Despite their best efforts, the member of staff playing the young man appeared no calmer or less angry. However, the 'young man' admitted that the exercise had been more successful than it appeared, he had felt better but he had felt no intention to admit this to those trying to help him.

Actually the staff did make me feel better but I wasn't going to let them know.
(Youth Inclusion Project worker)

The group recognised the scenario and felt that they would be less deterred from continuing with calming techniques when confronted by a young man who appeared not to be responding to their input.

One group, however, expressed disappointment with the participative structure of the session. They felt that they had not benefited from the exercises but would have found a question and answer session more useful, providing an opportunity for them to raise specific issues. This group had a much higher level of mental health awareness and interaction with service providers than the groups that expressed greater satisfaction with the sessions. This suggests that the generic content of the session was perhaps more suited to groups dealing with less acute mental health problems on a daily basis, or where staff have less formal contact with mental health provision. On the basis of its own evaluation, the project team subsequently worked to develop a more instructive session to offer to groups, if requested.

For the Manchester project, maintaining interest and commitment from young men over four weeks of sessions was a significant issue and improved attendance on the two later courses may be linked to changes in the course structure. The second two courses contained more

opportunities for discussion and interaction with less emphasis on theoretical concepts and writing exercises. However, engagement with the course appeared, in terms of participants' own evaluation of the usefulness of the course, to be more successful with older young men. The least successful course of the four was with the youngest group (who were young offenders); the most successful course was with those on probation, who were the oldest group of participants.

Sustainability

In pre-course interviews with participants in the Bedfordshire project, expectations ran high regarding the potential for the course to facilitate networking between agencies, and to produce an enduring legacy of inter-agency co-operation. It was widely believed that effective change would be best achieved by ensuring that 'knowledge and skills cascade down' within organisations. Some concern was expressed about how networking between agencies could be sustained at the end of the pilot given the risk that day-to-day work pressures could distract participants from continuing to develop their work with young men. However, it was also hoped that projects would continue to monitor and share information on the planned Project Action Plans. In relation to schools, it was envisaged that the training could be used to assist in developing quality standards and criteria around promoting emotional well-being, and that, as a second stage, schools that meet the required standards could be accredited. The opportunity to incorporate learning points from the course into the training of adoptive and foster parents, for example, was described as 'unique' and that 'the fall-out from the training could therefore be quite wide'. It was reported that the project had generated such a positive response in the adoption and fostering agency that a new post targeting work with young people was about to be created, half of which had been designated for mental health promotion work.

In post-training course interviews and survey findings, opportunities to network with other agencies were most commonly identified by participants as the most valuable aspect of the course. However, it was also widely reported that more time could have been given to enabling participants to present information about their work, and to share experiences and knowledge. It was generally felt that, under pressure of time, training course leaders tended to regard networking as something that should happen outside of the course during breaks, and that consequently, fewer opportunities were presented for the training group itself to function as a learning resource.

A more serious factor concerns the extent to which participating agencies developed a Project Action Plan, in line with the original objectives of the course. A majority (n=9) reported in the affirmative. However, it was widely reported that the decision to delay the development of Project Action Plans to the end of the course had limited the potential of the course to incorporate a more practical focus, and had also reduced opportunities for course participants to receive the support they needed to progress with an action plan.

The Camden project team maintained a flexible concept of how training sessions could be offered in the future and the degree to which on-going input from the project would be required to ensure that staff remained confident to offer advice and to make referrals. The developmental approach to the sessions permitted the project team to exercise flexibility on how and what they delivered in a follow-up session and to tailor these to the specific needs of each group. Whilst some staff groups welcomed consolidation sessions two months or so

after the initial session, others declined and expressed a preference for undertaking follow-up work on their own. The team set up a regular fifteen minute training session every two months with job centre staff to maintain interest and to provide updates. Ensuring continuity was recognised as more difficult in some settings, particularly in centres with a high percentage of part-time staff and frequent staff turnover.

Both the Camden and Manchester projects have developed strategies to continue to offer training courses to young men. The Camden project is currently working towards developing the training role of staff of partner organisations, to enable them to deliver the sessions for young men directly. The Manchester course is being adapted as a portable training pack to be used in a variety of settings by other trainers. It is anticipated that this will be completed and published in early 2006. The project is also working towards validation and accreditation of the course through the Open College Network to offer a qualification to future participants. Partner agencies have indicated that they would use the course independently after initial support from the project.

Evaluating the impact of the training on young men's attitudes and behaviour over the longer term was beyond the scope of the current evaluation, and would require longitudinal study. Moreover, both Camden and Manchester worked with only a small number of young men and immediate evaluation in the sessions offers no clue to future behaviour, despite positive comments around help seeking and supporting friends.

5. DEVELOPING PROMOTIONAL MATERIALS AND EVENTS

The Camden project was the only pilot project that focused on the production of a series of health promotion materials specifically directed to young men's mental health. Because of this emphasis and its capacity to inform the development of work elsewhere, this specific aspect of the project's work will be focused on here.

The team conducted a review of mental health promotion materials for young men and consulted widely with professionals and with focus groups of young men to develop the materials. The final package of materials comprised a conventional booklet together with contemporary media, film and website that would appeal to young men. The materials were designed to interlink and carried a common brand: 'Sort Out Stress'. A professional film maker was retained to produce a three minute animated film with a voice-over provided by a young man, selected over several months to provide the 'right' voice to describe experiences to which others would relate. Set against a background of Camden scenes, the film narrates the story of a young man's descent into depression and drug use, and his gradual recovery.

A website, which was developed in parallel with the booklet, was designed by an IT specialist in close consultation with the project team. It aimed to encourage young men to think about stress. It also offered information on specific mental health conditions and coping strategies. The website gave listings of local services and provided links to other relevant websites. The project team arranged for the website to be hosted separately from established Camden health websites in order to reduce its links with statutory health services.

Focus groups with young men to identify and test materials

Consultation with young men to explore their views about the meaning of 'mental health promotion', and of promotional materials specifically, formed a key part of the project's development process. Focus groups were arranged during November and December 2004, accessed mainly via partner agencies. The time invested in setting up initial meetings to talk to partners was substantially longer than the project team had estimated, with the time from introductory calls to the setting up of focus groups varying from three weeks to three months. Despite agencies expressing support and enthusiasm to engage with the project, young men were difficult to recruit to take part in focus groups, even with the additional incentive of mobile telephone tokens. In total, 70 young men were eventually recruited to participate. As materials were developed, further consultation took place with three reference groups of young men to discuss modifications to the booklet and the website.

The project aimed to produce a booklet that would be easily accessible and have a strong impact. The search for existing available materials identified several sets of programmes and *Headkit, Manual* and *Coolheads* were used to initiate discussion on developing materials with focus groups of young men. During the focus groups discussions, these existing materials received a very mixed response. Young men criticised the excessive amount of information included in materials and the busy art work. However, the team had difficulty in obtaining critical feedback on the content of the booklets and concluded that the young men lacked the knowledge and skills to assess the materials in terms of quality of content and accuracy. Subsequently, the project team consulted Trevor Lloyd of the Men's Health Forum, an

independent agency that works to improve the health of men of all ages. He assisted the project by reinterpreting the feedback received from young the men's focus groups and one member of the project team described his contribution thus:

Even though we had listened to the focus groups, he gave us another way of interpreting the groups. We were bringing our psychology knowledge to understanding the focus groups and in writing the material rather than interpreting what the young men were saying. We were listening to the groups but we needed to write it through the eyes of the young men rather than as clinicians.
(Pilot project team member, Camden)

The booklet was reduced in length and streamlined in the light of the feedback received. The format in terms of colour, style and layout was also revised substantially to improve its appeal to young men. The final booklet incorporated advice on recognising and managing stress and offered information about agencies that provide services for young men in Camden and addressed preconceptions of the use of GPs. Readers were also signposted to the *Sort Out Stress* website.

Disseminating health promotion materials

The project team acknowledged that the conventional route for disseminating NHS publications, via the PCT library and public health agencies tended to restrict distribution to places that few young men visit, such as GP surgeries, community centres, libraries or similar locations. In order to reach as many young men as possible, the project therefore undertook a broader publicity campaign. The booklet, website and film were launched at a major event in May 2005, accompanied by an extensive programme of publicity, using posters, flyers, TV and radio coverage before the event to gain the maximum exposure.

Of the 30,000 booklets printed, over 3,500 were distributed in the three months following the launch via a range of outlets. To further publicise the website, flyers and postcards were distributed by a commercial company. Over 8,000 flyers and postcards were sent to nightclubs in the Camden area. Tenacious marketing by the team secured free advertising for the website for one month from a local bus operator on all its buses.

Marketing the film to a wider cinema audience proved more problematic than the project team had foreseen. The film, which was of three minutes and seventeen seconds duration, was regarded as too long for standard cinema advertising and consequently, most cinemas were unwilling to accept the film for transmission. The film was not placed with any of the larger commercial cinema chains because companies were unwilling to waive advertising fees and because, in terms of a promotional film, it was perceived to be too lengthy. However an independent cinema in the borough showed the film at the end of September for two weeks, twice nightly and for a further week for one nightly performance. The film was fortunate to be granted a waiver for certification by the local council but additional cost was involved in converting the film from video to a cinema format.

The materials also formed an integral part of the training packages of the project, both for professionals and for young men, ensuring that the booklets and advertising of the website are maintained by the partners involved. Jobcentres reported that they regularly distributed the booklet to their clients.

Outcome evaluation

Evidence for evaluating the impact of the booklet, website and film as mental health promotion tools was limited. Some feedback was obtained from staff and young men who viewed the materials in the training sessions, but it was not possible to assess how young men might use these resources at times of future need.

The number of young men accessing the project's website provided a quantitative element for evaluation. During the first month of operation, June the website received over 440 hits and this increased by around 50% during July, the month that coincides with the period that the website was receiving free publicity on a local bus line. The number of visits rose sharply in September, with most of the rise in the second half of the month. At least some of this rise may be attributed to the cinema showing of the film. However the data give no indication of how the website is used.

Table 1 Traffic analysis on www.sort-out-stress.c.uk , June –September 2005

	June	July	August	September
Total visits to website	442	665	528	937
Number of distinct internet visitor addresses	198	333	300	597
Duration of typical visit (minutes)	1.29	0.98	0.81	0.74
Duration of longest visit (minutes)	22	26	18	12

Staff working in a hostel for homeless young men reported that the images used on the project's website would not appeal to the young men with whom they worked. The scene of a comfortable room, furnished with a range of personal items, was not perceived as one with which their clients would readily identify.

The film was used in training sessions for staff and young men. The youngest group (14-15 year olds) attending a community centre session, displayed little reaction to the film and the story it portrayed. The project team attributed this reaction to the film content, which portrayed an older young man with problems of a different order to those experienced by this particular audience. Older young men generally expressed more interest and were able to identify more closely with the issues raised by the film. In a hostel centre, one young man said 'that's reality, that's how it is'.

Staff who saw the film during their training sessions expressed mixed views. In some settings, the film was perceived as offering a useful and relevant story that would resonate with young men. However, at a hostel dealing with the homeless, some staff commented that the film over- emphasised the role of professional help. For them, two people sitting at a table talking about problems was not a realistic scenario for their client group, many of whom lacked the emotional vocabulary to express their distress.

6. INVOLVING YOUNG MEN

Whilst all three pilot projects worked with young men, the stage and degree of their involvement varied. The Camden project worked from the outset with young men, conducting a series of focus groups to test out materials for their acceptability and to amendment materials accordingly. The Manchester project, whilst focusing almost exclusively on the development of a training course for young men, did not engage them as active participants in the early design of course material. However, both the Camden and the Manchester projects used feedback from initial sessions to further develop and refine the content and delivery of their training courses. By contrast, the training course for non-mental health professionals developed by the Bedfordshire project did not involve young men in its development.

Focus groups with young men

As mentioned earlier, the Bedfordshire project initially planned to ask agencies participating in the training to organise their own focus groups with young men in order to obtain feedback on how their services could be improved (known as a Project Action Plan). It was also agreed that young men's views on how the small grant of £500 could be spent would be sought. This course of action was subsequently replaced by a programme of three focus groups, which were jointly hosted by Men's Health Forum and the pilot project co-ordinator, as follows:

Asian Young Men's Focus Group
Young Men's Focus Group (13-15 years)
Young Men's Focus Group (16-19 years)

It was reported that focus groups would explore young men's perceptions on mental health, their knowledge of current services, issues regarding access to services, and their ideas for improving services in the future. Discussions were taped and transcribed. Analysis was completed by the Men's Health Forum and presented on the fourth and last day of the training programme.

In terms of attendance, the project co-ordinator reported that twelve young men, aged between 15-16 years, attended the focus group for young Asian men. All participants were from one specific youth group. The focus group for 16-19 year olds was attended by six young people from different organisations, including an upper school (n=2), a youth group (n=2) and from a project for homeless young people (n=2). Eight young men participated in the focus group for 13-15 year olds (four from an upper school, two nominated by Dunstable Town Council, and two nominated by Connexions).

A report on focus group findings was prepared by the Men's Health Forum. The report concluded that a broad consensus had emerged between all focus groups that crime, anti-social behaviour, gang activity, social isolation and living in a 'run-down neighbourhood' all contributed to poor mental health among young men. Conversely, the support of friends and family members were identified as conducive to mental well-being.

Most of the young Asian men were identified as at risk of school exclusion and were attending a behaviour support unit. The group was described in the report as more 'angry',

less ‘mature’, and more inclined to be ‘provocative’ than other focus groups. Nevertheless, participants were reported as articulating a number of clear views. In particular, focus group participants were reported as placing a high value on the support offered by the youth group they attended. At times, the youth group in question appeared to function as a safety net against further social exclusion:

‘If it wasn’t for (the youth worker) and the group, half of us would be junkies and others would be dead or in prison’.
(Participant, Asian youth group)

Indeed, the quality of the relationship with the youth worker was contrasted with a generalised alienation with formal service providers. In some respects, the youth worker’s role was perceived by young men as making other professional interventions redundant:

‘We don’t need professionals, we’ve got (the youth worker)’
‘(The youth worker) makes referrals only if he can’t help us’.
(Participants, Asian youth group)

Young men who participated in the other two focused groups were described in the report as less alienated and more interested in discussing young men’s mental health. In this respect, young men appeared as willing to engage in a constructive dialogue and therefore as potential stakeholders in improving their mental health, ‘if only they could take responsibility’. Quotes from the report highlight a common sense of inertia and of perceived powerlessness:

‘Jobs were more available in the past…these days it’s different’.
‘Today, you’ve got to have qualifications for everything’.
‘Careers people in schools helps the wrong people…help the people who know where they want to go’.

In relation to primary care services, mixed views were expressed about GPs, some being perceived as unresponsive and insensitive to the needs of young men, but others as more helpful. The tendency for doctors to treat symptoms, rather than the causes of depression was also highlighted:

‘I won’t always go to my GP as it’s good to get by without drugs’.

As far as young men’s awareness of local services, youth groups and services emerged as having a higher profile than other services. It was also reported that young men who commonly described local services as ‘unresponsive’ were not speaking from experience, and those that had made contact were generally more favourable in their views. The report concluded that services perceived by young men as most successful employ staff who are ‘responsive’ and ‘actively involved’, have clear ground rules, and have ‘decent facilities’.

The Camden project also involved young men from the outset by holding focus groups and reference groups to inform the development of the project’s promotional materials. A total of 68 young men, ranging between the ages of 14-25, took part in 10 groups. The groups were held at youth centres, homeless organisations, a job centre and a secondary school and provided an ethnically diverse population of young men (31% White British, 22% Black African, 15% Bangladeshi). In general, under 16s were less willing participants and recruitment of this age group proved less effective. Focus groups tended to comprise mostly

16-18 year-olds. The number of participants in the groups ranged from three to 10 young people.

Each focus group was conducted by two members of the project team, either in the afternoon or early evening at venues well known to the participants, generally a centre they attended regularly. The team adopted a flexible approach in conducting the groups, as each setting presented different problems in terms of continuity of participation and engagement. During some sessions, staff from the hosting agency were present and assisted with facilitating the group, playing a more prominent role in some than in others. At a Jobcentre, the team conducted one-to-one interviews as young men attending the centres were unwilling to wait until enough young men were present to form a focus group. Focus groups were recorded by the team so that tapes were available for later analysis.

Over the course of the first six months, three reference groups were established from among focus group participants to further develop and refine materials. The reference groups were small, comprising two to three young men who were mainly in the older age range (18-25 years). The team found that specific comment and feedback on the booklet revisions were easier to achieve with smaller groups. Initially, the project team concentrated on engaging groups of young men to explore beliefs and attitudes about mental health. When these topics had been fully explored, the team moved on to involving groups in testing the information and promotional materials under development by the team.

The project identified key themes from focus group discussions, including profound distrust of GPs and health services generally. It became clear that the young men tended to have little faith in the value of ‘talk’, preferring to discuss practical solutions to their problems. They tended to distrust formal, statutory services, believing that GPs and psychiatrists, because of their different social backgrounds, would be unable to understand their problems and would simply prescribe drugs. Friends and family represented the first port of call when any need arose. The groups displayed a lack of awareness of potential sources of help beyond the immediate family and friends.

The language used to discuss mental health issues was identified as a key factor in helping to make training sessions more acceptable to young men. For example, young men expressed a preference for ‘advice’ lines rather than ‘help’ lines because seeking ‘help’ was perceived as potentially threatening to their self-esteem. Services such as Connexions were identified as useful resources since they were located outside of statutory health services; consequently, seeking help from these sources was perceived as more acceptable and less risky. Young men feared that personal information would be shared between agencies, for example by GPs and the police, without their consent or knowledge.

In terms of working with young men to raise their awareness of mental health issues, groups identified pro-active outreach or community-based work as probably the most effective strategy. Expecting young men to approach primary care services was regarded as less likely to improve access to services. Questions of class and culture were discussed and young men attending groups in more deprived areas expressed the view that GPs would not be able to resolve mental health problems immediately. Consequently for the young men, no effective rapid response to their problems meant that they perceived GPs as ineffective sources of help.

The project team observed that attending the focus groups and hearing first hand the views and beliefs of young men of mental health and service provision had been a valuable lesson

but a steep learning curve. Most of the team had little previous contact with community groups, being primarily clinic based. One member of the team commented that the focus groups had led him to revise his thinking on how he interacted with young men.

We were all pleasantly surprised at how committed the young men were. We believed that young men were difficult to engage and we expected them to be difficult and scary. But they weren't, they were happy to talk about issues.
(Pilot project team member, Camden)

Involving young men in training proved more challenging than organising and conducting focus groups. One contributory factor may have been that incentives were not offered for attendance at training whilst these had been provided for focus group participants. Alternatively, the training session may have been perceived by the participants as too structured, offering insufficient opportunity to express their views. Indeed, the project team described a training session with a group of younger men (average age 14 years) where the training had to maintain a fast pace as a means of maintaining order and avoiding pauses that would lead participants to resume their conversations. However, keeping up the pace required sustained concentration from the young men, with the project team asking questions constantly. The team commented that the session resembled an 'English comprehension exercise' rather than a free-flowing discussion.

All the young men were nice and we did not receive any hostile reaction, it simply felt like they were not at all interested in the topic. …. The discussion following the film went okay, everyone contributed though it felt like answers were given because they thought that was what we wanted to hear, in an effort to move the session on faster rather than because they had actually thought about it.
(Pilot project team member, Camden)

In Manchester, feedback from participants on pilot courses informed the further development of subsequent courses. Some young men expressed a view that the course was not relevant to the problems they faced in their everyday lives. Few participants were employed and for them the need to earn an income was seen as the key to solving almost all the problems they faced. Some young men identified problems at home or with their families or peers. Others perceived a lack of freedom to develop friendships because peer pressure for social recognition involved them spending time with people they did not like to gain credibility. A common thread in the groups was the perception of their vulnerability to crime, especially gun crime.

Outcome evaluation

Involving young men emerged as the weakest area of the Bedfordshire project's work programme. Two main factors were identified to explain this pattern of development: that the project co-ordinator perceived this area of work as outside of her expertise in terms of knowledge about local youth projects and also in relation to the skills required to work directly with young men. The project's external consultants were also influential in advising against requiring participants to organise their own focus groups with young men, as originally planned.

Both Manchester and Camden projects involved young men in evaluating the training they received. Young men taking part in the Manchester sessions gave session evaluation forms a mixed reception, seeing yet another paper and pen exercise as unacceptable. Group sessions with the evaluator to talk about the course provided a richer source for evaluation data. The Camden team decided that completing an evaluation form would be an exercise too far for the young men attending what was essentially a brief, hour long session. The project opted for a short taped session at the end of the training. At both Camden and Manchester, some young men chose not to take part in any evaluation exercise.

Sustaining attendance during sessions, or over several sessions, was problematic for both projects when working directly with young men. Young men actively 'evaluated' the sessions by voting with their feet or by expressing adverse comments or sidetracking the session. Three of the four groups in the Manchester project benefited from having a sound, if small, core of participants who attended regularly and took the course more seriously than less engaged members. The young men were critical of those who attended but did not participate or engage in the sessions. Post session evaluation sheets described '*people being immature*' and '*ruining*' the session. One group was particularly critical of non-contributors in the sessions' discussions and activities. Just sitting and '*not giving input*' meant that the group did not have enough discussants. The group with young offenders was the least engaged of all the groups. This group included younger men aged 14 to 16, and sessions were frequently interrupted by requests for breaks and overt expressions of boredom and dissatisfaction. A member of staff attributed this to literacy problems of the young men taking part.

The moment he saw a pencil and paper, you'd lost him.
(Gillian, Youth Offending Team)

Both Manchester and Camden projects recognised the important role of partners in facilitating sessions. The project worker, meeting young men as part of a brief intervention, relies on the hosting partner to use their established relationship with the participants to get the best out of any session. Having some background information about the young men taking part in a session and assistance with those who might have specific problems would have helped delivery of courses in Camden and in Manchester. In both locations, some sessions were difficult to manage, not because of wilful disruption, but through dominance of discussions by a few, exceptionally vocal, participants.

The acceptability of the trainer involved was an issue raised in both Camden and Manchester. The Camden team were mindful that the deliverers of the course were both white, middle class males in their twenties. They were aware of work by the Men's Health Forum that indicated that a black male might offer a more acceptable model for the young men and the project was exploring the inclusion of a local rap poet to work with delivering the session. At the same time they were also concerned that the session might be better delivered by a worker with whom the young men were already familiar rather than by an outsider. The Manchester project worked with groups over a longer period rather than just one session and so offered the worker greater opportunity to develop rapport with the young men. Partners hosting courses in Manchester spoke positively about the project worker as being instantly recognisable as someone to whom young men could relate. In one evaluation interview, young men commented that they felt very comfortable with the worker and that they had felt confident in talking openly with him after his assurance of confidentiality. Indeed a member of another group said that when he arrived at the first session and saw the leader, '*I thought he was one of us*'.

7. MULTI-AGENCY CO-OPERATION

The evaluation identified a number of challenges and benefits to multi-agency working as a means of promoting the mental health and well-being of young men. In researching the effectiveness of the pilots as multi-agency initiatives, the following key questions emerged as of crucial importance:

Has a mutual understanding been achieved regarding respective roles and responsibilities among participating agencies?
How can partner agencies help pilots to engage with young men?
How involved have partner agencies been in deciding and generating ideas about the project, and therefore a sense of ownership?
How well do pilot projects fit with the objectives of participating agencies?
Will pilot projects build a lasting sense of partnership?

The evaluation suggests that, in order to be effective, partnership initiatives are required to strike a balance between a number of polarities, such as providing leadership and achieving consensus; focusing on the task while maintaining positive relationships; and seeking involvement while also making demands on partners' time and resources.

Role clarification

All three projects placed considerable emphasis on the value of working in partnership with other agencies as a means of meeting projects' objectives.

In terms of the day-to-day management of the Bedford project, the co-ordinator reported at an early stage that there appeared to be a lack of clarity concerning her role and responsibilities in relation to the project's multi-agency steering group. She had expected to 'represent' the steering group, and implement their agreed programme of work. In practice, it became apparent that the project co-ordinator was expected to manage, rather than solely co-ordinate the project's activities. There was some ambiguity, concerning the extent to which the steering group perceived its role as providing leadership, or rather a 'sounding board' for the project co-ordinator. One saw the role of the Steering Group as 'strategic', and considered management responsibilities to be the proper remit of the project co-ordinator. A second identified the co-ordinator's line manager as responsible for the day-to-day management of the project. A third reported that the steering group provided the framework and that the co-ordinator was responsible for progressing the work.

Engaging with young men

Aware of the diversity of the young male population of the borough, the Camden project adopted a broad-brush strategy in terms of the agencies to approach to attempt to engage a wide range of young men within the project. Partners included an organisation working with young gay men, a Bangladeshi community group, several Neighbourhood Renewal organisations and community centres, job centres, hostels and youth centres.

In the early work of developing these partnership relationships, the project team recognised the importance of establishing personal contacts with their partners. Whilst numerous telephone calls often made only limited progressed, a personal visit to partners was essential to create a working relationship. The team felt that their partners appreciated that they went to them, at a time convenient to the partner. Visiting youth centres in the evenings *'showed we are not too precious to go out at night to find out what they want'.* Summing up the project, one of the team workers commented *'Every part of the project is about building relationships'.*

The Manchester project recognised engagement with agencies already working with the target group of young men was central to its strategy in working with those with few formal qualifications, the unemployed and those with offending behaviour. The project sought links with employment services and in the criminal justice system, the youth offending team and probation services. Again, the project worker was required to pursue partners to establish working relationships and to gain acceptance of the pilot courses with hosting partners. To place one of the pilot courses required numerous telephone contacts and four face-to-face meetings with a range of representatives from the hosting agency before agreement was achieved. The project also benefited from being established as a partnership initiative. Once the project was underway, regular meetings with the steering group provided a focus for the project, keeping it on track by providing a regular reporting structure.

Influencing the development of the project

In Bedfordshire, *mentality*, the external training consultancy, reported exercising considerable influence over the scope and contents of the work. Members of the project steering group reported varying levels of involvement, such as contributing to discussions concerning who should be invited to participate in the training programme, in encouraging a preventive approach to addressing young men's mental health, and by promoting young men's participation in the development of the pilot.

Regardless of the extent of their involvement, steering group members commended the 'open approach' of the project manager for helping them to feel that they were genuinely involved in the project's development: 'there was a very open debate at the initial planning stage and after funding was agreed, this open approach continued'. Emphasis was given to the 'judicious use of e-mail' and to the usefulness of one-to-one meetings with key partners on the Steering Group as aiding a sense of involvement and in allowing the project co-ordinator to benefit from their expertise and contacts in the local community. The project's success in involving schools was attributed to this mode of working. Equally important, it was noted that the feedback offered the project co-ordinator was incorporated as the work progressed:

'Every step of the way, I have been able to feed back with suggestions, and they have been taken on board, so the communication is superb and this is sometimes a challenge if the project co-ordinator is based in one place and a number of different external agencies are involved'
(Amanda, steering group member)

None of the partner agencies was able to identify any barriers to their involvement. This was widely attributed to the enthusiasm, skills and commitment of the project co-ordinator who was described as 'a vital cog in the wheel, able to move all the different strands forward'.

Unlike the other two pilots, the Camden project did not work to a multi-agency advisory or steering group. Instead, the team worked closely with a number of partners to discuss training needs and in developing the resource materials. Partners were pleased that the team had provided them with the opportunity to influence the way the teaching materials were developed. The team had listened to staff working in a range of environments with young men, tailoring the training sessions to fit their specific needs. The team accompanied the detached youth workers on one of their regular meetings with young men on the streets, providing an introduction to the grittier side of Camden life and an experience that one team member described as eye-opening but a privilege to undertake. Another team member explained that their visits to partners and to the young men gave them a new perspective on what they were attempting.

It's been a different way of looking at men's mental health – it's about taking it out of the clinic. We've learnt to do things differently because of this.
(Pilot project team member, Camden)

Importantly, partners perceived the consultation process to work in both directions. Partners used their discussions with the team to clarify their training requirements and to review the way they worked currently with young men. The partners appreciated that the team listened to what they had to say about the young men with whom they worked regularly and took on board their views and experiences. A youth centre manager that served a mainly Bangladeshi population explained that he urged the project to use other words than mental health.

They were really professional, they came to talk to staff first, before the two sessions with the young men.
(Youth centre manager, Camden)

The team believed that their partners valued their approach. In the past, partners had experienced 'professionals' coming in to deliver one off sessions, imposing ideas and then leaving. The project team believed that acknowledging the role of their partners and incorporating their ideas into the development of the project helped to establish positive relationships.

How do pilot objectives 'fit' with participating agencies' objectives?

Partner agencies in Bedfordshire were able to identify the 'fit' between the project's programme of work and their own organisation's service priorities. For example, the youth service reported that young people who were not in education, employment or training were particularly vulnerable to mental health problems, and that addressing the mental health needs of this group might assist in reducing their social exclusion. The health needs of looked after children were also cited as a priority for social services, and it was anticipated that the programme would assist staff in training foster and adoptive parents on issues of young people's mental health.

Also in Bedford, the local Healthy Schools Programme was described as a particularly useful umbrella for addressing young people's mental health needs, particularly in relation to anti-bullying work, raising awareness around issues of drug and alcohol use, confidence-building, as well as more challenging mental health problems. It was also stated that the 'holistic assessment framework' used by Connexions in its work with 13-19 year-olds had led to the wider reporting of mental health issues and that consequently, there was an urgent need to improve the skills of Personal Advisors, including their ability to network and make appropriate referrals.

Partners working with the Camden team reported a positive match of their objectives with those of the project. The Jobcentre staff saw improving the mental health of its clients as key to improving employment prospects. Combating the negating effects of depression and stress exacerbated by unemployment, would help clients engage more positively with retraining or job seeking. Additional benefits were recognised in providing staff with the skills to connect with stressed clients to improve the day to day running of the centre and help reduce strain on members of staff.

However, fitting project objectives with those of the partner agency was sometimes problematic for the pilot projects. Several agencies were initially hostile when approached by the project, based on past experiences of working with service providers. Some perceived statutory health services as well funded and well resourced when compared with their own agency, and these services often appeared inaccessible when they attempted to refer young men to them. One hostel had been upset by a recent decision to discontinue funding for an anger management course and was not pleased to find money being spent on the pilot instead of a course they particularly valued. One partner agency observed that they had had high expectations of the project initially but reported that, so far, these had not been fulfilled. This partner believed that the service provision locally did not match the needs of young men, particularly the crisis services that their clients found difficult to access. They had hoped that the project would highlight the limitations of the service and impact on the level of provision.

Partners working with the Manchester project were supportive of the work the project had undertaken, perceiving the objectives of the course as wholly supporting their work. More importantly, the partners viewed the course as filling a gap in the work that they were already undertaking. A youth offending team officer described how the course would assist both the young men taking part and indirectly help her.

By helping the young men to get the skills to communicate, it will make our job easier and more effective. After all a lot of what we do with the young men is around getting them to communicate with us.
(Gillian, Youth Offending Team)

Building lasting partnerships

All three projects recognised the need to develop relationships with partners that would offer the opportunity to sustain mental health promotion beyond the life of the pilot projects. Whilst the Bedfordshire project had been designed to fit within the one year framework, Camden and Manchester, with the benefit of additional funding, are ongoing projects with further time to work towards developing lasting partnerships with other agencies. All three projects invested

time during the period evaluated in establishing their contact and working relationships with the partners they identified as key to promoting young men's mental health in their local areas. All three acknowledged that developing partnerships took more time and commitment than they had initially anticipated.

Both Camden and Manchester recognise the need to continue to invest time and commitment to engage and support partners if the aim of mainstreaming mental health promotion within partner systems is to be achieved. From the experiences of the two projects, this target is more likely to be met when working with statutory organisations than with the voluntary sector. In Camden, the aim is to mainstream the pilot work in the employment service, and in those schools where contacts have been established. In Manchester, partners working within youth offending team and youth unemployment have expressed a willingness to incorporate regular courses within the standard 25 hours weekly education and training that the centres offer.

Sustaining the project's work in other settings is likely to prove more challenging. Youth and voluntary sector-managed centres that rely on part-time and occasional staff have offered fewer opportunities to integrate mental health promotion in their work. Establishing lasting partnerships with agencies experiencing changes in personnel or priorities was problematic. Even during the lifetime of the evaluation, staffing changes hindered the work of the pilots. The experience of the Camden project in arranging training sessions for young men in one youth centre is illustrative. After successfully organising a focus group and staff training, the young men's training could not be arranged as the leader had moved on and partnership negotiations had to begin again.

However both Camden and Manchester projects acknowledged that to sustain lasting relationships with partners requires on-going active participation and therefore continuing resources. To sustain its partnership working, the Camden project estimates that a lead clinician would be required to sustain the training and to provide support and supervision to staff who deliver workshops to young men. The project identified possible future funding for this work might be sourced from 'Choosing Health' funding from within the PCT or from the local authority. In relation to the Manchester project, appropriate future sources of funding support might include the Crime and Disorder Partnership or the city council.

8. EMERGING MESSAGES FROM THE PILOT PROJECTS

The three pilot projects evaluated in this study undertook only brief interventions in localised settings and aimed to achieve longer-term outcomes as well as short-term impacts. In the light of the mainly qualitative and cross-sectional methods employed by the evaluation, the extent to which the study can inform lessons for the future strategy for mental health promotion for young men is limited. Nevertheless, a number of key themes emerged from the evaluation that are of general relevance to health promotion initiatives for young men. Additionally, issues are highlighted that have specific relevance to the development of training courses and the production of health promotion resources for non-mental health professionals and for young men.

Key themes or principles of general relevance to health promotion initiatives targeted at young men

Overall, the evaluation highlighted the importance of:

building on existing knowledge and expertise concerning the relative effectiveness of different approaches and methods for promoting young men's mental health by reviewing published evidence and liaising with other experienced personnel in the field.

clarifying who the target audience is (professional background or age group, for example) and what the initiative aims to achieve.

clarifying understandings of what is meant by 'mental health promotion' and selecting a model of mental health that will inform the proposed programme of work. For example, will the initiative emphasise notions of well-being and discuss the role of self-help and effective coping strategies or will it focus on identifying and responding to signs and symptoms of mental ill-health?

consulting widely with professionals who work with young men, and young men themselves, to ensure that training courses and health promotion materials match their needs.

involving young men in the development of health promotion initiatives at an early stage and as a matter of good practice in order to ensure that their views and responses are integrated into projects as they develop.

actively listening to young men concerning their understandings of mental health, the problems that support and demote their well-being, and their views about the likely effectiveness of different strategies for mental health promotion. This may entail a need for greater awareness and reflection on the part of health professionals concerning their beliefs and assumptions about young men and mental health problems.

acknowledging that ‘young men’ are not a socially homogenous group and that class, culture and age are key factors influencing life circumstances and experiences. Therefore, seeking to develop a ‘generic’ training or range of health promotion materials that ‘fits all’ is not appropriate. Future initiatives are required to research the needs of the target audiences.

obtaining expert advice on the planning of multi-media campaigns in relation to budgeting and dissemination. In particular, the production of short films for cinema presentation needs to take into account licensing procedures and criteria for transmission.

In addition to these general themes or principles, findings highlighted a number of important lessons of potential relevance to future health promotion initiatives that seek to engage a) directly with young men, b) with non-mental health professionals, and c) with partner agencies.

Working directly with young men

The pilots confirmed that young men had ample ideas and opinions about mental health and mental health services and can offer valuable and alternative perspectives to those of the mental health professionals working with them. Findings indicate that health promotion initiatives targeted at young men are more likely to be successful if training courses and other health promotion initiatives:

utilise community-based locations, such as youth centres and youth-oriented services, rather than expecting young men to attend more formal service settings, such as GP surgeries.

avoid overly formal ‘classroom’ type settings, especially for the most vulnerable and for those for whom literacy may be a significant barrier to participation.

involve staff in partner agencies to assist in managing group dynamics during training sessions or discussion groups.

address issues of presentation (visually and in terms of the language used), appeal (raising issues of interest and relevance to young men), and acceptability (in terms of the message conveyed).

identify and engage with young men’s beliefs about acceptable ways of responding to stress and other mental health problems and their level of emotional literacy. Some young men expressed a preference for exploring practical solutions over ‘talking’ therapies.

address the importance of social disadvantage as a key factor in shaping young men’s views about what contributes to mental health problems (such as unemployment, crime, gang activity, social isolation and poor housing conditions) and what helps them to cope (the support of friends and family).

incorporate opportunities for older young men to explore issues that might otherwise be regarded as taboo subjects in their peer group and promote discussions about options for managing stress and other coping strategies.

tailor training and group-work methods to the age-group of participants. Younger men may be more difficult to engage and may benefit from methods and approaches that address their interests, cognitive capacities, and peer group cultures. Writing exercises should be avoided where young men have literacy problems.

engage trainers who are relatively close in age and/or ethnic origin to participants may help to facilitate young men's involvement.

obtain young men's views about the design (colour, typeface and format) and content (extent and kinds of information presented) of health promotion materials. This can be achieved by 'testing' materials among the intended audience.

Develop a range of innovative and brief methods for evaluating training courses and avoid paper exercises if participants are likely to have literacy problems.

Working with non-mental health professionals

Findings suggest that professionals need to synthesise and take seriously what young men tell them about their beliefs, ideas and experiences of mental health and mental health services. Findings also indicate that training courses designed to enhance the capacities of non-mental health professionals to promote young men's mental health should endeavour to:

match the needs of participants as far as possible, taking into account differences in levels of awareness and skills among course participants, but also the severity of mental health problems in their client group.

offer a menu of 'generic' courses (exploring understandings of mental health promotion, preventive approaches, problem-solving skills, strategies for engaging young men in discussions about mental health, and information on referrals to sources of expert help) and courses that address specific issues in young men's mental health (such as depression or post-traumatic stress disorder).

strike an appropriate balance between imparting information (particularly on theoretical issues and therapeutic models for responding to mental health problems) and improving skills for promoting mental health and engaging with young men.

select training methods that are most likely to appeal to the intended audience. Informants generally expressed a preference for group discussions and interactive methods over more didactic approaches.

draw upon the skills, professional knowledge and experience of participants as a valuable resource and allow sufficient time for networking between agencies.

Improving young men's access to health (including mental health) services

Young men's perceptions of statutory health services remain a significant barrier to improving access. Young men involved in the pilot projects identified fear of the potentially stigmatising label of having a mental health problem and a range of perceived risks associated with approaching GPs or other health services with mental health problems. Findings indicate that, in order to enhance young men's access to health services generally, and mental health services in particular, health promotion initiatives should aim to:

address young men's perceptions of health services. Findings show that some young men distrust GPs and other health providers, particularly in relation to matters of confidentiality. They may also anticipate a lack of empathy on the part of GPs towards mental health problems and may be reluctant to seek help if they expect their GP to prescribe drugs as a form of treatment.

undertake pro-active and community-based outreach programmes. These approaches were perceived by young men as more acceptable (because less threatening to their self-esteem) and less risky (in terms of the likelihood of staff sharing information with other agencies, such as the police).

integrate concepts of mental health promotion into the everyday work of non-health service agencies, such as employment services, Connexions and other youth-oriented agencies.

adopt alternative terms to 'mental health' (such as 'stress management' or 'well-being') to encourage partners and young men to engage with future projects and to ensure that mental health issues are discussed in a non-stigmatising way.

provide information and advice for family members and friends of young men who are experiencing stress or other mental health problems. Young men generally regarded friends and family as a more immediate and trust source of support.

Working in partnership

Findings from the evaluation indicate that successful partnership working entails:

clarifying expectations and defining the respective roles and responsibilities of partner agencies at the outset.

developing links with agencies and maintaining those links via face-to-face contact and, to a lesser extent, via telephone contact.

identifying substantive benefits that were likely to accrue to partners as a result of their participation, such as providing staff with skills and resources to help them directly in their day to day work, offering a service that the partner alone is unable to

provide, or financial incentives to recompense partners for the time or resources they committed to working with the pilot.

helping partners to appreciate that they were actively involved in promoting the well-being of young men in their day-to-day work even if they did not formally recognise the role they were playing.

ensuring that partners are consulted about the design and content of health promotion initiatives, such as training courses, in order to match their experiences and needs.

enlisting the support of partner agencies in order to gain access to otherwise hard-to-reach young men, and to support mental health teams in their direct work with young men.

sustaining and extending mental health promotion initiatives by undertaking capacity-building within partner agencies. A number of strategies were identified to achieve this, such as offering brief follow-up sessions to address specific issues or training needs, training professionals who work with young men to be trainers, promoting the use of mental health promotion resources as a focus for discussion in a variety of contexts, and seed-funding small-scale health promotion initiatives in partner agencies.

providing training for partner agencies and staff who work with young men and offering training to the young men within the same agency as this offered an opportunity for continuity of support. Brief interventions with young men, particularly the more vulnerable, may be more effective if on-going support is available from non-health service sources that they trust and with whom they have regular contact.

Policy implications and recommendations for the development of a mental health strategy to reduce suicide among young men.

Findings indicate that any future policy developments should acknowledge the important role played by non-statutory and youth-oriented agencies in supporting young men's mental health in an informal way. In addition, findings suggest that more could be done to raise awareness among primary care and mental health professionals concerning young men's perceptions of service provision, and professional attitudes and responses that are perceived by young men as more or less acceptable.

Whilst pilot initiatives can provide short-term drivers for projects, more sustained support is required if partner agencies, and particularly non-statutory agencies, are to maintain their involvement in future policy and service developments.

The dissemination of lessons learned from the evaluation of the pilot projects forms an important output in its own right. In order to build on this knowledge, a summary of the findings should be disseminated widely among statutory mental health service providers and non-statutory agencies working with young men.

More specifically, if the work of the pilots is developed or replicated elsewhere, consideration should be given by the NSPAG and other health service providers to:

Identifying the optimum scale of future initiatives – whether these are local authority- or Primary Care Trust-wide.

Providing sufficient resources to match the intended objectives of mental health promotion initiatives targeted at young men.

Ensuring that health promotion initiatives are tailored to the specific needs of target audiences.

Conducting further research to explore ways of addressing the health promotion needs of younger men (14-15 years of age and under).

Providing information and support for family members and friends of young men who are experiencing stress or other mental health problems.

Adapting and refining the resources produced by the Camden pilot project as follows:

the web site could be adapted for use in other areas in a modified format to incorporate local service information

the film could be professionally edited for generic cinema showing across the country with local services highlighted locally. This area of work might fall within the remit of the SHIFT anti-stigma [3] campaign.

Compare the findings of the research presented here with evaluations of other initiatives in the field, such as the Applied Suicide Intervention Skills Training (ASIST) programme in Scotland.[4]

Investigate options for measuring the impact of mental health promotion initiatives involving young men over a longer time-frame.

[3] SHIFT is a five year government funded programme which aims to embed anti-stigma work in four key areas, including public organisations, private organisations, the media and young people.

[4] ASIST is a two-day intensive, interactive and practice-dominated course designed to help caregivers recognise risk and learn how to intervene to prevent the immediate risk of suicide (www.wellontheweb.org)

REFERENCES

Appleby, L. (2000) Safer services: conclusions form the report of the National Confidential Inquiry. *Advances in Psychiatric Treatment* **6:** 5-15.

Brock, A.., Griffiths, C. (2003) Trends in the mortality of young adults aged 15-44 in England and Wales, 1961-2001. *Health Statistics Quarterly* **19:** 22-31.

Crisp, A. H., Gelder, M.G.G., Rix, S., Meltzer, H., Rowlands, O. (2000) Stigmatisation of people with mental health illness. *British Journal of Psychiatry* **177:** 4-7.

Department of Health (1999) *Saving Lives: Our Healthier Nation.* London: The Stationary Office.

Department of Health (2002) *National Suicide Prevention Strategy for England.* London: Department of Health.

Department of Health (2004) *National Standard, Local Action: Health and Social Care Standards and Planning Framework.* London: Department of Health.

EPPI-Centre (2002) *A scoping exercise for a review of the effectiveness of health promotion interventions of relevance to suicide prevention in young men (aged19-34).* London: Institute of Education.

Griffiths, C., Rooney, C., Brook, A. (2005) Leading causes of death in England and Wales. *Health Statistics Quarterly* **28:** 6-17.

Men’s Health Forum (2000) *Young Men and Suicide: An audit of local service provision and young men’s take up of services.* London: Men’s Health Forum.