

# Research and evaluation review

2006–2007



**Health**  
Promotion  
Agency

# Research and evaluation review

2006–2007

# Foreword

The Health Promotion Agency for Northern Ireland (HPA) supports regional health promotion and public health initiatives by disseminating knowledge and evidence of effective approaches and interventions.

Northern Ireland's public health strategy, *Investing for Health*, highlights the need for quality research on the effectiveness of public health interventions and on people's beliefs and concerns.

Each year, as part of our support for this strategy, we carry out research and evaluation exercises related to our own programmes and to the work of promoting health. This review of research and evaluation work reflects some of the activities that we have carried out in 2006/07.

We report on the evaluation of two breastfeeding projects: the Breastfeeding Welcome Here scheme, to promote the social acceptability of breastfeeding; and a breastfeeding awareness CD ROM for schools, to support the Northern Ireland Breastfeeding Strategy's recommendation that breastfeeding education is undertaken at both primary and post-primary level.

The Get Active in the Community Cash Grant Awards scheme runs annually and we report on the evaluation and recommendations that will inform the ongoing development of the scheme. The evaluation of the 2006/07 physical activity public information campaign, 'Every small step is a forward step' is also reported.

Three pieces of research were carried out in the area of mental health: an evaluation of the Mental Health First Aid pilot programme, and qualitative and quantitative surveys on public attitudes, perceptions and understanding of mental health in Northern Ireland.

The annual No Smoking Day initiative was evaluated to measure the level of awareness and participation in the day. The report also details the evaluation of *Cook it!*, a community nutrition education programme.

We also report on a survey of young people aged 11–16 years, and the perceptions and behaviour of parents of young people aged 11–16 years in relation to alcohol, drugs, mental health and risk-taking behaviours.

This report will be of use to those involved in public health in Northern Ireland, whether they have a professional involvement or an organisational or personal interest. We hope, by making this information widely available, to encourage collaboration among all those working to promote the health of the public in Northern Ireland. By giving wider access to research information, we also hope to ensure better use of resources.

The research and evaluation initiatives described have been carried out within the priority areas and programmes of work that the HPA has been commissioned to deliver on a regional basis.



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# Evaluation of the Breastfeeding Welcome Here scheme

The Breastfeeding Welcome Here scheme is part of an ongoing commitment to improve support for breastfeeding mothers by promoting social acceptability of breastfeeding. The scheme aims to increase breastfeeding duration rates and improve social acceptability for mothers who wish to breastfeed their babies while out and about. The scheme is supported by the Health Promotion Agency for Northern Ireland (HPA) and the Northern Ireland Breastfeeding Strategy Implementation Group. The Northern Ireland Breastfeeding Strategy includes a commitment for the development of community support for breastfeeding outside the home.<sup>1</sup>

The Breastfeeding Welcome Here scheme asks businesses to welcome breastfeeding mothers and display a sticker and poster to make the public and mothers know they are part of the scheme. The initiative is primarily aimed at cafés, restaurants and shops with seating areas as well as hotels and hairdressers. A list of members is available at [www.breastfedbabies.org](http://www.breastfedbabies.org)

Investing for Health officers, representing local councils, have been helping to increase participation in the scheme by working with the HPA to sign up council premises and facilities to the Breastfeeding Welcome Here scheme.

The scheme was launched in May 2005. As of November 2006, there were 91 businesses and council facility members.

## Aim

To assess the Breastfeeding Welcome Here scheme and ascertain any changes or recommendations required to inform future development.

## Objectives

- To gain insight into why members decide to join the scheme.
- To assess members' levels of satisfaction with the Breastfeeding Welcome Here scheme.
- To assess the perceptions and experiences of both staff and customers of the scheme.

- To obtain feedback on the support materials for promoting and joining the scheme.
- To provide recommendations for improvements to the administration of the scheme and its support materials.

## Method

Postal questionnaires were developed to meet the above objectives. One questionnaire was developed for business members and an adapted version for council members. Contact details for all members were obtained from the HPA membership database. Members were excluded from the survey if they had been a member of the scheme for less than three months or if they had not yet had their assessment carried out.

## Sample

Questionnaires were sent out to 48 businesses in November 2006. Reminder letters and an additional copy of the questionnaire were sent to non-respondents in December 2006. In total, responses were received from 22 businesses (a 46% response rate).

Questionnaires were sent to 43 council premises in early February 2007, with reminders sent out at the end of the month. In total, 17 responses were received; however, one of these council returns related to three council premises (overall responses from 44% of premises).

All results in the following section are presented as numbers rather than percentages due to the small sample size. Results are presented for the business and council members separately.

## Key findings

### Joining the scheme

Businesses were asked how they found out about the scheme. The most commonly reported way was by being approached by a health worker (n=9) or a customer (n=6). Two businesses reported that they found out about the scheme through the website. When asked how they felt about being approached to join the scheme, all businesses were happy.

Three respondents made the suggestion that the way the scheme is introduced to businesses could be improved by promoting the benefits of membership to both customers and businesses.

Businesses were asked why they chose to be involved in the scheme and were presented with a number of options (this question was not relevant to council members). The main reason selected by businesses for being involved in the scheme was to support breastfeeding mothers (n=19), followed by enabling breastfeeding mothers to recognise their business as supportive of breastfeeding (n=16). Another reason given, aside from those options offered to respondents, was that as mothers themselves, they were aware of the problems faced by breastfeeding mothers (n=4).

Council respondents were asked how they felt about their council joining the scheme, and all of the responses were positive. Council members were then asked if they had attended the presentations given to premises' managers to make them aware of the council joining the scheme. Fourteen respondents reported that they had attended this presentation, while three did not. Out of those who attended the presentation, eight found it very useful and five found it somewhat useful. No-one reported that it was not useful.

### The assessment procedure

As part of the scheme, all premises (businesses and councils) need to go through an assessment procedure. A senior member of each business must sign a written agreement stating that they will adhere to the membership criteria. Following this, the business is issued with the scheme certificate and window sticker. Monitoring of the business is carried out through members of local breastfeeding support groups and local trust breastfeeding coordinators. An individual from one of these organisations then visits the business to assess whether it is meeting the criteria of the scheme.

Nineteen businesses reported that they received adequate information about the assessment process before it was carried out, while two said they did not. Three respondents gave suggestions for improvements that could be made to the assessment process. Two mentioned that the

assessor should phone ahead of making the visit or give prior notice of a date and time. One respondent suggested that this process should be updated every year.

Sixteen council members reported that they received adequate information about the assessment process before it was carried out. The one remaining respondent did not answer this question.

### Staff awareness and acceptance of the scheme

All 17 council respondents reported that all of their current staff are aware that their facility or centre is a member of the scheme. All but one of the businesses reported that all of their current staff are aware that their business is a member of the scheme (n=21). The remaining respondent did not know.

On the whole, reactions from staff in both businesses and council premises was positive and accepting. Fourteen businesses reported that their staff reacted positively when they were told about the scheme. Eight council responses indicated that staff were supportive or accepting and six were positive.

### Materials and resources

The businesses ratings for the resources were mostly positive. The membership certificate received the best reaction, with 17 respondents rating this as good. One respondent rated the A5 booklet poorly and two rated both the poster and window sticker poorly. There were positive reactions to the Breastfeeding Welcome Here materials from the council respondents. Two thirds of council respondents rated each resource as good, while all of the remaining ratings were 'average' except one council that rated the window sticker as poor. The window sticker was the only material that was rated as poor by any council respondent.

Businesses and councils were given the opportunity to provide suggestions on how the materials and resources could be improved. Eight suggestions were made for improvements to the window sticker; it currently doesn't stick well to the window and it should be made bigger. Four businesses suggested that the poster should be made bigger and one stated that it would be more practical if it was laminated.

All council respondents currently display both the sticker and the membership certificate. Two businesses reported that they do not currently display the sticker and three do not currently display the membership certificate. Ten councils and 10 businesses reported that they display the poster.

### Promoting customer and staff awareness

Respondents were asked if they did anything, in addition to displaying the sticker and certificate, to make their customers or users aware of the scheme. Four councils and 13 businesses reported that they did not. Three councils and two businesses reported that they increased awareness through word of mouth to customers. Businesses also provided information on a range of other activities such as having an awareness promotion day.

Respondents were then asked if they did anything else to make their staff aware of the scheme. Staff were informed through meetings and at staff training (councils n=7, businesses n=8).

Respondents were given a list of three resources and asked whether any of them would be useful in making staff aware of the scheme and its criteria. Businesses were more keen than councils to have these extra resources. Thirteen businesses agreed that a poster for staff and a factsheet would be useful. Ten would be interested in a frequently asked questions (FAQ) sheet for staff. For councils, six would be interested in having a poster, five requested an FAQ and five requested a factsheet.

### Attitudes to the scheme

Respondents were asked what, if anything, they feel their centre or facility has gained from being part of the scheme. There were mixed responses ranging from 'demonstrating that the facility is family friendly' to 'having no impact'. Most of the responses from councils were positive (n=10), including the premises 'having a family friendly approach' and 'showing that they are breastfeeding friendly'.

The most commonly mentioned benefits that businesses said they had gained from being a member of the scheme were: more family orientated, supportive of mothers, and promoting mother and baby health (n=13). Only one business reported that there were no real gains.

Businesses and councils were presented with a number of statements relating to views on the scheme and asked to rate their level of agreement or disagreement with each. Seventeen businesses either agreed or strongly agreed that the scheme has been positive for their business, while only two disagreed with this statement. Eleven council respondents either agreed or strongly agreed that the scheme has been positive for their centre or facility, while only one disagreed with this statement. All councils agreed that they are happy to be part of the initiative to encourage breastfeeding, and 19 of the businesses agreed with this (three neither agreed nor disagreed).

All 17 council respondents and all 22 business respondents reported that they are happy to continue being part of the scheme.

### Conclusion

The evaluation of the Breastfeeding Welcome Here scheme has shown good levels of satisfaction among members. All council premises members and almost all business members who responded to the survey agreed that they were happy to be part of this wider initiative to encourage breastfeeding.

Businesses and councils reported a number of things they feel their business/premises gained by being a member of the scheme. The overall theme is that they are able to demonstrate they are a family-friendly, supportive environment. It has allowed them to show their support for breastfeeding and encourage breastfeeding mothers to use their premises.

Feedback from members gained through this evaluation will be used to inform the future development of the scheme and its administration.

### Dissemination

This report was distributed to members of the Breastfeeding Strategy Implementation Group.

### Reference

1. Department of Health and Social Services. Breastfeeding Strategy for Northern Ireland. Belfast: DHSSPS, 1999. [www.dhsspsni.gov.uk/breastfeeding.pdf](http://www.dhsspsni.gov.uk/breastfeeding.pdf)

# Evaluation of the *Breastfeeding awareness for schools* CD ROM

The Northern Ireland Breastfeeding Strategy recommends that breastfeeding education is undertaken at both primary and post-primary school levels.<sup>1</sup> To facilitate this process in the post-primary setting, the Health Promotion Agency for Northern Ireland (HPA), in collaboration with the Council for the Curriculum, Examinations and Assessment (CCEA), developed an electronic teaching resource primarily aimed at pupils in Years 10 and 11. The CD ROM aimed to assist teachers to approach breastfeeding in a way that is interesting and thought provoking, and encourages discussion in the subject. The CD ROM was designed to consist of two lessons, each of which could be delivered in the recommended time of 30 minutes, allowing them to be easily completed in a single lesson period.

The HPA's regional breastfeeding coordinator demonstrated the CD ROM resource to teaching staff from across Northern Ireland at the teacher agreement trials held over two days in October 2006. The teachers in attendance were mostly, but not exclusively, responsible for teaching child development and home economics. At the end of these sessions, all teachers received a copy of the CD ROM to take back to their school.

## Aims

- To assess the suitability and usefulness of the *Breastfeeding awareness for schools* CD ROM as a teaching resource for use in post-primary schools.
- To assess if information gained by pupils will help to positively influence the choices they make as prospective parents in the future.
- To assess the relevance of the CD ROM for the target audience.

## Objectives of the pilot study evaluation

To explore with teachers:

- readiness and enthusiasm to use a resource for the teaching of breastfeeding;

- views on the suitability and applicability of the resource to different age groups (within post-primary education);
- views on how the resource meets the needs of the curriculum for different subject areas;
- views on the practical aspects of using the resource in lessons with pupils;
- views on how pupils reacted to the resource;
- whether they felt the resources met their own expectations and met the specific aims of the resource itself;
- whether the pilot approach adopted was an appropriate model for integration into the school curriculum.

To explore with pupils:

- overall enjoyment of the lesson;
- messages and learning gained from the lesson;
- opinions on the design and images in the resource;
- the suitability of the resource for their age group;
- their views on the content and delivery of the programme.

## Methodology

The evaluation of the pilot study involved four aspects:

- feedback forms from teachers at the teaching agreement trials;
- scoping exercise to ascertain use of the resource;
- teacher feedback from those who used the resource in their school;
- feedback from pupils who took part in the lessons.

Teachers who attended the teaching agreement trial training days (n=39) were asked to complete a proforma giving their immediate feedback on the resource. Teachers were then contacted by phone and post between January and March 2007 to ascertain use of, or intended use of, the resource and to determine if they would be willing to take part in the pilot evaluation study.

Overall, it was determined that 28 of the 39 teachers who received the resource used the CD ROM during the 2006/2007 school year. Twenty five of the 39 individuals who received the resource agreed to take part in the teacher feedback. A questionnaire was developed and sent to these individuals. In total, 16 teachers (from 15 schools) returned the feedback form once they had used the resource (60% response rate). Ten schools agreed to take part in the pupil feedback process and were sent enough questionnaires for all children in their class. Completed forms were returned from seven schools. A total of 90 pupils were involved and all pupils who took part were in Year 11.

## Key findings

### Feedback from agreement trials

The majority of teachers saw the resource as being suitable for Years 11 and 12 (n=37 and n=33 respectively). Nine thought it was suitable for Year 10 pupils, and seven thought it was suitable for pupils at post-16 and AS Levels.

Teachers were asked to rate their initial impression of the CD ROM and the feedback received was extremely positive, with no negative comments expressed. All of the teachers (n=39) strongly agreed or agreed that the resource was visually appealing, used appropriate content and was at an appropriate level of understanding for the target audience.

Almost all teachers agreed that both lessons met the learning needs of the curriculum for Key Stage 4 child development (n=37) and home economics (n=31). All teachers said they would likely use the resource, and 35 said they would very likely use it.

### Feedback from scoping exercise on use of the resource

Teachers who were unable to take part in the teacher feedback process at the agreement trials, or who did not return their questionnaires, were telephoned to obtain some information about which classes they used the resource with. Nine teachers used the resource with Year 11 and Year 12, and four

teachers used the resource for revision of the topic of breastfeeding with their pupils.

## Teacher feedback form

### Suitability of the resource

All teachers (n=16) who took part in the teacher feedback form reported that they found the resource useful or very useful. No teacher reported having any concerns or reservations about using the resource with, or providing the resource to, their pupils.

All teachers (n=16) agreed that the resource was appealing and appropriate for their pupils, and all strongly agreed or agreed that the resource was up to date, visually appealing, sensitive to the pupil group, used an appropriate level of language, contained appropriate images, and that these images were appealing to the pupil group.

All of the teachers strongly agreed or agreed that lesson one met its objectives of: increasing knowledge about the importance of breastfeeding to health; exploring teenagers' attitudes to breastfeeding; and examining the global impact of low breastfeeding rates. The majority also strongly agreed or agreed that lesson one met its objectives by reflecting the history of infant feeding patterns (n=15) and allowing opportunities for discussion on breasts, sexuality and nurture (n=13).

There was complete agreement that lesson two met all its objectives, which included: to review social and cultural barriers to breastfeeding; to reiterate the importance of breastfeeding to maternal and child health; to explore the biological difference between breastfeeding and formula feeding; to examine the basic anatomy and physiology of human lactation; and to gain basic understanding of how breastfeeding works.

### Teachers' expectations and pupils' reactions

All teachers reported that they thought their pupils had enjoyed the lesson. All reactions reported were positive, with 12 teachers stating that their pupils were interested, attentive or enthusiastic during the lessons. Eight teachers also reported that the resource

generated discussion or debate between the pupils.

After teaching the lesson, 14 teachers reported that they perceived changes in their pupils' attitudes towards breastfeeding, while two did not. Teachers reported that they perceived an increase in confidence (n=13) and a willingness (n=13) in their pupils to discuss the subject of breastfeeding.

### Pupils' views

Feedback was received from 90 pupils, all from within Year 11. The resource was used with the majority of these pupils during child development classes (n=76). Only one of the classes that took part in the pupils' evaluation was a coeducational class; all of the others were all-girl classes (n=12).

Pupils' opinions on the visual appearance of the resource were generally positive, with 89% reporting that the colours and the images/photographs used were good. Ninety three percent thought that these lessons were suitable for their age group.

### Knowledge about breastfeeding

Pupils were asked what they thought was the most important reason to breastfeed for the baby. Sixty nine percent cited health and 21% cited that breast milk provides the correct nutrition for the baby. Health (67%) was also cited by pupils as the most important reason for mothers to breastfeed, while bonding was the second most reported reason (29%), followed by weight loss, which was mentioned by 24% of pupils.

When pupils were asked 'what is the main thing you will remember from the lesson?' the most commonly reported were the benefits of breastfeeding for mother and baby (38%), followed by the specific health benefits of breastfeeding (18%) and the advantages of breastfeeding over bottlefeeding (16%).

### Pupils' attitudes

Ninety eight percent of pupils reported that they had enjoyed the lesson and the thing they most enjoyed was learning new information about breastfeeding and the advantages over bottlefeeding (51%).

Just under half of the pupils provided a response to the question 'what, if anything, did you enjoy least?'. Of these, over half (55%) of pupils said that there was nothing they didn't enjoy about the lessons; however, three pupils reported that the thing they enjoyed least was watching the mother breastfeed the baby and the section on 'what formula can't provide'.

Sixty seven percent felt comfortable discussing breastfeeding in the lesson, 14% did not feel comfortable and 19% said they were unsure if they felt comfortable.

In total, 91% of the 84 pupils who answered the question agreed that they would definitely think about breastfeeding if they had a baby.

## Conclusion

The pilot evaluation has shown the CD ROM to be a suitable and useful resource for teaching breastfeeding in the post-primary school setting. The resource was welcomed by teachers and pupils alike and provided a forum where class discussions around breastfeeding could take place.

The CD ROM was developed to fulfil the requirements of the curriculum related to breastfeeding for the subjects of child development, home economics, health and social care, and science.

It should be noted that the CD ROM was not evaluated by science teachers and that few male pupils had the opportunity to evaluate the lessons.

## Dissemination

A summary document is available on the HPA website at [www.healthpromotionagency.org.uk/Resources/breastfeeding/Breastfeeding\\_awareness\\_eval.htm](http://www.healthpromotionagency.org.uk/Resources/breastfeeding/Breastfeeding_awareness_eval.htm)

## Reference

1. Department of Health, Social Services and Public Safety. Breastfeeding Strategy for Northern Ireland. Belfast: DHSSPS, 1999.

# Evaluation of the Get Active in the Community Cash Grant Awards scheme 2006/07

The Northern Ireland Physical Activity Strategy aims to increase participation in physical activity, especially among those who exercise least. One of the strategy objectives is to increase the opportunities for participation in the community. As part of a public information campaign, the Get Active in the Community Cash Grant Awards scheme was developed by the Health Promotion Agency for Northern Ireland (HPA) in collaboration with Disability Action and the Northern Ireland Council for Voluntary Action, and funded by the Department of Health, Social Services and Public Safety. Since 2003, the scheme has been administered by the Community Foundation for Northern Ireland. The scheme offered grants of up to £500 to community and voluntary groups to support projects to promote physical activity in the community. Whereas in previous years groups had to have activities completed by October and were permitted to undertake only one session of activity, in 2006 the scheme allowed projects to take place any time between May 2006 and February 2007. However, the groups had to organise a minimum of five sessions of activity.

The scheme had the following objectives:

- To help people overcome the main barriers to being physically active such as: no one to exercise with; lack of access to facilities; lack of confidence; and lack of willpower.
- To provide opportunities for people to acquire new skills through participating in physical activity.
- To raise awareness of the health benefits of regular moderate physical activity.
- To raise awareness of local leisure facilities and physical activity opportunities.

## Aims of the evaluation

- To assess how the Get Active in the Community Cash Grant Awards scheme met its aims and objectives in 2006.

- To make recommendations for future schemes.

## Objectives

These were to establish:

- the range of target groups, activities and numbers of participants in the different projects;
- how the award money was spent;
- how the local organiser assessed the success and outcome of their projects.

## Methodology

Questionnaires were distributed by post to the contact persons of all projects that received grants.

## Sample and response

In 2006 there were 177 applications to the scheme and awards were made to 127 applicants. Of these 127 groups, completed evaluations were returned by 109 within the deadline of 8 January 2007, a response rate of 86%.

## Key findings

A total of 4,573 people participated in the various projects. The number of people participating in the individual projects ranged from 10 to 593. Participants came from a range of age brackets, with 60 groups reporting having participants aged 50–60, 55 groups with participants aged 60–70, 46 groups with participants aged 26–49 and 33 groups with participants aged 17–25.

Though the majority of projects (64%) were mixed in terms of gender, there were more female than male participants across all projects (78% compared to 22%). A total of 34% of projects were female only and two projects (2%) were male only.

Forty five percent of the projects had dancing as the main activity, 24% had walking and 17%

had aerobics. The rest focused on a range of activities including keep fit, activities for the disabled, swimming, and cycling. The majority of projects were new initiatives (70%), suggesting that the scheme allowed community groups to embark on new ventures that might not otherwise have been possible.

Almost all (99%) of the groups confirmed that their project met the overall aim of the strategy, developing new or existing physical activity community initiatives aimed at encouraging the sedentary population to become more active. The organisers overwhelmingly felt that their projects were successful in meeting the objectives of overcoming barriers, acquiring new skills, promoting health benefits of physical activity, or promoting local facilities.

### Overcoming barriers

The most common barriers to participation in physical activity were having no one to exercise with, a lack of facilities, or people feeling a lack of confidence or willpower. Almost all organisers (99%) reported that their project had overcome this barrier, commenting that 'bringing together people in the community/socialising/exercising with others encouraged participants' (comment received from 32 groups). Some groups commented on 'getting people out of the house/motivate people to become less sedentary/participants using local facilities' (comment received from 31 groups).

### Acquiring new skills

A total of 93% of organisers reported that the members of their group have acquired new skills through participation in their project. Organisers reported that participants had learned new 'dancing skills' (comment received from 34 groups), while others reported on participants with 'confidence skills/self-esteem developed' (comment received from 19 groups).

### Awareness of health benefits

Almost all organisers (99%) thought their project raised participants' awareness of the health benefits of physical activity. Organisers

commented that participation made 'members aware of the importance of health and fitness/feeling mentally and physically healthier' (comment received from 83 groups) or that participation 'showed participants that exercise can be enjoyable' (comment received from nine groups).

### Awareness of local leisure facilities

The majority of organisers (79%) also felt that 'through the class activities, members were made aware of local leisure facilities and local physical activity opportunities' (comment received from 37 groups). Others commented 'some members use local leisure facilities/local groups for classes/activities separate to the programme activity' (comment received from 20 groups).

## Recommendations

Respondents were asked to give their recommendations on how to improve the scheme for the future. The key themes emerging from the responses obtained were:

- Additional funding, funding over a longer period of time and funding of a wider range of activities.
- The allocation of a larger grant.
- There should exist a database of professional, enthusiastic tutors and tutors should keep regular contact with group participants.
- Publicise the scheme well in advance using local press and word of mouth.
- Ensure activities are available to all (including the aged, those with disabilities and those who are socially isolated).
- Ensure activities are targeted to meet participant needs, perhaps by involving participants when planning is taking place.

## Dissemination

This report was distributed to members of the Northern Ireland Physical Activity Strategy Group.

# Evaluation of the physical activity public information campaign 2006/07

## Background

In 2005 the Health Promotion Agency for Northern Ireland (HPA) developed a new public information campaign on physical activity entitled 'Forward steps', which was launched in February 2006 and ran again in January 2007. The primary target audience for the campaign was women aged 25–44, particularly those with children under 11, with the whole population as a secondary target audience. The campaign aimed to improve knowledge among the target audiences about the health benefits of regular moderate physical activity and encourage an increase in participation in physical activity.

Evidence for the development of the campaign was gathered from the *Northern Ireland Health and Social Wellbeing Survey (HSWB) 2001*, which indicates that young women aged 16–24 (14%) were more likely than young men (8%) to be sedentary. A similar proportion of women in the 25–34 and 35–55 age groups were also sedentary; however, this figure increased dramatically to 23% in the 45–54 age group. In addition, young women (27%) were less likely than young men (38%) to participate in recommended levels of physical activity.<sup>1</sup>

The survey also indicated that while most people find excuses, or have barriers, to doing physical activity, women in general tended to perceive more barriers to exercise than men. Being too busy, too tired to exercise, or lacking in motivation to exercise were particularly evident in the survey results.

BMI measurements taken in the Health and Social Wellbeing Survey (1999) showed that women in the 45–54 age group were more overweight or obese than women in the younger age groups.<sup>2</sup> However, lifestyle behaviours adopted early in life are shown to persist throughout a person's life. It is important therefore that healthy behaviours become a habit early in life.

## 'Forward steps' campaign

The 2007 campaign ran from January – February 2007 and utilised various media elements such as television, radio advertising, posters and leaflets. The slogan used was '*Every small step is a forward step*' and all campaign elements were branded with the '*Get a life, get active*' slogan. Focus groups were carried during the initial development of the campaign to pre-test creative concepts and messages for the advertising.

The television advertisement was produced to promote the message that 30 minutes of moderate physical activity on five or more days of the week helps protect health and it illustrated ways to fit this into a busy day. The advertisement focused on mothers with young children and reflected that mothers hold down busy jobs as well as being responsible for childcare and running a household. An important element of the campaign was making physical activity appeal to mothers and not appear as another thing that needs to be fitted into an already busy day.

Radio advertisements were introduced to enhance the salience of the campaign messages, and to actively engage people to be active by distributing step counters. Step counters were also given away through the campaign website [www.getalifegetactive.com](http://www.getalifegetactive.com)

Leaflets entitled '*Get a life, get active*' and '*Go walking*' were distributed to GP surgeries and a further leaflet '*Step this way for better health*' was provided with the step counters.

The 2007 campaign also featured bus/adshel advertising. The first advertisement '*Hop off early*' promoted getting off the bus a stop early and walking, while the second advertisement '*Walk to school*' suggested parents walk their children to school. These posters were also distributed to GP surgeries and schools.

## Aim

To evaluate the effectiveness of the 2006/07 physical activity public information campaign 'Forward steps'.

## Objectives

- To assess awareness of the campaign and its component parts and materials.
- To ascertain perception of the basic message.
- To assess the level of understanding of the health benefits of regular moderate physical activity.
- To assess the impact of the campaign in respect of its objectives, focusing particularly on knowledge about what constitutes physical activity and how it differs from being generally 'active'.
- To assess whether there has been any change in attitudes towards physical activity (eg people are less likely to give excuses such as haven't the time, too tired, exercise is boring).
- To assess what, if any, changes have been made regarding participation in physical activity and walking in particular.

## Methodology

A quantitative survey approach was adopted using face-to-face interviews with a representative sample of the Northern Ireland population. In addition, in order to ensure a sufficient number of mothers in the sample with children aged 11 or younger, an appropriate booster sample was applied. Fieldwork on the survey was conducted between 7 February and 24 February 2007.

## Sampling

A sample of 1,000 members of the Northern Ireland population was carried out using quota controls for: age; sex; social class; and area of residence. A separate booster sample of 123 mothers with children aged 11 years or younger was also conducted.

## Key findings

### Campaign awareness

Eighty five percent of the sample population of Northern Ireland adults (aged 16+) could recall seeing at least one element of the campaign,

with 94% of the campaign target audience (mothers with children aged 11 or under) exposed to the campaign, compared with 83% of those outside the target audience.

Recall of the campaign was mainly through the TV advertisement (73%); however, significant proportions of respondents were able to recall other elements of the campaign (radio 23%; posters 26%; leaflets 33%; and the campaign website 8%).

The majority of those who could recall the TV advertisement said that it was thought provoking (81%), believable (91%) and relevant (62%).

### Impact of campaign

Forty percent of the sample population of all adults in Northern Ireland said the overall campaign had encouraged them to be more active, with over half (54%) of those in the campaign target audience saying this was the case, compared to 37% of others.

Specifically, almost half (47%) of all respondents and 57% of the target audience (women with children aged 11 years or under) who saw the campaign TV advertisement said it had encouraged them to be more active. Thirty six percent of all respondents who saw the campaign posters and 47% of those in the target audience reported that the posters had encouraged them to be more active.

Those exposed to the physical activity campaign were more likely than those who weren't to have engaged in the recommended level of physical activity (30 minutes on at least five occasions in the previous week, 41% v 26%). The campaign target audience were more likely than others to have engaged in moderate physical activity for more than 10 minutes in the last seven days (80% v 69%).

Almost 7 in 10 respondents (68%) had walked at a brisk or fast pace for at least one mile in the four weeks prior to being surveyed, with those in the campaign target audience (77%), and those exposed to the campaign (70%), more likely to have done so.

When asked what were the main barriers to being more physically active, being 'too busy' (38%) and 'not having enough time' (38%) were the main obstacles cited. This pattern of response has remained unchanged from that reported in the 2001 Health and Social Wellbeing survey.<sup>1</sup>

A desire 'for good health' (89%) and 'to build a stronger heart' (86%) were the main factors that would motivate respondents to take regular exercise.

One in five (20%) of all respondents were aware of the recommended 10,000 daily steps that should be achieved in order to maintain good health. Of those exposed to the campaign, 22% of all respondents and 24% of the target audience were more likely to be aware of this information when compared with those not exposed to the campaign (9% all respondents v 19% target audience).

Among those parents who take their children to school (n=248), almost half (48%) had taken their children to school by car in the week prior to being surveyed, with 39% walking. Over half of the campaign target audience (56%) walked their children to school in the previous week, compared with 28% of others.

## Conclusions

The evidence from this evaluation shows that the overwhelming majority of the sample population of Northern Ireland adults have been exposed to the physical activity public information campaign 'Forward steps', with TV advertising confirmed as the most important vehicle for promoting exposure to the campaign messages. The campaign was shown to be effective in encouraging more people to be

active, especially those in the target group. The evaluation has also provided evidence of a link between exposure to the campaign and increased levels of physical activity.

Lack of time and being too busy continue to be perceived as the main barriers to engaging in regular physical exercise, while a desire 'for good health' and 'to build a stronger heart' were the main factors that would motivate respondents to take regular exercise. It is recommended that future campaigns should focus on trying to encourage physical activity as an integral part of an individual's lifestyle and promote the physical health benefits of regular exercise.

## Dissemination

Information on the 'Every step is a forward step' campaign was reported in *Inform* Issue 47 June/July 2006 and the campaign evaluation findings were highlighted in Issue 53 June/July 2007 edition.

## References

1. Northern Ireland Statistics and Research Agency. Health and Social Wellbeing Survey. Belfast: NISRA, 2001.
2. Northern Ireland Statistics and Research Agency. Health and Social Wellbeing Survey. Belfast: NISRA, 1999.

# Public attitudes, perceptions and understanding of mental health in Northern Ireland

## Background

Following concern over the increasing number of suicides in Northern Ireland, in 2006 the Department of Health, Social Services and Public Safety (DHSSPS) published *Protect life: a shared vision. The Northern Ireland suicide prevention strategy and action plan 2006–2011*, which aimed to reduce the risk of suicide and self-harm while increasing protective factors against the risk of suicide among the Northern Ireland population.<sup>1</sup> One of the actions of this strategy was to implement a public awareness campaign to “de-stigmatise mental health and encourage help seeking behaviour”. In order to effectively inform and develop this campaign, the Health Promotion Agency for Northern Ireland (HPA) commissioned a survey of the general public to ascertain public knowledge and perceptions about mental health and mental illness.

## Aim

The survey aimed to examine the views and perceptions of adults in Northern Ireland with regard to mental health, exploring levels of mental health literacy, stigma and attitudes around help seeking.

## Objectives

- To assess public perceptions on the prevalence of mental health problems in Northern Ireland.
- To assess levels of mental health literacy, including knowledge and beliefs about mental health problems.
- Examine help seeking behaviours, prevention and treatments.
- Look at stigma surrounding mental health issues.
- Gauge public experience of mental health problems.

## Methodology

The HPA placed a set of questions on an omnibus survey in March 2006. The

questionnaire was administered via face-to-face interviews carried out at 45 randomly selected sampling points throughout Northern Ireland. Quota sampling was used to achieve a sample representative of the Northern Ireland adult population. The questionnaire was devised by the HPA research team and included questions from surveys used to inform mental health programmes in Australia, Scotland and England.

## Sample

A total of 1,013 took part in the survey, of which 46% were male and 54% female. Those aged 16-24 years accounted for 13% of the total sample, 25-34 year olds made up 20%, 35-49 year olds made up 30%, 50-64 year olds made up 21% and those aged 65 and over accounted for 17%. Social class groups were categorised as ABC1 (43%); C2 (21%) and DE (36%) (based on the occupation of the chief income earner in the household).

## Key findings

### Understanding mental health as a health issue

- There appeared to be a lack of awareness of mental health as an actual health issue. Respondents were more inclined to cite physical health issues, such as cancer and heart disease, when discussing major health problems in Northern Ireland.
- Respondents believed they had more control over their physical health than their mental health (93% compared with 79%).
- In addition, most positive lifestyle changes reported by participants related to improving physical rather than mental health. Few changes were made to proactively improve mental health, although almost a quarter (23%) attempted to socialise more with friends, and 17% had talked to people about things that were bothering them. Such lifestyle changes tended to be made by females and those in the ABC1 social class group.

## Stigma

- The survey used a stigma scale that had previously been used in Scottish surveys. Respondents in Northern Ireland were very similar to those in Scotland prior to Scotland's anti-stigma campaign 'See me'.
- There was little variation in stigma scores between sex and age group. There was a slight (but statistically significant) variation between the social class groupings, with the ABC1 group having slightly more stigmatising attitudes than the C2 and DE groups. Indeed, the DE grouping was also more likely to admit having had personal experience of a mental health problem.
- While almost all respondents (98%) recognised that anyone could experience a mental health problem, fewer participants reported a willingness to talk to a person with mental health problems (68%), and more importantly, over half the sample (55%) admitted that they would not want to disclose their own mental health problem.
- Just under half (45%) felt that people with mental health problems should not be allowed to do important jobs, and 4 in 10 (41%) felt that the public should be better protected from people with mental health problems. One in four (26%) believed that people with mental health problems are "often dangerous".
- Two fifths of the sample (40%) considered it likely or fairly likely that an individual suffering from schizophrenia would do something harmful or violent to themselves, while almost one in four (24%) believed that an individual with schizophrenia would do something harmful or violent to other people.

## Mental health literacy

- The survey suggested low levels of mental health literacy and awareness of mental health disorders, which varied according to personal characteristics. Females exhibited better knowledge of certain mental health problems than males, as did those in the ABC1 social class grouping. Those in the youngest and oldest age groups were least aware of specific problems.
- Almost two thirds of respondents (63%) tended to underestimate the prevalence of mental health problems.

- Just over two in five respondents (43%) were able to correctly recognise symptoms of schizophrenia, with one third (33%) mislabelling schizophrenia as depression. Just over three quarters (77%) were able to accurately identify signs of depression, with females more likely than males to recognise the symptoms.
- Respondents were less inclined to believe that individuals could recover from schizophrenia in comparison with depression.
- Just over one in seven (15%) respondents indicated they had experienced a mental health problem themselves – less than the estimated figure of one in five (HSWB) or one in four of the population.<sup>2,3</sup> This is possibly due to respondents either failing to recognise that they have experienced a mental health problem, or being unwilling to report it due to stigma. The youngest and oldest age groups – and males in particular – were least likely to indicate they had any personal experience of mental health problems (either themselves or through others).

## Help seeking

- When respondents were asked to whom they would most likely turn if they had a mental health problem, the most popular response was a GP (67%) – although younger respondents were least likely to turn to their GP for help when compared with older individuals. There was a reluctance to talk to male family members and friends, which may indicate a perceived lack of sympathy from male friends and relatives.
- Findings suggest that help seeking can be made more difficult by two factors – the failure to identify or articulate a problem, and stigma.

## Recommendations

- It may not be timely to attempt to reduce stigma just by challenging attitudes. Knowledge is poor. This research suggested a need for qualitative research to examine in greater detail the public understanding of mental health. A cycle exists where ignorance of the issue leads to stigma, yet stigma prevents the issue being talked about in a way that will improve knowledge and improve recognition and help seeking.

- This research also demonstrated that a campaign whose key message is simply to seek help would also be untimely as knowledge and recognition is so poor.
- If individuals are unaware they can protect their mental health, and unable to recognise the signs of a mental health problem, it is unlikely they will seek treatment for the problem.
- The cycle could be broken by an effective programme of public information that also attempts to educate people about mental health as an issue.
- Public information needs to be twofold: reducing stigma and communicating knowledge at the same time.
- Any work to address help seeking should not only target people who are at risk of suffering mental health problems, but also GPs and 'significant others' – those closely connected to people who are at risk of experiencing mental health problems (eg mothers, partners).
- As 16-24 year olds were least likely to say they would contact their GP, it would be helpful to examine and address young people's reluctance to go to their GP for help.
- It would also be of value to ensure that GPs are aware of the reluctance among this important and vulnerable age group and that they seek to address this issue themselves.

## Dissemination

This report was disseminated at a seminar on World Mental Health Day on 10 October 2006.

## References

1. Department of Health, Social Services and Public Safety. Protect life: a shared vision. The Northern Ireland suicide prevention strategy and action plan 2006–2011. Belfast: DHSSPS, 2006.
2. Northern Ireland Statistics and Research Agency. Health and Social Wellbeing Survey 2001. Belfast: NISRA, 2001.
3. Is anybody there? National survey into mental health and friendship. Mental Health Foundation, 2001. Available at [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

# Qualitative research into public understanding and perceptions of mental health

## Background

Following concern over the increasing number of suicides in Northern Ireland, in 2006 the Department of Health, Social Services and Public Safety (DHSSPS) published *Protect life: a shared vision. The Northern Ireland suicide prevention strategy and action plan 2006–2011*, which aimed to reduce the risk of suicide and self-harm while increasing protective factors against the risk of suicide among the Northern Ireland population.<sup>1</sup> One of the actions of this strategy was to implement a public awareness campaign to “de-stigmatise mental health and encourage help seeking behaviour”.

In order to effectively inform and develop this campaign, the Health Promotion Agency for Northern Ireland (HPA) commissioned a survey of the general public to ascertain public knowledge and perceptions about mental health and mental illness. Findings suggested a lack of knowledge adding to stigma. Stigma prevented discussion, which in turn also contributed to lack of knowledge. In addition, the research suggested that it was premature to carry out a help seeking campaign; the knowledge around mental health among the public was so poor, there was lack of recognition of problems.

Previous literature around suicide prevention and mental health public information campaigns had suggested that broadly hitting approaches are not successful and campaigns need to be specifically tailored to address those misconceptions and different populations based on a strong research base.<sup>2</sup> This qualitative research was designed to explore understanding and perceptions of different key groups within the population in order to give direction and aid targeting of any public information campaign.

## Aim

The aim of the research was to examine in depth the views and perceptions of adults in Northern Ireland with regard to mental health, coping and help seeking.

## Objectives

- To assess current understanding of the terms mental health and mental illness.
- To examine specific knowledge and attitudes around the mental health issues, including attitudes towards those they know to be experiencing a mental health problem and feelings about disclosing a problem.
- To look at help seeking behaviour, including barriers to help seeking.
- To consider the information needed to enable individuals to take care of their own and others' mental health, and the best means of providing this information.
- To look at protective or coping skills relating to mental health.
- To inform an effective public information campaign tackling the issue of mental health and help seeking.

## Methodology

To gain a deeper understanding of public perception of mental health issues, a qualitative research approach was adopted using a variety of methods including group discussion and one-to-one in-depth interviews.

In total, six focus groups, eight mini focus groups, four paired depth interviews and eight depth interviews took place. To ensure that a broad cross section of the general public was included in the research, participants were selected by gender and age group, social class, health board area and also by other influencing factors, such as sexual orientation and prior experience of a mental health problem.

Techniques were used to help stimulate discussion. Public information campaign materials from other countries, including Scotland, New Zealand and Australia were used to gauge the public's reaction and readiness for certain themes.

In total, 92 participants were consulted throughout Northern Ireland.

## Key findings

### Understanding of the term 'mental health'

The majority of participants were unclear of the distinction between 'mental health' and 'mental illness'. Most regarded 'mental health' in negative terms ("someone who is not right in the head") or equated the term only with severe illness such as depression, schizophrenia and dementia. A link with emotional wellbeing was made by a small number of participants.

Respondents had limited knowledge about mental health issues, in particular types and symptoms of mental health problems. It was interesting to note, however, that as participants came to understand a broader definition of mental health through the discussion, some of those who had previously indicated they had no experience of mental health problems came to realise that they in fact did have experience of a mental health problem, either personally or through a close friend or relative.

Attitudes towards those with mental health problems were ambivalent. Knowledge and perceptions of some mental health issues were probed by the use of vignettes and scenarios.

After gauging reactions to various scenarios, some participants demonstrated sympathy and concern while others suggested that the character in question was attention seeking or bluffing. Participants who had personally experienced a mental health problem were more knowledgeable and generally more sympathetic to others who may be experiencing a problem, compared to those who had never been affected, in particular younger age groups and males.

### Factors that had a negative effect on mental health

Factors that participants viewed as having a negative effect on their mental health included: financial worries; work related stress or unemployment; family conflict; breakdown of relationships; loneliness and bullying. Younger participants talked about the stresses associated with school and transition into higher education.

In general, most participants did not actively practise self-care or coping skills. Many were aware of activities they do to de-stress, relax or

cheer themselves up. Male and female respondents tended to try different activities. Females recognised the importance of socialising and spending time with friends and family. Male participants were more likely to favour physical activities. Most, however, did not associate these activities with a conscious effort to take care of their mental health. Young males in particular stated that they had never thought about their mental health as there is "nothing wrong with them".

Those who had experienced mental health problems in the past had placed a greater emphasis on the need to look after emotional wellbeing, mentioning several coping strategies including: exercise; socialising with friends and family; listening to music; and having a well-balanced diet.

### Perceived barriers to help seeking

Two main barriers to help seeking exist: lack of recognition of problems and stigma.

All participants described the stigma associated with mental health problems. Feelings of shame, embarrassment and the social consequences of admitting a mental health problem were some of the perceived barriers to help seeking. This view was particularly prevalent among younger males who felt that mental health problems were difficult to talk about and share with friends and family. Indeed, techniques to encourage discussion among the group were not required in the female focus groups. However, younger males were difficult to engage in discussion until stimulus material was used.

Other factors discussed as barriers to seeking help were low motivation and fear of the outcome.

Participants especially noted that a person can only seek help if they first recognise that they have a problem. Lack of recognition emerged throughout discussions and was particularly obvious when those who originally assigned themselves to a group of those not affected (personally or via a family member) by mental health problems came to realise that they were.

### Factors that would encourage help seeking

Participants felt that recognition of a problem

and then seeking help may require the intervention of a close friend or family member, but this is dependent on family/friends already being aware of symptoms and issues. So, increased awareness and understanding in society about mental health problems was recognised by participants as a key to providing encouragement to openly seek help.

Participants also believed that people with a mental health problem could be encouraged to seek help if they knew of others who have had – and recovered from – a similar mental health problem, and if they were aware that something could be done to help them.

### Sources of help

Many participants believed that those who were experiencing mental health problems should seek help from a professional. Those who had experienced mental health problems said that people should seek help from their GP. When asked if a close friend or relative would be a good person to discuss problems with, many (particularly males) were sceptical as to whether they could fully open up to someone close to them. However, as stated, many participants felt that the stage of getting professional help may have to be facilitated or encouraged by a close friend or family member. If participants recognised they had a problem, other areas where they would seek help include leaflets, books and discussions with health and social care workers. Younger age groups also noted that they would use internet forums to discuss their problems.

### Recommendations

The support of family and friends, and increased public awareness and understanding, were viewed as key factors enabling those with mental health problems to seek help.

Family and friends can only be supportive if there is awareness of an issue and this in turn highlights a need for improved public awareness. However, as the term mental health held many negative connotations, it would seem there is a need for an earlier starting point of getting people to understand what mental health refers to and that it is applicable to everyone. This may allow more open discussion on the matter, which may in turn increase knowledge and understanding.

Almost all participants recognised the need for a general public information campaign describing the extent and wide-ranging impact of mental health problems in Northern Ireland. Many participants were optimistic that such a campaign could remove the stigma attached to mental health issues, and encourage people to look after their own mental health and wellbeing. Participants also highlighted the need for tailored campaigns targeting specific vulnerable groups within the population, such as young people, or young males.

Most participants felt campaigns should offer information about the different symptoms associated with problems such as depression and anxiety, thus enabling individuals to recognise the occurrence of mental health problems. The use of local statistics relating to the extent of mental health problems in Northern Ireland was also considered helpful. Sources of help and further advice for those experiencing mental health problems should also be provided, with websites felt to be particularly appropriate for those less likely to discuss their problems with others, such as young people (and young males in particular).

The research suggests that a phased campaign to destigmatise mental health and encourage help seeking is required. First, the subject of mental and emotional health should be explained in a way that encourages the public to understand that it is relevant and applicable to everyone. This should then prepare the way for more specifically targeted and sensitively themed campaigns to take place over time.

### Dissemination

The full report detailing public understanding and perceptions of mental health is available from the HPA upon request.

### References

1. Day C, Pennebraker D, Anderson R. Population mental health promotion campaigns: Analysis and critique. Technical Report No. 01-04. West Perth, Western Australia: Centre for Mental Health Services Research, 2001.

# Evaluation of the Mental Health First Aid pilot programme in the Cooperation and Working Together region

## Background

Mental Health First Aid (MHFA) was originally developed in Australia and was adapted for the Scottish Executive's national programme for improving mental health and wellbeing.

The programme consists of 12 hours of evidence-based training, teaching participants how to recognise the symptoms of mental health problems such as psychosis, depression and anxiety.

The course, as the name implies, provides training in Mental Health First Aid, which is help given to a person experiencing a mental health problem before professional help can be obtained. The aims of MHFA are:

- to preserve life where a person may be a danger to themselves or others;
- to provide help to prevent the mental health problem developing into a more serious state;
- to promote the recovery of good mental health;
- to provide comfort to a person experiencing a mental health problem.

The Cooperation and Working Together (CAWT) group was a cross-border initiative, set up in 1992 by the Health Service Executive in the Republic of Ireland, and the Southern and Western Health and Social Services Boards in Northern Ireland, to improve health and wellbeing in their respective areas. One of the key priorities was the promotion of mental health among young adults and, in 2005, a partnership of CAWT, Aware Defeat Depression and the Health Promotion Agency for Northern Ireland (HPA) implemented a pilot programme of Mental Health First Aid.

This pilot programme was evaluated by the HPA.

## Aim of evaluation

The research aimed to evaluate the process of implementing the pilot Mental Health First Aid training programme, and investigate the

resources needed for the successful roll out of the programme across the CAWT region.

## Objectives

- To assess feasibility and sustainability, including the necessary infrastructure, resources and personnel required to implement the programme, with its focus on young people aged between 16 and 25 years.
- To investigate participants' experiences and attitudes towards the training programme, including views on the organisation and delivery of the course.
- To assess the impact of the course on participants' attitudes towards mental health, reported knowledge and skills in dealing with mental health issues, and perceived benefits to the client group.
- To make recommendations for improvement and roll out of the programme in order to maximise sustainability.

## Sample

A total of 15 instructors across the CAWT area were fully trained to deliver Mental Health First Aid. Instructors were required to work in pairs to deliver at least two MHFA courses in their area between January and May 2006. Instructors delivered 21 courses to approximately 234 participants in this period. All instructors and all participants were included in the evaluation.

## Methodology

Prior to the training, 15 instructors completed a baseline questionnaire to assess attitudes, knowledge and current views on MHFA. A second questionnaire was completed after training to measure changes in attitudes and to establish initial views on delivering MHFA (n=10). Thirteen instructors also participated in three focus group discussions, which focused on effectiveness of delivery, content of training and participants' reactions.

Instructors were also asked to complete diary feedback after each course to highlight issues around MHFA, participant suitability and group dynamic, as well as practical issues around preparation and supporting resources required.

MHFA course participants completed pre- and post-training questionnaires focusing on knowledge and attitudes towards mental health issues, and willingness to help someone with a mental health problem. The pre-training questionnaire was completed by 231 participants, and after an interval of three months, 110 participants completed a follow-up questionnaire. This resulted in a response rate of 48%, with the resultant post-training sample broadly representative of the original sample of 231. The post-training questionnaire also tested participants' recall of the MHFA approach and asked whether or not participants had made use of it.

### Key findings

One of the aims of the MHFA training programme was to target those who worked specifically with young adults. A substantial number of key individuals who work with this client group participated in the programme, with 52% of participants working in healthcare settings, 29% in education, and the remaining 18% in youth work, child protection and family support, supported accommodation, telephone helplines or voluntary work.

### Impact of training on participants

The majority of respondents felt that the training had substantially increased their awareness of the symptoms of mental ill health (95%) and sources of professional help (93%) and, in addition, had given them the initial skills to assist an individual showing signs of mental illness. Moreover, increased knowledge about mental health issues was sustained even after three months following the training programme, suggesting high levels of information retention.

Following the programme, most respondents reported higher levels of confidence and motivation to help someone presenting with a mental health problem, with 89% agreeing MHFA training had better equipped them to help those exhibiting symptoms of mental ill health.

After receiving training, almost 8 out of 10 respondents had encountered someone with a mental health problem (79%), and of these, almost all were able to put what they had learned on the course into practice (98%). Over half of these respondents (55%) indicated that they had offered support to clients aged 16-25 years.

### Process issues

Although feedback from both participants and instructors was extremely positive, some individuals raised concerns about the time allocation for course delivery, although it was acknowledged that the consecutive two day approach was most effective as it allowed for better group bonding and participation.

It was also suggested that course content and materials should draw on local context, information and statistics. Instructors suggested an edit of the content and sequencing of sessions. Some instructors felt course materials should be adapted for use with lower literacy participants.

It was felt that potential instructors should have a background in dealing with mental health issues, and that the selection and recruitment of instructors should continue to be a rigorous process. A need for ongoing emotional support for MHFA trainers via mentor peer support was also highlighted.

### Sustainability

All of the instructors believed there was demand for MHFA training. Both instructors and participants felt that the range of future participants should be broadened to include those working outside the realms of health and education.

The appointment of an MHFA training coordinator or coordinating body was perceived to be vital for sustaining MHFA, with responsibility for administration, organising future training and participant recruitment, thus freeing up instructors to concentrate solely on course delivery. Another aspect of this coordination role should be to promote MHFA within the regional mental health policy context in Northern Ireland and the Republic of Ireland.

Instructors recommended that MHFA should complement other mental health courses, such as ASIST (Applied Suicide Intervention Skills Training), to prevent replication of resources.

Charging a fee to attend training was raised as a potential means of financially sustaining the programme, although this was perceived as a potential barrier to some prospective participants.

Continuing development for instructors was also suggested as a means of sustaining MHFA. It was proposed that MHFA in Ireland

should have its own trainers using the expertise already present in Ireland, without a reliance on Scotland.

Establishing a direct link with other MHFA countries who have successfully implemented the programme (ie Australia and Scotland) could identify examples of best practice and sustainability.

### **Dissemination**

A more detailed summary report is available as a PDF on the HPA website [www.healthpromotionagency.org.uk](http://www.healthpromotionagency.org.uk)

# Cook it! An evaluation of a community nutrition education programme

The *Cook it!* programme aims to support people in the community who want to enhance their cooking skills and who have an interest in healthier eating, particularly where cost is a consideration. *Cook it!* offers hands-on practical experience of cooking and preparing food as well as enhancing individuals' knowledge of healthy eating and the hygienic handling of food.

In 2004 Big Lottery funding was secured to deliver the *Cook it!* programme for three years (until 2007). During this phase of the programme, *Cook it!* was supported by a regional *Cook it!* officer based at the HPA, and managed locally by four *Cook it!* teams located in: Causeway Health and Social Services Trust; North and West Belfast Health and Social Services Trust; Southern Health and Social Services Board; Western Health Action Zone. Each of the four *Cook it!* teams were responsible for training tutors at local level and providing them with updates and support visits as required. The tutors were in turn responsible for organising, planning and delivering the six week *Cook it!* programme to group participants within the community. An evaluation of the Big Lottery funded phase of the programme, which was designed and managed by the HPA with support from the local coordinators, ran between March 2005 and March 2007

## Aim

To evaluate the process of running, organising and managing *Cook it!* and to assess whether the provision of an interactive nutrition education programme, alongside the development of skills, made an impact on people's eating patterns.

## Objectives: tutors

- To assess tutors' views on the *Cook it!* tutor training provided.
- To evaluate tutors' views on organising and running *Cook it!* programmes.
- To determine the level of support tutors have received and its usefulness.

- To assess changes in nutrition knowledge.
- To ascertain any wider impacts of the course on tutors' confidence and self-esteem.

## Objectives: participants

- To determine the knowledge, attitudes and behaviour of participants in relation to dietary measures including shopping, cooking and eating habits.
- To assess the sustainability of the impact of the programme on dietary behaviour.
- To evaluate the wider aspects of the initiative, including changes implemented in the family setting.
- To ascertain any wider impacts of the course on participants' confidence and self-esteem.

## Method

Tutors who were accepted onto a *Cook it!* tutor training course completed a pre- and post-training questionnaire. One year later tutors were sent a follow-up postal questionnaire.

Participants completed a questionnaire entitled '*Cook it!* challenge 1' prior to taking part in the programme and '*Cook it!* challenge 2' immediately after completing the six week programme. Both these questionnaires were administered within the *Cook it!* group setting. A 50% sample of those participants who completed both questionnaires, and consented to follow-up, were asked to complete a third questionnaire called 'Food for thought'. This questionnaire was administered as a postal questionnaire six to nine months following participation in *Cook it!*

Eight focus group discussions were carried out with a diverse range of participants, who had taken part in a *Cook it!* programme six months previously.

## Sample

Pre- and post-training questionnaires were available for 118 tutors. Of these, 66 completed the follow-up questionnaire one year later, a response rate of 56%.

In total, 478 participants completed *Cook it!* challenge 1 and 2 (a response rate of 68%). Seventy three percent of these individuals (n=350) agreed to take part in the follow-up evaluation six to nine months after completing the *Cook it!* programme. 'Food for thought' was returned by 65 of the 150 individuals who received the questionnaire, representing a response rate of 37%.

## Key findings

### Tutors

#### Training and programme delivery

At the one year evaluation, tutors were asked their views on the core two day training they had received. All tutors considered the *Cook it!* training to be very or quite easily understood, relevant and interesting.

Since their training, four out of five tutors (80%) had delivered the *Cook it!* programme either alone or with another tutor. The majority of these programmes were delivered to women's groups (51%), young or single parents' groups (49%), or mother and toddler groups (28%). Nearly a fifth of tutors (17%) delivered *Cook it!* to people with learning difficulties.

#### Delivering the *Cook it!* programme

At the one year follow up, all or the majority of tutors reported working with groups (100%), cooking (93%), providing utensils (88%) and seeking environmental health support (100%) to be easy or very easy.

However, tutors did not find recruiting groups as easy as they had envisaged. Ninety seven percent of tutors said they were very confident about recruiting groups post-training, yet only 77% described this as easy or very easy in the follow-up survey. Similarly, 93% of tutors were very confident about finding time to deliver *Cook it!* post-training; however, only 39% of tutors reported this as easy or very easy in the one year follow-up evaluation.

#### Tutors' knowledge

Significant improvements were noted in tutors' knowledge on a variety of nutrition topics. These changes included a significant reduction in the number of tutors who agreed with the statement

'Cream and butter are part of the dairy group' and 'Honey is better for you than sugar'.

However, when tutors were asked to identify what foods from a list were not part of the fruit and vegetable group, significantly more tutors at the one year follow up reported incorrectly that sultanas were not part of the fruit and vegetable group (11% prior to training compared to 30% at the one year follow-up). Prior to training, 91% of tutors correctly identified strawberry jam as not being part of the fruit and vegetable group; however, this figure significantly decreased to 68% at the one year follow-up.

#### Tutor support

Ninety eight percent of tutors reported having had contact with the local *Cook it!* team since training. The contact was in a number of different formats and ranged from telephone calls to individual meetings with the *Cook it!* team.

### Participants

#### Barriers to healthy eating

The percentage of those stating 'I don't have healthy recipes' as a barrier to healthy eating decreased significantly from 61% prior to attending *Cook it!* to 25% after completing the programme. Those who reported 'I don't have the willpower' decreased significantly over the course of the six week programme from 63% to 53%; however, lack of willpower still remained the top reason preventing people eating more healthily after *Cook it!* No further significant changes were noted in barriers at the six to nine month stage.

#### Knowledge of healthy eating

Prior to *Cook it!* results showed 87% of participants were aware of the recommendation to eat five portions of fruit and vegetables a day. This rose significantly to 95% after *Cook it!* A significant rise was seen in women (88% to 95%), those with children (90% to 97%), those without children (81% to 91%) and those who lived with a partner (90% to 98%). No further changes were noted at the six to nine month stage.

#### Shopping habits

Significantly more participants reported looking at the amount of fat in foods (58% post *Cook*

*it!* compared to 43% pre *Cook it!*) and reading the labels before purchasing foods (57% post *Cook it!* compared to 45% pre *Cook it!*).

The follow-up results showed consistently that changes in shopping habits were maintained over the six to nine month period. However, further improvements were noted in that significantly more participants in the follow-up group reported that they checked the labels after six-nine months (84%) than did so after the six week programme (61%).

### **Eating habits**

Participants reported a number of changes in eating habits after completing *Cook it!* The frequency with which participants ate processed meat or chicken products (including meat pies, sausage rolls, burgers, sausages and breaded chicken) significantly decreased after the six week programme. Fifteen percent reported consuming these foods on most days before *Cook it!* compared to 8% afterwards. The long-term follow-up (six to nine months) concluded that further significant changes were evident in how often participants consumed these products – 31% reported eating these foodstuffs less than once a week prior to *Cook it!* compared to 22% at the six week stage.

A significant decrease was also seen in the frequency with which participants consumed biscuits, cakes, buns and pastries over the six week period. This reduced by almost 50% from 18% to 10%. No further significant reductions were noted at six to nine months.

Fruit and vegetables were consumed on a more frequent basis after the *Cook it!* programme. Over a third of the group (36%) consumed fruit every day after *Cook it!* compared to 30% before the programme. Similar changes were observed for the consumption of vegetables. Twenty nine percent of the group consumed vegetables once a day before *Cook it!* compared to 35% after the programme. No further changes were noted at six to nine months; however, the increased frequency of consumption of fruit and vegetables was maintained.

### **The wider impact of *Cook it!***

Many participants welcomed the social inclusion

the programme brought and reported the social aspect to be one of the most enjoyable features of the programme. In addition to the changes in nutrition knowledge and practice, other lifestyle changes were reported in the qualitative research. Many individuals took up regular physical activity and walked to work or walked for pleasure. Many participants tried to get their family involved in exercise and participants reported they had tried to reduce the amount of time the family watched TV.

### **Improvements to *Cook it!***

All participants reported that they enjoyed *Cook it!* and that they would recommend it to a friend. Although three quarters (73%) of participants agreed the course was the right length, the qualitative research determined many participants would welcome more than six *Cook it!* sessions so that the groups could try more recipes. Another strong opinion among participants was the desire to receive further recipes by post. This was said by many to help boost willpower and help maintain newly established healthy eating practices.

### **Conclusion**

*Cook it!* has proven itself over three years to be a well developed programme teaching nutrition knowledge and skills in a fun and interactive way within the community setting. The programme stands out as an excellent example of a tiered nutrition education programme that improves nutritional knowledge, impacts on eating behaviour and also influences other aspects of lifestyle, including physical activity, social inclusion and self-esteem.

The evaluation highlighted a number of recommendations to the current programme. These included incorporating additional workshops for tutors on fruit and vegetables and the proposal to send *Cook it!* participants further recipes to help individuals maintain healthy eating practices.

### **Dissemination**

A summary report is available as a PDF on the HPA website [www.healthpromotionagency.org.uk](http://www.healthpromotionagency.org.uk) A full report will be available in 2009.

# Evaluation of 'You don't have to be drunk to be doing real damage' public information campaign 2006

## Background

In 2002 the Drug and Alcohol Strategy Team at the Department of Health, Social Services and Public Safety commissioned the Health Promotion Agency for Northern Ireland (HPA) to develop and implement a programme of public information.

This first phase of the public information campaign (phase 1 'Nobody enjoys a drunk') was launched in March 2003 and targeted all drinkers and young adult drinkers in particular. The campaign sought to raise the profile of binge drinking as a public health issue, to highlight the societal costs attributable to drinking to excess/intoxication, to encourage the view among drinkers that such a pattern of drinking is socially unacceptable, and to make the target audience think about the amount of alcohol they drink.

The second phase of the public information campaign (phase 2 'Jamesy') was launched in March 2004. The focus in the second phase moved from the social unacceptability of drinking to excess, to what constitutes a binge and the health risks associated with binge drinking. The campaign targeted all adult drinkers, with a particular emphasis on the 30–45 year old age group. The emphasis on 30–45 year olds was because it was felt that this age group would be more receptive to information about the health effects of binge drinking than the younger age group, who are more concerned about the more immediate negative effects of binge drinking.

In October 2006 the HPA launched a new approach to continue the phase 2 campaign with 30–45 year old binge drinkers. The new approach carried messages about a range of health problems, including heart disease and stroke, which could be attributed to binge drinking. This new approach sought to continue to raise public awareness about binge drinking

and the impact it has on health, in particular what constitutes binge drinking and the serious health effects associated with this type of drinking.

The campaign was launched on 16 October 2006 and centred on a 40 second television advertisement highlighting the health effects of binge drinking – ie stroke, heart disease, cancer, mental health problems – and outlining what is meant by “a binge”. The advertisement finished with the phase 2 slogan: “You don't have to be drunk to be doing real damage”. The campaign was supported by a range of materials, including an A5 information leaflet, an A3 poster, an alcohol unit calculator and the website [www.knowyourlimits.info](http://www.knowyourlimits.info)

## Campaign aim

To raise awareness about binge drinking and the impact it has on health.

## Campaign objectives

- To raise awareness that drinking five or more drinks in a session (men) and four or more drinks in a session (women), even once a week, has serious health risks associated with it.
- To raise awareness about the health risks associated with drinking at these levels.
- To encourage the target group to think about how much they drink.
- To encourage those drinking at levels associated with serious health risks to reduce the amount of alcohol they consume.

## Methodology

The research consisted of a representative survey of 1,017 adult drinkers followed by a 267 booster household survey with adult drinkers between the age of 30 and 45 years. The methodology was consistent with that previously implemented for evaluations of prior phases of the campaign, to allow for comparisons to be made across the phases. Fieldwork took place between 13 November and 7 December 2006.

All interviews were face-to-face household interviews.

## Sample

A combination of random and quota sampling was applied, with the main population survey adhering to quotas and the 50 sampling points being randomly selected throughout Northern Ireland.

## Key findings

### Campaign awareness

Respondents were asked if they were aware of any television advertisements portraying the negative effects of alcohol. If so, they were then asked to describe this advertisement. Of the total representative sample (n=1017), unprompted recall of the 'Sponge' television advertisement was 28%.

Those who were unaware of the TV advertisement were prompted by a showcard of images from the advertisement. Recall increased to 50% (prompted and unprompted combined).

There was a significant difference between genders for awareness of the television ad, with females more likely to be aware than males ( $p \leq .05$ ). There was also a significant difference between age groups, with the 30–44 year old group (target group) most likely to be aware (55%) and the 60+ group least likely to be aware (39%) ( $p \leq .01$ ). There was a significant difference between socioeconomic groups for unprompted recall, with the AB, C1 and F (student) groups more likely to have unprompted recall than the C2 and DE groups ( $p \leq .01$ ).

Those respondents who stated that they were aware of the HPA 'Sponge' advertisement (n=289) were asked if they could recall the slogan ('You don't have to be drunk to be doing real damage'). Twenty seven percent of respondents were able to fully recall the slogan used, with a further 47% of respondents partially able to recall the slogan.

### Awareness of other campaign elements

Seven hundred respondents were asked about awareness of other elements of the campaign (leaflet, poster, bottle bag, website and unit calculator wheel).

Thirty one percent of those asked could recall seeing the leaflet (217 respondents). There was a significant difference between socioeconomic groups for recall of the leaflet, with the AB group most likely (40%) and the DE group least likely (23%) to recall it ( $p \leq .05$ ). The GP surgery was the main location where respondents saw the leaflet (46% of those who could recall seeing the leaflet), followed by off-licence (22%).

A similar proportion of respondents recalled the poster that accompanied this campaign (32%). Females were more likely than males to recall the poster (36% compared to 28%,  $p \leq .05$ ).

The unit calculator wheel was recognised by 32% of respondents.

Eight percent were aware of the HPA website [www.knowyourlimits.info](http://www.knowyourlimits.info) but less than 1% had visited the site. Age groups most aware of the website were the 30–44 and 45–59 year old groups (11% for both). The AB socioeconomic group was most likely to be aware of the website (13%).

### Overall awareness

Overall awareness of any element of the campaign (including TV, leaflet, poster, bottle bags, unit calculator wheel and website) was 57%. This was derived from awareness reported for any of the elements mentioned above. There was a difference between socioeconomic groups, with AB most likely to be aware (63%) and DE least likely (49%,  $p \leq .01$ ).

### Opinion of television advertisement

In order to evaluate the success of the television advertisement, those who said they had seen it (n=488) were asked to rate how believable, thought provoking and relevant they found it to be. Ninety four percent found it either very or somewhat believable, while 90% stated that it was very or somewhat thought provoking. Twenty five percent of respondents reported that they did not find the advertisement to be at all relevant to themselves. The 30–44 year old target group had the highest percentage of respondents who felt that it was very or somewhat relevant to them (81%).

### Main message of the campaign

Respondents who could recall viewing the television advertisement were asked what were the main messages they picked up about drinking alcohol. Responses were grouped into categories. The responses were combined so that a figure was calculated for the percentage of respondents mentioning any message connected with the effect of drinking or binge drinking on health. Overall, 84% of respondents mentioned something related to the effects of alcohol on health as a main message of the television advertisement. There were no significant differences between demographic variables for picking up on a health message.

Respondents were asked if the television advertisement made them think about their current drinking behaviour. Four out of 10 respondents had been encouraged to think about their current drinking behaviour (43%). There was a significant difference between age groups in terms of the advertisement encouraging respondents to think about their current drinking behaviour ( $p \leq .01$ ). The age groups most likely to respond 'yes' were the 30–44 and 45–59 year olds (both 47%).

Those who responded that they had thought about their current drinking behaviour were asked in what respect they had done so. The most commonly identified actions were to be careful when drinking (36%) and thinking about the effect of alcohol on their health (32%). The effect of alcohol on health was a key message of the television advertisement.

### Binge drinking

Overall, 13% of males in the representative sample correctly stated the number of drinks that constitute a binge for men. There was no difference between those exposed and those not exposed to the campaign. However, those exposed to the campaign were more likely to provide an answer to this question (15% of those who were exposed to the campaign stated 'don't know' compared to 31% of those who had not seen the campaign). This might suggest that the campaign at least heightened awareness that there was a binge level. More women (21%) correctly stated the

number of drinks that constitute a binge for women. There was slight variation between those exposed to the campaign and those not exposed (23% of those who saw the campaign could correctly state the limit compared to 18% of those not exposed). As with males, those exposed to the campaign were more likely to have provided an answer to this question (of those who had seen the campaign, 23% stated 'don't know'; of those who had not seen the campaign, 38% stated 'don't know').

### Actual knowledge

Those respondents who had previously stated that they were aware of the term 'unit of alcohol' (89%) were asked to estimate how many units of alcohol a variety of different drinks contain. The purpose of this was to look beyond their perceived knowledge and to test their specific alcohol related knowledge. The responses of those who could recall campaign elements that highlighted units (leaflet, website, bottlebag and alcohol unit calculator wheel) were compared with those who could not recall any of these elements.

There was a significant difference in the estimates between those who could recall these campaign elements and those who could not. For many of the drinks highlighted, those who could recall these campaign elements were more likely to correctly estimate the number of units than those with no recall (and also less likely to say 'don't know'). For example, 71% of those who had recall of a unit focused campaign element correctly estimated the units in a pint of beer, compared to 59% of those with no recall. Sixty two percent of those with recall (leaflet, website, bottlebag) correctly estimated the units in a glass of wine compared to 48% of those with no recall.

### Impact of campaign

Respondents who were aware of any element of the public information campaign were significantly more likely to say that knowing how much alcohol they drink is important (aware of the campaign: 58% thought it was important to know how much alcohol they drink; not aware of the campaign: 44% thought it was important,  $p \leq .001$ ).

Those aware of the campaign were also significantly more likely to rate knowing the alcohol content within their drinks as important (aware: 49%, not aware: 36%,  $p \leq .001$ ).

Those aware of the campaign were also significantly more likely to have counted their drinks during a drinking session (of those exposed to the campaign, 59% had counted their drinks; of those not exposed to the campaign, 48% had counted their drinks,  $p \leq .001$ ).

Again, those who were aware of the campaign were significantly more likely to have counted the units of alcohol during a drinking session when compared to those who had not viewed any element of the campaign (of those exposed to the campaign, 23% had counted their units; of those not exposed to the campaign, 13% had counted their units,  $p \leq .001$ ).

## Recommendations

Awareness of the TV element of the campaign was down on previous years; however, the proportions of respondents viewing the ad as believable and thought provoking remained high (94% and 90% respectively) and the proportion finding the advertisement relevant to them increased on the previous year from 67% to 75%.

The campaign sought to raise awareness that drinking five or more drinks in a session (men) or four or more in a session (women) has serious health risks associated with it. Actual retention of the binge drinking levels was low at

13% and could be built upon. However, awareness of a daily guideline has increased from 23% in 2003 to 41% after this campaign. In addition, the extra campaign elements added in this phase, which included unit information (unit calculator wheel, bottle bag and the website) appears to have added to an increase in knowledge levels. Actual awareness of the term 'unit' has increased from 71% in 2003 to 89% for this campaign.

The proportion considering it important to know how much alcohol they drink has stayed steady at 52% (53% in 2003, 51% in 2004). However, 43% of respondents had been encouraged to think about their current drinking behaviour (this compared with 25% in the previous year's campaign).

Awareness of the advertisement was down on previous years. Among those who saw it, the ad was successful in getting the message across about the health effects of alcohol, but correct retention of the binge message was poor. The supporting elements of this campaign had good recall and had a positive impact on unit knowledge. Elements like these should be considered for future campaigns.

## Dissemination

Findings were presented to the Binge Drinking Taskforce at the Department of Health, Social Services and Public Safety, and an article was published in *Inform* Issue 53 June/July 2007. A full consultants report is available from the HPA.

# Evaluation of No Smoking Day 2007

No Smoking Day (NSD) is an annual UK event which in 2007 took place on Wednesday 14 March. The slogan for the 2007 campaign was 'Make a fresh start'. It was hoped that this would be the year for a fresh start for many smokers in view of the new smoke-free legislation, whereby it is illegal to smoke in enclosed and substantially enclosed public spaces throughout the UK. The NSD campaign is funded and run by an alliance of organisations, including health promotion bodies, professional organisations and charities, all with the joint aim of reducing smoking-related diseases.

## Aim

To assess awareness of No Smoking Day 2007 in Northern Ireland and track reported participation in the event.

## Objectives

- To establish smoking prevalence.
- To establish how smokers feel about stopping smoking.
- To assess awareness of No Smoking Day 2007.
- To assess participation in No Smoking Day 2007.
- To assess awareness of No Smoking Day 2007 advertising and publicity.
- To determine support for smoke-free legislation.

## Methodology

A series of questions were placed on a Northern Ireland Omnibus survey. The questions were the same as those used to evaluate the campaign in Great Britain (GB).

## Sample

A total of 1,021 interviews were carried out in Northern Ireland with a representative sample of the adult population (aged 16 years and over). The probability sample was stratified by region, with demographic quotas set on the basis of age, sex and social class characteristics. The fieldwork took place between 22 and 29 March 2007.

## Key findings

### Prevalence of smoking

Respondents were asked to choose from a list of statements describing their smoking status. Approximately one third of the sample currently smoked cigarettes (33%), a three percentage point increase on 2006 (30%). This figure is higher than the 2005/2006 Continuous Household Survey figure of 26% due to differences in sampling methodology. A very small proportion of the sample smoked cigars or pipes (n=8; <1%). While 46% said they had never smoked, 20% of the respondents used to smoke but 'don't anymore'. The prevalence of cigarette smoking was seen to decrease with age, with 43% of 16–24 year olds smoking compared to 24% of those aged 55 or over. The prevalence of smoking was highest in the DE social class (45%) followed by C2 (35%), and lowest in the ABC1 social class (22%).

All cigarette smokers were asked about the number of cigarettes they smoked during a typical day. There was minimal change from the previous year for those smoking 10 cigarettes or less a day (34% in 2007 and 35% in 2006), 11–20 cigarettes (49% in 2007 and 48% in 2006) and those smoking 21 or more cigarettes a day (17% in 2007 and 16% in 2006). As in previous years, males tended to smoke more heavily than females, with 20% of male smokers smoking 21 or more cigarettes per day (no change from last year's figures), compared to 14% of female smokers (13% in 2006). Twice as many smokers in social class DE (20%) smoked 21 or more cigarettes a day compared to those in social class ABC1 (10%).

### How smokers feel about stopping smoking

Contentment with smoking fell by over 50%, with 6% of smokers stating that they liked smoking and had no intention of stopping in 2007, compared to 13% in 2006. This puts a stop to the year on year rise in contentment with smoking seen since 2004 and could reflect an increased desire for smokers to quit in light of the new legislation and increasing

awareness of the dangers of smoking. As before, it is the older age group (55+) who are most likely to say that they are content with their smoking and have no intention of stopping (14%).

A small increase was observed in people reporting that they would like to stop smoking one day (30%) when compared with the previous year (28% in 2006). Females (11%) were slightly more likely than males (9%) to want to stop smoking soon. Those aged 25–34 were most likely to state a desire to stop soon (17%), with those aged 45–54 least likely (6%). Those from social class ABC1 were most likely to report that they would like to stop soon (15%), while those from class DE were least likely (7%).

#### Awareness of No Smoking Day

Eighty percent of respondents were aware that 14 March 2007 was No Smoking Day. As in previous years, awareness of NSD in Northern Ireland remains higher than in GB (55%). Awareness was also higher among smokers (88%) than non-smokers (76%).

As in previous years, more females were aware of the campaign (82%) than males (78%). In 2007, awareness was highest for those aged 35–44 years (84%) and lowest for those aged 45–54 years (78%). Those in social class DE were most aware of NSD 2007 (83%) and ABC1 were least aware (77%). Awareness of NSD 2007 was highest for those smoking 21 or more cigarettes per day (89%) and lowest for those smoking 10 or less (84%). When analysed in comparison to how smokers felt about their smoking, awareness of NSD was highest among those who 'would like to stop soon' and those who 'stopped for a while but are smoking again' (91% and 90% respectively). Interestingly, the least awareness was among those who were 'trying to stop at the moment' (81%).

#### Smokers' quitting rates

All smokers who were aware of NSD were asked 'Did you stop or try to stop on NSD?' Eighteen percent of these smokers reported they had stopped or tried to stop on NSD, an increase on last year (15% in 2006).

#### Smokers' actual participation

As in 2006, nearly a quarter (23%) of smokers in Northern Ireland who were aware of NSD participated in the day by quitting for a time, cutting down, accessing information about stopping smoking, or taking part in an event or competition. Thirteen percent of smokers aware of NSD made a quit attempt, that is, they stopped smoking for part or all of the day or longer. This was the same as last year and higher than in GB (9%).

There was little difference in quitting rates between men and women (14% versus 12%). Those aged 35–44 years were most likely to have made a quit attempt (21%), while the 45–54 year olds were least likely to have made a quit attempt.

Across social class groupings, fewer people in ABC1 and DE made quit attempts (13% and 12% respectively) compared with those from social class C2 (17%,  $n < 30$ ). Substantially more respondents who smoked five cigarettes or less a day made a quit attempt (24%) compared to those who smoked 21 or more a day (6%).

#### Awareness of publicity or advertising

All respondents (including non-smokers) were asked if they had seen or heard any advertising or publicity for NSD. Awareness of publicity for the day was high at 78%. This is slightly up on last year (75%) and much higher than in GB (46%).

Awareness of publicity or advertising for NSD 2007 was highest among those aged 35–44 (83%), smokers (85%) and those from social class C2 (81%). There was the least awareness in those aged 16–24 (73%) and those from social class ABC1 (74%).

#### Prompted source of awareness of advertising/publicity

All those respondents who were aware of any advertising or publicity for NSD were then asked about the source of their awareness. Television advertisements were the main source cited, both in Northern Ireland (59%) and GB (35%). In Northern Ireland this was followed by television programmes (31%) and the posters (17%).

### Help to stop smoking

Smokers who stopped for at least part of NSD were asked if they used any help to stop smoking. As with previous years, the majority of people who stopped for part of NSD or longer did not use any help (62%).

### Northern Ireland smoke-free legislation

On 30 April 2007, six weeks after NSD 2007, Northern Ireland saw the introduction of new smoke-free legislation. This legislation means that in Northern Ireland it is now illegal to smoke in enclosed and substantially enclosed workplaces and public places.

As part of the NSD 2007 evaluation, respondents were asked if they would support or oppose a law to make all workplaces smoke-free. There was overwhelming support for such a law, with 70% of smokers, 92% of ex-smokers and 96% of non-smokers in

support. Ninety percent of smokers who supported the law were aware that 14 March 2007 was NSD. Twice as many smokers who supported the smoke-free legislation were likely to say they wanted to give up smoking soon (11% compared to only 5% who opposed the legislation). In contrast, twice as many smokers who said they liked smoking and had no intention of giving up opposed the smoke-free legislation (11% compared to 5% who supported it).

### Dissemination

This information was published in *No Smoking Day 2007 Northern Ireland Evaluation*, produced by the Health Promotion Agency for Northern Ireland.

It is available as a PDF from the HPA website at [www.healthpromotionagency.org.uk](http://www.healthpromotionagency.org.uk)

# Examining the risk-taking behaviours of young people aged 11-16 years

The HPA commissioned this programme of qualitative research with young people in January 2007 to examine and to further understand risk-taking behaviour among young people aged 11–16 years across Northern Ireland.

This research will be used to inform the future direction and development of work with young people and risk-taking behaviours, particularly regarding experimentation with alcohol and cannabis. The HPA was keen to hear directly from young people themselves to find out about their information and support needs and how they could be targeted more effectively in the future.

## Aim

To engage with young people and explore with them the context of their current lifestyle and risk behaviours. A further aim was to explore young people's information and support needs and how best these needs could be met.

## Objectives

The main objectives of this research were to understand a number of issues pertinent to young people, including:

- the concerns and issues of young people;
- the nature of young people's use of alcohol and cannabis and the contexts it occurs in;
- attitudes towards drinking alcohol and trying cannabis;
- awareness of what impacts upon the mental health of young people;
- the strategies young people use for coping when feeling low or depressed;
- young people's understanding and perception of risk, health impacts, and what misinformation they might hold;
- their attitude towards health messages and how they perceive information targeted at them;
- their preferred medium for communication and who they find credible or believable as sources of information.

## Methodology

A programme of qualitative research was designed and undertaken between February and April 2007. It consisted of five focus groups and nine mini-focus groups. The groups were conducted as single sex groups and covered Year 8 to Year 12 pupils in schools. In addition, a group of male participants aged 14–16 years from a juvenile justice centre were involved in a mini-focus group.

## Key findings

### Preferred activities

The young people mentioned a wide range of activities that they participate in, both during the week and at the weekend, including sports, watching television, playing games consoles, and using social networking sites on the internet. Some of the younger children attended youth clubs, while some of the older children attended bars and clubs. All groups mentioned spending time with friends at the weekend, from both inside and outside school, and this usually involved going to friends' houses, and hanging around streets/parks/shopping centres. Boys were more likely to mention football and computer games, while for girls the most popular activities were watching TV and shopping with friends. Most of the boys in the juvenile justice group enjoyed similar activities to that of the school groups (ie sport, going out with friends); however, they also mentioned anti-social behaviour and taking drugs as spare time activities.

### Alcohol

Almost all of the young people had tried alcohol. This ranged from a few sips to more regular drinking behaviour in some of the older groups. From Year 10, some of the young people indicated that they would be drinking regularly, and from Year 11, most were drinking regularly although not every week and always with friends. All of the boys in the juvenile

justice group drank alcohol except one who said he no longer did. Most drank every weekend and sometimes during the week. These boys generally preferred beer, spirits (vodka), Buckfast and Goldschlager. They generally drank outside in public places, ie car parks, streets or parks.

There was a general perception that it was 'normal' to drink, although many female drinkers stated that it would be unacceptable to be very drunk and not in control of behaviour. Boys, however, did not mention this as being a problem.

The amount consumed in one session ranged from a couple of beers or five alcopops, to a large bottle (two litres) of cider. Boys were more likely to drink beer, with girls more likely to drink spirits (mostly vodka). Boys who did mention drinking spirits said this was without mixers. Universally, the most frequently mentioned drink was WKD, an alcopop.

For those who drink, the perceived benefits included increased confidence, losing inhibitions, being less shy, liking the taste, feeling part of the crowd, being in a better mood, and for fun. Boys in the juvenile justice centre mentioned having a good time, making you happy and "staggering home" as positive aspects.

All groups were able to discuss the negative aspects of drinking alcohol, including both long- and short-term impacts, for example hangovers, being sick, being vulnerable, fighting, getting caught, feeling emotional, liver damage, and addiction. Price was also considered a negative aspect by the juvenile justice group.

Among those who drank, the most popular venues were friends' houses and the street, parks and bars/clubs. Gender differences emerged regarding venues, for example girls were more likely to drink in bars/clubs and were less likely to drink in the street or a public place, whereas boys were more likely to drink in the street or public places. There was a perception among boys that girls found it easier to get into bars and clubs.

Obtaining alcohol did not appear to be a problem; often an older friend or sibling would

buy it for them. The cost of alcohol did not seem to prohibit access – a lot of respondents had part-time jobs, used pocket money or accessed savings. From Year 11 onwards some parents bought or gave alcohol to their children. There was no evidence to suggest that this either encouraged or discouraged alcohol consumption, but some boys in particular commented that it led them to realise they enjoyed the taste of alcohol. Among the older groups, some individuals reported being served in off-licences and they knew from which premises they could easily purchase alcohol.

### Drugs and solvents

The majority of young people viewed drug taking as risky, and certainly more risky than drinking alcohol. This was reflected in behaviour as few of the young people in the research had tried drugs, whereas most had tried alcohol.

Experimentation with drugs among the young people was confined to Year 12, involving only a few participants. A small number of older pupils felt that drugs 'work out cheaper' than alcohol. The physical effects were also thought to be similar except the after effects of alcohol were thought to be worse than drugs because of hangovers and vomiting. There was a feeling from researchers that some younger pupils were reluctant to admit to drug taking in a group situation. Young people in Year 10 and above felt that it would be relatively easy to obtain drugs and mentioned knowing drug dealers in their local area.

Positive aspects to taking drugs were thought to be: feeling good, getting high and having hallucinations. All groups were also able to point out a number of negative aspects of drugs including: addiction, paranoia, tiredness, risk of accidents, 'come down' or withdrawal, and bad skin and teeth. There was an overall perception that some drugs could be extremely dangerous, and some referred to the possibility of death as a result of taking drugs.

When asked specifically about cannabis, many thought that this would not be as dangerous as other drugs.

Young people were very confused about the classification of cannabis and some thought it was legal for medicinal purposes. Although most felt it was illegal, the young people felt that the consequences of having cannabis in your possession would depend on the quantity and whether it appeared for personal use or for supply to others. Young people only mentioned physical risks of cannabis when asked and did not connect it with any behavioural risks. Only one Year 12 girl mentioned cannabis affecting mental health.

Awareness of drugs was high in the juvenile justice group, with one boy admitting to taking Ecstasy regularly and the others admitting to trying cannabis. This group felt that the perceived health effects of cannabis included pain relief, and a number of negative effects such as lack of concentration, vomiting, paranoia and mental health problems. The main drugs in current use were felt to be Ecstasy, acid and cocaine. This group of respondents was the only one to discuss how prescription drugs could be used recreationally.

Among the boys in the juvenile justice group, the positive aspects of taking drugs included: getting high, feeling happy and relaxed, and getting to sleep quicker. Negative aspects included: paranoia, lack of concentration, vomiting, comedowns and depression. Heroin was felt to be a 'dirty habit' and all agreed they would not engage in taking it.

It seemed that drug education was not provided consistently across schools – a minority mentioned external talks, for example from the PSNI. Few expressed the need or desire for further information, although a few mentioned accessing the 'Frank' website which they had seen via television advertisements. Solvent abuse was mentioned in many of the groups, particularly among the younger age groups. Some young people had received talks on solvent abuse via external groups such as the PSNI or community groups and the fact that these talks often involved videos to show the effects of solvent abuse was welcomed by the young people. No positive aspects of solvent abuse were mentioned and the main negative effect was thought to be the high risk of death.

### Worries and coping

The specific worries or concerns of young people varied between gender and age group. Girls tended to be most worried about weight and body image, and much of this was attributed to the media. Boys were more concerned about bullying, violence and fighting. No specific differences were noted in terms of school type; however, there appeared to be more concern about sectarianism and violence among the urban Belfast group than the rural groups where this was generally not mentioned. Most young people were able to talk freely about their worries and concerns; however, some of the older male groups seemed to be less willing to admit their worries, saying this was not the done thing among boys their age. These male groups talked in more general terms, for example regarding school, exam and homework worries, which seemed to be universal among all groups.

When asked about what they do to help cope with stresses and worries, young people listed a range of activities for 'cheering themselves up' although these were not recognised as 'coping mechanisms'. These included: listening to music, talking to friends, playing sport and comfort eating, although the latter was mentioned by girls only.

Talking to friends about concerns or worries was often the first port of call for young people, followed by talking to parents and siblings. Some boys mentioned that they did not talk to anyone about their worries, giving the general feeling that this was not the 'done thing' among boys their age. Some young girls discussed how they had attended counselling both inside and outside school; however, not all who had attended understood the methods used. Speaking to a teacher about worries/concerns was not felt to be commonplace among the young people, except perhaps in relation to a school matter. Regarding communication with parents, some felt that their parents did not take them seriously. This was particularly evident in girls' relationships with their fathers, and some did not talk to their parents due to embarrassment or not wanting to worry or stress them out.

Boys in the juvenile justice group were very reluctant to admit to any worries and concerns and a number said they wouldn't talk to anyone, while one said he would go and get drunk. However, a variety of people, both family and professional, were mentioned as people they could potentially talk to, if they wanted to. Most stated they were reluctant to approach their GP, even in relation to a health matter, and would prefer to attend hospital.

### Sources of advice

The main source for advice on health related issues was felt to be the internet; however, leaflets, television and personal contacts were also mentioned. Young people generally felt that most schools provided little or no sex education and although some had limited knowledge of contraception, this did not come via schools. Older groups in particular felt that there was a need for 'real life' sex education and advice on sexual health rather than simply the message not to have sex.

Older groups also felt that credible sources of information about risk-taking behaviours would be from people who had been involved in these behaviours in the past, for example a recovered drug addict.

Regarding helplines, the most frequently mentioned was Childline, but 'Frank' and Samaritans were also mentioned. Almost all stated that they would prefer to talk to someone they knew about their problems face to face, although for some it appeared that the anonymity with a helpline was a positive aspect.

With regard to campaigns, social networking sites had been used by the vast majority of young people and all participants watched television. The majority did not feel that text messaging was a good way to provide them with health information due to cost, the irritability of feeling bombarded, and parents reading text messages.

Among boys in the juvenile justice group, friends and the internet were given as sources of information; however, they felt they had no interest in and would not be receptive to information on drinking and drugs and therefore could give no ideal way to present it. None of the boys felt they would use a helpline, although Samaritans and Childline were mentioned and additionally upon prompting, 'Frank'. Some television campaigns were recalled, including drink-driving and smoking, and while these advertisements were felt to be good, the boys did not feel they would modify their behaviour as a result of advertisements. The only further issue which arose with young people in this group was that of car crime in their local areas.

### Dissemination

Findings were presented at a HPA seminar on young people and alcohol in March 2008. The consultants report is available on request from the HPA. A report combining findings from this work with that of work done with parents will be published in Spring 2009.

# Perceptions and behaviour of parents of young people aged 11-16 years

The HPA commissioned this programme of exploratory qualitative research with parents of young people aged 11–16 years across Northern Ireland between February and March 2007.

## Aim

The research aimed to explore the information needs of parents of young people aged 11–16 years in relation to their concerns for their children.

## Main objectives

To explore:

- the concerns and worries of parents for young people;
- what parents consider to be the current norms for young people with regard to alcohol, drugs and sexual activity;
- how they currently communicate with their children, and issues around parent-child communication;
- awareness of how much their own beliefs and behaviour influences that of their children;
- their current knowledge and awareness of the health impacts of lifestyle and perceptions of risk;
- what factual information and support parents need;
- how they would like to receive information/support.

## Methodology

A programme of qualitative research was designed and undertaken between February and March 2007. Eight focus group discussions and a further four mini-focus groups were conducted with parents throughout Northern Ireland. Parents were recruited based on gender, marital status, socioeconomic group and age of children for both the standard and mini-focus groups. In addition, parents were recruited for the mini-groups based on children's gender, as the discussion focused on boys' and girls' issues separately.

## Key findings

### Concerns, worries and perceived risks

Drugs and alcohol were key concerns for all

parents but were underpinned by peer pressure; for example, if a child affiliates with a "bad crowd" it was perceived that they were more likely to get involved in these activities. Although sex was mentioned when asked if there was anything else that they worried about, it was mostly a worry for those who had children in a 'steady relationship'.

Regarding drugs, parents perceived the greatest risk to be solvent abuse, although many believed their children would not get involved in this activity. After solvent abuse, other unspecified drugs were viewed to be the next greatest risk, with cannabis generally viewed as slightly less risky than other drugs. Alcohol, cigarettes and sex were all viewed as things that all teenagers will try; however, parents perceived them to be more controllable.

### Drugs

To some extent, parents were unsure when children would start to experiment with drugs. Media portrayal suggests experimentation starts at the age of 11. However, parents thought it was more likely to start at the age of 14 or 15 and would probably start with cannabis. It was considered by some parents that there is now a social drugs culture, with alcohol being replaced by recreational drugs such as Ecstasy. Most parents demonstrated a lack of drugs awareness although they felt that they had some knowledge regarding availability and price. It was considered that drugs are not expensive and are readily available, with most groups quoting what they felt the price of Ecstasy to be. There was little awareness of the price of any other drugs.

Parents felt they would know if their children were taking drugs based on intuition. They supposed the signs to look for included mood swings, a change in behaviour and a change in appetite.

Regarding cannabis, its perceived use for medicinal reasons appears to depict it in a slightly better light, portraying it as a 'safe' drug to some parents. However, it was also mentioned by parents that experimentation may start with cannabis and may well lead onto harder drugs.

## Alcohol

Experimentation with alcohol was thought to start at around 12–13 years. Most parents felt that young people will experiment with alcohol before drugs and by 14 most children are drinking. This was considered to be a fairly acceptable age by the majority of parents and, for some fathers, your child was not normal unless they had started experimenting with alcohol by then. "If a child gets to 14 without having a drink they've done something wrong" (focus group fathers of 15–16 year olds, C2DE).

The effects of alcohol were viewed as destructive, however, and parents were concerned, particularly for young girls becoming more vulnerable when under the influence of alcohol. It was also perceived that alcohol fuels most antisocial behaviour. In general, parents considered that they were well informed about alcohol and felt they could talk to their children about the dangers. However, only a few participants mentioned the health risks to young teenagers or the health risks into adulthood as issues for concern.

Some parents felt torn as to how to deal with drinking under the age of 18 years. Many felt it their responsibility to "train" children to respect alcohol, in an attempt for children not to view alcohol as prohibited (and therefore more attractive). Parents were aware that their children watched them when they were drinking and generally parents did not like their children to see them drunk. Those parents who reported drinking in the home saw no problem drinking in front of their children.

They believed there was a lot of pressure on their children to drink and although they did not want to encourage this by buying them alcohol, they felt pressurised to do so. Some parents felt that providing drinks for their children, often as young as 14, to go to parties, would encourage them to develop a more mature attitude to alcohol. It should be noted, however, that the amounts given to children by parents in most of these examples would constitute a binge episode for an adult male drinker. This highlights that parents themselves are misinformed about safe drinking limits and therefore may not be in a good position to be 'trainers' or reliable examples.

In the examples cited by parents, the 'training' did not include discussing the strength of different drinks in terms of units, safe amounts to drink, or an explanation of binge drinking. However, it did involve allowing the child to drink within the home, in the hope that they would not drink unsupervised outside the home. Some parents were concerned about the introduction of alcopops as they felt it encouraged their children to binge drink due to the taste being similar to soft drinks. However, many parents actually offered children alcopops as their first drink.

A further misperception held by parents was that those children who had already drunk dangerously had somehow 'learnt their lesson' and would therefore not do it again.

## Solvent abuse

Sniffing aerosols was viewed by parents as the most risky activity that their child could be involved in. There was a high level of awareness that experimentation with aerosols, especially the first time, can lead to death. Generally, however, there was a perception among parents that their child would not sniff aerosols as they were well informed of the risks.

## Sex

Parents relayed that the media suggest sexual experimentation begins when children are 11 or 12 years old. They, however, believed that it is more likely to start when children are aged 14 or 15 years and in a 'steady' relationship. Sex and fear of pregnancy was particularly strong for parents of daughters. However, knowledge about sexually transmitted infections (STIs) was very poor among parents and was not perceived as a main concern. Parents did have some concerns about how sex and promiscuity is portrayed in the media, but they talked little to their children about these issues, with fathers often leaving it up to mothers and generally giving the impression that with sons there was no need to talk. A majority of parents were also of the view that sex education is covered in school, but without having consulted the school about the content or extent of this education.

### Mental health

Most participants considered that mental ill health in young people can be triggered by external pressures such as bullying, drugs and peer pressure. They felt that the media has a big impact with regard to issues around mental health, with parents in most groups citing a high awareness of teenage suicides, and increased rates of depression. Those who considered that mental health issues were not something for their child to worry about tended to believe that coming from a stable family and not living in the suicide hotspots, such as West Belfast, ensured their child had good mental health. Those living in Belfast and Londonderry were more likely to believe that it could happen to their children as they had more knowledge of mental health problems in their communities. A smaller number of parents cited first-hand experience of depression and self-harming among their own children, and in particular among daughters' friends. Parents were not aware of positive steps they could take, or encourage their children to take, to protect their mental health.

### Parents' influence

For the most part, parents of the young people did not perceive that they were the number one influence in their child's life. Most considered and resigned themselves to the idea that they stopped being the key influence when their children left primary school, and that peer group and the media now exerted a stronger influence. Parents recognised that their behaviour could have a significant impact on the behaviour of their children. They also recognised that they were not always good role models, and this often depended on what mood they were in. Particular areas where this may have been the case included drinking alcohol and losing your temper. Regarding friendships, parents felt that they had more influence over their children's friends at primary school but that this was not really possible at secondary school unless there were major concerns.

### Communication

The majority of parents considered it crucial to eat together as a family around the dinner table as they felt it kept communication open within the household. Most communication, therefore, took place around the dinner table, with approximately

half of all respondents insisting that the television was switched off during meals. Fathers certainly felt that this was the time when they had most communication with their children. Mothers mentioned that traveling in the car also presents a good opportunity to talk about sensitive subjects, such as sex. Parents claimed they don't have any 'off limits' subjects; however, the issues of sex, alcohol or drugs are discussed rarely and only in fleeting comments. Often mothers tried to discuss these topics if they came up in the media or via television soaps.

If a child said they knew all they needed to know about sex, for example, parents for the most part would not probe any further despite not knowing what their child had been told or taught. Those who did talk about sex, drugs or alcohol were most likely to talk about their own values and morals around these topics, and how their children should want other people to see them. Parents also felt it is important to allow their children to initiate conversations on sensitive subjects, and often they reported finding out the most about their children when they talked about what has been happening to their friends or others in their class or school.

In general, very few households had rules; rather parents preferred to talk about boundaries or guidelines. Parents did state that there were often problems with communication with young people. For some, this lack of conversation became very frustrating, especially when they suspected a problem with their child. Asking too many questions, however, was not thought appropriate by some parents.

Having self-control and an ability not to react were seen as important in keeping communication channels open. Many parents perceived that losing their temper was one of the biggest problems regarding communication and the most damaging to their relationship with their child. Fathers also had specific communication difficulties in that they often found it hard to deal with serious subjects and found it easier to make light of the issue. It also appeared that some fathers did not feel this was part of their role, and they perceived that mothers were more empathetic and sensitive to their child's situation.

## Information

Parents perceived that children primarily find out about alcohol, drugs and sex from school via drugs awareness and sex education, and that they have a high awareness of these issues. They believed that peers, older pupils and the media can have an impact on their child's awareness. Parents believed they were responsible for their children with regard to sex education and drugs awareness; however, some thought they shared this responsibility with schools. Despite that, in general, parents were not aware of what their child is taught at school, and few, if any, sought information from school on what their child was being taught.

Parents were keen for schools to teach their children about the risks of drug taking. Only two parents had proactively sought information on drugs, alcohol and sex to share with their child. More encouragingly, at least one participant from each group had been to a parents' evening on the subject of drugs awareness, which they found very useful and worthwhile. One cause for concern, however, was that parents claimed they would only look for information on a given area when a problem arose.

With regard to ways of receiving information, parents would most likely use the internet, although they would be unsure of reliable sites. Some felt a general leaflet targeted at parents would be interesting, even if they didn't have a specific problem. Parents felt a helpline would only be used when all other sources failed. Although parents did not therefore express a need for any further information, it should be noted that they have a major role to play in their child's development. Parents should be encouraged to equip themselves with the correct information and be more proactive in their children's lifestyle choices.

## Recommendations

A substantial majority of parents included in these groups appear to have relinquished influence over their child's behaviour, resigning themselves to be a minor influence after peers and the media. In addition, it is perceived that a lot of information and guidance on these issues is provided in schools and therefore parents feel they have no reason to add to this to any extent. Emphasising this further was the fact that parents did not feel the need for information, and while the issue of pregnancy was

a fear, the issue of sexual health was of little concern to them.

This research also revealed a lack of communication in general between children and parents, and more particularly with fathers. In a lot of cases, communicating with their child on difficult issues was seen as "the mother's role" or the role of school. Indeed, for many, the idea that "they do all that at school", and feeling a lack of influence over their children, meant that parents took little responsibility for their children's risk-taking behaviour, or provided guidance that was well meaning but poorly informed.

This research suggests that providing information to parents that will require parents to be proactive may be a waste of resources as they feel this type of information is not required. Parents first need to be reminded of the fundamental importance and significance of their role. Information to parents that highlights the importance of parent-child communication and the link to risk and protective factors may motivate parents to take a more proactive interest. Studies show that the more young people are exposed to protective factors (such as strong family bonds, healthy standards set by parents, opportunities for family involvement, recognition and praise for positive behaviour), the less likely they are to report taking part in activities such as problem drinking.<sup>1</sup> Warm, supportive and involved parenting has been associated with later initiation of alcohol use.

## Dissemination

Findings from this research were presented at a seminar 'Young people and alcohol' in March 2008. A full report will be published in spring 2009.

## Reference

1. Beinart S et al. Youth at risk? A national survey of risk factors, protective factors and problem behaviour among young people in England Scotland and Wales. London: Communities that Care, 2002.



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