DOCTOR OF PHILOSOPHY

Development of a participatory arts intervention to promote mental health and wellbeing among men 'at risk' of suicide

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Development of a participatory arts intervention to promote mental health and wellbeing among men ‘at risk’ of suicide

Thesis submitted for the degree of Doctor of Philosophy (PhD)
School of Nursing and Midwifery
Queen’s University Belfast
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Abstract

Introduction:

Male mental health is a growing public health concern. The male suicide rate is three times higher than the female rate in Northern Ireland. Men living in areas of high social disadvantage in Northern Ireland are considered a particularly vulnerable group to suicide. Men are often reticent to seek support for mental health issues. However, mental health promotion interventions that adopt gender-sensitive approaches have reported positive mental health outcomes among men. Participatory arts interventions (PAI) have been found to reduce anxiety and depression and promote social connectedness, autonomy and self-esteem. However, the acceptability and effectiveness of PAIs to promote mental health among men remains underexplored. Moreover, there are limited opportunities for the refinement or optimisation of current PAIs due to the lack of clear intervention descriptions in the field. Therefore, the aim of the thesis was to develop a PAI to promote mental health among men in areas of high social disadvantage in Northern Ireland.

Methods:

The study design aligned with Phase 1 Development of the MRC guidance for developing complex interventions. Stage 1 – Systematic Review consisted of a mixed methods systematic review to assess the acceptability, effectiveness and gender-responsiveness of PAIs to promote mental health among men. Stage 2(a) – Understanding Experiences included focus groups and interviews with men in areas
of high social disadvantage in Northern Ireland (n=41) to explore the issues that contributed to psychological distress, the impact of extant PAIs on their mental health, and barriers and facilitators to engagement in PAIs. Finally, Stage 2(b) – Design of Intervention consisted of online consultations with men in areas of high social disadvantage in Northern Ireland (n=5) and service providers with a remit for mental health, men’s health and/or digital arts (n=11). This served to identify preferences for intervention features, content, approaches to delivery, and outcomes in order to develop an outline description of a PAI.

Results:

Stage 1 highlighted that PAIs are acceptable among adults but methodological issues limit the conclusions that can be drawn with regard to evidence of effectiveness. There is a dearth of studies in the literature that focus on men. Stage 2(a) identified that isolation, a lack of meaningful occupation, difficult life transitions and childhood experiences were the key factors contributing to psychological distress among the target population. However, PAIs can address some of these issues by enhancing connectedness, self-efficacy and personal growth, and emotional processing. Findings also elucidated a number of gender-sensitive approaches to enhance male engagement in PAIs. It was determined digital storytelling (DST) would be an appropriate art form for consideration by key stakeholder for further development. Findings from Stage 2(b) elucidated a number of preferences and practical considerations to make DST more acceptable among men. This resulted in the development of the Living Legacy Intervention. The proposed intervention and logic model are presented.
Conclusion:

The work undertaken in this thesis has made several contributions to knowledge in the fields of participatory arts, men’s health and mental health. It has provided a summary of the international literature in relation to the acceptability, effectiveness and gender-responsiveness of PAIs to promote mental health among men. It has identified a number of issues that contribute to psychological distress among men in areas of high social disadvantage in Northern Ireland. It has elucidated mechanisms of action that underpin positive mental health outcomes among men that engage in PAIs. It has presented a number of gender-sensitive approaches to enhance male engagement in PAIs. Finally, it has developed an evidence-based, user-informed, gender-sensitive DST intervention. Recommendations for future research and practice are discussed.
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<tr>
<td>PAI</td>
<td>Participatory Arts Interventions</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Control Trial</td>
</tr>
<tr>
<td>TFA</td>
<td>Theoretical Framework of Acceptability</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<td>UK</td>
<td>United Kingdom</td>
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Chapter 1: Introduction
1.0 Introduction
This chapter begins by describing the ‘silent epidemic’ of male mental health in high income countries (Section 1.1). It draws on Connell’s social constructionist theory on masculinities to briefly elucidate some of the key issues that are proposed to contribute to the high rate of male suicide. Moreover, it draws attention to the men in areas of high social disadvantage in Northern Ireland who are considered a suicide prevention priority group in Northern Ireland. This is followed by a brief review of gender-responsive approaches that are utilised to engage men in mental health promotion. Finally, a case is made for the use of participatory arts to promote mental health among men and the need to develop an evidence-based and user-informed participatory arts intervention. This is covered in Section 1.2. The chapter concludes with the aims and objectives of the thesis (Section 1.3) and an overview of the subsequent chapters (Section 1.4).

1.1. Why Focus on the Mental health of Men in Areas of High Social Disadvantage in Northern Ireland?

1.1.1. Masculinities and Mental Health
The issue of men’s mental health has been described as a ‘silent epidemic’ (Whitely, 2018). Common mental health problems such as anxiety and depression are a main contributor to men’s burden of disease globally (Baker et al., 2014). The extent of this ‘silent epidemic’ is illuminated by the male suicide rate which is three and a half times higher than the female rate in high income countries (WHO, 2014). Despite this, females have higher rates of suicide ideation, suicide attempts and common mental health problems such as anxiety and depression (Boyd et al., 2015; Girugs et al., 2017; Miranda-Mendizabal et al., 2019; Schrijvers et al., 2012). This is often termed the “gender paradox” of suicide (Canetto & Sakinofsky, 1998).
While sex refers to the anatomical and physiological variances between males and females (Giddens, 2009, p601), gender encompasses socially constructed roles and acceptable behaviours involving different social norms and expectations (Connell, 1995; Moller-Leimkuhler, 2003). These norms, behaviours and expectations are influenced by early socialisation and cultural institutions which dictate what is considered masculine or feminine. Therefore, gender is considered something we do rather than something we are. More recently, a body of evidence has drawn on Connell’s relational theory of masculinities to explore the interconnectivities between masculinities and mental ill-health among men (Apesoa-Varano et al., 2018; Connell & Messerschmidt, 2005; Mac An Ghaill and Haywood, 2012; O’Donnell & Richardson, 2020; Oliffe et al., 2017; Richardson et al., 2013, Scourfield, 2005). The argument for how this theory fits within the social constructivist paradigm of this study is discussed in further detail in Section 3.2.1.

Central to this theory is that patriarchal power and adherence to hegemonic masculine ideologies influence men’s health practices and illness experiences. Hegemonic masculinities hold their position of power through cultural beliefs in an idealised ‘masculine standard’. In high income countries this is often represented by white, middle-class, middle-age, heterosexual men and characterised by a desire for power, control, aggression, courage, self-reliance, rationality, competitiveness, efficiency and success whilst simultaneously concealing vulnerability and weakness (Coleman, 2015, Moller-Leimkuhler, 2003, Payne et al., 2008, Pirkis et al., 2017). Applying Connell’s frame to the risk factors most often implicated in male suicide, unemployment and financial insecurity can disrupt men’s sense of role and status
due to the centrality of the provider role in the construction of the masculine self (Carrigan et al., 1985, Payne et al., 2008, Turner et al., 1994). Men’s higher suicide rate compared to suicide attempt rate is proposed to be a result of their use of more lethal means, for example the use of hanging or firearms versus an overdose. This is proposed to reflect a hypermasculinity of sorts where lethality is associated with mastery and where ‘failure’ is less acceptable (Payne et al., 2008). Men can also be reticent about seeking support for mental health problems in a bid to remain stoic and self-reliant (Galdas et al., 2005, Pirkis et al., 2017). This may result in men coping through more ‘male-acceptable’ outlets such as alcohol and substance misuse (Richardson et al., 2013). These maladaptive coping mechanisms can escalate to what Brownhill et al. (2005) describes as the ‘big build’ which can contribute to suicidal behaviour.

Connell notes that these dominant forms of masculinities often benefit from a ‘patriarchal dividend’ in terms of honour, prestige, and a right to command (Connell, 2005). As such, hegemonic masculinities’ exalted position creates subordinated and marginalised masculinities which are viewed as less legitimate and are judged to fall short of the masculine standards (Gough et al., 2016). This can expose particular groups of men to stigmatisation and discrimination which is associated with psychological distress (Haas et al., 2011, Kalt et al., 2013). It is also proposed that the competitive nature of hegemonic masculinities lends itself to a social comparison narrative amongst men - not only to be successful in culturally accepted ways, but to feel successful in relation to other men (Scourfield, 2005). It is therefore likely that more subordinated or marginalised groups of men may face
a significant challenge – caught in a bind between being part of a dominant and ‘privileged’ social grouping, yet unable to attain the idealised standards of this grouping or to accrue a ‘patriarchal dividend’ – at least by comparison with other, more dominant, male groupings. Indeed, marginalised men have highlighted the challenges to access the social and economic resources required to meet the ‘masculine standards’ of middle-age and felt powerless to contest such inequities which had negative implications for their mental health (O’Donnell & Richardson, 2020).

Common mental health problems such as depression and anxiety are also more prevalent among females compared to men (Boyd et al., 2015; Girugs et al., 2017; Seedat et al., 2009). However, the symptoms of common mental health problems are incongruent with the idealised ‘masculine standard’ and so men may express their distress through externalising behaviours such as anger, irritability and alcohol/substance misuse (Verona et al., 2004; Richardson et al., 2013). However, these responses fall outside the standard diagnostic criteria for common mental health problems which may prevent diagnosis and treatment (Martin et al., 2013; Rice et al., 2018). Therefore, it is likely that there is an under-reporting and undertreatment of common mental health problems among men rather than a lack of psychological distress.

1.1.2. Deprivation, Men and Mental Health in Northern Ireland
This male suicide rate in Northern Ireland is the highest in the UK and is three times greater than the female rate (O’Neill & O’Connor, 2020). It has risen significantly since the Good Friday Agreement in 1998 from 14 per 100,000 to 25 per 100,000 in 2018 (NISRA, 2020). The rise was particularly sharp between 2004 and 2006 when
the rate doubled from 13 per 100,000 to 27 per 100,000. The centralisation of coroner’s services from seven separate districts is perhaps an explanatory factor (NISRA, 2020). Moreover, these suicide statistics are now being disputed as discrepancies were found in the data between drug-related deaths and suicide deaths. Additional scrutiny measures to differentiate between drug-related and suicide deaths were implemented in 2019 and there was a 30% reduction in suicides reported (NISRA, 2020). A similar review is now underway for the figures pertaining to 2015-2018.

Nonetheless, the factors contributed to suicide among men in Northern Ireland is complex but may be linked to a wide range of social factors included the legacy of the “Troubles” and social deprivation. In a survey of 4340 people in Northern Ireland, 7% of men had seriously considered suicide with 30% of those making a suicide attempt (Tomlinson, 2012). Those that had conflict related trauma were more likely to report suicidal ideation; men were more likely to report conflict related trauma (Bunting et al., 2012). The legacy of the Troubles is also associated with a high prevalence of common mental health problems in Northern Ireland such as depression, anxiety and PTSD which are also associated with increased risk of suicide (Tomlinson, 2012; Bunting et al., 2012).

Men in areas of high social disadvantage are considered one of the most “at risk” groups to suicide and are noted as a priority group within the Northern Ireland national strategy to reduce suicide (Department of Health, 2019). The number of suicides in the most deprived areas of Northern Ireland were four times higher than those in the most affluent areas from 2015-2017 (O’Neill & O’Connor, 2020).
However, community level interventions targeting this cohort are largely absent from the literature. As such there is a clear need for interventions to promote mental health and wellbeing among this cohort. Identifying risk and protective factors is a key step in developing appropriate interventions to target groups “at risk” of suicide (WHO, 2012). However, the factors contributing to psychological distress among this cohort remain underexplored. There is debate over how social position increases suicide risk but some suggestions include more adverse experiences, powerlessness, stigma and disrespect, social exclusion and employment (Platt, 2011). Thus, it may be likely that social defined roles associated with masculinities and socio-economic status intersect with the unique social context of Northern Ireland to create overlapping systems of subordination and marginalisation that severely impacts the mental health of men in these communities. Whether these issues are underpinning psychological distress among men in areas of high social disadvantage in Northern Ireland remains unclear. Therefore, there is clear need to explore the lived mental health experiences of this cohort in order to inform the development of an appropriate intervention. Indeed, this aligns with a key recommendation to further suicide prevention approaches in Northern Ireland which calls for “targeted suicide prevention support at a community level in areas most affected by the Troubles” and to “involve people with lived experiences in the design and delivery” of appropriate interventions (O’Neill & O’Connor, 2020, p6). However, mental health promotion and suicide prevention among men is often challenged by gender-related barriers such as men’s reticence to seek support for mental health issues. Therefore, engaging men in mental health
promotion requires navigating these masculine norms through incorporating gender-responsive approaches into appropriate interventions (Struik et al., 2019).

1.2. Why Focus on Participatory Arts to Promote Mental Health Among Men in Areas of High Social Disadvantage in Northern Ireland?

1.2.1. Gender-Responsive Approaches

Gender-responsive approaches are those that consider the impact of gender norms, roles and relations during the development and delivery of health promotion programmes (WHO, 2011). There are five domains ranging from those that perpetuate gender inequality [i.e. gender-unequal] to those that transform power relationships between the sexes [i.e. gender-transformative]. The use of gender-sensitive approaches – those that “recognise the specific needs and realities of men based on social construction of gender roles” (WHO, 2007, p4) – sit in the middle of that continuum and have been found to support male engagement in mental health promotion (Oliffe et al., 2019; Robertson et al., 2015; Robertson et al., 2018; Struik et al., 2019). A number of studies have identified examples of gender-sensitive approaches that can support male engagement which includes: all-male groups; action-orientated or interactive approaches; non-medicalised and informal environments; not framing the intervention around mental health; enabling autonomy; strengths-based approaches that focus on existing capacities; and using male interests as a ‘hook’ to facilitate engagement (Lefkowich et al., 2015; Robertson et al., 2018; Seaton et al., 2017; Struik et al., 2019). Vitally, all of these approaches work with, and not against cultural ideals of masculinity which can help to navigate men’s reticence to engage in a mental health process (Galdas et al., 2014). There have been concerted efforts to deploy these strategies within a
number of initiatives to shift the trend of poor help-seeking, common mental health problems and suicide among men.

*Man Therapy* is a website that targets middle-aged men and utilises a humorous and practical approach to raise awareness on the signs and symptoms of depression. Men who engaged with the website reported that the campaign positively impacted their knowledge, attitudes and behaviours in relation to depression and anxiety (IPSOS SRI, 2014). Australia’s *Man Up* campaign was a television programme that utilised men’s lived experiences to explore the relationship between suicidal behaviour, masculinity and help seeking. An RCT demonstrated a significant increase in intention to seek help among participants who watched the series compared to a control group (King et al., 2018). Central to these campaigns was the use of male role models to normalise taboo issues and to re-frame help-seeking as a masculine ideal, an approach that has been found to interrupt suicidal behaviour among men (Oliffe et al., 2012; Jordan et al., 2012).

Interventions based in the workplace have also garnered acceptability in reaching out to men to advance mental health promotion and suicide prevention efforts. A notably intervention is *Mates in Construction* which has demonstrated evidence of effectiveness in positively impacting stigma, suicide literacy and intention to seek/offer help (Ross et al., 2020; King et al., 2018). Consulting with men in the development process was noted as a key factor to developing trust and credibility with the programme. The use of technology to engage men around mental health has also shown to be favourable. A telephone and online chat service in Belgium was found to have a greater reduction in suicide in males compared to females (Pil
et al., 2013). MoodGym, an online interactive cognitive behavioural therapy programme, was found to decrease symptoms of depression and anxiety in adolescents - post-intervention and for a 6-month follow up period - compared to a control group, with a greater decrease in depressive symptoms observed in males compared to females (Calear, et al., 2009).

Exercise-based programmes that use sport as the “hook” to engage men have also shown some efficacy in improving men’s mental health outcomes (Nathan et al., 2013; Sharp et al., 2020; Drew et al., 2020). Football United reported a significant decrease on the ‘peer problem scale’ and significant increase on the ‘prosocial scale’ among teenage boys compared to a control group following participation (Nathan, et al., 2013). The Hat Trick programme also demonstrated a significant reduction in depression risk and improved quality of life post-intervention which was maintained at a nine month follow-up (Sharp et al., 2020).

A final example of utilising gender-sensitive approaches is the Men’s Shed movement which has been widely accepted by older men in communities in Australia, Ireland and the UK. Men’s Sheds are community-based and participants engage in a range of activities such as woodworking, gardening and music. Men’s Sheds provide opportunities for informal learning, skills sharing, camaraderie and a sense of purpose (Kelly et al., 2019; Bergin & Richardson, 2020). Indeed, numerous studies have reported improved mental health outcomes following engagement with a Men’s Shed (Flood & Blair, 2013; Lefkowich & Richardson, 2016; Milligan et al., 2013). Reduced social exclusion and isolation were reported among participants which were attributed to an increased sense of purpose, accomplishment, control,
self-esteem and a support network (Milligan et al., 2013). Indeed, developing new skills, feeling a sense of belonging and contributing to the community were also self-reported positive outcomes (Lefkowich & Richardson, 2016). Moreover, participants also reported reduced mental health stigma and increased willingness to seek support from a wider range of sources (Flood & Blair, 2013). This is particularly important when considering men’s reticence to seek support for mental health issues and demonstrates the power of male peers in normalising taboo issues and transgressing linkages between masculinities and mental health (Oliffe et al., 2019). Although many Men’s Sheds engage in participatory arts such as woodworking and music, the evidence for effectiveness and acceptability of participatory arts to promote mental health among men remains underexplored.

1.2.2 The Case for Participatory Arts to Promote Mental Health Among Men
Participatory arts interventions (PAIs) are gaining recognition as a non-clinical approach for the management and promotion of mental health and wellbeing (APPG, 2017). PAIs can be defined broadly as arts-orientated, group-based activities aimed at attaining and maintaining health and wellbeing (APPG, 2017). They involve a variety of art forms but are broadly categorised in five domains: (i) performing arts (music, dance, and theatre); (ii) visual arts, design and craft; (iii) literature; (iv) community and cultural festivals; and (v) online, digital and electronic arts (Davies et al., 2012). PAIs are distinct from art therapies which are based on different theoretical principles and require a registered therapist for implementation (Sonke et al., 2017). PAIs are delivered by artists in an informal community setting and involve active (e.g. creating) rather than ‘passive engagement’ (e.g. viewing) (Davies et al., 2012; Stickley et al., 2018). From this perspective PAIs would appear to be a
novel medium to promote mental health among men due to its non-clinical, informal, group-based, and action-orientated format. Evidence suggests that participatory arts may reduce depression and anxiety symptoms (Fancourt et al., 2016; Williams et al., 2018), aid “recovery” among people experiencing common mental health problems (Gallant et al., 2019; Hui et al., 2019) and improve mental wellbeing (Crone et al., 2013; Fancourt & Finn, 2019). Recent systematic reviews have identified the positive impact of participatory arts on social relationships, a sense of belonging, confidence and self-esteem, empowerment, self-expression and identity re-formation (Sheppard & Broughton, 2020; Stickley et al., 2018; Zarobe & Bungay, 2017). Considering this preliminary evidence, PAIs might be a meaningful vehicle through which to promote mental health among men in areas of high social disadvantage in Northern Ireland.

1.2.3. The Need to Develop a New Participatory Arts Intervention
A significant criticism of the field of participatory arts is the lack of clear intervention descriptions, theoretical underpinnings and logic models describing the mechanisms of action (Daykin et al., 2017; Dunphy et al., 2018; Sheppard & Broughton, 2020). Therefore, there are limited opportunities for the refinement or optimisation of current interventions and there is a significant need for more robust, rigorous development of PAIs in the field. This lends support for the need to develop a new PAI to promote mental health among men in areas of high social disadvantage in Northern Ireland. More specifically, there is a need to identify PAI content, approaches to delivery and outcomes within PAIs to further the field of participatory arts.
Numerous studies have identified a lack of male engagement with PAIs (Fancourt & Mak, 2020; Lehman & Dumais, 2017; Mak et al., 2020). A recent analysis of 6,867 adults in the UK who engage in PAIs found that males face more barriers to engagement in PAIs compared to females due to fewer capabilities, opportunities and less motivation to engage (Fancourt & Mak, 2020). Rather than the summation that men are simply not interested in PAIs, it could be argued that PAIs are not being developed or delivered to adequately meet the needs and interests of men. Moreover, the evidence of effectiveness for PAIs among men also remains unclear. Indeed, there have been calls for further research to explore the gendered factors that mediate mental health and wellbeing outcomes in PAIs, particularly among men (Daykin et al., 2018; Sheppard & Broughton, 2020). Therefore, there is a need for a systematic review to assess the overall acceptability, gender-responsiveness and effectiveness of PAIs in order to identify strategies that could improve male engagement in PAIs and to identify the gendered pathways through which men may experience positive mental health outcomes. This would maximise the knowledge and understanding of the current evidence and provide a coherent evidence-based approach to intervention development. Secondly, there is a need to explore the lived experiences of men in areas of high social disadvantage in order to identify the problems to be addressed, mechanisms underpinning positive mental health outcomes via engagement in PAIs, and the barriers and facilitators to engagement. Lastly, there is a need to explore key stakeholders’ preferences to guide the development of key intervention components (e.g. outcomes, content and modes of delivery). This combination of an evidence-based and user-informed
approach would maximise the likelihood that the intervention is both acceptable and effective.

1.3. Aims and Objectives of Thesis
Against this backdrop, this thesis has the following aim: To develop a participatory arts intervention to promote mental health among men in areas of high social disadvantage in Northern Ireland. To meet this overarching aim, the following objectives will be explored;

1. To assess the evidence for effectiveness, acceptability and gender-responsiveness of PAIs in promoting mental health and wellbeing among adults, with a particular focus on men.

2. To identify the needs, preferences and opinions of men in areas of high social disadvantage in Northern Ireland and key service providers with a remit for men’s health, mental health and participatory arts to develop an outline description of a PAI. More specifically:

   a. To identify the issues contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland.

   b. To explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland.

   c. To identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland.

   d. To explore the preferences and opinions of key stakeholders on potential intervention features, content, approaches to delivery and outcomes in order to develop an outline description of a PAI.
Therefore, this study will fill a gap in the literature by providing an outline description of a PAI that could be utilised with men in areas of high social disadvantage in Northern Ireland. Moreover, each one of these objectives fills a gap in the current literature and provides key contributions to knowledge in the fields of participatory arts, men’s health and suicide prevention.

1.4. Thesis Overview
Chapter 2 provides the first systematic review in the field to assess the effectiveness, acceptability, and gender-responsiveness of all five participatory art forms, with a particular focus on men. This meets Objective 1. Chapter 3 provides an overview of the methods used to meet Objective 2 as well as the theoretical and intervention development frameworks that underpin this thesis. Chapter 4 presents the findings of the qualitative focus groups and interviews with men in areas of high social disadvantage. This chapter is significant as it advances the literature on the issues contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland, the mechanisms underpinnings positive mental health outcomes among men who engage in PAIs and the barriers and facilitators to engagement in PAIs. Chapter 5 presents the findings from the online consultations with men in areas of high social disadvantage and key service providers with a remit for men’s health, participatory arts and mental health. This helped to identify appropriate intervention features, content, approaches to delivery and outcomes which shaped the development of a PAI. An outline description of the developed PAI is presented in Chapter 6. Finally, Chapter 7 provides a summation of the key contributions to knowledge, the study limitations, and offers recommendations for
future research and practice in the field of participatory art, men’s health and suicide prevention.
Chapter 2: A Systematic Review of the Acceptability, Effectiveness, and Gender-Responsiveness of Participatory Arts Interventions in Promoting Mental Health and Wellbeing

2.0. Introduction
This chapter presents a systematic review exploring the acceptability, effectiveness and gender-responsiveness of participatory arts interventions (PAIs) in promoting mental health and wellbeing among adults, with a specific focus on men. The aims of this review were to further the evidence-base for the use of PAI to promote mental health and wellbeing among adults and to inform the development of a PAI to promote mental health among men in areas of high social disadvantage in Northern Ireland. More specifically, to identify potential pathways through which men could accrue positive mental health outcomes via PAIs, to identify potential barriers and facilitators to male engagement and to identify art forms that might be acceptable to men. The chapter begins with a brief overview of existing systematic reviews in the field of participatory arts and provides a rationale for this systematic review. The methods used in this review are then provided which include the systematic search strategy, the eligibility criteria, study selection and data extraction and the quality appraisal process. This is followed by a summary of the included studies and a narrative synthesis of the main findings. Finally, the chapter closes with a discussion of the findings, limitations of the review, recommendations for further research and implications for intervention development.

2.1. Rationale for Systematic Review
Common mental health problems such as depression and anxiety are major contributors to the overall global disease burden (WHO, 2017; Vos et al., 2015). The scarcity of mental health services, resources and trained professionals, alongside the stigma associated with mental ill health may prevent individuals from seeking or obtaining adequate support (Lake & Turner, 2017; Saraceno & Shekhar, 2002).
Indeed, just 37% of people with common mental health problems in the UK reported receiving treatment for such issues (Department of Health, 2014). There is a need to explore additional approaches that are acceptable and effective in supporting individuals with common mental health problems and to alleviate the burden on mental health services. Indeed, the WHO outline self-care and informal community-based organisations as central tenets in the optimal mix of services for supporting mental health (WHO, 2009). Moreover, in building on the argument that mental health goes beyond the absence of symptoms and should include more positive and holistic concepts to support wellbeing (Slade, 2010), there is also a need for approaches that promote positive mental health. Participatory arts are gaining recognition as a non-clinical approach for the management and promotion of mental health and wellbeing. Recent evidence suggests that participatory arts may reduce depression and anxiety symptoms (Fancourt et al., 2016; Williams et al., 2018), aid “recovery” among people experiencing common mental health problems (Gallant et al., 2019; Hui et al., 2019) and improve mental wellbeing (Crone et al., 2013). Participatory arts are typically delivered by artists in community settings and involve ‘active engagement’ (e.g., creating) rather than ‘passive engagement’ (e.g. viewing) (Davies et al., 2012; Stickley et al., 2018). They are distinct from art therapies which are practiced by licensed therapists, regulated by professional bodies and which have established a body of evidence with precise interventions (APPG, 2017). The robust evidence for precise participatory arts interventions (PAIs) is inconclusive.
Previous systematic reviews on participatory arts have focused on specific art forms such as music and dance (Sheppard & Broughton, 2020) and visual arts (Tomlinson et al., 2018). These reviews identified a positive effect on stress, mental health stigma, social isolation, social capital, autonomy, self-esteem, identity, and a sense of achievement (Sheppard & Broughton, 2020; Tomlinson et al., 2018). Whilst these reviews provide important insights in relation to the benefits of music, dance and visual arts, they represent just two of the five primary art forms as classified by Davies et al. (2012). Although two previous reviews have explored the mental health and wellbeing impacts of a wider range of participatory arts, they both utilised rapid review methodologies, did not conduct quality appraisal and were focused on qualitative studies (Stickley et al., 2018) or children (Zarobe & Bungay, 2017). Therefore, a systematic review that includes a wider range of arts forms and study designs and that appraises the quality of the literature is needed to provide a broader understanding on the effectiveness for PAIs in promoting mental health and wellbeing among adults. Moreover, no review to date has systematically assessed the acceptability of PAIs using the theoretical framework of acceptability (TFA). Acceptability relates to the extent to which people delivering/receiving an intervention consider it to be appropriate, based on anticipated/experienced cognitive and emotional responses (Sekhon et al., 2017). Assessing acceptability is important as an intervention that is burdensome or non-engaging will likely result in participants not experiencing the full benefits of the programme (May, 2013). Therefore, assessing the evidence for the acceptability of PAIs in promoting mental health and wellbeing could provide an overview on the factors that facilitate or
impede engagement across a range of domains and identify gaps where further research is needed.

Lastly, no review to date has considered the acceptability and effectiveness of PAIs among men. Men’s mental health has emerged as a public health priority and conformity to traditional masculine norms, particularly men’s reticence to seek support and to engage in formal mental health processes, is often implicated (Payne et al., 2008; Pirkis et al., 2017). As highlighted in Chapter 1, gender-sensitive approaches have shown promise in reaching and engaging men in mental health interventions such as working in non-clinical environments, adopting action-orientated and strengths-based approaches, and enabling autonomy and ownership (O’Donnell & Richardson, 2018; Robertson et al., 2018; Seaton et al., 2017; Struszczyk et al., 2019). Many of these approaches form the central tenets of PAIs yet the acceptability and effectiveness of PAIs among men remains unclear. Indeed, there have been calls for a focus on gender in relation to factors that mediate wellbeing outcomes and engagement in participatory arts (Daykin et al., 2018; Sheppard & Broughton, 2020). Therefore, this review addresses the following questions;

1. What is the evidence of effectiveness for PAIs in promoting mental health and wellbeing among adults?
2. What is the evidence of acceptability for PAIs in promoting mental health and wellbeing among adults?
3. What is the evidence of effectiveness and acceptability for PAIs in promoting mental health among adult men?
2.2. Methods

2.2.1. Electronic Sources and Search Strategy
The review protocol was registered on PROSPERO (No. CRD42018106825) and follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). A systematic search was conducted using the electronic databases MEDLINE, PsycINFO, CINAHL, Arts & Humanities Citation Index and Social Science Citation Index. Search terms were informed by a subject librarian, previous reviews (Tomlinson et al., 2018; Zarobe & Bungay, 2017) and refined through an iterative process. Searches used a combination of controlled vocabulary (MesH) and free text terms (See Table 1 Configuration of Search Terms). Search terms were categorised using an adapted version of PICO to structure the review, focusing only on problem (i.e. common mental health problems and wellbeing) and intervention (i.e. the range of participatory art forms). The inclusion of a population group and a outcome were omitted from the search string but were alternatively included in the eligibility criteria. It was felt that this sensitive approach would maximise the return of relevant articles and minimise the risk of ‘missing’ articles (e.g. as a consequence of an indexing error).

2.2.2. Eligibility Criteria
The search was restricted to empirical studies of PAIs published over the past 25 years (1.01.1993 to 27.11.2019) that reported on outcomes relating to common mental health problems and mental wellbeing among adults aged ≥18 years old. This 25 year time span was appropriate as it aligned with the time period used in similar reviews (Daykin et al., 2018; Lecky, 2011; Sheppard & Broughton, 2020). As no resources were available for translation, only papers published in English were
included. An intervention was defined as the delivery of an activity or activities *designed* to improve health status (O’Cathain et al., 2019). Studies were restricted to ‘active engagement’ in the following art forms: (i) performing arts (music, dance, and theatre); (ii) visual arts, design and craft; (iii) literature; (iv) community and cultural festivals; and (v) online, digital and electronic arts (Davies et al., 2012). Studies conducted in a clinical or care-home environment or that primarily focused on physical illnesses or serious mental health conditions (e.g. personality-, bi-polar-, cognitive- and/or psychotic disorders) were excluded. The review set out to focus exclusively on men but there was a dearth of such studies and/or those that reported sex disaggregated data. Therefore, the eligibility criteria were adapted to include studies where males accounted for ≥25% of participants. This represented a pragmatic decision to balance the gendered focus of the review against the proportion of men in the majority of published studies.
### Table 1: Configuration of Search Terms

<table>
<thead>
<tr>
<th>Main Heading (descriptor) Terms (MeSH)</th>
<th>Mental Health/ or Mental Disorders/ or Stress, Psychological/</th>
<th>ART/ or Creativity/ Photography/ or Dancing/ or Music/ or Poetry/ or Paint/ or Paintings/ or Sculpture/ or Textiles/ or Literature/ or Writing/ or Play and Playthings&quot;/ or Video Recording/</th>
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<tr>
<td><strong>Entry Terms</strong></td>
<td>suicid*.mp or mental health.mp or (&quot;mental wellbeing&quot; or &quot;mental well-being&quot;).mp or mental disorder.mp. or psychological disorder.mp. or Psychological distress.mp or Emotional distress.mp or (&quot;self harm&quot; or &quot;self harm&quot; or self-injur* or &quot;self injur**&quot;).mp. or (well-being or wellbeing).mp.or anxiety.mp or depression.mp or PTSD.mp</td>
<td>AND (art or arts).mp. or (art-based or arts-based).mp. or creativ*.mp. or (visual art or visual arts).mp. or photograph*.mp. or drama.mp. or (dance or dancing or dancers).mp. or music.mp. or (singing or sing).mp. or poetry.mp. or (story or stories or storytelling or story-telling or &quot;story telling&quot;).mp. or (sketch or sketching).mp. or sculpture.mp. or craft.mp or handicraft.mp or pottery.mp or clay.mp or printmaking.mp. or woodwork.mp. or textile?.mp. or illustration.mp. or(film-making or &quot;film making&quot;).mp. or (moving image or moving images or moving imaging).mp. or (animation or animating).mp. or (mural or murals).mp. upcycling.mp. or (soundscape or soundscaping).mp or literary art.mp. or expressive writing.mp. or (art-making or arts-making).mp. or puppet.mp. or puppetry.mp. or (drum or drumming).mp. or graffiti.mp. or video making.mp.</td>
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2.2.3. Study Screening
The database search returned a total of 28,512 records which after removal of duplicates left 20,719 records. These study titles and abstracts were screened against the eligibility criteria by the lead author (SO’D). A second reviewer (ML) independently reviewed 10% of study titles and abstracts. Following this screening stage, 404 potential papers were identified to be further screened for eligibility via their full-text. The full-texts were screened independently by both reviewers. Discrepancies were arbitrated by a third reviewer (KG). This resulted in the inclusion of 32 articles. A PRISMA flowchart of this process can be found in Figure 1. The primary reasons for exclusion at full-text screening related to: less than 25% males; not reporting the sex of participants; not meeting the definition of an “intervention” or the eligible art forms; art therapy; including non-art elements such as sport; not related to common mental health problems or mental wellbeing; and being conducted in a care home and/or clinical setting. These are also outlined in Figure 1. The search was initially conducted in May 2018 and resulted in the inclusion of 26 articles. The search was re-run and updated in November 2019 which resulted in the inclusion of 6 further papers.

2.2.4. Data Extraction
A data extraction tool was developed and pilot-tested to ensure the relevance of the following variables; participant demographics; study methodology; intervention components; effectiveness outcomes; acceptability domains; and gender-responsive approaches (See Appendix 1: Data Extraction Form). Acceptability data were guided by the TFA which consists of seven domains: affective attitude; burden; perceived effectiveness; ethicality; intervention coherence; opportunity
costs; and, self-efficacy (Sekhon et al., 2017). Gendered approaches were classified using the WHO gender-responsive assessment scale (WHO, 2011). The lead author (SO’D) conducted data extraction and a second reviewer (KG) conducted data extraction on 10% to quality assure the process.

**Records Identified Through Databases:** MEDLINE, PsychINFO, CINAHL, Arts & Humanities Citation Index and Social Science Citation Index. 
(n = 28,512 records)

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<th>Records after duplicates removed</th>
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<td>(n = 20,719 records)</td>
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<th>Records excluded</th>
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<th>Records screened for title &amp; abstract</th>
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<td>(n = 20,719 records)</td>
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<th>Full-text articles assessed for eligibility</th>
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<th>Studies included</th>
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<th>Full-text articles excluded, with reasons (n = 372)</th>
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<tr>
<td><em>Population</em> (i.e. ≤25% males; did not report sex; ≤18 yrs old; participants were professional artists) (n=150)</td>
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<tr>
<td><em>Intervention</em> (i.e. not an intervention, not participatory art or not eligible art form; included non-art elements; art therapy) (n=113)</td>
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<tr>
<td><em>Study type</em> (i.e. not empirical primary research; not in English; systematic review design; single case study) (n=54)</td>
</tr>
<tr>
<td><em>Outcome</em> (i.e. not primary outcomes) (n=32)</td>
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<tr>
<td><em>Setting</em> (i.e. care home or clinical setting) (n=23)</td>
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**Figure 1: PRISMA Flowchart**
2.2.4. Quality Appraisal
Methodological quality appraisal was conducted independently by two reviewers (SO’D & ML) using the Mixed Methods Appraisal Tool 2018 (MMAT) (Hong et al., 2018). There were high levels of agreement (>80%) and a third reviewer (KG) arbitrated discrepancies. Methodological quality was categorised as; Weak - meeting two criteria or less; Moderate - meeting three or four criteria; or Strong - meeting all five criteria. See Appendices 2-5 for the results of the quality appraisal process.

2.2.5. Methods of Synthesis
Due to the heterogeneity across study designs and outcome measures a narrative synthesis was conducted which relies on using textual information to summarise and explain findings of the synthesis (Popay et al., 2006). Firstly, descriptive characteristics were extracted to create a textual summary of results. Next, each study was read and reviewed in-depth in order to explore the relationships within and between studies. Lastly, these relationships were compared across studies to identify themes relevant to the three research questions. Once the themes were identified they were independently reviewed by the wider research team. A data-based convergent synthesis design was utilised and quantitative data was transformed into themes (Hong et al., 2017). The synthesis is presented in relation to the three review questions and the coding framework that emerged for thematic analyses is provided (Appendix 6: Coding Framework for Systematic Review).
2.3. Overview of Included Studies

2.3.1. Characteristics of Studies
Thirty two studies were included - 21 qualitative (Ascenso et al., 2018; Dingle, et al., 2013; Giaver et al., 2017; Heard et al., 2013; Heenan, 2006; Horghagen et al., 2014; Howells & Zelnik, 2009; Knestaut et al., 2010; Lawson et al., 2014; Makin & Gask, 2012; Nagji, et al., 2013; Perkins et al., 2016; Shakespeare & Whieldon, 2018; Stickley & Eades, 2013; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith, 2014; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Williams et al., 2019(a); Wilson & Kent, 2016), nine quantitative (Clift & Morrison, 2011; Gür & Caglayan, 2017; Hacking et al., 2008; Irle & Lovell, 2014; Ishihara et al., 2018; Pezzin et al., 2018; Sun & Buys, 2016; Williams et al., 2019(b); Wilson et al., 2017) and two mixed methods (Margrove et al., 2013; Poulos et al., 2019). One mixed method study did not contain a sufficient qualitative element so only its quantitative data was retained (Clift & Morrison, 2011). Study characteristics are available in Table 2: Summary of Qualitative Studies & Qualitative Elements of Mixed Method Studies and Table 3: Summary of Quantitative Studies & Quantitative Elements of Mixed Method Studies.

2.3.2. Characteristics of Participants
There was a pooled total of 1,058 participants (41.8% male). Fifteen studies reported data to calculate a mean age of 51 years old. A wide range of population groups were included: previous/current users of mental health services (Ascenso et al., 2018; Perkins et al., 2016; Shakespeare & Whieldon, 2018; Stickley & Hui, 2012; Stickley & Eades, 2013; Van Lith et al., 2011; Van Lith, 2014; Wilson & Kent, 2016), adults experiencing common mental health problems (Horghagen et al., 2014,
Makin & Gask, 2012) veterans (Pezzin et al., 2018), Aboriginal & Torres Islanders (Sun & Buys, 2016), men’s shed members (Irle & Lovell, 2014) older adults (Ishihara et al., 2018, Poulos et al., 2019), homeless people (Knestaut et al., 2010; Thomas et al., 2011), prisoners (Heard et al., 2013; Wilkinson & Caulfield, 2017) university students (Gül & Caglayan, 2017; Nagji et al., 2013) and municipality employees (Giaver et al., 2017). A number of studies described the population as ‘adults experiencing mental health problems’, not otherwise specified (Clift & Morrison, 2011; Dingle et al., 2013; Heenan, 2006; Williams et al., 2019(a); Williams et al., 2019(b); Wilson et al., 2017). Four studies consisted of mixed groups including general population, adults with anxiety and/or depression, and adults with serious mental health conditions (Hacking et al., 2008; Howells & Zelnik, 2009; Lawson et al., 2014; Margrove et al., 2013). Given that the latter conditions were not the primary condition under observation, these studies were included.

2.3.4. Characteristics of PAIs
PAIs were mostly delivered by artists in community locations. Musical-, visual- and multimodal arts (a combination of art forms) were the most common PAIs and typical sessions were delivered for two hours, once per week for 10 weeks (ranging from 1 week to 2 years). Self-referral was the most commonly reported pathway (n=13) to engagement with PAIs (Giaver et al., 2017; Howells & Zelnik, 2009; Hacking et al., 2008; Ishihara et al., 2018; Pezzin et al., 2018; Knestaut et al., 2010; Lawson et al., 2014; Margrove et al., 2013; Nagji et al., 2013; Thomas et al., 2011; Wilkinson & Caulfield, 2017; Wilson et al., 2017; Wilson & Kent, 2016). Ten studies reported referrals from community health organisations and/or charities (Ascenso et al., 2018; Hacking et al., 2008; Irle & Lovell, 2014; Perkins et al., 2016; Pezzin et
al., 2018; Stickley & Eades, 2013; Stickley & Hui, 2012; Sun & Buys, 2016; Williams et al., 2019a; Williams et al., 2019b) whilst eight studies reported referrals through health professionals which included GPs, psychiatrists, psychologists, nurses, allied health professionals, pharmacists and “mental health workers” (Ascenso et al., 2018; Dingle et al. 2013; Heenan, 2006; Makin & Gask, 2012; Perkins et al., 2016; Poulos et al., 2019; Stickley & Eades, 2013; Stickley & Hui, 2012; Wilson & Kent, 2016; Hacking et al., 2008). Seven studies did not report the referral route (Clift & Morrison, 2011; Gül & Caglayan, 2017; Heard et al., 2013; Horghagen et al., 2014; Shakespeare & Whieldon, 2018; Van Lith et al., 2011; Van Lith et al., 2014).

2.3.5. Gender-Responsive Approaches
Four studies focused exclusively on men (Irle & Lovell, 2014; Heard et al., 2013; Thomas et al., 2011; Wilkinson & Caulfield, 2017). However, just one study in the review reported a gender-sensitive approach (Irle & Lovell, 2014). This PAI was conducted in a Men’s Shed environment and prioritised strengths-based approaches where men could share their existing skills and capacities. The remaining 31 studies were classified as gender-blind – they did not report on the specific needs of participants in relation to gender norms. Just one study provided sex-disaggregated data (Ishihara et al., 2018).

2.3.6. Quality Appraisal of Included Studies
The methodological quality of evidence varied (13 weak; 11 moderate; 3 strong). The most common issues in quantitative studies related to; not reporting if PAIs were administered as intended (Gül & Caglayan, 2017; Hacking et al., 2008; Irle & Lovell, 2014; Sun & Buys, 2016; Williams et al., 2019(b); Wilson et al., 2017); incomplete outcome data (<80%) (Hacking et al., 2008; Irle & Lovell, 2014; Williams
et al., 2019(b); Wilson et al., 2017); unclear description of, or eligibility criteria for, the target population (Gül & Caglayan, 2017; Hacking et al., 2008; Williams et al., 2019(b)); not accounting for confounding factors (Gül & Caglayan, 2017; Irle & Lovell, 2014; Poulos et al., 2019; Wilson et al., 2017) and assessors not being blinded (Ishihara et al., 2018; Pezzin et al., 2018). The most common issues in qualitative studies related to the credibility and confirmability of the data (Ascenso et al., 2018; Giaver et al., 2017; Heenan, 2006; Horghagen et al., 2014; Howells & Zelnik, 2009; Knestaut et al., 2010; Shakespeare & Whieldon, 2018; Stickley & Eades, 2013; Thomas et al., 2011; Van Lith, 2014; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Wilson & Kent, 2016), lack of rich data and in-depth analysis (Dingle et al., 2013; Giaver et al., 2017; Knestaut et al., 2010; Marie Heard et al., 2013; Nagji et al., 2013; Wilkinson & Caulfield, 2017; Williams et al., 2019(a); Wilson & Kent, 2016), and the potential for social desirability bias due to the research team being involved in both the delivery and evaluation of the PAI (Heenan, 2006; Heard et al., 2013; Nagji et al., 2013; Stickley & Hui, 2012). The most common issue in mixed method studies was the meta-interference of the integrated data (Margrove et al., 2013; Poulos et al., 2019).
### Table 2: Summary of Qualitative Studies & Qualitative Elements of Mixed Method Studies

<table>
<thead>
<tr>
<th>Author &amp; Country</th>
<th>Population &amp; Referral Route</th>
<th>Intervention Description</th>
<th>Temporal Assessment of Acceptability</th>
<th>Acceptability Indicators</th>
<th>MMAT Quality Grade</th>
</tr>
</thead>
</table>
| • Ascenso et al. 2018<sup>(ii)</sup>  
• UK                                                                 | • Population: ‘Mental health patients & (in)formal carers’ (n=39)  
  • 28.2% male  
• Referral: psychologists, psychiatrists, GPs, mental health and carer support organisations / charities | • Art Form: Drumming  
• Duration: 6-10 wks, once per week & 1.5hr sessions  
• Setting: Not specified  
• Facilitator: Professional drummer selected through open competition  
• GRS: Gender-blind | • Retrospectively – ‘Within weeks of completing intervention’ | • Perceived Effectiveness: Positive emotions; achievement; absorption; self-awareness; positive identity; connectedness  
• Self-Efficacy: No high expectations & low skill threshold improved self-efficacy | Moderate |
| • Dingle et al. 2013  
• Australia                                                   | • ‘People with mental illness & social                                                     | • Art Form: Choir Singing  
• Duration: 1yr, once per wk & 3.5hr sessions  
• Setting: Community hall                                      | • Concurrent & retrospectively - T1:                                                      | • Perceived Effectiveness: ↑Positive emotions; self-perception & self-expression; connectedness; routine & structure. | Moderate |
<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Referral</th>
<th>Art Form</th>
<th>Duration</th>
<th>Setting</th>
<th>Facilitator</th>
<th>GRS</th>
<th>Perceived Effectiveness</th>
<th>Burden</th>
<th>Ethicality</th>
<th>Self-Efficacy</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giaver et al., 2016, Norway</td>
<td>Municipality Employees (n=10)</td>
<td>Existing health workers or agency</td>
<td>Choir Singing</td>
<td>12 wks, once per wk &amp; session length not specified</td>
<td>Not specified</td>
<td>Musician</td>
<td>Gender-blind</td>
<td>Connection, achievement, recognition &amp; self-esteem.</td>
<td>Long commute to venue increased burden</td>
<td>Choral singing a ‘feminine’ activity</td>
<td>Perceived poor vocal skills</td>
<td>Weak</td>
</tr>
<tr>
<td>Heard et al., 2013, Australia</td>
<td>Prisoners (n=10)</td>
<td>Self-referral</td>
<td>Drama</td>
<td>12 wks, once per wk &amp; no session length given</td>
<td>Prison</td>
<td>Actors, theatre maker &amp; practitioner</td>
<td>Gender-blind</td>
<td>Social skills &amp; support networks built on trust, respect &amp; shared experiences</td>
<td>Focus on art, not on being a prisoner</td>
<td>Weak</td>
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</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Referral</td>
<td>Art Form</td>
<td>Duration</td>
<td>Setting</td>
<td>Facilitator</td>
<td>GRS: Gender-blind</td>
<td>Perceived Effectiveness</td>
<td>Burden</td>
<td>Self-Efficacy</td>
<td>Notes</td>
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<tr>
<td>Heenan, 2006 UK</td>
<td>‘People with mental health problems’ (n=40) 37.5% male</td>
<td>GP or psychiatrist</td>
<td>Painting</td>
<td>10 wks, 10hrs per wk &amp; session frequency &amp; length specified</td>
<td>Community centre</td>
<td>Art teacher</td>
<td>Gender-blind</td>
<td>↑self-esteem; empowerment; self-reflection; stepping stone to other activities.</td>
<td>Focus on art and no pressure to disclose MH reduced burden</td>
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<tr>
<td>Horghagen et al., 2013 Norway</td>
<td>Adults with long-term mental illnesses (n=12) 25% male</td>
<td></td>
<td>Crafts</td>
<td>PAI delivered on on-going basis; session length &amp; frequency not specified</td>
<td>Community ‘meeting space’</td>
<td>Occupational therapist &amp; social worker</td>
<td>Gender-blind</td>
<td>Concurrent – Observation s for 4hrs, once per wk for 7 months</td>
<td>Routine; familiarity &amp; management; stimulation; purpose; achievement; peer support; social contact; uplifting</td>
<td></td>
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<tr>
<td>Howells &amp; Zelnik, 2009 USA</td>
<td>General population &amp; people who ‘self-identified as having a</td>
<td></td>
<td>Multimodal</td>
<td>PAI delivered on on-going basis PAI &amp; session frequency or length not specified</td>
<td>Concurrent &amp; retrospectiv e- T1- beginning of PAI &amp; T2 -</td>
<td></td>
<td>New identities; ↑self-perception; connectedness</td>
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</tbody>
</table>

Moderate
<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Description</th>
<th>Art Form/Duration/Setting/Facilitator/GRS</th>
<th>1yr later Observations</th>
<th>Perceived Effectiveness</th>
<th>Burden</th>
<th>Affective Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Knestaut et al., 2010</em></td>
<td>Homeless people (n=11) 27.3% male Referral: self-referral</td>
<td>Art Form: Dance Duration: 8 wks; twice per wk Setting: Homeless shelter Facilitator: Dance instructor GRS: Gender-blind</td>
<td>Retrospective – Not specified</td>
<td>Positive emotions; relaxing; energising; distraction.</td>
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<tr>
<td><em>Lawson et al., 2014</em></td>
<td>Adults living with CMHP (n=8) 62.5% male Referral: self-referral</td>
<td>Art Form: Painting &amp; Drawing Duration: 2yrs &amp; session Setting: Museum Facilitator: Artist &amp; museum staff GRS: Gender-blind</td>
<td>Concurrent – ‘10 months into project’</td>
<td>↑self-worth &amp; belonging, separate self from illness labels, meaningful occupation/routine and anticipated painful project ending.</td>
<td>Burden: Strengths-based approach a positive Affective Attitude: Highly valuable experience</td>
<td>Strong</td>
</tr>
<tr>
<td><em>Makin &amp; Gask, 2012</em></td>
<td>Adults with chronic CMHP (n=15) 46.6% male Referral: self-referral</td>
<td>Art Form: Painting, drawing, pottery &amp; photography Duration: Up to 6mths; up to 2 sessions per wk &amp; 2hrs</td>
<td>Retrospective – ‘Recently after completing’</td>
<td>Enjoying life; re-engaging with hobbies, goal-setting; ↓rumination; absorption in activity; social contact</td>
<td></td>
<td>Strong</td>
</tr>
<tr>
<td>Study</td>
<td>Referral</td>
<td>Setting</td>
<td>Facilitator</td>
<td>GRS</td>
<td>Art Form</td>
<td>Duration</td>
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<tr>
<td>Margrove et al., 2012</td>
<td>Referral: socially prescribed by GP</td>
<td>Community centre</td>
<td>Artist</td>
<td>Gender-blind</td>
<td>Art Form: Multimodal</td>
<td>6-12 wks, once per wk &amp; 2hr sessions</td>
</tr>
<tr>
<td>UK</td>
<td>Setting: Community centre</td>
<td>Facilitator: Artist</td>
<td>GRS: Gender-blind</td>
<td></td>
<td>Art Form: Drama</td>
<td>6 wks, once per wk &amp; 2.5hr sessions</td>
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<tr>
<td></td>
<td>Referral: Self-referral or referred by a “mental health worker”</td>
<td>Duration: 6-12 wks, once per wk &amp; 2hr sessions</td>
<td>Setting: Community venue</td>
<td>Facilitator: Professor of drama, actor &amp; theatre facilitator</td>
<td>Art Form: Drama</td>
<td>Duration: 6 wks, once per wk &amp; 2.5hr sessions</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Patient Group</td>
<td>Referral</td>
<td>Art Form</td>
<td>Duration</td>
<td>Setting</td>
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<tr>
<td>Perkins et al., 2016&lt;sup&gt;(i)&lt;/sup&gt;</td>
<td>UK</td>
<td>‘Mental health patients &amp; (in)formal carers’ (n=39)</td>
<td>28.2% male</td>
<td>Drumming</td>
<td>6-10 wks, once per week &amp; 1.5hr sessions</td>
<td>Not specified</td>
</tr>
<tr>
<td>Poulous et al. 2019*</td>
<td>Australia</td>
<td>Older adults (n=127)</td>
<td>25.9% male</td>
<td>Multimodal</td>
<td>8-10 wks, no frequency &amp; session length not specified.</td>
<td>Not specified</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Setting</td>
<td>Facilitator</td>
<td>GRS</td>
<td>Concurrent Duration</td>
<td>Perceived Effectiveness</td>
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<tr>
<td>Shakespear e &amp; Whieldon, 2017 (i)</td>
<td>UK General population &amp; ‘people who experience mental health conditions’ (n=20) 30% male Referral: not reported</td>
<td>Community space</td>
<td>Musician</td>
<td>Gender-blind</td>
<td>On-going basis PAI, once per wk &amp; 1.5hr sessions</td>
<td>Enhanced mood; ↑social capital &amp; skills; re-connecting with self &amp; routine</td>
</tr>
<tr>
<td>Stickley &amp; Hui, 2012 (ii)</td>
<td>UK Current/previous users of mental health services (n=16) 50% male Referral: Mental health professional in primary and secondary care sectors,</td>
<td>Community location</td>
<td>Artist</td>
<td>Gender-blind</td>
<td>10wks; once per wk &amp; session length not specified</td>
<td>Acceptance &amp; belonging; self-exploration; achievement; therapeutic; determine new future</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Population</td>
<td>Referral</td>
<td>Art Form</td>
<td>Duration</td>
<td>Setting</td>
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<tr>
<td>Stickley &amp; Eades, 2013 (i)</td>
<td>UK</td>
<td>2 yr follow up with participants from Stickley &amp; Eades, 2013 (n=10)</td>
<td>Mental health professional in primary and secondary care sectors, and voluntary sector</td>
<td>Multimodal</td>
<td>10wks; once per wk; no session length given</td>
<td>Community location</td>
</tr>
<tr>
<td>Thomas et al., 2011</td>
<td>Australia</td>
<td>Homeless people (n=4)</td>
<td>self-referral</td>
<td>Drawing &amp; Painting</td>
<td>PAI delivered on-going basis PAI &amp; session length &amp; frequency not specified</td>
<td>Concurrent - ‘over 2 month period’</td>
</tr>
<tr>
<td>Study</td>
<td>Setting</td>
<td>Art Form</td>
<td>Duration</td>
<td>Perceived Effectiveness</td>
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<tr>
<td>Van Lith et al., 2011, Australia</td>
<td>Homeless facility</td>
<td>Painting, drawing, sculptures, ceramics &amp; textiles</td>
<td>PAI delivered on-going basis; average engagement 2 yrs; no session frequency or length specified</td>
<td>Meaningful occupation; absorption; releasing tension; overcoming challenges; recognition personal growth; connectedness.</td>
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<tr>
<td>Van Lith, 2014, Australia</td>
<td>Psychosocial rehabilitation centre</td>
<td>Painting</td>
<td>PAI delivered on-going basis; session length &amp; frequency not specified</td>
<td>Self-reflection; achievement; absorption; distraction; enhanced mood</td>
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<tr>
<td>Wilkinson</td>
<td>Prisoners</td>
<td>Gamelan music</td>
<td>Retrospective</td>
<td>Therapeutic;</td>
<td></td>
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</tr>
</tbody>
</table>

**Facilitators:**
- Artist
- Not specified

**GRS:** Gender-blind

**Mental Health 'Consumers':**
- (n=18) 33.3% Male
- (n=12) 41.6% Male

**Referral:**
- not reported

**Concurrent – T1:** baseline, T2: 6 months and T3: 1 yr.

**Perceived Effectiveness:**
- Moderate
- Weak
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Description</th>
<th>Characteristics</th>
<th>Art Form</th>
<th>Duration</th>
<th>Setting</th>
<th>Facilitator</th>
<th>GRS</th>
<th>Concurrent &amp; Retrospective T1</th>
<th>Perceived Effectiveness</th>
<th>Perceived Effectiveness</th>
<th>Effectiveness</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caulfield, 2017</td>
<td>UK</td>
<td>(n=13) 100% male</td>
<td>Self-referral</td>
<td>Multimodal</td>
<td>Duration: 1 wk &amp; session frequency or length not specified</td>
<td>Setting: Prison</td>
<td>Facilitator: ‘Experienced charity workers’</td>
<td>Gender-blind</td>
<td>T1: ‘2-3 weeks into participation’ &amp; T2: Post-intervention (creative writing) &amp; 1 yr later (choir)</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Moderate</td>
<td>Weak</td>
</tr>
<tr>
<td>Williams et al. 2019a</td>
<td>Australia</td>
<td>‘Adults with chronic mental health conditions’ (n=48) 50% Male</td>
<td>Community mental health organisations</td>
<td>Multimodal</td>
<td>Duration: Choir singing – PAI delivered on on-going basis, weekly &amp; 2.5hr sessions. Creative Writing – 10wks; weekly; &amp; 2hr sessions</td>
<td>Setting: Not specified</td>
<td>Choir singing - professional conductor &amp; musician Creative Writing - Fiction writer</td>
<td>Gender-blind</td>
<td>T1: ‘2-3 weeks into participation’ &amp; T2: Post-intervention (creative writing) &amp; 1 yr later (choir)</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Moderate</td>
<td>Weak</td>
</tr>
<tr>
<td>Wilson &amp; Kent, 2016</td>
<td>UK</td>
<td>Mental health service users (n=6)</td>
<td></td>
<td>Visual arts</td>
<td>Duration: PAI delivered on on-going basis; session</td>
<td>Concurrent – 1yr post-establishment of group</td>
<td><strong>Perceived Effectiveness</strong>: ↑social inclusion; self-esteem; pride; distraction</td>
<td>Gender-blind</td>
<td>T1: ‘2-3 weeks into participation’ &amp; T2: Post-intervention (creative writing) &amp; 1 yr later (choir)</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Belonging &amp; acceptance; peer support; self-belief; overcoming challenges; purpose; positive emotions</td>
<td>Moderate</td>
<td>Weak</td>
</tr>
<tr>
<td>Author &amp; Country</td>
<td>Study Design</td>
<td>Population &amp; Referral Route</td>
<td>Intervention Description</td>
<td>Comparison group(s)</td>
<td>Outcome Measure(s)</td>
<td>Data Time-Point(s)</td>
<td>Key Outcomes</td>
<td>MMAT Quality Grade</td>
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<tr>
<td>Ishihara et al. 2018</td>
<td>Pilot randomised control trial</td>
<td>Older Adults (n=55) 34.5% male</td>
<td>Art Form: Photography</td>
<td>Control</td>
<td>Center for Epidemiologic Studies Depression Scale (CES-D) Kessler 6-Item</td>
<td>T1: 3 wks pre-intervention T2: 1 wk post-</td>
<td>Sig ↓ in CES-D compared to control. Sig ↑ positive affect compared to control. No differences on K-</td>
<td>Moderate</td>
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</table>

PAI= Participatory Arts Intervention; GRS=Gender Responsiveness Scale; IPA= Interpretative Phenomenological Analysis; wk(s)=week(s); yr(s)=year(s); T1, 2 = Time-point (1,2) *=Qualitative element of mixed methods study

(i)=Perkins et al. (2016) & Ascensco et al. (2018) reporting on same PAI with same participants with different questions.
(iii)=Williams et al. (2019a) & Williams et al. (2019b) reporting on same PAI with same participants but different outcomes (qualitative & quantitative).
(iv)=Wilson et al. (2017) & Margrove et al. (2012) reporting on the same intervention with different participants.
<table>
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<tr>
<th>Study</th>
<th>Design</th>
<th>Country</th>
<th>Sample</th>
<th>Referral</th>
<th>Art Form</th>
<th>Duration</th>
<th>Setting</th>
<th>Facilitator</th>
<th>Measures</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pezzin et al. 2018</td>
<td>Pilot randomised control trial</td>
<td>USA</td>
<td>Veterans with PTSD (n=40)</td>
<td>Self-referral &amp; community mental health</td>
<td>Guitar playing</td>
<td>6 wks, weekly &amp; 1hr sessions</td>
<td>Community veteran facility</td>
<td>Guitar instructor</td>
<td>Psychological Distress Scale (K-6)</td>
<td>6, apathy or SWLS scales.</td>
<td>No difference with regard sex, age or depressive tendencies.</td>
</tr>
<tr>
<td>Gül &amp; Çağlayan, 2017</td>
<td>Quasi-experimental</td>
<td>Turkey</td>
<td>University students (n=39)</td>
<td>None</td>
<td>Drama</td>
<td>14wks; once per wk &amp; 4hr sessions</td>
<td>University</td>
<td>None</td>
<td>Ryff Psychological Wellbeing Scale (RPWS)</td>
<td>Moderate</td>
<td>No sig changes in RPWS</td>
</tr>
</tbody>
</table>

- **Facilitator**: Not Specified
- **GRS**: Gender-blind
- **Art Form**: Guitar playing
- **Duration**: 6 wks, weekly & 1hr sessions
- **Setting**: Community veteran facility
- **Facilitator**: Guitar instructor
- **GRS**: Gender-blind
- **Art Form**: Drama
- **Duration**: 14wks; once per wk & 4hr sessions
- **Setting**: University
- **Facilitator**: Not Specified
- **GRS**: Gender-blind
- **Art Form**: Not Specified
- **Duration**: Not Specified
- **Setting**: Not Specified
- **Facilitator**: Not Specified
- **GRS**: Gender-blind
- **Art Form**: Not Specified
- **Duration**: Not Specified
- **Setting**: Not Specified
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- **Art Form**: Not Specified
- **Duration**: Not Specified
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- **Art Form**: Not Specified
- **Duration**: Not Specified
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- **Art Form**: Not Specified
- **Duration**: Not Specified
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- **Duration**: Not Specified
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- **Duration**: Not Specified
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- **Art Form**: Not Specified
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- **GRS**: Gender-blind
- **Art Form**: Not Specified
- **Duration**: Not Specified
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- **GRS**: Gender-blind
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- **Facilitator**: Not Specified
- **GRS**: Gender-blind
- **Art Form**: Not Specified
- **Duration**: Not Specified
- **Setting**: Not Specified
- **Facilitator**: Not Specified
- **GRS**: Gender-blind
- **Art Form**: Not Specified
- **Duration**: Not Specified
- **Setting**: Not Specified
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Population &amp; Referral</th>
<th>Art Form</th>
<th>Setting</th>
<th>Facilitator</th>
<th>GRS</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irle &amp; Lovell, 2014</td>
<td>Observational Study</td>
<td>Men’s shed members (n=31), 100% Male</td>
<td>Choir singing &amp; musical instruments</td>
<td>Men’s shed</td>
<td>Musician</td>
<td>Gender-blind</td>
<td>Outcome Rating Scale (ORS), Goldsmith Music Sophistication Index (GMSI)</td>
<td>T1: Baseline, T2: Week 6, T3: Post-Intervention</td>
</tr>
<tr>
<td>Sun &amp; Buys, 2016</td>
<td>Quasi-experimental</td>
<td>Aboriginal &amp; Torres Islanders with chronic conditions (n=117), 32.5% male</td>
<td>Choir singing</td>
<td>Community venue</td>
<td>Musician</td>
<td>Gender-blind</td>
<td>Indigenous Risk Impact Screen (IRIS), Brief Resilience Scale (BRS), Social Connectedness Scale (SCS), Social Support Index (SSI)</td>
<td>T1: Baseline, T2: Post-Intervention</td>
</tr>
<tr>
<td>Wilson et al., 2017&lt;sup&gt;(iv)&lt;/sup&gt;</td>
<td>Observation Study</td>
<td>General population &amp; adults with mental health problems (n=106)</td>
<td>Art Form: Multimodal</td>
<td>None</td>
<td>Warwick-Edinburgh Mental Wellbeing Scale (WEMWS)</td>
<td>T1: Baseline</td>
<td>T2: Post-Intervention; T3: 3 months later; T4: 6 months later</td>
<td>Sig ↑ in WEWMS &amp; SIS which lasted for 3 months before declining.</td>
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</tr>
<tr>
<td>Hacking et al., 2008</td>
<td>Observation Study</td>
<td>Adults ‘with mental health needs’ (n=62)</td>
<td>Art Form: Multimodal</td>
<td>None</td>
<td>Social Inclusion Scale (SIS)</td>
<td>T1: Within 4wks of joining</td>
<td>T2: 6 months</td>
<td>Sig ↑ in SIS &amp; IES &amp; sig ↓ for CORE-OM.</td>
</tr>
<tr>
<td>Referral</td>
<td>Setting</td>
<td>Facilitator</td>
<td>GRS: Gender-blind</td>
<td>Empowerment Assessment (IEA)</td>
<td>Clinical Outcome in Routine Evaluation (CORE-OM)</td>
<td>Sig ↓ for CORE-OM</td>
<td>Outcome</td>
<td></td>
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</tr>
<tr>
<td>Mix of self-referred, GP referred and people referred from secondary services</td>
<td>Community setting</td>
<td>'Project worker'</td>
<td>Gender-blind</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clift &amp; Morrison, 2011</td>
<td>Observation Study</td>
<td>'People with serious &amp; enduring mental health issues' (n=42)</td>
<td>26.2% Male</td>
<td>None</td>
<td></td>
<td></td>
<td>Weak</td>
<td></td>
</tr>
<tr>
<td>Art Form: Choir singing</td>
<td>Duration: 8 months; once per wk &amp; session length not specified</td>
<td>'Trained facilitator'</td>
<td>Gender-blind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting: Community centre</td>
<td>Facilitator: 'Trained facilitator'</td>
<td>GRS: Gender-blind</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Population</td>
<td>Referral</td>
<td>Intervention</td>
<td>Measures</td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Findings</td>
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</tr>
<tr>
<td>William et al. 2019(b)</td>
<td>Observational Study</td>
<td>Adults with chronic mental health conditions (n=59)</td>
<td>Same intervention as Williams et al. 2019(a)</td>
<td>Choir vs Creative Writing</td>
<td>Warkwick-Edinburgh Mental Wellbeing Scale (WEMWBS)</td>
<td>T1: Baseline</td>
<td>T2: Mix of data points collected 2-12 months later.</td>
<td>Sig ↑ in WEMWBS for both groups. The greater identification with group the greater the mental wellbeing improvements over time</td>
</tr>
<tr>
<td>Margrave et al., 2012(iv)</td>
<td>Quasi-experimental</td>
<td>General Population &amp; adults with mental health issues; (n=26)</td>
<td>Art Form: Multimodal</td>
<td>Natural waiting list control</td>
<td>Warwick-Edinburgh Mental Wellbeing Scale (WEMWS)</td>
<td>T1: Baseline</td>
<td>T2:</td>
<td>Sig ↑ in WEMWS &amp; SIS for intervention group vs no change for control</td>
</tr>
</tbody>
</table>

**UK**
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Referral</th>
<th>Art Form</th>
<th>Facilitator</th>
<th>Setting</th>
<th>Duration</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Poulous et al. 2019 Australia</td>
<td>Quasi-experimental</td>
<td>Older adults (n=127) 25.9% male</td>
<td>Self-referral or referred by a mental health worker</td>
<td>Art: Multimodal  Duration: 8-10 wks, no frequency &amp; session length not specified</td>
<td>Facilitator: Artist GRS: Gender-blind</td>
<td>Setting: not specified</td>
<td>Duration: 8-10 wks, no frequency &amp; session length not specified</td>
<td>Sig ↑ in WEWMS. The mean increase did not differ by number of courses attended (e.g. 1-2 courses vs 3-4 courses)</td>
</tr>
</tbody>
</table>

PAI= Participatory Arts Intervention; wk(s)=week(s); yr(s)=year(s); T(1,2)= Time-point (1,2); Sig=Significant
*Quantitative element of mixed methods study
(iii)= Williams et al. (2019a) & Williams et al. (2019b) reporting on same intervention with different participants.
(iv)= Wilson et al. (2017) & Margrove et al. (2012) reporting on the same intervention with different participants.
2.4. Findings from Narrative Synthesis

2.4.1. Effectiveness of PAIs
Eleven studies reported 18 different mental health and wellbeing measures. Included studies largely adopted an observational (Clift & Morrison, 2011; Hacking et al., 2008; Irle & Lovell, 2014; Williams et al., 2019(b); Wilson et al., 2017) or uncontrolled pre/post-test design (Gül & Caglayan, 2017; Poulos et al., 2019). Two RCT designs were included – both were pilot studies (Ishihara et al., 2018; Pezzin et al., 2018). Moreover, only one study was powered to show effect (Sun & Buys, 2016). Therefore, these results should be interpreted with caution.

2.4.1.1. Mental Wellbeing and Quality of Life
Six studies reported significant improvements in mental wellbeing (Irle & Lovell, 2014; Margrove et al., 2013; Poulos et al., 2019; Williams et al., 2019(b); Wilson et al., 2017), positive affect (Ishihara et al., 2018) and quality of life (Pezzin et al., 2018). Group identification was associated with improved mental wellbeing over time (Williams et al., 2019(b)). Conversely, two studies found no effect on mental wellbeing (Gül & Caglayan, 2017) or life satisfaction (Ishihara et al., 2018).

2.4.1.2. Common Mental Health Problems and Psychological Distress
Longer-term engagement with PAIs was associated with reduced psychological distress (Clift & Morrison, 2011; Hacking et al., 2008; Sun & Buys, 2016) and clinically significant reductions among some participants (Clift & Morrison, 2011; Hacking et al., 2008). Reduced psychological distress was explained by improvements in resilience, social connectedness, and social support (Sun & Buys, 2016). Preliminary evidence indicated that PAIs reduce symptoms relating to depression (Ishihara et al., 2018; Pezzin et al., 2018) and PTSD (Pezzin et al., 2018).
2.4.1.3. Social Relationships
Statistically significant improvements in social inclusion (Hacking et al., 2008; Margrove et al., 2013; Wilson et al., 2017), social support (Sun & Buys, 2016) and social connectedness (Sun & Buys, 2016) were reported following PAIs lasting 6-12 weeks (Margrove et al., 2013; Wilson et al., 2017), 18 months (Sun & Buys, 2016) and PAI delivered on an on-going basis (Hacking et al., 2008).

2.4.1.4. Empowerment
One study reported significant improvements in empowerment, with those scoring higher on psychological distress at first entry realising the greatest improvement (Hacking et al., 2008).

2.4.2. Acceptability of PAIs
24 studies reported on acceptability (Ascenso et al., 2018; Dingle et al., 2013; Giaver et al., 2017; Heard et al., 2013; Heenan et al., 2006; Horghagen et al., 2014; Howells & Zelnik, 2009; Ishihara et al., 2018; Knestaut et al., 2010; Lawson et al., 2014; Makin & Gask, 2012; Margrove et al., 2013; Nagji et al., 2013; Perkins et al., 2016; Poulos et al., 2019; Shakespeare & Whieldon, 2018; Stickley & Eades, 2013; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith, 2014; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Williams et al., 2019(a); Wilson & Kent, 2016). Most studies assessed acceptability retrospectively (70.8%) with fewer assessing acceptability concurrently (41.7%) or prospectively (4.2%). Almost all studies reported on the TFA domain ‘perceived effectiveness’ (95.8%). Fewer studies reported on ‘self-efficacy’ (41.7%), ‘burden’ (37.5%), ‘affective attitude’ (16%) or ‘ethicality’ (4%). No studies reported on ‘intervention coherence’ or ‘opportunity costs’. The varied art forms and population groups within and across studies made
it difficult to determine if specific art forms were more or less acceptable to particular population groups.

2.4.2.1. Perceived Effectiveness
Perceived effectiveness is defined as the extent to which an intervention is perceived to have achieved its intended purpose (Sekhon et al., 2017). PAIs were perceived to benefit mental health and wellbeing via; Connectedness; Emotional Regulation; Meaning-making & Re-defining Identity; and Personal Growth & Empowerment. The negative implications of PAIs are presented as Unintended Adverse Effects.

Connectedness. PAIs are an outlet for social contact and friendships which elicit a sense of belonging, acceptance and social confidence (Ascenso et al., 2018; Dingle et al., 2013; Giaver et al., 2017; Horghagen et al., 2014; Howells & Zelnik, 2009; Lawson et al., 2014; Makin & Gask, 2012; Nagji et al., 2013; Perkins et al., 2016; Shakespeare & Whieldon, 2018; Stickley & Eades, 2013; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019; Wilson & Kent, 2016). This was facilitated by a non-judgemental, friendly and relaxed environment (Heenan, 2006; Howells & Zelnik, 2009; Makin & Gask, 2012; Margrove et al., 2013; Stickley & Hui, 2012; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019). Shared interests in art and/or similar mental health experiences enabled the development of trust, rapport and peer support around mental health issues which was highly valued (Ascenso et al., 2018; Heenan, 2006; Howells & Zelnik, 2009; Makin & Gask, 2012; Perkins et al., 2016; Stickley & Hui, 2012; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019; Wilson & Kent, 2016). Reduced social isolation was reported among individuals with mental health
problems and older-aged adults (Heenan, 2006; Horghagen et al., 2014; Howells & Zelnik, 2009; Margrove et al., 2013; Williams, Dingle, Calligerios, et al., 2019; Wilson & Kent, 2016). Spatial closeness, physical synchrony, working toward a collective goal and reciprocal feedback on artwork were factors unique to PAIs that helped to strengthen connectedness and develop social-, communication- and collaboration skills (Ascenso et al., 2018; Horghagen et al., 2014; Perkins et al., 2016; Shakespeare & Whieldon, 2018).

**Emotional Regulation.** PAIs generated ‘positive’ emotions such as joy and happiness (Ascenso et al., 2018; Dingle et al., 2013; Knestaut et al., 2010; Shakespeare & Whieldon, 2018; Van Lith, 2014; Williams, Dingle, Calligerios, et al., 2019) and negated the impact of ‘negative’ emotions by being relaxing, stress relieving and energising (Ascenso et al., 2018; Dingle et al., 2013; Heenan, 2006; Horghagen et al., 2014; Knestaut et al., 2010; Makin & Gask, 2012; Margrove et al., 2013; Nagji et al., 2013; Thomas et al., 2011; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Wilson & Kent, 2016). States of deep concentration were noted as intrinsic pleasurable experiences (Ascenso et al., 2018; Lawson et al., 2014), that created an altered sense of time (Ascenso et al., 2018) and enabled participants to become ‘distracted’ from their mental health symptoms (Ascenso et al., 2018; Heenan, 2006; Knestaut et al., 2010; Lawson et al., 2014; Makin & Gask, 2012; Perkins et al., 2016; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Wilson & Kent, 2016). PAIs were an outlet for emotional expression which was liberating, cathartic, therapeutic, gave greater access to emotions and was a valued form of ‘communication’ for those who were
shy, marginalised, or found it difficult to express emotions (Dingle et al., 2013; Heenan, 2006; Makin & Gask, 2012; Marie Heard et al., 2013; Perkins et al., 2016; Shakespeare & Whieldon, 2018; Stickley & Hui, 2012; Van Lith et al., 2011; Wilson & Kent, 2016).

**Meaning-Making and Re-Defining Identity.** Engagement in PAIs was reported as a positive, constructive and worthwhile activity that elicited a sense of meaningful occupation, purpose and ‘something to look forward to’ (Dingle et al., 2013; Howells & Zelnik, 2009; Lawson et al., 2014; Makin & Gask, 2012; Margrove et al., 2013; Poulos et al., 2019; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019). The regularity of sessions elicited a sense of structure and control in life (Ascenso et al., 2018; Dingle et al., 2013; Horghagen et al., 2014; Lawson et al., 2014; Makin & Gask, 2012; Shakespeare & Whieldon, 2018). The artistic process provided a space for active reflection that enhanced self-awareness and enabled participants to reimagine the meaning of past events (Nagji et al., 2013; Stickley & Hui, 2012; Van Lith et al., 2011). The art product acted a coping tool to reflect on mental health experiences and ‘distance travelled’ since its creation (Van Lith et al., 2011). Participants re-connected with ‘well-functioning’ personal competencies which had a catalysing effect for development in other aspects of life (Ascenso et al., 2018; Dingle et al., 2013; Lawson et al., 2014; Makin & Gask, 2012; Poulos et al., 2019; Shakespeare & Whieldon, 2018; Stickley & Eades, 2013; Stickley & Hui, 2012; Thomas et al., 2011). Participants experienced new roles (e.g. artist) which helped to form identities beyond ‘illness’ and facilitated a sense of hope about the future (Ascenso et al.,
2018; Dingle et al., 2013; Howells & Zelnik, 2009; Lawson et al., 2014; Marie Heard et al., 2013; Stickley & Eades, 2013; Williams, Dingle, Calligeros, et al., 2019).

**Personal Growth and Empowerment.** Overcoming challenges and personal growth through the artistic process led to the self-recognition of wider abilities and strengths which enhanced self-belief and self-esteem (Ascenso et al., 2018; Dingle et al., 2013; Heenan, 2006; Lawson et al., 2014; Makin & Gask, 2012; Marie Heard et al., 2013; Shakespeare & Whieldon, 2018; Stickley & Hui, 2012; Thomas et al., 2011; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019). The acquisition of knowledge and skills, the creation of tangible art products that personified improved competencies and attendance of PAIs through to completion contributed to a sense of achievement, self-confidence and self-worth (Giaver et al., 2017; Horghagen et al., 2014; Makin & Gask, 2012; Margrove et al., 2013; Stickley & Eades, 2013; Van Lith, 2014; Van Lith et al., 2011; Wilkinson & Caulfield, 2017; Wilson & Kent, 2016). Positive feedback on art-work reinforced such feelings (Dingle et al., 2013; Giaver et al., 2017; Poulos et al., 2019; Thomas et al., 2011; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019). PAIs also enabled individuals to make small manageable decisions, to be self-resourceful, to perform familiar tasks and to engage in non-mental health conversations which augmented feelings of agency and normality (Ascenso et al., 2018; Horghagen et al., 2014; Thomas et al., 2011; Van Lith et al., 2011).

**Unintended Adverse Effects.** Self-imposed pressure to reach high artwork standards, a lack of follow-on activities, tensions within the group, overly solicitous facilitators impacting autonomy, and dependency on the PAIs resulting in ‘painful
endings’ were recorded as unintended adverse effects of participating in PAIs (Dingle et al., 2013; Giaver et al., 2017; Lawson et al., 2014).

2.4.2.2. Burden
Burden is defined as the perceived amount of effort that is/was required to participate in an intervention (Sekhon et al., 2017). Family commitments, long commutes, location of rehearsals and illness fatigue were barriers to engagement (Dingle et al., 2013; Giaver et al., 2017). Flexibility with the disclosure of mental health problems and the level of the participation alongside a strengths-based approach that focused on the art rather than mental ill health appeared to reduced PAI burden (Heenan, 2006; Lawson et al., 2014; Margrove et al., 2013; Marie Heard et al., 2013; Perkins et al., 2016; Shakespeare & Whieldon, 2018; Stickley & Hui, 2012).

2.4.2.3. Self-Efficacy
Self-efficacy is defined as the confidence to perform the behaviour required to participate in the intervention (Sekhon et al., 2017). A perceived lack of ‘artistic abilities’ was a barrier to engagement (Giaver et al., 2017; Poulos et al., 2019; Williams, Dingle, Calligeros, et al., 2019). PAIs that require a lower skill threshold and with no pressure to achieve a high standard appeared to enhance self-efficacy (Ascenso et al., 2018; Horghagen et al., 2014; Perkins et al., 2016; Shakespeare & Whieldon, 2018). Positive feedback and an encouraging facilitator that provided guidance rather than strict instruction also enabled autonomy and improved intervention self-efficacy (Perkins et al., 2016; Poulos et al., 2019; Shakespeare & Whieldon, 2018; Van Lith et al., 2011; Williams, Dingle, Calligeros, et al., 2019).
2.4.2.4. Affective Attitude
Affective attitude is defined as how an individual feels about the intervention before and/or after participation (Sekhon et al., 2017). Three PAIs reported high levels of enjoyment post-intervention (95% of participants) (Ishihara et al., 2018; Margrove et al., 2013; Wilson et al., 2017) whilst one PAI was described as a highly valuable experience (Lawson et al., 2014).

2.4.2.5. Ethicality
Ethicality is defined as the extent to which an intervention has good fit with an individual’s value system (Sekhon et al., 2017). A perception that choral singing was ‘feminine’ was cited as a barrier to engagement in one study (Giaver et al., 2017).

2.4.3. Effectiveness and Acceptability of PAIs among Men
Four studies reported exclusively on men – one on effectiveness (Irle & Lovell, 2014) and three on acceptability (Marie Heard et al., 2013; Thomas et al., 2011; Wilkinson & Caulfield, 2017). All were graded as methodologically weak. Improvements in mental wellbeing were reported among men in an uncontrolled pre/post-test study (Irle & Lovell, 2014). All the acceptability studies reported on the TFA domain perceived effectiveness (Marie Heard et al., 2013; Thomas et al., 2011; Wilkinson & Caulfield, 2017). PAIs were perceived to benefit more tangible outcomes such as social relationships, acquiring skills, achievement, affirmation, routine, structure and ‘something to look forward to’. Less was reported within the sub-theme emotional regulation.
2.5. Discussion
This review has systematically assessed the acceptability and effectiveness of PAIs to promote mental health among adults. A lack of experimental studies powered to show effect and the methodological bias of the evidence as a whole limits the conclusions with regard evidence of effectiveness. Concerns around the appropriateness and feasibility of conducting experimental studies within the ‘arts in health’ field may be an explanatory factor (Daykin et al., 2017; Skingley et al., 2012; Skingley et al., 2014). The variability of outcome measures, number of interacting components and the lack of detailed intervention description challenge comparisons across PAIs. Methodological heterogeneity and difficulties in drawing effectiveness conclusions are findings consistent with similar reviews in the wider field of ‘arts in health’ (Callinan & Coyne, 2018; Daykin et al., 2008; Leckey, 2011).

Although the evidence of effectiveness is not robust, PAIs appear to be an acceptable modality. The fact that self-referral was the most commonly reported referral route across the studies is perhaps a contributing factor. Emergent interests in evaluating launched interventions and afterthoughts about scaling programmes that attract end-users may also explain why most studies assessed acceptability retrospectively and reported on perceived effectiveness. PAIs were perceived effective in benefiting mental health and wellbeing via connectedness, emotional regulation, meaning-making and re-defining identity, and personal growth and empowerment. A degree of caution is needed with regard unintended adverse effects. These findings add more robust evidence to previous rapid reviews that identified the benefits on relationships and belonging, confidence and self-esteem, empowerment, distraction, self-expression and identity re-formation
(Stickley et al., 2018; Zarobe & Bungay, 2017). Indeed, the review findings reflect both the CHIME mental health recovery framework (Connectedness; Hope; Identity; Meaning in life; Empowerment) and the PERMA model of wellbeing (Positive Emotion, Engagement; Positive Relationships; Meaning; Achievement) (Leamy et al., 2011; Seligman, 2011).

In addition to perceived effectiveness, it is equally important to understand the optimal mechanisms of engagement. However, fewer studies reported on such concepts. Indeed, a smaller number of studies reported on the TFA domains burden, self-efficacy, affective attitude and ethicality and no studies reported on intervention coherence or opportunity cost. Nonetheless, barriers to engagement included venue accessibility and reduced physical capabilities (burden), a perceived lack of artistic abilities (self-efficacy) and the femininity of choral singing (ethicality). Flexibility in participation and disclosure of mental health and strengths-based approach appeared to reduce burden whilst a lower skill threshold, no pressure to achieve high standards, positive feedback, and a skilled facilitator that enabled autonomy enhanced participants’ self-efficacy. These findings are similar to Fancourt et al. which concluded that individuals with common mental health problems are more likely to engage in participatory arts if they experienced greater psychological and physical capabilities, social opportunities, and automatic and reflective motivation (Fancourt et al., 2020). However, most acceptability studies were assessed retrospectively or concurrently with participants who likely enjoyed the PAI and found it helpful. Thus, these findings are limited in highlighting reasons for non-engagement or drop-out.
The evidence of acceptability and effectiveness of PAIs among men is severely limited by the low number of studies that focused on men. All four of these studies were graded as methodologically weak. Moreover, it appeared just one study intentionally targeted men and had a gender-sensitive approach (Irle & Lovell, 2014) whilst the others focused on population groups that disproportionately represent men (i.e., prisoners and homeless people). There is a clear need for future research focusing on the development of PAIs that are acceptable and effective in promoting mental health and wellbeing among men.

2.6. Limitations of Review
Although the review set out to examine the acceptability and effectiveness of PAIs in promoting mental health and wellbeing among men, there was a dearth of studies that focused on men or that utilised gendered approaches. While the review is limited in drawing conclusions relating to men, it highlights the need for further research formally evaluating the acceptability and effectiveness of PAIs on men’s mental health. The review focuses on PAIs in non-clinical settings and only applies to common mental health problems and general mental wellbeing outcomes. The review was also limited to peer reviewed studies published in English and restricted to particular art forms, which may have excluded evidence.

2.7. Recommendations for Future Research
More controlled robust studies with longitudinal outcomes are recommended. However, the exclusive use of such designs would limit the field. Indeed, many PAIs may have limited potential for scale but offer valuable insights. Building acceptability evaluations into PAIs across the range of TFA domains and graduating those with appropriate end-user volume to more experimental designs might help
to appropriately establish the evidence of effectiveness. If randomisation is not feasible, an appropriate comparison sample is recommended (Dingle et al., 2019). More rigorous qualitative research that assesses acceptability prospectively, concurrently and retrospectively across all the TFA domains would be useful to identify optimal mechanisms of engagement for PAIs. Reporting data that is disaggregated by referral route would also be useful in this regard. Utilising existing guidelines for the conduct of qualitative research such as the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007) would also help to strengthen the overall methodological quality of qualitative PAI research (Dingle et al., 2019).

There is a need to use standardised evaluation methods and to provide clearer descriptions of interventions to encourage transparency, replicability, and to inform the development of logic modelling describing the mechanisms of action within PAIs (Daykin et al., 2017; Dunphy et al., 2018). Echoing previous research, PAI research should be underpinned by a theoretical framework and measure appropriate theoretical constructs (Dingle et al., 2019). An example might include brief quantitative measures assessing each of the CHIME recovery domains or elements of the PERMA model of wellbeing (Seligman, 2011; Stickley et al., 2018). Documenting intervention components using the PHE Arts, Health and Wellbeing Evaluation Framework would also enable greater comparison between interventions (Daykin et al., 2017; Dunphy et al., 2018; Zarobe & Bungay, 2017). Although using standardised approaches may compromise flexibility - a perceived positive feature of PAIs - improved reporting on implementation fidelity (Carroll et
al., 2007) could offset such concerns and contribute to greater methodological quality. A high proportion of included studies focused on performance-, multimodal- and visual arts. Future research would benefit from exploring other art forms that are underrepresented such as digital, online and electronic arts and literature.

There is a need for more PAI studies that specifically target men. More specifically, incorporating gender-responsive approaches in PAIs is crucial to improving male engagement and to identifying the acceptability and effectiveness of PAIs in promoting mental health among men. Sex-disaggregated data in mixed sex groups and gender analyses would also be useful in this regard. The findings of this review coupled with the Check-Mate Tool, a set of guidelines for incorporating gender-related influences in men’s mental health promotion programmes (Struik et al., 2019), could provide a basis for the development of acceptable PAIs for men. Consulting with men to assess the prospective acceptability of proposed PAIs might be a useful starting point to designing acceptable interventions.

2.8. Implications for Intervention Development
The limited evidence of effectiveness, acceptability and gender-responsiveness of PAIs coupled with inconsistent reporting on intervention characteristics made it difficult to identify suitable PAI components to promote mental health among men. This lends further support for the need to identify the needs, preferences and opinions of men in areas of high social disadvantage in Northern Ireland and key service providers in order to develop an outline description of an acceptable PAI (i.e. Objective 2). Nonetheless, PAIs were perceived to benefit mental health and
wellbeing via connectedness, emotional regulation, meaning-making and re-defining identity, and personal growth and empowerment. These represent potential mechanisms through which men could accrue positive mental health outcomes via PAIs. These pathways will be probed with men in areas of high social disadvantage in Northern Ireland to explore if they are representative of their experiences in engaging with participatory arts. The barriers and facilitators to engagement in PAIs (see Section 2.4.2) will also be explored with men in areas of high social disadvantage in Northern Ireland and close attention will be paid to identifying gender-responsive approaches that may improve male engagement. This will help to identify suitable intervention components and approaches for delivery. Particular attention will also be paid to exploring underrepresented art forms such as digital, online and electronic arts and literature.

2.9. Conclusion
This chapter provided an assessment of the effectiveness, acceptability, and gender-responsiveness of participatory arts to promote mental health and wellbeing among adults, with a particular focus on men. It extends on a traditional literature review in assessing the quality of the research, reviewing the measures and methodologies used in the quantitative research and synthesising the overarching themes in the qualitative literature. It points out clear gaps in the literature in relation to the lack of interventions focused on men and makes a number of recommendations to advance the PAI field. It has also highlighted a number of considerations that should be considered during intervention development. The next chapter will outline the methodological approach taken to achieve Objective 2 of this study.
Chapter 3: Methodology
3.0. Introduction
This chapter outlines the aims and objectives of this study, including the study design, sampling, recruitment, methods of data collection and analysis where the rationale for each component is discussed. Ethical considerations and reflections on the research process thus far are also discussed.

3.1. Aims and Objectives of Thesis
The aim of this thesis was to develop a participatory arts intervention (PAI) to promote mental health among men in areas of high social disadvantage in Northern Ireland. The MRC guideline for developing complex interventions was the guiding framework through which to design this study (Craig et al, 2008). In particular, this study aligns with Phase 1 Development which calls for; (a) Identifying the Evidence Base; (b) Identifying and Developing Appropriate Theory; and (c) Modelling Processes and Outcomes. The objectives of the study were aligned with Phase 1 Development. The key objectives were:

1. To assess the evidence for effectiveness, acceptability and gender-responsiveness of PAIs in promoting mental health and wellbeing among adults, with a particular focus on men.
2. To identify the needs, preferences and opinions of men in areas of high social disadvantage in Northern Ireland and key service providers with a remit for men’s health, mental health and participatory arts to develop an outline description of a PAI. More specifically:
   a. To identify the issues contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland.
b. To explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland.

c. To identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland.

d. To explore the preferences and opinions of key stakeholders on potential intervention features, content, approaches to delivery and outcomes in order to develop an outline description of a PAI.

3.2. Research Paradigm
A research paradigm provides an overall framework for a researcher’s belief system with assumptions about ontology, epistemology, theory and methodology. Ontology is concerned with beliefs about reality and the basic elements it contains. Epistemology relates to how knowledge is acquired and validated. Theory is concerned with defining and explaining relationships within and between concepts. Finally, methodology relates to the philosophical underpinnings of how data is produced and analysed. Ontology and epistemology are discussed in this section. Concepts of theory and methodology are discussed in Section 3.2.1 and Section 3.2.2. The overall research paradigm for this study was that of constructivism which is principally concerned with understanding the subjective world of human experience (Guba & Lincoln, 1989). Emphasis is placed on understanding the individual and their interpretation of the world around them; hence the overarching thesis that reality is social constructed (Hyde et al., 2004, p52; Creswell, 2013, p24). Constructivism adopts a relativist ontology - a single phenomenon may have multiple interpretations rather than one single truth (Creswell, 2003; Mertens, 2009). The epistemological position is that of subjectivism, reality needs to be
interpreted to discover the underlying meaning of events and activities. Constructivists attempt to gain a deep understanding of a phenomenon and its complexity rather than generalising the base of understanding for the whole population (Creswell, 2007). Thus, the goal of the research is to rely on participants’ views of the situation, which are often negotiated socially, culturally and historically and formed via interactions with others (Creswell, 2013, p24). A major advantage of this approach is not only a deeper understanding of objects, human or events, but a deeper understanding of their social context. As such, this paradigm is particularly suited to the objectives of this study. The researcher recognises that their own personal, cultural and historical experiences shape their interpretation (Creswell, 2013). Thus, the researcher’s intent is to make sense of the meanings that others have about the world. An overview of the research paradigm adopted for this thesis is presented in Table 4.

**Table 4: Research Paradigm & Definition of Terms**

<table>
<thead>
<tr>
<th>Research Term</th>
<th>Definition</th>
<th>Application to Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradigm</td>
<td>Overall framework for viewing reality</td>
<td>• Constructivism</td>
</tr>
<tr>
<td>Ontology</td>
<td>The nature of reality and the basic elements it contains</td>
<td>• Relativism</td>
</tr>
<tr>
<td>Epistemology</td>
<td>Nature of knowledge and how it is acquired and validated</td>
<td>• Subjectivism</td>
</tr>
<tr>
<td>Theory</td>
<td>Defines and explains relationships between and within concepts</td>
<td>• Social Construction of Masculinities</td>
</tr>
</tbody>
</table>
Methodology

- Philosophical assumptions upon which a study is based along with the methods of data collection and analysis
- MRC Guidance
- Systematic Review
- Focus Groups and Interviews
- Online consultations
- Thematic analysis

3.2.1. Theoretical Underpinning
Connell’s theoretical framework on masculinities and gender relations was adopted as the key underpinning theory for this thesis (Connell, 2005). This was briefly described in Section 1.1.1. Other theories on masculinities and health practices were considered such as biological-determinist theories and sex role theory (Parson & Bales, 1956; Kraemer, 2000). Biological-determinist theories on masculinities view men’s health behaviours and outcomes as a product of the genetic/hormonal evolutionary process (Kraemer, 2000). These theories largely relate to two concepts; (i) the ‘fragility’ of men at birth and the subsequent effect on health outcomes as a result of the XY chromosome combination; and (ii) the hormonal influences (particularly testosterone) of the Y chromosome driving health behaviours of men to ensure survival. These approaches do not fit within the constructivist paradigm of this study and fail to account for health inequities between men. Therefore, it was deemed unsuitable for this thesis.

Conversely, sex role theory on masculinities questions these biologically determinist behaviours and assumes that societal expectations about a person’s societal status creates conformity to a given role, encouraged through a range of ‘rewards’ or ‘sanctions’ (Parson & Bales, 1956). This translates to men’s health in two ways; (i) conforming to masculine norms in itself is detrimental to health; and (ii) failing to fulfil societal expectations creates feelings of failure, stress and strain (Pleck, 1995;
Haywood & MacGhaill, 2003). Although this approach is useful in understanding men’s behaviours, it presents men as static empty vessels that are socialised, or not (Robertson, 2009). Indeed, in not differentiating between sex and gender, this theory creates rigid and fixed views about sex differences, making it difficult to explore relations between the sexes, to explore the intersection of gender with other identity characteristics such as class (e.g. low socio-economic status) and/or geographical location (e.g. Northern Ireland)(Connell, 2005). Finally, the focus on macro ‘socialisation’ does not allow us to consider how societal structures and institutions impede or facilitate men’s engagement (Robertson, 2009). Indeed, the assumption of a singular male personality obscures the various forms of masculinities that men can demonstrate and thus do not fit within a constructivist paradigm. Connell’s relational theory on masculinities considers relations within groups of men and the intersection of gender with social class and geographical location (i.e. men in areas of high social disadvantage in Northern Ireland); and enables the identification of factors associated with societal structures that can facilitate or impede men’s engagement with mental health promotion (Connell, 2005). Some have argued that Connell’s work is more appropriate within a critical realism paradigm as masculinities are products of culture and social relations that are historically and contextually mediated (Carpenter, 2000; Martin, 1998). However, Connell’s theory also proposes that gender is not a static category but dynamic socially constructed relationships which are produced and reproduced through people’s interactions (Pleck et al., 1994a; Courtenay, 2000). Most importantly, gender does not reside within the person, but rather in social transactions defined as gendered [i.e. gender is a dynamic social structure]
Therefore, a plurality of masculinities can exist which can be drawn on and enacted differently by the individual in different contexts (Courtenay, 2000). From this perspective, and due to the relational nature of Connell’s theory, it is also appropriate within a constructivist paradigm. Therefore, Connell’s theory was deemed the most appropriate underpinning theory for this thesis.

3.2.1.1. Connell’s Theory on Masculinities
Relational theories on gender and masculinities differentiate between sex and gender. Sex refers to the anatomical and physiological variances between males and females (Giddens, 2009, p601), gender encompasses socially constructed roles and acceptable behaviours involving different social norms and expectations (Connell, 1995; Möller-Leimkühler, 2003). These norms, behaviours and expectations are influenced by early socialisation and cultural institutions which dictate what is considered masculine or feminine. Therefore, gender is considered something we do or that is performed rather than something we are.

Masculinity is fluid and not a consistent entity in any social group - it is performed differently across a range of activities, settings and cultures and may even change within cultures over time. Thus, it is more appropriate to use the term masculinities to account for the differences between varying groups of men. Through this lens, formations of gender can be understood as habitual practices that are open to change dependant on the circumstances. Masculinities are viewed as configurations of social practice and are ordered hierarchically in certain ways (Robertson, 2009). Indeed, masculinities are often competing and conflicting, locating themselves in relation to what is known as hegemonic masculinities. Hegemonic masculinities are described as the “most honoured way of being a man”; requiring “all other men to
position themselves in relation to it” and which “ideologically legitimates the global subordination of women to men” (Connell & Messerschmidt, 2005, p832 in Gough et al., 2016). Therefore, masculinities are not a personality type or determined static social practices, but fluid social practices that are historically contingent, hierarchically ordered, and collectively ‘performed’ that are incorporated in social structures which then replicate themselves (Connell, 2005; Robertson, 2009).

Although the dominant or hegemonic form of masculinities is subject to change and varies between cultures, it is most often represented in high-income countries by white, middle-class, middle-age, able-bodied, heterosexual men. Connell notes that these dominant forms of masculinities often benefit from a ‘patriarchal dividend’ in terms of honour, prestige, and a right to command (Connell, 2005). As such, hegemonic masculinities exalted position creates a number of subordinated and marginalised masculinities which are viewed as less legitimate and judged to fall short of the ‘masculine standard’ (Gough et al., 2016). Some examples of this include gay men, men with disabilities, ethnic minority men or men in areas of high social disadvantage. Indeed, men within these social demographic groups face increased exposure to stigmatisation and discrimination, which may increase their vulnerability to suicide (Clements-Nolle et al., 2006; Haas et al., 2010; Kalt et al., 2013). It has also been proposed that the competitive nature of hegemonic masculinity lends itself to a social comparison narrative amongst men - not only to be successful in culturally accepted ways, but to feel successful in relation to other men – which may contribute to male suicide (Scourfield, 2005). It is likely therefore that more subordinated or marginalised groups of men may face a significant
challenge – caught in a bind between being part of a dominant and ‘privileged’ social grouping, yet unable to attain the idealised standards of this grouping or to accrue a ‘patriarchal dividend’ – at least by comparison with other, more dominant, male groupings. The cumulative impact of on-going discrimination and ‘failures’ to achieve masculine standards may also strain men’s adaptive capacities, a finding of a previous study on discrimination and suicide (Peng, 2009).

Hegemonic masculinities retain its exalted position through cultural beliefs in ‘traditional masculine ideologies’. These traditional ideologies often include a desire for power and dominance, aggression, courage, independency, rationality, competitiveness, efficiency, success, and control whilst simultaneously concealing vulnerability and weakness (Möller-Leimkühler, 2003; Payne et al., 2008). Independence, self-reliance, and invulnerability for example have been linked to a lower likelihood of men seeking help, the delay of which is associated with increased risk of suicidal behaviour (Galdas et al., 2005; Levant et al., 2009; Nam et al., 2010; Coleman, 2015). Hegemonic masculine ideologies are also associated with other suicide risk factors which have been described in Section 1.1.1.

In response to better engage with men around health topics, there have been calls to challenge the ‘deficit model’ that depicts men as a ‘problem to be fixed’ (Kiselica & Englar-Carlson, 2010). There has been a growing evidence-base for the use of gender-responsive approaches to positively engage men around their health. These are also described in the Section 1.2.1 and prioritise approaches that work with, and not against, cultural ideals of masculinities (Galdas et al., 2014). It is against this backdrop, that this thesis will seek to identify suitable intervention components in
order to develop a PAI to promote mental health among men in areas of high social disadvantage in Northern Ireland.

3.2.2. Methodology – Qualitative Inquiry
This thesis adopts a qualitative methodology in line with the constructivist paradigm outlined previously. The development of an effective health intervention requires an in-depth knowledge of the target problem, what works, for whom and under what conditions (Craig et al., 2008; Gilgun & Sands, 2012). In the early stages of intervention development, formative research to understand the target problem, contextual barriers & facilitators, and community perceptions, experiences and knowledge is crucial to ensuring its optimal design (Power et al., 2004; Chandler et al., 2013). In the latter stages of intervention development, consulting with potential ‘end-users’ and ‘end-providers’ about the relevance, content, benefits and limitations of an intervention can improve the acceptability of the intervention and its overall implementation (Monaghan et al., 2011; Ayala & Elder, 2011). Quality inquiry was deemed the most appropriate methodology in order to acquire an in-depth understanding of these factors (i.e. Objectives 2).

There is a dearth of research exploring the mental health experiences of men in areas of social disadvantage in Northern Ireland. Different relational, contextual, historical and psychosocial factors which are important in understanding mental ill-health are not always easily captured in categorizations, measurements, replications or objective scores (Hjelmeland & Knizek, 2010; Fitzpatrick, 2011). Quantitative studies highlight the magnitude of the problem and factors associated with mental ill-health but they are restricted in telling us how specific factors may contribute to mental ill-health or an ‘objective score’ (Hjelmeland & Knizek, 2010).
As such, it is critical to explore the social context and the meanings people attach to psychological distress in order to understand their suicide vulnerability. Qualitative research is particularly suited to exploring meanings attached to mental health experiences and the social context that shapes them (Fossey et al., 2002). Indeed, there have been calls for such a qualitative approach to explore the topic of suicide with men in areas of high social disadvantage (Platt, 2011; Scourfield et al., 2012; Batty et al., 2018; O’Connor & Portzky, 2018).

Secondly, including potential ‘end-users’ and ‘providers’ perspectives throughout the design of an intervention is likely to result in a more relevant and acceptable intervention that is sensitive to cultural and geographical contexts (Power et al., 2004; Craig et al., 2008; Gilgun & Sands, 2012). Qualitative inquiry is an effective way to involve such key stakeholders in the design process and can provide valuable insights into what should be done to maximize the likelihood of improved mental health outcomes (Craig et al., 2008; Clark et al., 2016). Qualitative research adopts an interpretive, naturalistic approach and attempts to make sense or interpret social phenomena from the perspective of participants’ lived experiences (Denzin & Lincoln, 1994). As such, qualitative methodologies can draw on more in-depth knowledge of men’s experiences of participatory arts and the barriers and facilitators to engagement which may contribute to a more optimally designed intervention. Moreover, qualitative methodologies are particularly useful when little is known about the implementation problems and can be valuable in understanding participants’ perspectives about the relevance, content, benefits, limitations and overall acceptability of an intervention (Monaghan et al., 2011;
Ayala & Elder, 2011; Atkins et al., 2017). As there is a lack of available research on PAIs to promote mental health among men, a qualitative approach was deemed most appropriate to explore these phenomena.

3.3. Rationale for Study Design

3.3.1. Frameworks for Intervention Development
The guiding principles upon which to design this study was the UK’s Medical Research Council (MRC) framework for developing complex interventions. This framework will be supplemented by the taxonomy of approaches for intervention development which provides more specific and pragmatic instructions (O’Cathain et al., 2019).

Other intervention development frameworks that were considered included; Intervention Mapping (Bartholomew et al., 2016); Six Steps for Quality Intervention Development (6SQuID; Wight et al., 2016), and Experience-Based Co-Design (Robert, 2013). Intervention Mapping is a rigorous six-step systematic approach for intervention development with broad concepts relating to planning, theory and evidence (Bartholomew et al., 2016). However, the comprehensiveness of this approach is also considered to be one of its major drawbacks. Intervention mapping is reported to be highly technical, prescriptive and time-consuming (Hansen et al., 2017). Indeed, the skills, resources and timeframe required for this approach was beyond that of the candidate and thus it was deemed unfeasible within the context of this PhD thesis. 6SQuID offers detailed guidance on both the earlier and later stages of intervention development via a systematic and logical six step process (Wight et al., 2016). However, a criticism of this approach is the lack of significant engagement with ‘end-users’ during the development process (O’Cathain et al., 2019).
A key objective of this study was to consult with men throughout the development process and therefore this framework was also considered inappropriate. Conversely, experience-based co-design relies on in-depth user experiences to inform intervention development (Borgstrom & Barclay, 2019). A key method of this approach involves filming interviews and focusing on patient ‘touch points’ of engaging with a service. A ‘trigger film’ is then created and shown to co-design groups to stimulate conversations and to identify priorities for change. However, this approach is best suited for service improvement rather than novel developments. The MRC framework provides an evidence-based approach that considers end-user experiences and their specific social contexts, thus providing the most appropriate and achievable approach to match the timeframe and resources available for this study. While the MRC guidance is more traditionally associated with a positivist approach, it also calls for the use of qualitative research to provide insights into the likely processes of change and to consider end-users’ preference and opinions on the design of the intervention (Craig et al., 2008). Against this backdrop, an increasing amount of intervention development studies aligned with the MRC guidance are utilising qualitative methodologies that adopt a constructivist paradigm (Allan et al., 2019; Draper-Rodi, 2016; Duggleby & Williams, 2015; Sinnott, 2016). Duggleby & Williams suggest that to overcome potential epistemological differences between the MRC guidance and constructivism, researchers should only deliver the intervention to the population group that is the focus on the formative research and prioritise approaches that enable flexibility with how participants engage with the intervention. This will be considered during the development of intervention in this thesis.
3.3.1.1. MRC Guidance for Developing Complex Interventions

The MRC defines an intervention as ‘complex’ by its multiple and interacting components, the behaviours required by those delivering it, the degree of variability in outcomes, number of levels targeted by the intervention, and the flexibility and extent to which it can be tailored to address relevant outcomes in a target population (Craig et al., 2008). This complexity can present various practical and methodological problems when delivering or evaluating such an intervention. As such, it is important to maximise the likelihood of an intervention being effective and sustainable in the development process in order to avoid research waste on potentially flawed interventions (Bleijenberg et al., 2018). To address this issue, the UK MRC published a framework to assist researchers with developing and evaluating complex interventions which has been widely recognised and extensively utilised (Campbell et al., 2000; Craig et al., 2013). The framework consists of a systematic iterative four phased process; (i) Development; (ii) Feasibility/Pilot Testing; (iii) Evaluation, and (iv) Implementation. The authors recommend using the best available evidence and appropriate theory, to test them using a carefully phased approach and to carry out a series of pilot studies targeting each of the key uncertainties in the design. This should be followed by exploratory and definitive evaluations, dissemination of the results and further research to assist with and monitor the implementation process. The key function and activities of each phase is outline in Figure 2.
As noted in Section 3.1, the current study aligns with Phase 1 Development. Within this phase, the guidance recommends conducting a systematic review to identify the existing evidence-base. The guidance also highlights the need to draw on existing theories and primary research involving key stakeholders to develop a theoretical understanding of the likely processes of change. Finally, modelling of processes and outcomes is recommended at this early stage to provide important information about the design of the intervention and the evaluation. Despite the wide utilisation of the MRC framework for developing complex interventions, it has been criticised for its lack of pragmatic instruction within this development phase (French et al., 2012; Wight et al., 2015; Hawkins et al., 2017). In response to these criticisms, a systematic review of intervention development approaches and actions was funded by the MRC in order to provide more specific instructions (O’Cathain et al., 2019).

3.3.1.2. Taxonomy of Approaches for Intervention Development

The taxonomy of approaches for intervention development provided supplementary guidance for following the MRC framework in this study (O’Cathain et al., 2019).
et al., 2019). This taxonomy has identified eight approaches for guiding the intervention development process; (i) partnership-based; (ii) target population-based; (iii) theory and evidence-based; (iv) implementation-based; (v) efficiency-based; (vi) stepped or phased-based; (vii) intervention-specific, and (viii) combination approaches. As noted previously this thesis is guided by an evidence and theory-based approach (i.e. MRC guidance). However, this thesis will also consult with men throughout the development process in order to shape the intervention components. This is crucial to developing an acceptable intervention and centralising men in the decision-making process is a key principle of engaging men in health promotion (Richardson et al., 2013; Lefkowich et al., 2015; Robertson et al., 2015). This is known as a partnership approach within the taxonomy of approaches for intervention development where potential ‘end-users’ are included in at least equal decision-making throughout the design of the intervention (O’Cathain et al., 2019). The authors also distinguish between the terms ‘development’ and ‘design’ of the intervention. ‘Development’ relates to the whole process of intervention development (e.g. inclusive of systematic review & empirical primary research) whilst ‘design’ is reserved for the point at which decisions in the development process are made about the specifics of the intervention (e.g. target problem to be addressed, content, format, delivery). Therefore, this thesis adopts an evidence and theory-based approach to the overall development of the intervention and a partnership approach to the design of the intervention.
The taxonomy of approaches outlines seven domains of action within the overall development; (i) Conception; (ii) Planning; (iii) Designing; (iv) Creating; (v) Refining; (vi) Documenting; and (vii) Planning Future Evaluation. It provides further instructions within each domain, encompassing a total of 18 specific actions which are outlined in Table 5 below. O’Cathain and colleagues also provide a table outlining the most common actions to each of the approaches to intervention development/design. The actions that were most associated with the “evidence-based approach” and the “partnership-approach” approaches were Actions 2-9. Therefore, these actions helped to shape the study objectives, research questions and topic guides within the overall thesis. Although Action 11 was not associated with either of the approaches mentioned, it was felt crucial to the development of the intervention and so was also included.

**Table 5: Summary of Domains and Actions Identified in the Taxonomy of Approaches for Intervention Development**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conception</td>
<td>1. Identify that there is a problem in need of a new intervention</td>
</tr>
<tr>
<td>2. Planning</td>
<td>2. Establish a group to guide development, thinking about engagement of relevant stakeholders.</td>
</tr>
<tr>
<td></td>
<td>3. Understand the problem or issues to be addressed;</td>
</tr>
<tr>
<td></td>
<td>(i) Understand the experiences, perspectives &amp; psychosocial context of the potential target group</td>
</tr>
<tr>
<td></td>
<td>(ii) Assess the causes of the problem</td>
</tr>
<tr>
<td></td>
<td>(iii) Describe &amp; understand the wider context of the target population &amp; the context in which the intervention will be implemented</td>
</tr>
<tr>
<td></td>
<td>(iv) Identify evidence of effectiveness of interventions for</td>
</tr>
</tbody>
</table>
these problems, or for similar interventions.

(v) Understand wider stakeholders’ perspectives of the problem & issues

4. Make a decision about the specific problem that an intervention will address, and the aims & goals of an intervention.

5. Identify possible ways of making changes to address the problem (what needs to change, how to bring about this change, and what might need to change at various individual, interpersonal, community and/or society levels)

6. Specify who will change, how and when.

7. Consider real world issues about cost and delivery of an intervention

8. Consider whether it is worthwhile continuing

### 3. Designing

9. Generate ideas about solutions, components and features of a programme

10. Re-visit decisions about where to intervene (different levels mentioned in action no. 5)

11. Make decisions about content, format and delivery of intervention

12. Design an implementation plan, thinking about who will adopt and maintain the plan

### 4. Creating

13. Make prototypes or mock-ups of the intervention where relevant

### 5. Refining

14. Test on small samples for feasibility & acceptability and make changes if necessary

15. Test on a more diverse population, moving away from the setting the development took place

16. Optimise the intervention for efficiency prior to full RCT

### 6. Documenting

17. Document the intervention, describing it so others can use it and offer instructions on how to deliver the
### 3.4. Study Design

Informed by the MRC guidance, this study has been conducted in two stages;

- **Stage 1 – Systematic Review** (Reported in Chapter 2)
- **Stage 2 – Empirical Primary Research**

Stage 1 Systematic Review is described in detail in Chapter 2 of this thesis. However, it must be briefly highlighted that Stage 1 aligns with Objective 1 of this study and Actions 1, 2, 3(iv) and 5 of the taxonomy of approaches for intervention development. This chapter outlines the methodology underpinning Stage 2 – Empirical Primary Research. This stage is comprised of two parts: Stage 2(a) – Understanding Experiences; and Stage 2(b) – Design of the Intervention. Stage 2(a) – Understanding Experiences aligns with Action 3(i); 3(ii), 3(iii), 5 and 7. Stage 2(b) – Design of the Intervention aligns with Actions 4, 9 and 11. A diagrammatic overview of the study and how each stage resonates with the study objectives and the guiding intervention development frameworks is outlined in Figure 3 below (Craig et al., 2008; O’Cathain et al., 2019).
**Objective 1**

**Study Stage 1 – Identify the Evidence Base**
- Systematic review of arts-based interventions to promote mental health among men

**Objective 2(a)(b)(c)**

**Stage 2(a) – Understanding & Exploring Experiences**
- Explore men’s experiences of mental ill-health, mental health benefits of PAIs and barriers and facilitators to engagement

**Objective 2(d)**

**Stage 2(b) – Design of Intervention**
- Consult with men’s groups to co-design and refine intervention.
- Consult with ‘providers’ to guide development of intervention.

**Alignment with MRC Phase 1 Development**

- (a) Identify the Evidence
- (b) Identify and Develop Theory
- (c) Model Processes and Outcomes

**Alignment with Actions in Taxonomy of Approaches for Intervention Development**

- Identify a problem that requires a new intervention [Action 1]
- Establish a group to guide development [Action 2]
- Identify evidence of effectiveness of similar interventions [Action 3(iv)]
- Identify possible ways of making changes to address the problem [Action 5]
- Understand the experiences, perspectives & psychosocial context of the potential target group [Action 3(i)]
- Describe & understand the wider context of the target population & the context in which the intervention will be implemented [Action 3(iii)]
- Assess the causes of the problem [Action 3(ii)].
- Identify possible ways of making changes to address the problem [Action 5]
- Consider real world issues about cost and delivery of an intervention [Action 7]
- Make a decision about the specific problem that an intervention will address, and the aims & goals of an intervention [Action 4]
- Generate ideas about solutions, components and features of a programme [Action 9]
- Make decisions about content, format and delivery of intervention [Action 11]
3.5. Stage 2(a) Understanding Experiences

3.5.1. Rationale for Focus Groups and Interviews

Stage 2(a) Understanding Experiences aligns with Objective 2(a), (b) and (c) which are:

- To identify the problem to be addressed among men in areas of high social disadvantage in Northern Ireland
- To explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland
- To identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland

A key step in the planning process of intervention development requires an understanding of the problem or issues that need to be addressed and the context that the intervention is intended to be implemented in (Craig et al., 2008; O’Cathain et al., 2019). In order to adequately explore these issues, semi-structured interviews and focus groups were conducted with men in areas of social disadvantage in Northern Ireland. Other methods were considered. Participant observation is noted as a useful approach to capture the ‘backstage culture’ of a phenomenon while providing in-depth detail (DeMunck & Sobo, 1998). This would have been a useful method to explore the dynamics of PAIs but would provide little information with regard the factors contributing to psychological distress among this cohort. Focus groups capitalise on communication between research participants which can highlight cultural values, group norms, and enable the analysis of a range of interpersonal communications (Kitzinger, 1995). Focus groups have been noted as a useful data collection method when discussing sensitive
topics - particularly in the presence of friends and/or colleagues of a group - as participants can feel relatively empowered and supported within the group (Morgan, 1993; Bloor et al., 2002). However, focus groups may increase the risk of group thinking or conformity when discussing sensitive topics, where the information shared does not reflect individual mental health experiences (Gibbs, 1997). Conversely, individual interviews allow the researcher to locate specific ideas within particular individuals (Denscombe, 2003). Interviews may also provide an opportunity for individuals to speak more freely about stigmatised topics such as psychological distress which might be avoided in the group setting. This may be particularly relevant for men against the backdrop of ‘traditional’ masculine ideologies of stoicism and invulnerability. However, interviews may not adequately highlight collective experiences of participatory arts. Therefore, in order to maximise the value of data collected, to illicit in-depth data about the mental health experiences of men in areas of social disadvantage in Northern Ireland and their collective experiences of engaging in participatory arts, both focus groups and semi-structured interviews were used. Importantly, this provided participants with a choice to engage in a data collection method of their preference. This approach was felt to offer control to participants and to their maximise participation.

3.5.2. Rationale for Semi-Structured Focus Groups and Interviews
Both the focus groups and interviews used a semi-structured approach. A semi-structured approach follows a number of key questions that help define the areas to be explored, but also allow for deviations to pursue emerging ideas and responses (Britten, 1999, p11-19). A structured approach closely follows a specific set of questions in a pre-determined order with no room for deviations or follow-up
questions (Denzin & Lincoln, 2008, p124). While this method may provide more comparable information, they are typically short in duration, more suited to a positivist research paradigm and do not allow for a ‘depth’ of experiences (Gill et al., 2008; Edwards & Holland, 2013). Conversely, unstructured interviews are particularly suited when significant ‘depth’ of experiences is desired and when little is known about the topic area (Gill et al., 2008). They usually have little or no preconceived theories, ideas and/or organisation, enabling the participant to talk freely from their own perspective and frame of reference (Edwards & Holland, 2013). This approach was deemed unsuitable for this study as the candidate wished to explore specific experiences relating to psychological distress, benefits of participatory arts and barriers and facilitators to engagement. As such, semi-structured focus groups and interviews were the most appropriate method to provide a sufficient amount of structure to explore these topics of interest whilst also enabling a degree of flexibility to explore new lines of inquiry.

The systematic review and the intervention development frameworks were used to develop the topic guide (See Appendix 7). The topic guide focused on three specific areas; experiences of mental ill-health; impact of participatory arts on mental health; and barriers and facilitators to engagement in participatory arts. The systematic review identified potential mechanisms of change and barriers/facilitators to engagement which were used as prompts in the data collection process. The topic guide was reviewed by the research team, other academic staff, and community men’s health facilitators in order to determine their
appropriateness to the overall thesis objectives, suitability of language and how they might ‘land in the room’.

3.5.3. Stage 2(a) – Sample Size
Choosing a sample size in qualitative research is an arena of much debate and practical uncertainty (Vasileiou et al., 2018). A sample size is most commonly justified as a result of data saturation – i.e. no new additional data being found (Sandelowski, 1995; Guest et al., 2016; Vasileiou et al., 2018). Despite this, there are no pragmatic instructions for estimating the sample size required for data saturation (Morse, 1995; Vasileiou et al., 2018). A study conducted by Guest et al. (2006) found that 90% of all codes had been developed by the twelfth interview within a homogenous sample. In a further study, Guest et al. (2016) found that 90% of all themes had been developed between three and six focus groups. Therefore, it was determined that twelve interviews and six focus groups would be recruited for Stage 2(a) of the study. Data collection ceased once no new information was observed during data collection.

3.5.4. Stage 2(a) – Sample Selection
Men were recruited based on assigned risk via their socio-demographics rather than having any known suicidal behaviour. It is often difficult to untangle the concepts of mental health promotion and suicide prevention - where one stops and the next begins. Indeed, mental health promotion can ameliorate the effects of mental ill-health and vice versa (WHO, 2002). In this regard the two approaches of promotion and prevention can be complementary (WHO, 2002). Rather than argue where mental health promotion stops and suicide prevention begins, this study embraces this ‘grey area’. This study sought to develop an intervention to promote
mental health among a group vulnerable to suicide; not to prevent suicide among suicidal individuals. Therefore, the intention was to recruit an ‘at risk’ group of men rather than suicidal men.

Men in areas of high social disadvantage are considered one of the groups most “at risk” to suicide in Northern Ireland and are listed as a priority group within the national strategy to reduce suicide (Department of Health, 2019). The suicide rate in the 20% most deprived areas in Northern Ireland is four times higher than the rate in the 20% most affluent areas (NISRA, 2020). Therefore, men were recruited from areas of high social disadvantage which were classified as a geographical community that ranked within the 20% most deprived communities in Northern Ireland. This was determined using the Northern Ireland Multiple Deprivation Index (NISRA, 2017). Men were eligible to participate if they were 18 years of age or older, and engaged in extant participatory arts activities in an existing men’s group that was located in an area of high social disadvantage in Northern Ireland. Although participants were not asked for their postcode to confirm their residency in the area, gatekeepers confirmed that all men lived in the community. Men were excluded if they lacked the capacity to consent, did not engage in participatory arts in a men’s group or could not speak English. Participants were recruited from existing groups in order to tap into the group dynamics of participatory arts. This was more appropriate to inform the development of the intervention compared to experiences from individual men who engage in participatory arts on their own. Participants were sampled using purposive and snowball sampling techniques. Purposive sampling involves using specialist knowledge about a particular group to
select subjects who represent the intended population group (Berg, 2010). Snowball sampling relies on referrals made among key contact persons or ‘gatekeepers’ who share or know of others who possess the characteristics that are of research interest (Biernacki et al., 1981).

3.5.5. Stage 2(a) - Recruitment
Firstly, a list of the 20% most deprived communities in Northern Ireland was devised using the Northern Ireland multiple deprivation index. The researcher then used online resources and consulted with local organisations/charities such as the Belfast Men’s Health Group, Men’s Health Forum in Ireland and the Irish Men’s Shed’s to identify men’s groups engaged in participatory arts in these communities. Once these groups were identified, the ‘gatekeepers’ of these groups (most commonly the men’s health facilitator) were contacted and asked to share the study information sheet with potential participants (see Appendix 8). If the ‘gatekeepers’ responded positively, the researcher organised a date to meet the men face to face. Oliffe & Mróz (2005) noted that recruiting men to discuss health and illness is more effective if done so via face to face meeting rather than recruiting men via advertising or emails. In this face to face meeting, the researcher outlined the study, the commitment required, the voluntary nature of participation, confidentiality and its limitations, and the consent form in depth (See Appendices 9 and 10). The men were given at least seven days to inform the gatekeeper if they were willing to participate in the study. The men informed the ‘gatekeepers’ if they were interested in participating in the study and indicated a preference for a focus group or interview. An appropriate time and date was
organised between the researcher and the ‘gatekeeper’ to obtain consent and to conduct data collection.

3.6. Stage 2(b) – Design of Intervention
Stage 2(b) Design of Intervention aligns with Objective 2(d) which is:

- To identify preferences for content, approaches to delivery and outcomes of a PAI to promote mental health among men in areas of high social disadvantage

As noted previously, this study is guided by a partnership approach wherein potential ‘end-users’ have at least equal decision-making with the research team throughout the development process (O’Cathain et al., 2019). Key partnership approaches in intervention development include co-design, co-production, and co-creation (O’Cathain et al., 2019). Although these terms bare similarities, they are often confused and used interchangeably (Sanders & Stappers, 2008; Voorberg et al., 2015). In the design literature, co-creation is defined as a broad term relating to any act of collective creativity (Sanders & Stappers, 2008). Co-design refers to the collective creativity of ‘designers’ and people not trained in design across the whole span of the design process (Sanders & Stappers, 2008). A systematic review of co-creation and co-production approaches in the management field notes little differences between the two with the caveat that co-creation places more emphasis on “added value” (Voorberg et al., 2015). Although the authors report that co-creation and co-production are similar, they distinguish different types of co-creation/co-production depending on the ‘end-users’ involvement in design, delivery of the intervention or both. Finally, in the field of public services, co-production refers to professionals’ and service-users’ involvement in both the
design and delivery of services (Bovaird, 2007; Boyle & Harris, 2009), Co-design refers to professionals’ and service-users’ involvement in the design but not the delivery. Informed by these studies and for the purpose of this thesis, co-design will be defined as the equal involvement of researchers and key stakeholders (i.e. end-users and potential facilitators) in decision-making throughout the design of the intervention. This is the approach that was taken in this thesis.

3.6.1. Impact of COVID-19 on Stage 2(b) Procedure
It was intended that six face to face co-design workshops would be conducted with men from Stage 2(a) and service providers with a remit for mental health promotion, participatory arts, and/or men’s health in order to develop the participatory arts intervention (PAI). Each workshop was aligned with a specific action of the taxonomy of approaches for intervention development. A flowchart of the intended co-design workshops are outlined in Figure 4.

However, COVID-19 had a significant impact on Stage 2(b) of this study which meant these face to face co-design workshops could not be completed. Ethical approval was sought to conduct three co-design workshops online which was granted in late July, 2020. Attempts were made to organise these co-design workshops online with the men and the service providers. However, it proved extremely difficult and slow to contact stakeholders for this phase of this study as many of the gatekeepers (men’s group facilitators) had been furloughed from their jobs. The drawn-out recruitment process and competing time commitments meant it was difficult to organise a time that was suitable for everyone. Moreover, the men who agreed to participate highlighted a desire for individual consultations.
rather than the group-based format. Therefore, individual online consultations were conducted with the men and the services providers.

**Figure 4: Flowchart of Intended Co-Design Workshops Prior to COVID-19**

The consultations followed the original workshop aims to: (i) decide on the problems to be addressed; (ii) to generate content for the intervention; and (iii) to identify the format and delivery of the intervention. These consultations began with a verbal summary of the findings from Stage 2(a). The researcher presented a sample of a PAI (inclusive of ‘sessions plans’) as a starting point to develop the content, format and delivery of the intervention. The researcher then asked a series of semi-structured questions (See Appendix 11). These were focused on the relevance of the problems to be addressed, attitudes towards the participatory art form, likelihood to participate or deliver such a programme, perceived barriers and facilitators to engagement, how the programme should be implemented and what
features should be changed to better suit the needs of the target group. This was an iterative process where each consultation informed the next. Key points of consensus or disagreement were presented to subsequent stakeholders in order to gain their opinions on the matter. Based on these consultations an outline description of an PAI was drawn up and sent to participants via email for feedback. However, few responses were received. This resulted in the development of the final outline description for the PAI.

3.6.2. Stage 2(b) – Sample Selection
Men were eligible to participate in Stage 2(b) if they met the eligibility criteria outlined in Section 3.5.4 and had participated in Stage 2(a). A sample size was not estimated for this stage of the study due to difficulties with recruitment. Therefore, the researcher aimed to recruit as many men as possible from Stage 2(a) to participate in Stage 2(b). Service providers were eligible to participate if they had a remit for working with; (i) men in the community setting (ii) mental health and/or suicide prevention and/or (iii) community arts. Service providers with a remit for working with or in the community of the men’s groups took priority, but those with expertise in a more regional or national role were also recruited.

3.6.3. Stage 2(b) – Recruitment
Following the end of the focus groups in Stage 2(a) the researcher informed participants that there were further opportunities to support the study with regard Stage 2(b) - Design of Intervention. The men were given at least 7 days to inform the gatekeeper if they were willing to participate in the next stage of the study. The gatekeeper informed the researcher if the group were interested in continuing their participation in the study. The researcher took note of what groups were interested
in participating in Stage 2(b) and agreed to follow up with them when the next stage of the study was due to be conducted. All men that participated in Stage 2(a) agreed to participate in Stage 2(b) prior to the COVID-19 pandemic. Following changes to the study design and ethical approval to conduct online consultations, the researcher contacted the gatekeepers from Stage 2(a). However, as noted previous, recruitment was a significant challenge. Nonetheless, some gatekeepers made contact with eligible participants who indicated their wish to participate. The gatekeeper circulated the contact details of willing participants to the researcher via email. The researcher contacted the men via email and circulated a copy of the participant information sheet (Appendix 12). If the men responded positively, the researcher organised a Microsoft Teams meeting to discuss the study, the commitment required, the voluntary nature of participation, confidentiality and its limitations, and to allow the participants to ask questions. The researcher then circulated an informed consent sheet via email (Appendix 13). The participants were given at least 7 days to inform the researcher if they were willing to participate. Willing participants returned the informed consent sheet via email and a suitable time was then organised to conduct an online consultation via Microsoft Teams.

Service providers were identified via local websites, online resources, through word of mouth via the men’s group recruited from Stage 2(a) and through organisations such as the Belfast Men’s Health Group, Men’s Health Forum in Ireland and the Irish Men’s Sheds. The researcher contacted service providers via email and shared the study information. The same processes outlined previously were followed to
obtain consent and to organise a suitable time to conduct the online consultation via Microsoft Teams.

3.7. Data Collection
All the data collected from interviews, focus groups and online consultations was collected by the researcher. When face to face meetings were organised the researcher engaged in informal conversations and asked for a tour of the facilities. This process served as an important means to build trust and rapport with the participants prior to commencing data collection. The researcher endeavoured to avoid raising unrealistic expectations about what benefits the intervention could potentially deliver when developed. The fact that participants might never receive the intervention or that it might prove to be ineffective was highlighted. However, it was suggested that participating in such research could enhance others’ understanding of mental health issues, raise the profile of men’s health work and provide an evidence-base for more groups to engage in participatory arts. The researcher highlighted the potential for the participants’ stories to help others, attempting to repackage masculine ideologies of responsibility/control and legitimise the discussion of their mental health experiences. This was also intended to offset the feeling that sharing mental health experiences was somehow a sign of weakness or vulnerability.

In order to minimise any perceived power imbalances between the researcher and the participants, focus groups and/or interviews were scheduled at a time and place of the participants’ choice. The researcher wore informal clothing and adopted a flexible and conversational style to questioning so participants could hold a level of
control over the process. The researcher also endeavoured to be open and understanding to the principal issues that arose and shared personal experiences where appropriate. In doing so, the researcher tried to ‘blend in’ rather than ‘blend out’; to emphasise the centrality of participants and to downplay the role of ‘interviewer’ (Oliffe & Mróz, 2005). Oliffe and Mróz suggest that a non-competitive, casual, punctual and organised interviewer is essential to establishing respect and building a good environment to discuss health issues among men. As such, the researcher arrived early to all data collection meetings and ensured that everything that was needed for data collection was well organised and distributed in an efficient manner. The face to face data was collected primarily in ‘Men’s Sheds’ venues although other forms of men groups were also recruited. Men’s Sheds are community-based, non-commercial organisations, where the primary activity is the provision of a safe, friendly, and inclusive environment and a space to gather and/or work on meaningful projects at one’s own pace, in one’s own time and in the company of other men (Keenaghan, 2015).

Prior to commencing data collection, all relevant documents were summarised and read aloud. The researcher asked participants if they had any questions and, subject to some minor clarifications, all participants signed and returned the informed consent sheets. Permission for the interview/focus groups/online consultations to be audiotaped was requested and the data collection commenced. No introductions were necessary between the men in focus groups. The researcher made it clear at the outset that what participants had to say was valuable, important and that there were no right or wrong answers. Open ended, clear and
Sensitive questions were used in a conversational approach to explore and unravel the lived experiences of the research participants. This is particularly important when trying to unpick subjective meanings that men give to mental health as distinct from having them describe symptoms as somewhat of a test of their mental health literacy (Oliffe & Mróz, 2005). The sequencing of questions is an important element to consider when conducting data collection around such sensitive topics. A laddered approach was adopted whereby the least invasive questions were asked before moving onto more sensitive topics (Price, 2002). This approach builds rapport before introducing more sensitive questions and reflects a more natural conversation between researcher and participant (Price, 2002).

When participants found it difficult to talk about sensitive topics the researcher showed empathy and encouraged participants to take as much time as necessary. Reflection and clarification of statements and viewpoints were useful to gain a deeper insight of an issue and to avoid misinterpretation. As the researcher became more experienced and confident, there was less of a reliance on the topic guides and more of a focus on opening up new lines of enquiries. Some participants were reticent to speak in focus groups and interviews. In these instances the researcher used the prompts, probes and loops to try and develop a more open conversation (Oliffe & Mróz (2005). Prompts encouraged participants to describe the detail of their experiences – “when did that happen?” or “how did that occur?” Probes were used to encourage reflection and introspection about events - “why do you think that happened?” or “where were your thoughts at that time?”. Finally, loops were used to rephrase questions and to revisit topics that might have been avoided or
misinterpreted. However, in using loops in earlier parts of the data collection process the researcher noticed that some participants became impatient and felt they had already answered the question. An example from one focus group is given below:

**Researcher:** We sort of touched on this at the start, but are there any other benefits to coming to a place like this? We spoke about friendship.

**Participant:** I think we have already covered it. Friendship and meeting new people, stuff like that.

Later in the interview I attempted to loop back around to questions on their experience of engaging in creative activities;

**Researcher:** I am sorry to go back to these creative activities but I just...

**Participant:** So are we like (laughter).

When these situations arose, I attempted to situate myself as an ‘acceptable incompetent’ and avoid being perceived as unprepared (Crabtree, 1992). The researcher highlighted that the participant had an expert opinion on topics that were unfamiliar to him and encouraged them to teach him about their experiences (Crabtree, 1992). The researcher was cognisant of when participants became impatient with the length of the interview, picking up on body language such as folding arms or explicitly checking the time. In these cases, he announced that he was conscious of the time, asked the final questions and invited participants to share any important information that was not covered. Following completion of the focus groups/interviews/online consultations, participants were thanked for their
contribution and were reminded about the mental health supports available to them.

**3.8. Data Analysis**

Focus groups, interviews and online consultations were audiotaped and transcribed verbatim. Thematic analysis was utilised which is a method for identifying, analysing, and reporting patterns within data (Braun & Clarke, 2006). Thematic analysis is not bound to any pre-existing theoretical framework, and thus is can be used within different theoretical models (Braun & Clarke, 2006). As a result, thematic analysis can be used to both unpick the surface of reality and to reflect reality (Braun & Clarke, 2006). Considering the interdisciplinary nature of this study, and the difference in inquiry between Stage 2(a) & Stage 2(b) (experiences vs opinions), thematic analysis was deemed the most appropriate method.

A key underpinning theoretical lens of this study was that of the social construction of masculinities (Connell, 2005). Through this lens, thematic analysis allowed the researcher to ‘unpick or unravel the surface of reality’ and explore how the intersection of masculinities, class, geographic location and other dimensions of identity are impacting men’s experiences of mental health and participatory arts. Thematic analysis can be conducted using a ‘bottom-up’ inductive approach or a ‘top-down’ deductive approach (Braun & Clarke, 2006). This thesis adopted an inductive approach meaning codes were generated from the raw data, not wed to a pre-existing code framework (Nowell et al., 2017). Stage 2(a) of this study looked for latent or interpretive themes to examine underlying ideas, assumptions and conceptualisations beyond the explicit or surface meaning (i.e. semantic themes).
Conversely, Stage 2(b) was analysed at the semantic level because it was more concerned with opinions rather than experiences. The supervisory team were consulted with during each phase of the analysis to ensure the reliability and validity of the findings (Mays & Pope, 1995). Braun and Clarke (2006) suggest six steps which encompass the full thematic analysis process: (i) familiarity of data; (ii) generating initial codes; (iii) searching for themes; (iv) reviewing themes; (v) defining and naming themes; and (vi) producing the report. How these six steps informed the data analysis process in this study is covered in detail below.

3.8.1. Familiarity of Data
The audio files were transcribed by the researcher to maximise familiarity with the data and to ensure that the verbal accounts retained their ‘true’ or intended meaning (which may be lost through third party transcription). It is proposed that the process of transcribing may also better equip the researcher with the interpretive skills needed to analysis the data (Lapadat & Lindsay, 1999). The researcher repeatedly re-read the transcripts before beginning the coding process and took notes and marked ideas in the margins as a reference points for subsequent phases. In Stage 2(a) the first four focus groups and interviews were transcribed immediately after being conducted and were read prior to conducting subsequent focus groups and interviews. This allowed the researcher to reflect on the data collection process and to reorder or modify the questions in the topic guide. Initially, the researcher led with questions about men’s experience of engaging in participatory arts, a topic that men were enthused to talk about. However, this resulted in an overly large proportion of the data on this topic and the researcher struggled to direct the conversation back towards mental health.
issues. In noticing this whilst still wishing to maintain a laddered questioning approach (Price, 2002), the researcher led with questions that elucidated supports to mental health before moving onto factors that contributed to psychological distress. By moving questions associated with mental health experiences towards the beginning of the focus group and interviews the researcher got a better balance of data in the three key topic areas.

3.8.2. Generating Initial Codes
An inductive approach to coding was utilised where the codes were ‘data driven’. Firstly, broad initial codes were generated to develop an emergent coding framework and the researcher endeavoured to code for ‘as many patterns as possible’ (Braun & Clarke, 2006, p19). Upon completion, multiple coding techniques were utilised wherein members of the supervisory team coded 10% transcripts, cross checking coding strategies and interpretation of the data (Barbour, 2001). Through reflecting on the data and codes, the research team refined the emergent coding framework. The transcripts were then re-coded using line by line coding techniques with the refined coding framework whilst still remaining open to new codes. The researcher attempted to retain contextual information where possible (Bryman, 2001) and wrote memos describing the data in cases where few words could not capture the complexity of the concept. Where there were multiple codes on one piece of data, the researcher attempted to identify the main idea that was being conveyed as suggested by Creswell (2015, p160). The researcher ensured to code and retain accounts from where the narrative departs from the dominant story of the analysis (Braun & Clarke, 2006). It is important to pay attention to
contradictory cases in order to give a more complete picture of the phenomena in question and to maintain rigour (Mays & Pope, 2000).

3.8.3. Searching for Themes
In this phase of data analysis, the researcher focused on sorting the codes into potential themes and collating data extracts that aligned with the emerging themes. The researcher created a table and grouped codes under each column that he felt had similarities. He developed conceptual maps and used memos generated via initial codes to track evolving relationships between emerging themes. The researcher presented these potential themes to the research team to cross-check the interpretation of data and to assist with collapsing the codes. At this stage, sub-themes and overarching themes to describe the data were generated. The researcher maintained a ‘miscellaneous codes’ group to account for codes that did not yet fit neatly within the emerging thematic framework (Braun & Clarke, 2006).

3.8.4. Reviewing Themes
This stage involved two levels of reviewing the themes to ensure that the data within themes were meaningfully coherent (i.e. internal homogeneity) and that there were clear and identifiable differences between themes (i.e. external heterogeneity; Patton, 1990). Firstly, the researcher read the collated data extracts aligned with each theme to ensure that they appeared in a coherent pattern. If they did not, the researcher assessed whether the theme was problematic, if there was a need to re-work the themes or whether the data extracted was best fitted within another theme. The next stage involved re-reading the transcripts against the themes to see if the themes were representative of the entire data set. This was also an opportunity to code any additional information that had been missing in
earlier stages. A concept map was developed to give an overview of sub-themes, themes and relationships between them.

3.8.5. Defining & Naming Themes
This stage was concerned with identifying the ‘essence’ of each theme in a clear and concise manner (Braun & Clarke, 2006). The researcher organised the collated data extracts in an internally consistent manner, accompanied with the research team’s narrative to tell the story within themes and across themes. The researcher endeavoured to avoid ‘paraphrasing’ the data extracts and to identify what was interesting about them and why. The researcher attempted to develop theme names that were concise and described what was unique about the theme.

3.8.6. Producing the Report
This stage involved the final write up of the themes in a clear, concise and logical manner to reassure the reader that the findings are valid and of merit (Braun & Clarke, 2006). The researcher provided sufficient data extracts to support the themes. In the write up, the researcher avoided superficial description of the data and attempted to create a narrative or argument in relation to my research objectives.

3.9. Trustworthiness of Qualitative Data
A number of steps have been proposed to improve the ‘trustworthiness’ of qualitative research. Lincoln & Guba (1985) propose that trustworthiness involves establishing credibility, fittingness, audibility, and conformability. Each of these will be discussed in turn.
3.9.1. Credibility
Credibility refers to the extent to which the findings and interpretations are credible with the sources from which the data were taken. In this study, credibility was achieved through spending time with participants and establishing rapport, audio-recording interviews, peer de-briefing and member checking (Jasper, 1994). Informal conversations were made with participants through face to face meeting prior to data collection and before focus groups/interviews. The researcher was open understanding and empathetic, shared personal experiences where appropriate. This all served as an important mechanism to build rapport and minimise power imbalances between the researcher and the participants. Audio-recording focus groups/interviews ensured that the researcher captured exactly what the participants had discussed. The researcher clarified statements and viewpoints during focus groups/interviews/online consultations in order to avoid misinterpretation and to gain a deeper insight into the topic at hand. The researcher provided a lay summary of the data analysis to participants who requested a copy and also presented the findings of Stage 2(a) to participants in Stage 2(b). This all served as added measures of credibility.

3.9.2. Fittingness
Fittingness refers to the extent of ‘fit’ between the context of the study and the context of where working hypotheses from the study are to be next applied (Guba and Lincoln, 1981). Put simply the probability that the research findings have meaning to others in similar situations. To achieve this, the researcher provided detailed descriptions of the community demographics and participant demographics (age, gender, employment status, marital status), which allows the
reader to assess the fittingness or transferability of this study to their own context. The study findings were discussed against previous empirical research and theoretical constructs in the men’s health, mental health and suicide prevention, and participatory arts field in a bid to demonstrate potential transferability to a wide range of fields. However, the assessment of transferability ultimately lies with the reader. It is difficult to make claims about generalisability of the findings due to the constructivist paradigm of the thesis. Finally, the study was underpinned by appropriate intervention development guidance (Craig et al., 2008; O’Cathain et al., 2019). The detailed development of an evidence based and user-informed intervention adds a greater level of rigour and clarity to the intervention.

3.9.3. Audibility
Audibility relates to the use of a competent evaluator to examine the consistency in the work of the researcher and demands that a ‘decision trail’ be documented, outlining decisions made throughout the research process, which may be evaluated by others. The research protocol for this study was peer reviewed by two independent academics outside of the research team. Any key decisions made in this research study were initially decided by the researcher and consistently agreed by the supervisory team as a whole. All minute meetings were uploaded to the ‘Record of Formal Meetings’ section on the researcher’s student QSIS account which is signed off by a member(s) of the supervisory team to check for accuracy. All data or information relating to this study was version controlled filed in a systematic way that makes it easy to find and use. The files were saved in line with the Queen’s University standard operation procedure for Research Governance Audit and Archiving Research Study Documents in the case that an audit is required.
during or after the conduct of the research. The student underwent annual progress reviews to ensure the quality of the work. Moreover, the systematic review has undergone a peer-review process in order to be published which is a further measure of auditability.

3.9.4. Confirmability
Confirmability relates to the data being factual and confirmable. This does not mean the researcher is not expected to be rid of subjectivity, but simply to report data in a way that is confirmable by others (Guba & Lincoln, 1981; Miles & Huberman, 1994). Confirmability of the data was maintained via multiple coding techniques (Barbour, 2001). Another member of the research team coded a small sub-sample of transcripts, cross checking coding strategies and interpretation of the data. The research team was consulted with during each phase of the analysis – data reduction, data display, and conclusion drawing and verification process (Miles and Huberman, 1994) - to ensure the reliability and validity of the findings. Conceptual maps and theme memos were utilised to track evolving relationships between codes and themes, and detailed descriptions of how codes translated into themes were provided. The researcher kept a reflective journal to track how his personal and professional experiences may have influence the data collection and data analysis process which acted as an additional measure of confirmability.

3.10. Ethical Approval & Considerations
Ethical approval was sought and granted by the Queen’s University Belfast School of Nursing & Midwifery Research Ethics Committee in November, 2018 (See Appendix 13). This was later amended and granted in July, 2020 (See Appendix 14) . Exploring mental health issues among groups vulnerable to suicidal is a sensitive
topic of research. Therefore, it was seen as critically important to be mindful of the complex challenges inherent in researching this area. Ethical considerations were given, in particular, to the following; (i) protecting the wellbeing and safety of research participants; (ii) data protection; (iii) voluntary participation; (iv) informed consent; and (v) welfare of the researcher. The following measures were taken in response to these ethical considerations.

3.10.1. Protecting the Welfare of Participants
A distress procedure was developed to support individuals who potentially displayed signs of distress throughout the data collection process (See Appendix 15). The facilitator of the men’s group was present in another room for each focus group/interview as an extra support for men who become distressed. Contact details for local and national mental health support services were provided for all participants (See Appendix 16). More sensitive and personal questions were asked in the middle-portion of the interview either side of more positive or supportive questions. Finally, the researcher is trained in both suicide prevention training (SafeTalk and ASIST) and ENGAGE training (Irish national training programme to engage men around mental health). Thus, the researcher was primed to identify and respond appropriately to an individual who becomes distressed or upset and was aware of the most respectful and effective way of engaging men around mental health.

3.10.2. Data Protection
All data was protected in line with General Data Protection Regulations (GDPR). All hard copies of data remained confidential and stored in a locked cabinet in an office in the School of Nursing and Midwifery, Queen’s University Belfast, for the duration
of the study. All soft copies of study data were stored on the university computer which was password protected and encrypted. Personal names and other identifying information were not used within the study in order to protect the anonymity of participants. The audio files of the focus groups, interviews and online consultations once transcribed, were deleted.

3.10.3. Voluntary Participation
Participation in focus groups, interviews and online consultation was on a voluntary basis. Participants were informed that they could withdraw from the project at any time. Following data collection participants could request for their information to be destroyed.

3.10.4. Informed Consent
Informed consent and reassurance of confidentiality were of paramount importance. Participants were given at least 7 days to respond to the researcher request to participate in the study. Participants were given a participant information sheet and asked to sign an informed consent form prior to participation. In the case of literacy being a possible issue, the researcher read the contents of both documents to the entire group and/or individual. The researcher also verbally summarized the key points in relation to confidentiality and anonymity at the beginning of each interview.

3.10.5. Welfare of the Researcher
Due to the potential for deep emotions and personal accounts of distressing nature to be encountered by the researcher, the author sought mental health support from a qualified psychotherapist.
3.11. Reflections on Recruitment & Data Collection – Implications for Men’s Health Research

Focus groups were a mechanism for the active construction of hegemonic masculinities. Examples included men using laughter and humour as a diversion tactic from discussing emotional topics; collective silence at the beginning of focus groups; belittling women following discussions around the positive role of women in supporting their mental health; and trying to assert dominance in the focus group by asking the researcher questions or by making jokes about the researcher. These performances of hegemonic masculine behaviour could be a tactic to maintain positions of power when discussing vulnerabilities that could weaken their masculinity identity (Jachyra et al., 2014; Mac an Ghaill et al., 2013; Schwalbe & Wolkomir, 2003; Williams & Heikes, 1993). This highlights a possible limitation of focus groups as a methodology in men’s health research work. However, probing further into why men might “laugh” at something that caused considerable distress and using men’s desire to control the focus group to guide subsequent questions were found to be useful tactics to overcome such issues. Therefore, an awareness of strategies to overcome these hegemonic masculine behaviours during data collection may help to overcome potential limitations associated with focus groups in men’s health research.

Others have drawn attention to the inherent challenges when trying to gain men’s confidence in a research process, particularly when gathering data on mental health issues (Schofield et al, 2000; White & Johnson, 1997). The importance of establishing rapport with the gatekeeper prior to meeting the men represented an important learning point in the PhD process. In order to do this, attempts were
made to establish common connections or acquaintances and discussions were held around wider men’s health work and on-going activities in the group. The gatekeepers with whom the researcher had established rapport tended to strongly advocate for the importance and need of the research. This translated to better relationships with the participants and focus groups with more rich descriptive data. Instances where rapport was not established with the gatekeeper often resulted in focus groups that were difficult to control, short in duration and that lacked in-depth data. Therefore, researchers who wish to use purposive and snowball sampling to recruit men in areas of high social disadvantage should prioritise establishing rapport with the gatekeeper in order to facilitate a better data collection process.

The next chapter will explore the mental health and participatory arts experiences of men in areas of high social disadvantage in Northern Ireland.
Chapter 4: Stage 2(a) - Understanding Experiences
4.1. Introduction
This chapter reports the findings from the qualitative research with men in areas of high social disadvantage in Northern Ireland who are engaged in extant participatory arts activities in a men’s group. This chapter will start by providing an overview of the men who participated in the research, a context and background to the main findings, an overview of the different themes that were generated and finally an in-depth description of each theme and sub-theme. The aims of this chapter were;

- To identify the issues contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland
- To explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland
- To identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland

4.2. Participant Demographics
A total of 41 men who engaged in extant participatory arts activities in men’s groups in areas of high social disadvantage in Northern Ireland participated in this study. It is important to note, that these men’s groups were not exclusively orientated towards participatory arts but it comprised a large degree of the activities undertaken in the group. When discussing barriers and facilitators to engagement, men were asked to draw from their general experience of the men’s group and more specific experiences related to participatory arts. The median age of participants was 64.5 years old (range 26-89 years old). A large proportion of men had engaged with their respective group due to retirement which is perhaps
an explanatory factor for the high median age. A total of 93% of all participants were not employed at the time of obtaining consent. In addition to the 42% of participants that were retired, 19% were away from work due to illness, 19% were unemployed and 7% were employed. Under half of the participants (46%) were married whilst the remainder were divorced or separated (24.4%), never married (22%) or widowed (7.3%). A total 39% of all participants lived alone. The deprivation rank ranged from those that lived in the top 0.35%-12.4% most deprived areas in Northern Ireland. A total of five focus groups were conducted which lasted on average, 56 minutes (range 30 minutes - 1 hour 36 minutes). A total of 11 men opted to participate in an interview which lasted on average 46 minutes (range 19 minutes – 1 hour). The degree to which participants were willing to disclose information ranged significantly which is reflected in the differences in duration across interviews and focus groups. Participant demographics are outlined in Table 6 and Table 7 below.

Table 6: Participant Demographics (Stage 2a Focus Groups)

<table>
<thead>
<tr>
<th>Group &amp; Duration</th>
<th>Pseudonyms</th>
<th>Age</th>
<th>Employment Status</th>
<th>Relationship Status</th>
<th>Living Alone</th>
<th>Deprivation Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group 1 (n=6)</td>
<td>John</td>
<td>63</td>
<td>Employed</td>
<td>Married</td>
<td>No</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td></td>
<td>Warren</td>
<td>53</td>
<td>Unemployed</td>
<td>Separated</td>
<td>Yes</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td></td>
<td>Karl</td>
<td>65</td>
<td>Retired</td>
<td>Widowed</td>
<td>Yes</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td>55mins</td>
<td>Daniel</td>
<td>46</td>
<td>Away from Work due to Illness</td>
<td>Separated</td>
<td>Yes</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td></td>
<td>Paddy</td>
<td>46</td>
<td>Unemployed</td>
<td>Never Married</td>
<td>No</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td></td>
<td>Joe</td>
<td>54</td>
<td>Unemployed</td>
<td>Married</td>
<td>No</td>
<td>3.8% percentile</td>
</tr>
<tr>
<td></td>
<td>Nick</td>
<td>47</td>
<td>Unemployed</td>
<td>Never Married</td>
<td>Yes</td>
<td>12.4% percentile</td>
</tr>
<tr>
<td>Focus Group 2</td>
<td>Name</td>
<td>Age</td>
<td>Employment</td>
<td>Marital Status</td>
<td>Employment Status</td>
<td>Percentile</td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>------------</td>
</tr>
<tr>
<td>(n=7) 59mins</td>
<td>Gareth</td>
<td>48</td>
<td>Employed</td>
<td>Married</td>
<td>No</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Frankie</td>
<td>61</td>
<td>Away from Work due to Illness</td>
<td>Married</td>
<td>No</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Jim</td>
<td>79</td>
<td>Retired</td>
<td>Widowed</td>
<td>Yes</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Peter</td>
<td>41</td>
<td>Unemployed</td>
<td>Separated</td>
<td>No</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Eddie</td>
<td>74</td>
<td>Retired</td>
<td>Never Married</td>
<td>No</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Liam</td>
<td>79</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Group 3</th>
<th>Name</th>
<th>Age</th>
<th>Employment</th>
<th>Marital Status</th>
<th>Employment Status</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=9) 30mins</td>
<td>Ray</td>
<td>76</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Fred</td>
<td>79</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Harry</td>
<td>84</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Ian</td>
<td>77</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Bret</td>
<td>58</td>
<td>Unemployed</td>
<td>Never Married</td>
<td>No</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Brendan</td>
<td>89</td>
<td>Retired</td>
<td>Widowed</td>
<td>Yes</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Seamus</td>
<td>65</td>
<td>Retired</td>
<td>Divorced</td>
<td>Yes</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Oscar</td>
<td>64</td>
<td>Unemployed</td>
<td>Never Married</td>
<td>Yes</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Damien</td>
<td>69</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Group 4</th>
<th>Name</th>
<th>Age</th>
<th>Employment</th>
<th>Marital Status</th>
<th>Employment Status</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=6) 41mins</td>
<td>Sean</td>
<td>61</td>
<td>Employed</td>
<td>Married</td>
<td>No</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Phil</td>
<td>85</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Josh</td>
<td>58</td>
<td>Away from Work due to Illness</td>
<td>Separated</td>
<td>Yes</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>David</td>
<td>70</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Joseph</td>
<td>73</td>
<td>Retired</td>
<td>Separated</td>
<td>Yes</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Niall</td>
<td>69</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Group 5</th>
<th>Name</th>
<th>Age</th>
<th>Employment</th>
<th>Marital Status</th>
<th>Employment Status</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>(n=2)</td>
<td>Joey</td>
<td>53</td>
<td>Away from Work due to Illness</td>
<td>Divorced</td>
<td>Yes</td>
<td>0.35%</td>
</tr>
</tbody>
</table>

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**Table 7: Participant Demographics (Stage 2a Interviews)**

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Duration</th>
<th>Age</th>
<th>Employment Status</th>
<th>Relationship Status</th>
<th>Living Alone</th>
<th>Deprivation Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Des</td>
<td>33mins</td>
<td>74</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>4.5% percentile</td>
</tr>
<tr>
<td>Victor</td>
<td>33mins</td>
<td>72</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>4.5% percentile</td>
</tr>
<tr>
<td>Jarlath</td>
<td>28mins</td>
<td>65</td>
<td>Retired</td>
<td>Never Married</td>
<td>Yes</td>
<td>4.5% percentile</td>
</tr>
<tr>
<td>Billy</td>
<td>1hr</td>
<td>79</td>
<td>Retired</td>
<td>Married</td>
<td>No</td>
<td>11.7% percentile</td>
</tr>
<tr>
<td>Wesley</td>
<td>35mins</td>
<td>68</td>
<td>Away from Work due to Illness</td>
<td>Married</td>
<td>No</td>
<td>11.7% percentile</td>
</tr>
<tr>
<td>Tim</td>
<td>1hr</td>
<td>52</td>
<td>Away from Work due to Illness</td>
<td>Married</td>
<td>No</td>
<td>11.7% percentile</td>
</tr>
<tr>
<td>Bob</td>
<td>58mins</td>
<td>58</td>
<td>Unemployed</td>
<td>Married</td>
<td>No</td>
<td>1% percentile</td>
</tr>
<tr>
<td>Kwame</td>
<td>47mins</td>
<td>56</td>
<td>Away from Work due to Illness</td>
<td>Divorced</td>
<td>Yes</td>
<td>1% percentile</td>
</tr>
<tr>
<td>Ger</td>
<td>19mins</td>
<td>65</td>
<td>Retired</td>
<td>Never Married</td>
<td>Yes</td>
<td>0.35% percentile</td>
</tr>
<tr>
<td>Patrick</td>
<td>34mins</td>
<td>53</td>
<td>Away from Work due to Illness</td>
<td>Never Married</td>
<td>Yes</td>
<td>0.35% percentile</td>
</tr>
<tr>
<td>Lee</td>
<td>51mins</td>
<td>26</td>
<td>Away from Work due to Illness</td>
<td>Never Married</td>
<td>No</td>
<td>11.7% percentile</td>
</tr>
</tbody>
</table>
4.3. Overview of Themes and Context to Findings
There were no observable differences in the data and initial codes emerging from
the interviews and focus groups. Therefore, the data sets were combined and
presented as four overarching themes rather than individual data sets. The four
overarching themes that were generated through the data analysis process were: (i)
Theme 1 - “I Have Come Out of My Shell” - From Isolation to Connection; (ii) Theme
2 – “Creativity Lifts Us Up”: Self-Efficacy & Personal Growth; (iii) Theme 3 - “The
Proper Psychiatrist”: Participatory Arts and Emotional Processing; and (iv) Theme 4
- Dynamics of Male Engagement in Participatory Arts. Theme 1-3 are predominantly
related to the sources of psychological distress and mental health benefits afforded
to men through engagement in participatory arts whilst Theme 4 is primarily
concerned with the barriers and facilitators to engagement. The most common
participatory art form discussed by participants related to crafts. More specifically,
woodworking activities like wood-burning, wood-turning, model-making and wood-
carving. Performance arts such as learning musical instruments, choir singing and
acting were the next most discussed art form followed by visual art activities such
as drawing, painting and photography. Finally, some participants noted their
interest in literary art activities such as calligraphy, writing and poetry.

The term ‘psychological distress’ is used throughout this chapter to indicate a
continuum of distress that was grounded in participants’ personal experiences
ranging from lower level mental health issues to suicidal behaviour. Men’s
experiences of psychological distress were inextricably linked to socially defined
roles associated with age and masculinity and the unique social context of
disadvantaged communities in Northern Ireland. Therefore, certain issues not only
directly impacted men’s mental health but also challenged their sense of place in society. Participants associated psychological distress with a sense of powerlessness, a lack of purpose, boredom, idleness and social exclusion. It was expected that sectarian violence and conflict associated with the ‘Troubles’ in Northern Ireland would feature more prominently throughout the transcripts, but this did not transpire. When this assumption was posed to participants, many simply acknowledged that it had an effect but they did not want to discuss the issue further. Indeed, many noted the cross-community nature of their group and how they did not want to bring up issues from the past that could cause problems within the group. This is an interesting finding in its own right. Conversely, many men discussed what it was like to feel ‘well again’ following a period of psychological distress and characterised it by having a smile on their face, feeling useful, having motivation to participate in daily life and re-engaging with previous interests. The four themes that were generated through the data analysis process will be explored in depth in the subsequent sections. Appendix 17 outlines the coding tree framework that was generated through the data analysis process. Table 8 also provides an overview of the themes.
Table 8: Overview of Themes and Sub-Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub Theme</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1: “I Have Come Out of My Shell” - From Isolation to Connection</td>
<td>“Nobody Ever Came”: Experiences of Isolation</td>
<td>Section 4.4.2.</td>
</tr>
<tr>
<td></td>
<td>“I Saw a Few Fella’s I Knew” - Routes to Connectedness</td>
<td>Section 4.4.3.</td>
</tr>
<tr>
<td></td>
<td>“You Feel as if you are Not on Your Own” - Belonging, Friendship &amp; Peer Support</td>
<td>Section 4.4.4.</td>
</tr>
<tr>
<td>Theme 2: “Creativity Lifts Us Up”: Self-Efficacy &amp; Personal Growth</td>
<td>“Loss of Your Sense of Self and Your Purpose” - Life Transitions &amp; A Lack of Meaningful Occupation</td>
<td>Section 4.5.2</td>
</tr>
<tr>
<td></td>
<td>“To Feel Useful Again” – Enhanced Self-Efficacy</td>
<td>Section 4.5.3</td>
</tr>
<tr>
<td>Theme 3: “The Proper Psychiatrist”: Art and Emotional Processing</td>
<td>“It Puts Me in a Reverie”: Negating ‘Negative’ Emotions and Generating ‘Positive’ Emotions</td>
<td>Section 4.6.2</td>
</tr>
<tr>
<td></td>
<td>“We Can Take That Mask Off”: Art as an Outlet for Emotional Expression</td>
<td>Section 4.6.3</td>
</tr>
<tr>
<td>Theme 4: “You can’t have an art class and expect all the men to just come along”: Dynamics of Male Engagement in Participatory Arts</td>
<td>N/A</td>
<td>Section 4.7.</td>
</tr>
</tbody>
</table>

4.4 “I Have Come Out of My Shell” - From Isolation to Connection

4.4.1. Introduction

Isolation was a key source of psychological distress among participants in this study. Section 4.4.2 explores the sources of isolation among the men which predominantly related to reduced social opportunities and withdrawal from social scenarios due to mental health issues. This section also identifies the perceived barriers men faced in seeking support and social contact to address their isolation. Section 4.4.3 relates to the facilitating factors that enabled men to engage with the group. Finally, Section 4.4.4 explores the social wellbeing benefits men accrued from engaging in
participatory arts which predominantly related to a sense of belonging, the forging of new friendships and peer support. The inclusivity and relatedness of the group, the informal environment, and the explicit advertisement as a ‘male space’ helped to build trust and rapport which formed the basis for developing friendships and peer support.

4.4.2. “Nobody Ever Came”: Experiences of Isolation

Isolation emerged as a key source of psychological distress and a primary motivation to engage with the group. The sources of isolation were multifaceted but appeared to primarily stem from being of an older-age and having reduced social circles, being out of work, the death of loved ones, living alone and/or experiencing depression and/or anxiety. This typically resulted in a lowering of social confidence and withdrawal from social events. Wesley stressed the problem of loneliness among older-age men and described how the death of friends, reduced social opportunities and a lack of purposeful activity contributed to his sense of loneliness;

“My problem was being sad, feeling lonely, feeling isolated. That is a big thing for a lot of people my age. When you are a young lad you have loads of friends, you are off to the dance and there is very little loneliness. When you get older, some of your friends have passed, you become isolated and you have nothing purposeful or constructive to do with your time” Wesley, 68, Interview.
Warren painted a rather stark picture of his isolation – underpinned by a mixture of unemployment, living alone and depression – as he awaited someone to visit him and expectant of that visitor being ‘death’;

“I was scared. I sat in the house, looking out the window, looking at the gate, waiting for someone to come. A knock on the door, family, anybody. Nobody ever came, nobody used that gate. I was waiting on death. I know that sounds strange but it is the truth”. Warren, 53, Focus Group 1.

Intergenerational poverty and community deprivation resulted in some men feeling abandoned or left behind and created a sense of ‘otherness’. A perceived lack of amenities in the community was also felt to further compound men’s isolation:

“We have lived through generations of conflict and unemployment. This is one of the most deprived areas of Northern Ireland, we are under the jurisdiction of [Location] and we get nothing from them for the area which makes the isolation worse for the lads. We are always considered the bottom of the barrel, them and us. So men in this area have very low self-esteem through things like that and the conflict” John, 63, Focus Group 1.

Indeed, this feeling of being left behind appeared to create a lack of trust for health and educational institutions among these men. Many spoke of their reticence to engage with these institutions and spoke of how they felt they would “catch them out” or tell others about their problems.

Although many participants felt compelled to address their feelings of isolation and acknowledged that the men’s group might help, they cited two primary barriers to
seeking help – a lack of social confidence and negative assumptions associated with the men’s groups. This juxtaposition of men to women with regard to social confidence was a common narrative throughout the transcripts where men were generally perceived as ‘shy creatures’ (Jarlath, 65, Interview). Although the root of this ‘shyness’ was not discussed in-depth, Des proposed that a lack of experience in social settings or ‘sitting talking’ emanated from adherence to masculine ideologies that equated such practices as feminine;

“Well men find it hard to mix in with groups, but ladies find no problem mixing. Ladies will go out and have coffee and talk among themselves but men won’t. You won’t see a couple of men going out and sitting talking. It’s in our nature to be macho. I don’t need to talk I don’t need to do this”. Des, 74, Interview.

The only space deemed acceptable for men to gather and talk was the pub, although this was often perceived as being reduced to empty and meaningless conversation. For other men, it was the more personal barriers of social anxiety and perceived ‘social ineptitudes’ (Tim, 52, Interview) that contributed to their reticence to engage with the men’s group. Furthermore, participants perceived there to be a stigma associated with men’s groups that acted as an additional barrier to engagement. Participants felt that many looked down their noses at men’s groups and believed they were for men who were retired, unemployed or experiencing mental health problems, or as Jarlath and Tim put it, ‘boring old farts’ and ‘boys that are a bit loopy’;
“I have been talking to a few men that are retired now and I tell them I go to the men’s shed. They say I couldn’t go down there. Some of them were carpenters and joiners...the type of men we need. They feel that the men's shed is beneath them. ‘I was a carpenter and joiner I’m not going down there to teach boring old farts how to do this that and the other’”. Jarlath, 65, Interview.

“There is a bit of a stigma. You tell people you are going to a men’s group and they say really? They look down their noses at it. They think it is boys that are all a bit loopy and all the rest. That is what a lot of people see it as”.

Tim, 52, Interview.

It seemed that engaging with the men’s group would in some way represent a relinquishing of pride associated with employment and the identity of a ‘working man’ which was often a key pillar of masculinity in participants’ lives. Indeed, in many instances participants introduced their previous occupation along with their name in the first seconds of the focus groups/interviews without being prompted to do so. Engaging with a men’s group was also associated with having mental health problems which had the potential to challenge idealised masculine standard of stoicism and invulnerability. Bob notes how advertising his group as a place for men with mental health problems may have put people of joining;

“They advertise it [the men’s group] as a place where men’s mental health can be addressed. It’s not always about mental health, it’s not, some people might just want to socialise. That would put people off coming here”. Bob, 58, Interview.
Therefore, engaging with the group or seeking support in response to psychological distress represented a double jeopardy of masculinity - being unable ‘to handle’ psychological distress and facing the ignominy of seeking support;

“It’s the same with depression, you are a man, you are head of the family and you shouldn’t feel like that. You are even more vulnerable if you do tell someone, you are weak. You don’t want other people knowing because you fear they are going to knock you back”. **Tim, 52, Interview.**

A more palatable option was to suppress such ‘vulnerabilities’ and avoid seeking support, a route which led to a crisis point for many. Indeed, reaching a crisis point was another primary motivation for engaging with a men’s group;

“You haven’t hit that low yet, that level of depression...rock bottom. It is because you hit that low part that you think you know what, just go for it”. **Paddy, 45, Focus Group 1.**

“I was going to take my own life. I went to the hospital... I had 5 weeks with the psychiatric nurse first. She suggested I come here then. Before my anxiety was killing me I never said a word in here, now I am quite mouthy [laughs] – maybe I am making up for lost time”. **Bob, 58, Interview.**

4.4.3. “I Saw a Few Fella’s I Knew” - Routes to Connectedness
Many men described the challenge in overcoming their inhibitions about attending the group for the first time and recalled walking past the door several times before ‘working up the courage’ to walk in. However, recognising members within the group helped to alleviate concerns with first contact and joining an established group as Victor described;
“I think one of the hardest things is coming to a group of people that are established. I walked past about three times before I came in the first time...

I walked past the door and had a quick glance and I saw nobody that I knew.

The third time I worked up the courage to come down. I saw a few fellas I knew and I never looked back since”. Victor, 72, Interview.

Indeed, many men engaged with the group as a result of encouragement from an existing member. More informal face-to-face outreach with men in local leisure and shopping centres was also seen as a crucial step in recruiting men. This acted as a ‘show and tell’ of sorts wherein current members explained the concept of their group and showcased the creative products produced within the group. Open days of the men’s groups’ facilities were also perceived as a good method to establish such connections. This helped to dispel myths of what the men’s group was about and stimulated an interest in the participatory arts on offer;

“The only way to do it is to go up to functions in the town. We would talk to men and say this is what we do and show him stuff we make... when they see some of the stuff we make they go ‘oh god I would like to do that’ or ‘I could do that’”. Jarlath, 65, Interview.

This outreach approach was viewed as a more fruitful recruitment strategy than general advertisement and ‘putting leaflets through doors’ (John, 63, Focus Group 1), which was largely perceived as ineffective. Other useful avenues to recruit new members included inveigling the support of women’s groups, health centres and disability groups. The familiarity of activities offered within the group often served
as the ‘hook’ to entice and engage men. This ‘hook’ for Tim was a music group whilst woodworking activities offered Ger a sense of belonging and ‘place’, representing an extension of his previous life;

“As I said I came around and the guitar really attracted me to the group you know, there was a good group of men playing music and we sort of built up over the past few years”. Tim, 52, Interview.

“I had nothing, I was just lying about the house. I knew nobody when I joined. I went out to the work shed the first day which I enjoyed. I was a joiner all my life whereas none of them were joiners. I can do bits and pieces there or help somebody else. I had a place in the shed you know”. Ger, 65, Interview.

Although the ‘hook’ was often the motivating factor for engagement, it was the social contact that often sustained men’s engagement. Therefore, the participatory arts became incidental to the knock on effects of building connection and peer support in a safe and nurturing environment as Bret explained;

“At the end of the day, it’s not about the art or the music or the woodturning. It’s about having a conversation. They [creative activities] count for nothing otherwise”. Bret, 58, Focus group 3.

4.4.4. “You Feel as if you are Not on Your Own” - Belonging, Friendship & Peer Support
The transcripts were dominated by men’s accounts of their positive relationships and connections with one other. Almost all men spoke of their flourishing friendships within the group which helped to address issues relating to social
isolation and elicited a sense of belonging and acceptance, as Victor put it – “the number of friends you have quadruples”. Indeed, the word “camaraderie” was a common response to questions relating to the primary benefit of engaging with participatory arts within the group;

“It’s a great environment for people like me when you retire or you are sitting in the house. It is the place to be, just the camaraderie of it”. David, 70, Focus Group 4.

These social interactions helped some men overcome their perceived lack of social skills and to “break down those barriers and socially interact” (Joey, 53, Focus Group 5). Bob also highlighted how the group helped him to come out of his shell and how he now considers himself quite talkative;

“Before I joined this group, my anxiety was killing me, I never said a word. Now, I have come out of my shell – I’m quite mouthy [laughs]. Maybe I’m making up for lost time”. Bob, 58, Interview.

Developing new friendships was a particularly positive experience for Joey, who noted it was more difficult making friends at an older-age;

“I made some friends which was nice, especially when you get to a certain age in life… you get to a point where you think I don’t need anybody else. When you do make a friend that is quite lovely, that was one of the real positives of coming here”. Joey, 53, Focus Group 5.
For other men such as Warren these friendships were ‘life-changing’ in that they helped to alleviate feelings of suicidal ideation and acted as a support mechanism to prevent reoccurrences of such thoughts;

“These lads give me confidence. I had nothing. I was at the bottom of the barrel. I went back on the drink, I started to cut myself…I got caught trying to hang myself. Then I came to this place... it just changed my life. It is also prevention from any reoccurrences. You are out talking about stuff most days and things don’t stay on your mind too long”. **Warren, 53, Focus Group 1.**

Having a setting that represented ‘a safe space’ where the men felt comfortable and relaxed was noted as particularly important. Much value was placed on having participatory arts delivered ‘in situ’ – i.e. in the building owned by the men’s groups – which were all embedded within the community. A key feature of a ‘safe space’ was that it was explicitly advertised as a male space as Phillip describes;

“The men’s shed makes a complete difference. You know it’s a place for men, it is in the name – a Men’s Shed”. **Phillip, 61, Focus Group 2.**

These ‘male spaces’ were often juxtaposed to other community groups which were perceived as female-dominated and by association, feminine spaces. Eddie recalled his experience of engaging in such community groups where he felt out of place and too inhibited to contribute;

“Remember that joint thing we did with [community group]? The vast majority of them were women. Women are better at getting involved in
things than men. They sort of took over and we lost out”. **Eddie, 74, Focus Group 2.**

The inclusivity of the group and sense of relatedness among members helped men to settle in and elicited a sense of belonging and acceptance. Many men described their group as friendly, welcoming and devoid of cliques or as David put it – “you feel at home”. Paddy also felt an unbridled level of acceptance and support when he first joined the group which starkly contrasted his personal life up until then;

*See as soon as you walk through that door? You are accepted. Everybody is saying the same thing – hi, how are you, how are you feeling today, do you need anything, do you need to go somewhere, do you need to do this? It is what they are offering you, something I never had before. I never had that”* **Paddy, 45, Focus Group 1.**

Participants shared a strong sense of relatedness which primarily stemmed from shared social backgrounds and/or mental health experiences. This sense of kindred spirits helped to develop trust and rapport between participants and ultimately form the foundations for an environment conducive to mental health peer support. Indeed, most men felt comfortable opening up to peers because of this sense of shared circumstances and mutual confidentiality in relation to what was shared within the group;

*“Before I came here I kept everything in. I was getting worse and worse. Men don’t talk but in here you can talk about anything. You know it doesn’t go outside that door”*. **Peter, 41, Focus Group 2.**
“When you go through life’s trials you need help to get out of that situation – [points to other members] they have all been in the same boat, they understand it. So you feel as if you are not on your own, everybody has problems, some people here have really bad problems, so it makes things a lot lighter on yourself, it makes life go on, it makes life worth living”. Josh, 58, Focus Group 4.

Participants also felt that having shared experiences meant they knew how to be there for one other in times of distress. The suggested approach was to be persistent in offering the opportunity to talk but not to pressurise the individual into opening up. This informal peer support was often contrasted to statutory mental health services or more formal support services which some men felt tended to be rushed and therefore disingenuous in their approach to help them. Moreover, Joey felt that peer support meant a great deal more than professional support because the former was offered unconditionally and without any sense of compulsion to do so whilst the latter emanated from being duty-bound or having to do so.

That is not to say the peer support took the place of professional support when needed. In many instances, men discussed signposting other services that they felt might be better able to support their peers and often discussed bringing members to relevant mental health appointments and assessments. Men also noted that humour, ‘banter’ and ‘slagging’ (slang for teasing in a light-hearted manner) were vital in promoting a relaxed and comfortable atmosphere. Telling jokes and stories over cups of tea, biscuits and routine activities was a key mode of male bonding and significantly contributed to a sense of camaraderie among the group. There
appeared to be unwritten rules of what constituted unacceptable ‘slagging’ but participants insisted that such incidents were rare and were resolved quickly. Such informal chat was felt to be supportive in terms of providing a relief and distraction from on-going mental health struggles (‘we talk rubbish but the rubbish helps’ Oscar, 64). It appeared that these more indirect or ‘shoulder to shoulder’ conversations were a more comfortable way of leading into conversation about sensitive topics as Tim explains;

“These sort of things [participatory arts] are coming at mental health from a different angle and that works better for men I think. You are here making something with somebody and then you would get into a conversation about mental health or something. There is a lot of jest and joking in it too but we talk in here”. **Tim, 52, Interview.**

Indeed, many men stressed the importance of action-orientated activities or ‘having something to do’ in men’s groups and highlighted how participatory arts helped to facilitate a comfortable space for men to socialise. Beyond creating a more comfortable space, ‘doing’ appeared to be a concept that was more acceptable among men compared to ‘sitting’ which held negative connotations. A sense of idleness and inertia seemed to be linked to men’s accounts of isolation with many speaking of being ‘stuck inside’, ‘sitting in the house’, ‘lying around’ or ‘sitting in the corner’. It seemed as if the act of sitting personified a lack of purposeful activity and reinforced feelings of isolation. Moreover, ‘sitting in a wee room’ in a men’s group was likened to a ‘day-centre’ which carried with it the stigma of mental health and men seeking support;
"I think what is important is having an activity to do like the arts. I didn’t want the group to be like a day-centre, where you would come by and sit down in a wee room talking about your problems. I wanted the group to be active doing things, cooking class, making stuff, going for walks” John, 63, Focus Group 1.

Working towards a shared goal with regard to participatory arts helped to create a collective identity among the group and contributed to a sense of belonging within the individual. Bob notes how the physical synchrony of collective creativity whilst playing musical instruments with others uplifted his mood and facilitated a sense of connectedness to his peers;

“We all work together...we are all playing together. I play along with him and I know he is coming in next. When we get it right and everything goes right and the end bit comes and you think f**k that was good, you get a buzz. We look at each other and smile” Bob, 58, Interview.

Although participatory arts helped to form and develop connectedness within the group, it also acted as a medium through which to establish connectedness with the wider community. Sam highlights how he felt disconnected from daily life since his retirement and how participatory arts brought him back into a world in which he had felt being a spectator;

“Loneliness is a big thing for people our age. You feel closed off from life. When you are retired, you look at what is going on around you. The world is going on and going past you – you are not involved in it. But things like these [participatory arts] bring you into that world, it keeps you in touch with
everything that's going on. You are involved with schools and further education, other people, other groups and other communities. You're not sitting back and thinking what will we do now, you are out there”. Sam, 65, Focus Group 3.

4.5. “Creativity Lifts Us Up”: Self-Efficacy & Personal Growth

4.5.1. Introduction
This theme covers the key changes and life transitions that contributed to psychological distress among men and how participatory arts helped to overcome such challenges and facilitated personal growth. Section 4.5.2 explores challenges and changes to employment, relationships, health and personal expectations that had negative implications for men’s mental health. Section 4.5.3 highlights how participatory arts elicited a sense of achievement, meaningful occupation, and validation which enhanced men’s self-efficacy and contributed to a more positive self-perception.

4.5.2. “Loss of Your Sense of Self and Your Purpose” - Life Transitions & Lack of Meaningful Occupation
Many participants struggled with key changes and transitions in their lives. Given the age profile of the group, these predominantly related to changes in employment, relationships and health. A lack of stimulation and perceived idleness were key sources of psychological distress among men which appeared to stem from retirement or being unable to find meaningful work. Many men struggled with a loss of routine, with finding motivation and purpose in life, and commonly cited their boredom and excess of ‘time on their[sic] hands’ (Joseph, 73, Focus Group 4).

With employment forming a central pillar of participants’ masculine identity, being out of work significantly impacted men’s sense of purpose and sense of self;
“I had time on my hands because I was retired. I was looking to fill up the hours...something to get me motivated, a reason to get out of bed in the morning”. Jaralth, 65, Interview.

“For me, it [psychological distress] has been about loss. Loss of your sense of self and your purpose”. Arnold, 59, Focus Group 5.

There was also evidence of a more acute awareness of vulnerability embodied in an ailing physical body as a result of the natural ageing process and/or injuries and illnesses amassed over time. This was compounded by the death of partners, friends and/or family members which was a significant transition point for many men. This negatively affected their mental health and forced them to confront the reality of their own mortality. ‘Doing’ was inextricably linked with masculinity, but for participants now faced with retirement and the ignominy of an impaired body no longer able to ‘do’, there was a sense of relinquishing control and shifting identity. Wesley, who suffered an aneurysm which affected his ability to walk, lamented the transition from his youthful and jovial past to a life of restricted mobility and altered masculine self:

“I had an aneurysm and I was incapable of walking. I had to learn how to walk again. Nothing seemed to matter after that, I didn’t care what was happening. You think you are going to be useless forever. From a fella running around the factory doing his work and acting the maggot. My abilities to do things disappeared. I couldn’t fix a car or fix anything about the house. That was not me”. Wesley, 68, Interview.
There was also an awareness of vulnerability with regard a perceived decline in cognitive functioning. Many men felt embarrassed with their forgetfulness about doing tasks and remembering people’s names (“that really gets to me if I forget someone or forget to do something” Wesley, 68, Interview). Cognitive health was also felt to be intertwined with physical health wherein a lack of physical stimulation was felt to compound a decline in cognitive function;

“...if your mind is active you are active; if you are lying about the house your mind dies”. Ger, 65, Interview.

With this idleness and lack of stimulation, participants felt there was a propensity to dwell on and ruminate about their problems – ‘you are sitting at home thinking about all the things that are wrong and your problems’ (Josh, 58, Focus Group 4). A lack of meaningful occupation and rumination also had negative consequences for men’s relationships with their children and partners. Paddy discussed his frustration with his own life and how he took it out on his children, which he felt was pushing them away. Likewise, Phil recounted his frustration and worry following a loss of power in his leg which negatively affected his relationship with his wife. However, he also notes how the support of his peers in the men’s group became an outlet and helped to improve his home life;

“When I lost [power in] my leg, I was down in the dumps. It was the same routine all the time and I was very hard to live with. I don’t know how she [wife] dealt with me. I would keep going on about my leg and I was worried about losing the other one. But the situation with my wife is far better
now...made a big difference to my life coming down here”. Phil, 85, Focus Group 4.

All in all, these transitions challenged the personal and societal expectations that men felt they ought to achieve in life. Tim used the analogy of a train to explain how the pursuit of life goals acted as a motivating factor to push him down the track of life but became the very things that ‘derailed’ his self-esteem and contributed to a sense of failure once he was forced to leave work due to illness. Arnold similarly discussed his difficulty in adapting his expectations following unemployment and divorce. However, he highlighted how being around peers with similar difficulties helped him to normalise his feelings, adapt his expectations and re-ignite a sense of purpose;

“To go through life our expectations change and we come to plateaus – what have I done with my life? What have I not got? That type of thinking can f**k with us. I had to understand what were those expectations, what tools and opportunities I was given to achieve those expectations and what expectations were unachievable. You get the instruction manual to life but you don’t get the time to finish it. These are the things you can talk about in men’s groups...you come to know what is realistic and how can we achieve these things together...you realise it’s not just me that is feeling this – wow this changes things”. Arnold, 59, Focus Group 5.

4.5.3. “To Feel Useful Again” – Enhanced Self-Efficacy
Having identified a lack of meaningful occupation and difficult transitions, participants went on to describe how participatory arts contributed to positive
transformations in their self-confidence, self-worth, sense of purpose and identity. This was commonly operationalized as feeling “useful again”. Participatory arts appeared to help men feel “useful” through: (i) offering routine and meaningful occupation; (ii) eliciting a sense of achievement and self-confidence in abilities; (iii) providing opportunities to contribute to one’s community and to benefit others; and, (iv) sharing knowledge and skills within the group. These enhanced feelings of usefulness facilitated a greater sense of self-efficacy and had knock-on-effects in other life domains. Engagement in participatory arts was felt to be a meaningful activity that was constructive, positive and a worthwhile use of time. This helped men to feel that they had a purpose and something to do with their time. Joe highlighted how participatory arts helped him to fill a void by offering him something to do and somewhere to go;

““This is where the creativity stuff comes in – to feel useful again. It keeps me occupied. Something happens in your life that you get down and you don’t feel useful to society anymore. You are in that society, going out to work and whatever, and then it kind of gets taken away from you. You are on the scrapheap, but this [participatory arts] helps you get out of that situation. It is somewhere to go, someone to talk to and something to do. It just keeps the mind straight”. Joe, 54, Focus Group 1.

Indeed, attending the participatory arts activities offered men a sense of structure and routine that helped to offset feelings of boredom and idleness;
“After retiring I had too much time on my hands. I had nowhere to go so this was an outlet. I come in to do it 3 days a week and it is very beneficial to me”. Séan, 61, Focus Group 4.

“It gives you something to do every day and something to look forward to...keeping yourself busy and active. If you sit down all day, in the corner, watch TV, it’s not good for you”. Phil, 85, Focus Group 4.

The acquisition of new skills and knowledge was a rewarding experience because it contributed to personal growth. Indeed, the most commonly reported benefit from engaging in participatory arts was a sense of achievement. Men often spoke of their amazement at what they could produce artistically and the sense of satisfaction and pleasure that accrued via the creative process. This sense of achievement positively contributed to men’s sense of self-confidence and self-esteem. The art-product itself was also viewed as a tangible outcome; the fruits of one’s labours that personified increased competencies and represented an investment of time, energy and dedication;

“You get pleasure and enjoyment from it...it is your work of art, you produced that, it came from you and you achieved something. You have put effort, time and energy into it and it is worth something because of that”. Jarlath, 65, Interview.

“There is a song by the M people called ‘What Have You Done Today to Make You Feel Proud’. That could be woodworking, painting, music or building a car. It’s a sense of I have done this, pride in my achievements, this
is what I have done, this is what I am able to do. Using the mind and putting those things into action and what we see in the fruits of our labour. Creativity lifts us up”. Arnold, 59, Focus Group 5.

The sense of achievement and mastery associated with acquiring new skills and knowledge led to greater self-confidence that cascaded into other areas of life. Billy noted how his perceived success in singing and poetry gave him greater self-confidence and the ability to better cope with past traumas. Tim also highlighted the power of participatory arts in overcoming self-doubt and perceived inadequacies associated with depression;

“I made my own way [through adverse childhood experiences] and through the singing and the poetry, it gave me confidence in the rest of my life. It allowed me to get rid of some of the s*** it my head from my school days”. Billy, 79, Interview.

“I said I cannot draw. The facilitator said you can draw. I did the drawing and it wasn’t great but you knew what it was. He (the facilitator) said that came out of you, it does not matter what it looks like. I know what it is and I can see it. Towards the end of the 6 weeks my drawings were a lot better. It’s getting rid of the ‘I can’t’. Depression says you can’t but once you get something out creatively you start to break that down”. Tim, 52, Interview.

Many men also spoke of how they felt useful by performing for others or gifting their art products to friends, family or the local community. Indeed, a dominant narrative throughout the transcripts was men’s desire for altruism and to give back to their community. As such, men favoured creative endeavours that were ‘useful’
and that enabled them to provide value to community members ("its art but it has a use" Karl, 65). Examples of such endeavours included making Christmas decorations for the local community and buddy benches for local schools, and singing in local shopping centres and nursing homes. The act of giving was a positive experience in and of itself but the positive feedback that was reciprocated from others copper-fastened improvements in self-esteem and self-belief. This also helped to offset the lack of purpose and disenfranchisement from community life that many men experienced;

"You feel that you are useful again. That you are doing something good for the general public. We got to nursing homes and sing now and again and it is satisfying to see people singing along and smiling. It is sort of like giving back to the community". David, 70, Focus Group 4.

Men also favoured participatory arts that enabled them to share their own expertise and knowledge within the group. This appeared to help men remember parts of themselves that were well functioning or that had temporarily been lost through displaced roles and perceived inadequacies. Joey described tapping into his background in drama to assist in the development of a play, which made him feel like he was making a worthwhile contribution to his group. Similarly, Ger explained the joy in passing on skills acquired from his previous profession and watching fellow group members grow in competence as a result;

"We developed a play last year. That was in my area of expertise and that helped my mental health so so much. I felt like I was contributing something
to the group. Taking whatever skills I have and helping others in a positive way”. Joey, 53, Focus Group 5.

“I was cutting wood and stuff because none of them could do that and some of them then started taking over what I was doing. It is passing on your skills to somebody else and then they are able to do it as well. It’s great to be able to share your knowledge with somebody else”. Ger, 65, Interview.


4.6.1. Introduction
This theme relates to how participatory arts act as a medium to enhance men’s mood and to process emotions. Section 4.6.2 explores how participatory art negates the impact of ‘negative’ emotions whilst also generating ‘positive’ emotions. It is important to note here that the terms ‘negative’ and ‘positive’ emotions are being used as they relate to the psychology literature on emotions. Positive emotions are those with a positive valence (i.e. joy, enthusiasm, happiness) and negative emotions are those with a negative valence (i.e. anger, fear, anxiety). Both are independent of each other. The author is not suggesting that ‘positive’ emotions are inherently good or ‘negative’ emotions are inherently bad. This phraseology is used to provide an understanding to the types of emotions that are being negated or generated through participatory arts. Section 4.6.3 highlights how participatory arts act as an outlet for emotional expression which can be cathartic and therapeutic, give wider opportunities to express emotions and are a valued alternative form of ‘communication’ for men who find it difficult to express emotions.
4.6.2. “It Puts Me in a Reverie” – Negating ‘Negative’ Emotions and Generating ‘Positive’ Emotions

A number of men who had experienced mental health issues as adults, traced the origins of adverse childhood experiences. Instances of corporal punishment in school, violent and alcoholic fathers, sexual abuse, exposure to violence, and severe deprivation during childhood cast a dark shadow over men’s lives and continued to haunt them into adulthood:

“My whole life has been difficult. When I was younger I was sexually assaulted. I could never trust people after that. That is when I got the butterflies, the permanent butterflies”. Bob, 58, Interview.

“I have memories of my mother trying to take her own life two or three times when I was young”. Tim, 52, Interview.

“A lot of rubbish in my head is from my young days. I would be lying in bed and get an image of that priest hitting me for no reason”. Billy, 79, Interview.

However, in highlighting these difficult early experiences, men also noted how participatory arts provided solace through immersion in a more soothing and nurturing endeavour that helped to counterbalance and distract them from past traumas. Participatory arts were a positive pursuit that represented something to focus on and that required concentration and effort. Liam highlighted the importance of participatory arts in distracting him from past experiences and likened his pursuits of visual arts and music to a ‘proper psychiatrist’;
“Art and music are really big for my mental health, I call them the proper psychiatrist. They focus your mind on one thing, if you’re doing something like music or art you are only focused on that. It is a good thing then it prevents me from focusing on all the negative stuff in my past”. Liam, 79, Focus Group 2.

Victor also highlighted how the creative process lifted him out of a more insular and ruminating state when he felt depressed and into a lighter and brighter state;

“When you suffer from depression you become insular, you are just thinking about yourself and your problems – you are always down on yourself. But whenever you are doing something creative in a group, like the choir or the art class, you are concentrating on that and everything else is gone. One of the best things we ever did was the formation of the choir”. Victor, 72, Interview.

This concentration and focus on the task at hand was felt to be a grounding experience where men became present and in the moment. Indeed, in some instances men compared participatory arts to ‘mindfulness’ and ‘relaxation courses’. In addition to providing a ‘distraction’ from mental health issues, complete focus on a creative task was a pleasurable experience in and of itself. Many participants spoke of their enjoyment of the quietness and described an altered sense of time and of being in a reverie when involved in participatory arts. Indeed, many participants described participatory arts as relaxing, calming and therapeutic. This was particularly related to art forms that required less physical activity such as painting, drawing and calligraphy;
“It puts me in a reverie and I forget everything else”. **Billy, 79, Interview.**

“It is therapeutic. There is just enjoyment in the quietness, just getting on with something you enjoy doing. You are sort of in your own world kind of a thing”. **Séan, 61, Focus Group 3.**

“All of a sudden it would be 12 o’clock at night and we would still be jamming away”. **Bob, 58, Interview.**

Engaging in participatory arts was also felt to remove the individual from a distressing environment or an environment that could cause further problems such as being in the pub and alcohol misuse. Beyond negating the impact of ‘negative’ emotions, participatory arts helped to generate positive emotions such as joy and happiness. Many found it difficult to articulate specifically what benefits they had accrued from engaging in participatory arts but noted that they were simply ‘uplifting’, provided a ‘boost’ or a ‘buzz’ and elicited a ‘feel good factor’ which had long lasting benefits beyond the cessation of the activity. There seemed to be an intrinsic joy and satisfaction experienced during the act of creation and a sense of awe in seeing the birth of ideas develop through to tangible products or performances as Séan and Victor described:

“You have something [painting] that a child would do but then he [facilitator] shows you where to put the shadows and with the swish of a brush the whole things just comes alive. It is amazing”. **Séan, 61, Focus Group 3.**
“The effect it has on your mental health – just creating something. It doesn’t go away, that positive feeling stays with you and you feel good about yourself. I created something”. Victor, 72, Interview.

Creative activities also generated great joy through the social processes of cooperation, ‘slagging’ and a sense of belonging that were central tenets to the delivery of participatory arts. John highlighted how the group camaraderie ensured that members went home smiling and that this experience sustained them for the rest of the day;

“The camaraderie of the group is so important. People would go away with a smile on their face. For me, that is the most important thing, that would keep a lot of lads going for the rest of the day” . John, 63, Focus Group 1.

Indeed, for men such as Warren who discussed his experiences of suicidal ideation, it was not just a ‘smile on his face’ but something much more profound and deep-rooted that reflected a more sustained therapeutic impact from his artistic endeavours:

“Well again? Jesus look at me now. I have people saying how well I look, look at the smile back on your face again”. Warren, 53, Focus Group 1.

4.6.3. “We Can Take That Mask Off”: Arts as an Outlet for Emotional Expression

Many men perceived self-expression as an innate feature of life and a basic function for communication, connectedness and feeling understood. Participatory arts were felt to be an outlet for self-expression which was described as cathartic and therapeutic. Participatory arts were valued as an alternative form of ‘communication’ particularly for men who found it difficult to express emotions
such as sadness due to a perceived pressure to be stoic and invulnerable as Arnold
alluded to with his reference to ‘masks’;

“As men we wear masks all the time and sometimes we wear them so tight
we can only feel the heat of the sun through them, never feeling the sun on
our skin. But creative activities allow us to express ourselves in ways that we
feel we are not allowed to. So that creativity allows us to take that mask off
which can be very therapeutic”. Arnold, 59, Focus Group 5.

Participatory arts were also felt to give greater meaning and depth to emotions that
could not be expressed alone via words. Tim highlighted the importance of creative self-expression (getting things out) in offsetting the insularity of depression (keeping things in) and avoiding more unhelpful or ‘male-acceptable’ coping mechanisms such as alcohol misuse and dangerous driving;

“What are we without art? Art is about expressing yourself and getting
something out because depression wants to keep you in. It has to come out
someway and it is better to get it out onto a page than drinking or rallying
up the road”. Tim, 52, Interview.

4.7. “You Can’t Have an Art Class and Just Expect Men to Come Along”
- Dynamics of Male Engagement in Participatory Arts
This theme relates to the factors that facilitated and sustained men’s engagement with participatory arts. Many participants described their initial reticence and scepticism about engaging in participatory arts, which they felt they were feminine hobbies and ‘not for working-class men’ (Joey, 53, Focus Group 5). These ‘sissy hobbies’ were juxtaposed to the sectarian violence that some men were exposed to
growing up in Northern Ireland (‘throwing bullets’) and feats of physicality and aggression in more male acceptable hobbies (the ‘clashing ash’ of the Irish sport of hurling);

“...men don’t look on art as a man’s hobby. It is a sissy hobby, sitting down painting pictures. We are Irish men, throwing bullets and clashing Ash [phrase for the clashing of wooden hurls in the Irish sport of hurling]” Victor, 72, Interview.

Moreover, as the yardstick for working class masculinities was framed around more traditional labouring tasks, this cast them further adrift from exploring opportunities that were perceived as feminine;

“Ordinary working class men haven’t had the freedom to explore these different ways of being, beyond what is expected of them. I should work 9-5 shovelling stuff or driving a lorry or greasing an engine. So that creates a barrier within that person to engage - no that’s not for me”. Joey, 53, Focus Group 5.

However, creating a safe space and a sense of trust between group members, as discussed in Theme 1, helped to alleviate concerns of feeling silly or emasculated by engaging in participatory arts. Moreover, the group provided men with opportunities to engage in participatory arts that they would otherwise not have had access to. Both Daniel and Oscar described how the safety of the group and the ease with which opportunities were provided facilitated their engagement with participatory arts:
“If you were asked to do it yourself you would kind of be wary. But once you are in the crowd... you just engage because you are in the safety of the group. It could be any activity, it wouldn’t matter what it is, we would do it... once you do it you realise you enjoy it.” Daniel, 46, Focus Group 1.

“I fancy doing a bit of painting now as well. I would have never thought about getting involved in those types of activities before I came here... if you’re not in a group like this you would have to go and buy a paintbrush and buy the paint. It [the men’s group] provides opportunities to get involved with stuff that you might have an interested in”. Oscar, 64, Focus Group 3.

Participants also described the encouraging and enthusiastic style of the men’s group facilitator as being crucial to their engagement in participatory arts. This approach inevitably piqued men’s interests without any pressure to participate. This ultimately left men feeling they had autonomy and the choice to participate as Jarlath explained;

“...he [facilitator] is enthused with the art activities. There is an energy there and he presents it as something you can do with your time. He would be full of encouragement. It naturally gets you interested and then when you are interested you enquire a bit more and get involved. There is no pressure there”. Jarlath, 65, Interview.

Establishing trust and rapport with the artistic facilitator was also cited as a crucial factor for successful engagement. This seemed to be particularly important considering many men were dubious about engaging in participatory arts, were
vulnerable due to on-going mental health issues, and mistrusted many statutory services and other societal institutions. Indeed, the researcher grappled with gaining trust and credibility during the research process with some men such as Karl openly articulating the distance he felt between himself and the researcher;

“If all society was brought down to where we are, then they would understand. No offence, but you are asking questions and you can see that you have no idea what it is like to be in our position”. Karl, 65, Focus Group 1.

Nonetheless, participants recounted how more effective artistic facilitators removed perceived power imbalances between themselves and the participants by not being overly strict and authoritative and by enabling men’s voices to be heard, respected and valued. Participants noted the importance of having ‘no chiefs’ or ‘figureheads’ leading the group and favoured facilitators who were down to earth, made them feel at ease and would have a cup of tea and a chat during the break. Strategies that revolved around giving men ownership over the process and prioritising peer led approaches in programme delivery were seen as fundamental and helped men to feel more relaxed to be guided and moved to do things. Joey notes the importance of prioritising peer led approaches in participatory arts to successfully engage men and to alleviate their fears about engaging;

“The model of engagement is so important. You can’t say right we are going to have an art class and expect all the men to come along. You have to be non-directive with some sort of an outcome...give those men a degree of ownership as well. The play we did, there was an outline idea but the only
hard outcome was to have a piece in a set time. We all had ownership to it, technically one guy was the mastermind but he didn’t say right this is what you have to do”. Arnold, 59, Focus Group 5.

In prioritising peer-led approaches men had further opportunities to share their existing knowledge and skills relating to the task at hand which further contributed to improved self-efficacy and positive self-perception. Although participants favoured self-guided strategies they also highlighted the importance of having a degree of structure and planned outputs as Arnold alluded to previously ("non-directive with some sort of an outcome"). Indeed, participants stressed the importance of producing something tangible at the end of the creative process. There was a perception that men were very much ‘outcome-based’ and that having a goal or a solution to work towards often resulted in a more positive engagement. However, in noting the importance of having an end product, it was highlighted that the quality of the product should not take precedence – recognition that the focus should be on the enjoyment of the creative process. This helped to alleviate concerns of a perceived lack of artistic skill and frustrations with the quality of the product. Joey highlighted that it is through the process rather than the final product that most of the mental health benefits are accrued;

“As men we are very outcome-based and in that we forget about the process. Process is as important or sometimes more important because it is in that process that those interactions occur. People are terrified of the arts because they think ‘I will not be very good at that’. You don’t have to be brilliant at what you do, you just have to enjoy it” Joey, 53, Focus Group 5.
Tim also recounted how the artistic facilitator’s prioritisation of the process rather than the product helped him to overcome his fear of failure and made him feel relaxed whilst engaging in a visual arts course;

“What I thought was really good was he [artistic facilitator] started off with ‘open your page’. He said ‘that page is quite intimidating...make a scribble on it’. ‘You have done a drawing. What of? Who cares’. That just opened the whole thing up... I did the drawings, they weren’t fantastic but you knew what it was”. Tim, 52, Interview.

In keeping with the concept of an informal environment, men also favoured flexibility with regard to their level of participation in participatory arts. Flexibility with participation acted as a bridge for men to dabble in participatory arts without feeling the need to fully commit. Indeed, the option to ‘come and go as you please’ was a factor that attracted many men to engage with participatory arts in the first place;

“The ability to come and go as you please. That is the thing that attracts me to these activities. You can come in and do whatever you want within reason. You don’t feel like you have to sit here for 6 hours. You can come in have a coffee and a chat and leave or you can get involved in the different arts and crafts projects”. Jarlath, 65, Interview.

This flexibility to dip in and out of activities was particularly important for men who experienced mental health issues and who subsequently missed attendance for a couple of days or weeks. Phillip highlighted how this flexibility with participation
meant that he felt no pressure in returning to the group after some time away and could fit seamlessly back into the group upon his return;

“That is one of the great things about here, if you were out of here for a few days or weeks because of depression, when you come back you don’t feel like a project is nearly complete or I am 2 or 3 weeks behind on a course. There is no kind of pressure for people coming back, you just come back in and sit on the same seat and get on with it”. Phillip, 61, Focus Group 2.

Other common techniques deployed by artistic facilitators to overcome participants’ fear of failure and perceived lack of artistic skills was beginning with activities that had a lower skill threshold to participate and graduating them to more difficult tasks. William explained how his group began with tracing pictures of scenery, before moving onto to portraits and more detailed tasks like shading and colouring. For participatory arts that were peer-led and conducted on an on-going basis, participants highlighted the importance of creating opportunities to which everyone could make a contribution. This was particularly important for men such as Wesley who had physical impairments that limited his participation in certain creative endeavours;

“The men accept that I am not fit to do the things the way they do them but I know I can maybe help in a small way. It gives you a sense you are not putting them out or leaning on them or taking advantage but you can still contribute”. Wesley, 68, Interview.
4.8. Implications for Intervention Development
This qualitative component aimed to inform intervention development by exploring the lived experiences of men in areas of high social disadvantage in Northern Ireland who engage in participatory arts in men’s group. The findings of this stage of the study identified a number of potential issues to be addressed by the intervention, potential mechanisms through which participatory arts might improve men’s mental health, and contextual barriers and facilitators to men’s engagement in participatory arts. These are summarised in the subsequent sections. A draft logic model is present in Figure 5 which outlined the key findings from this stage of the study.

4.8.1. Key Issues to be Targeted by the Intervention
The key issues that contribute to psychological distress among this cohort pertained to social isolation, a lack of meaningful occupation, difficult life transitions and adverse childhood experiences. Social isolation was attributed to diminishing social opportunities and withdrawal from social opportunities. Men were often reticent to engage with men’s groups due to the stigma that they are for men who are retired, unemployed or who had a mental health problem.

A lack of meaningful occupation and a sense of idleness appeared to stem from being out of work due to retirement, physical illness or being unable to find meaningful work. This resulted in a lack of routine, stimulation, purpose and motivation which were felt to contribute to ruminating thoughts and resulted in many men feeling “useless”. Various life transitions associated with employment, relationships and health also had negative implications for the men’s sense of self and identity. Finally, adverse childhood experiences were common among
participants with some examples relating to corporal punishment in school, violent and alcoholic fathers, sexual abuse, and exposure to violence and severe deprivation. These traumas inevitably left many men emotionally scarred throughout their adult life. These issues are proposed as the key problems to be addressed by the intervention in this thesis.

4.8.2. Potential PAI Mechanisms Underpinning Positive Mental Health Outcomes Among Men
Participatory arts can address the issues of social isolation, a lack of meaningful occupation, difficult life transitions and adverse childhood experiences through enhancing connectedness, self-efficacy and personal growth and emotional processing. A sense of relatedness stemming from shared interests in participatory arts and similar mental health and/or life experiences facilitated a sense of acceptance and belonging. The collective experience of working towards a common goal and physical synchrony in the creative process strengthened a sense of collective identity. Participatory arts help to facilitate a more comfortable space for men to engage in reciprocal peer support around mental health issues. Finally, it provided a medium through which men connected with others in the wider community. Therefore, in order to address social isolation intervention features should include: (i) group based activities that prioritise physical synchrony and working towards a collective goal; (ii) action-based activities to provide reciprocal sharing of stories and peer support; and, (iii) opportunities to connect with the local community.

Participatory arts provided men with a routine and a sense of purpose. The acquisition of new skills and knowledge elicits a sense of achievement and personal
growth whilst the art-product is a tangible outcome that personified these increased competencies. Men favoured participatory arts that enabled them to share their own skills and knowledge and/or to give back to the wider community. Positive feedback on men’s art-work reinforced feelings of enhanced self-efficacy. Therefore, to address the issue of a lack of meaningful occupation, intervention features should include opportunities for men to: (i) make manageable decisions, overcome challenges and develop routines; (ii) opportunities to acquire new skills and knowledge and to create “tangible” products; (iii) opportunities to share skills and knowledge within the group; (iv) opportunities to contribute to the community and benefit others; and, (v) receive feedback and encouragement.

Participatory arts acted as a medium to enhance men’s mood by generating ‘positive’ emotions and by negating the impact of ‘negative’ emotions. This provided a distraction and short-term relief from childhood adversities and difficult life transitions. Participatory arts also offered men the opportunity to express their emotions through an alternative means which was reported to be cathartic and therapeutic. However, men did not discuss what type of experiences they channelled through participatory arts that had this therapeutic effect. Nonetheless, participatory arts may represent a unique opportunity for men to self-reflect on childhood adversities and difficult life transitions and to create new meanings in response to past events thus producing a cathartic effect. Therefore, to address issues of difficult life transitions and adverse childhood experiences key intervention features should include opportunities to: (i) enhance mood by generating ‘positive’ emotions and negating the impact of ‘negative’ emotions: (ii)
self-reflect on life transitions and adverse childhood experiences; and, (iii) to express emotions on these experiences through participatory arts.

4.8.3. Delivery Approaches to Improve Male Engagement in PAIs
Participatory arts should be embedded in environments that are familiar to men, informal and specifically advertised as a male space. A shared sense of relatedness is crucial for men to engage in participatory arts and overcome their fears of feeling silly or emasculated. Men favour participatory arts that are action-orientated, result in tangible outputs and enable them to give back to others through sharing their skills/knowledge, putting on performances or gifting their artistic products. Offering men autonomy and ownership is crucial to engendering trust. This can be operationalized through prioritised peer-led approaches and the facilitator being receptive to feedback. Moreover, flexibility with participation can help to facilitate sustained engagement. However, men also favour a degree of structure. Therefore, it is important to strike a balance between the structure and flexibility of the programme. Attempts should be made to prioritise approaches that build men’s confidence to engage in participatory arts and that remove a “fear of failure”. This might include prioritising the process over the product, encouraging collaboration rather than competition, and beginning with activities that require a low skill threshold to participate which can be graduated to greater difficulties. Factors that were felt to impede engagement in participatory arts included cultural messages that participatory arts is feminine, specifically advertising men’s group as a place for those who are retired or who have mental health issues, and a perceived lack of skill to participate.
4.9. Conclusion
This chapter has presented the findings from focus groups and interviews with men in areas of high social disadvantage in Northern Ireland. This chapter is significant as it advances the literature on the issues contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland, the mechanisms underpinnings positive mental health outcomes among men who engage in participatory arts and the barriers and facilitators to male engagement. It has also highlighted a number of intervention components and approaches to delivery that should be considered in the development of the intervention. The next chapter will present key stakeholders’ preferences for intervention content, approaches to delivery and outcomes.
**Contextual Barriers:** cultural messages re ‘masculinities’ (creativity and/or socialising is feminine’) and low self-efficacy to engage in social scenarios/creative activities; lack of physical opportunities; physical disabilities.

**Contextual Facilitators:** informal environment, relatedness of group; action-orientated; peer-led approaches; tangible outcome; low skill threshold; ‘male space’; Strengths-based approach; altruism; autonomy

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**Figure 5: Initial Logic Model**
Chapter 5: Stage 2(b) - Design of Intervention
5.1. Introduction
This stage of the study aligns with Objective 2(d) – to explore the preferences and opinions of key stakeholders with regard intervention content, approaches to delivery and outcomes in order to develop an outline description of a participatory arts intervention (PAI). It was hoped that the systematic review or qualitative research with men would highlight an art form that was most effective or most acceptable among men. However, this did not transpire. Therefore, the researcher was guided by the implications for intervention development discussed in Chapter 2 (see Section 2.8) and Chapter 4 (see Section 4.8) to identify an art form for consideration in this design phase. For a number of reasons, digital storytelling was considered a worthwhile pursuit. The concept and rationale for choosing digital storytelling are discussed in Section 5.2. Section 5.3 will provide an overview of the key stakeholders who participated in this stage of the study whilst Section 5.4 presents a brief re-cap on the procedure used for these online consultations. An overview of the main findings is presented in Section 5.5 followed by a detailed description of the problems to be addressed and interest in DST (Section 5.6), preferences for approaches to delivery (Section 5.7), and preferences for features and content of the intervention (Section 5.8).

5.2. Digital Storytelling

5.2.1. What is Digital Storytelling?
Digital storytelling (DST) is an arts-based facilitated group process, where participants create a short video about a personal story that conveys meaning and thought-provoking messages (Lambert & Hessler, 2020). The participants have absolute control over their story content and context. They act as the creators,
producers and editors in the storytelling process (Hausknecht et al., 2017). The group facilitation creates a safe space for the creation of personal stories through individual and group reflection (Lambert & Hessler, 2020). Digital storytelling is defined by seven key components:

- **Self-Revelatory** – the author gains new personal insight through the telling of their story.
- **First Person Voice** – the stories are personal reflections in the first person voice and are characterised by conveying meaning and emotion.
- **Experiential** – the stories are about lived experiences, a description of a moment or moments in time.
- **Still images** – a reliance on still images (16-20 images) rather than moving images to create a relaxed viewing pace.
- **Soundtrack** – music or ambient sound to add meaning and impact.
- **Restrained length and Design** – a short video (2-5 minutes) with minimal video editing (pans, zooms, cuts, dissolves).
- **Intention** – a focus on self-expression and self-awareness over production value (i.e. process over product).

A typical DST intervention lasts 3 days involving approximately 20hrs of active collaboration. The DST process occurs in a group setting that is generally guided by a person trained in the DST method. The first activity typically involves participants or storytellers writing a 300-500 word script in response to open-ended writing prompts. These scripts are shared with other storytellers in the group, in the form of a “story-circle” and participants receive feedback from the group and the
facilitator. This serves to advance the development of the story and to establish connection and relatedness among the group. Storytellers refine their scripts and seek feedback from other storytellers until a finalised script is produced. These finalised scripts are then audio-recorded and used to guide the selection of images and ambient sounds. These are weaved together using minimal video-editing techniques and the final videos or digital stories are shared with the group at the end of the process. The DST facilitator then provides reflections of each video and conducts a facilitated discussion on the key learnings of the process. Therefore, a typical DST intervention consists of seven key steps:

- Identify the story
- Finding the emotional resonance of the story
- Describe a moment when something changed or you when you gained personal insight
- Bring the story to life in a visual way
- Use voice and sound to enhance the story
- Assemble and video-edit the story
- Share the story

This DST method has been popularised and refined by StoryCenter in the USA. A overview of a typical 3 day DST workshop provided by StoryCenter is outlined below in Table 9. This has been printed with permission from StoryCenter.
### Table 9: DST 3 Day Workshop (Printed with Permission from StoryCenter)

<table>
<thead>
<tr>
<th>Three Day Curriculum (3 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction to Form &amp; Aesthetics (1hr)</strong></td>
</tr>
<tr>
<td>- Discuss what defines a digital story and the seven steps of digital storytelling</td>
</tr>
<tr>
<td><strong>Individual Writing Time (2-6 hours)</strong></td>
</tr>
<tr>
<td>- Writing in response to different prompts</td>
</tr>
<tr>
<td>- Script revision following feedback from story circle</td>
</tr>
<tr>
<td>- Discuss approaches to script revision</td>
</tr>
<tr>
<td>- Is the script too long or too dry or lacks a sense of voice?</td>
</tr>
<tr>
<td>- Is the story buried?</td>
</tr>
<tr>
<td>- Show not tell</td>
</tr>
<tr>
<td>- Use your own words</td>
</tr>
<tr>
<td>- Trust the story form and audience</td>
</tr>
<tr>
<td><strong>Story Circles (3-5 hours)</strong></td>
</tr>
<tr>
<td>- Each person shares a verbal story or part of written script</td>
</tr>
<tr>
<td>- Storyteller directs the feedback process</td>
</tr>
<tr>
<td>- Goal of story circle is to:</td>
</tr>
<tr>
<td>- Advance the development of the story from first draft to next iteration.</td>
</tr>
<tr>
<td>- Establish sense of community among workshop participants</td>
</tr>
<tr>
<td>- Assess relative preparedness of all participants</td>
</tr>
<tr>
<td><strong>Audio-Recording (30 mins)</strong></td>
</tr>
<tr>
<td>- Discuss audio-recording equipment (phone, professional equipment)</td>
</tr>
<tr>
<td>- Discuss best practice in using audio-recording equipment</td>
</tr>
<tr>
<td>- Audio-record script</td>
</tr>
<tr>
<td><strong>Images and Storyboarding (2-6 hours)</strong></td>
</tr>
<tr>
<td>- Approaches to image selection, photography and storyboarding</td>
</tr>
<tr>
<td><strong>Software Tutorial (1-3 hours)</strong></td>
</tr>
<tr>
<td>- WeVideo tutorial 1 – basic introduction</td>
</tr>
<tr>
<td>- WeVideo tutorial 2 - Transitions/pans and Zooms/Soundtrack/Titles</td>
</tr>
<tr>
<td><strong>Production Time (5-9 hours)</strong></td>
</tr>
<tr>
<td>- Free time to create video</td>
</tr>
<tr>
<td>- Small group feedback on first edits</td>
</tr>
<tr>
<td>- Final production</td>
</tr>
<tr>
<td><strong>Screening (1-2 hours)</strong></td>
</tr>
<tr>
<td>- Screen stories</td>
</tr>
<tr>
<td>- Final thoughts</td>
</tr>
</tbody>
</table>
5.2.2. Rationale for Choosing Digital Storytelling

The rationale for choosing DST was guided by the implications for intervention development identified in both Chapter 2 (Section 2.8) and Chapter 4 (Section 4.8). Firstly, there is an identified need to explore underrepresented art forms such as digital, online and electronic arts to further the field of participatory arts. Secondly, the literature highlights the positive impact of DST on social connectedness, social support, meaning-making, emotional acceptance, sense of achievement, hopefulness and self-efficacy (DiFulvio, 2016; Gubrium et al., 2016; De Vecchi, 2016; Hausknecht et al., 2017; Rolbiecki et al., 2019). Indeed, a conceptual model of the effects of DST on mental health highlights social support, self-efficacy and emotional acceptance as the primary outcomes which are mediated through social modelling of peer support, mastery of news skills and emotional processing (Fiddian-Green et al., 2019). These DST outcomes and mediators align with recommendations in Chapter 4 (See Section 4.8.1. and Section 4.8.2) to enhance connectedness, self-efficacy and emotional processing to address the issues of isolation, a lack of meaningful occupation, difficult life transitions and adverse childhood experiences among men in areas of high social disadvantage in Northern Ireland. Lastly, many of the processes of DST align with the approaches to improving male engagement in PAIs outlined in the previous chapter (See Section 4.8.3). DST is mostly user-led wherein participants hold control over the content of their story and how the process is conducted. The personal nature of DST means that every individual is an expert in their own experience and participants do not require a high skill level to participate. These are consistent with recommendations to build men’s autonomy and ownership, prioritise the process over the product and begin
with an art form that requires a lower skill level to participate. For these reasons, DST was chosen as the art form to present to key stakeholders to develop the PAI.

However, there are some features of DST interventions that appear to conflict with the implications for intervention development identified in Chapter 4. The focus on a “story-circle” would appear to conflict with the need for action-orientated approaches that men favour and may carry the stigma of mental health and/or feminine behaviour (“sitting in a wee room talking about your problems”). Although DST interventions prioritise autonomy and ownership, they can be quite structured and delivered over a short space of time (3 days) which is in contrast to the flexibility with participation that men favoured. Therefore, a sample DST intervention was presented to key stakeholders in order to explore some of these contradictions and to identify preferences for the features, content and approaches to delivery of the intervention.

5.3. Stakeholder Demographics

Men in areas of high social disadvantage in Northern Ireland who participated in Stage 2(a) and service providers with a remit for men’s health, digital arts and/or mental health represented the key stakeholders for this stage of the study. It proved extremely difficult and slow to recruit men in areas of high social disadvantage in Northern Ireland for this stage of the study. Many of the ‘gatekeepers’ to these men had been furloughed from their job which challenged the recruitment process. Nonetheless, contact was established with 11 of the 41 men who participated in Stage 2(a) of the study of which six expressed an interest to participate in Stage 2(b). One of these men subsequently dropped out which

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resulted in five men participating in the consultation process. The recruitment of these five participants took almost five months. The demographics of these men are provided in Table 9. For ease of reference this cohort of stakeholder will hereafter be referred to as “men’s group members”.

The recruitment of service providers with a remit for men’s health, digital arts and/or mental health was also a time-consuming process but proved more successful with the recruitment of ten service providers. Their specific professional work experiences are outlined in Table 10. Similarly, for ease of reference this cohort of stakeholders will hereafter be referred to as “service providers”.

Table 10: Demographics of Men’s Group Members (Stage 2b online consultations)

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Employment Status</th>
<th>Relationship Status</th>
<th>Living Alone</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Séan</td>
<td>61</td>
<td>Employed</td>
<td>Married</td>
<td>No</td>
<td>32 minutes</td>
</tr>
<tr>
<td>Josh</td>
<td>58</td>
<td>Away from Work due to Illness</td>
<td>Separated</td>
<td>Yes</td>
<td>59 minutes</td>
</tr>
<tr>
<td>Joey</td>
<td>53</td>
<td>Away from Work due to Illness</td>
<td>Divorced</td>
<td>Yes</td>
<td>37 minutes</td>
</tr>
<tr>
<td>Arnold</td>
<td>59</td>
<td>Unemployed</td>
<td>Divorced</td>
<td>Yes</td>
<td>1 hour</td>
</tr>
<tr>
<td>Lee</td>
<td>26</td>
<td>Away from Work due to Illness</td>
<td>Never Married</td>
<td>No</td>
<td>41 minutes</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Occupation</td>
<td>Country</td>
<td>Experience Delivering Digital Arts</td>
<td>Experiencing Using Gender Sensitive Approaches</td>
<td>Duration</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Amy</td>
<td>Research Fellow</td>
<td>Australia</td>
<td>Yes</td>
<td>Yes</td>
<td>1 hour 21 minutes</td>
</tr>
<tr>
<td>Mary</td>
<td>Senior Lecturer</td>
<td>Ireland</td>
<td>Yes</td>
<td>Yes</td>
<td>39 minutes</td>
</tr>
<tr>
<td>Liam</td>
<td>Statutory Men’s Health Practitioner</td>
<td>Ireland</td>
<td>No</td>
<td>Yes</td>
<td>1 hour 7 minutes</td>
</tr>
<tr>
<td>Cormac</td>
<td>Non-statutory Men’s Health Practitioner</td>
<td>Northern Ireland</td>
<td>Yes</td>
<td>Yes</td>
<td>1 hour 37 minutes</td>
</tr>
<tr>
<td>Kate</td>
<td>Men’s Shed Facilitator</td>
<td>Northern Ireland</td>
<td>No</td>
<td>Yes</td>
<td>54 minutes</td>
</tr>
<tr>
<td>Aine</td>
<td>Community Health Worker</td>
<td>Ireland</td>
<td>No</td>
<td>Yes</td>
<td>51 minutes</td>
</tr>
<tr>
<td>Peter</td>
<td>Prison Mental Health Nurse</td>
<td>Northern Ireland</td>
<td>Yes</td>
<td>Yes</td>
<td>1 hour 3 minutes</td>
</tr>
<tr>
<td>Ciara</td>
<td>Digital Community Artist</td>
<td>Northern Ireland</td>
<td>Yes</td>
<td>Yes</td>
<td>58 minutes</td>
</tr>
<tr>
<td>Niamh</td>
<td>Digital Community Artist</td>
<td>Northern Ireland</td>
<td>Yes</td>
<td>No</td>
<td>43 minutes</td>
</tr>
<tr>
<td>Mona</td>
<td>Digital Storytelling Facilitator</td>
<td>USA</td>
<td>Yes</td>
<td>No</td>
<td>1 hour 5 mins</td>
</tr>
<tr>
<td>Ross</td>
<td>Digital Storytelling Facilitator</td>
<td>USA</td>
<td>Yes</td>
<td>No</td>
<td>51 minutes</td>
</tr>
</tbody>
</table>
5.4. Overview of Stage 2(b) Procedure

The procedure for Stage 2(b) was outlined in Chapter 3 (See Section 3.6.1) along with the impact of COVID-19 on this stage of the study and the rationale for conducting online individual consultations as opposed to face-to-face co-design workshops are also outlined. Nonetheless, the procedure for conducting these online individual consultations are briefly re-capped in this section.

Online individual consultations were conducted with the key stakeholders to: (i) decide on the problems to be addressed and to gauge interest in DST; (ii) generate solution, components and features of the intervention; and (iii) identify content, format and delivery of the intervention. These align with Actions 4,9 and 11 of the taxonomy of approaches for intervention development as outlined in Figure 3 (See Section 3.5 Study Design). These consultations began with an oral summary of the findings from Stage 2(a). Stakeholders were then introduced to the concept of DST and watched two sample digital stories. One digital story was selected on the basis of having a storyteller of similar age and background to the target group. The second story was created by the researcher, thereby offering a relevant and relatable version of the DST process, featuring a familiar face. With permission, an outline of the 3 day digital storytelling workshop created by StoryCenter was then presented to participants (See Table 8). The researcher then asked a series of semi-structured questions (See Appendix 10). These were focused on the relevance of the problems to be addressed, attitudes towards DST, likelihood to participate or deliver such a programme, perceived barriers and facilitators to engagement, how the programme should be implemented and what features should be changed to better suit the needs of the target group (i.e. men in areas of social disadvantage in
Northern Ireland). This was an iterative process where each consultation informed the next. Key points of consensus or disagreement were presented to subsequent stakeholders in order to gain their opinions on the matter. Based on these consultations a draft outline description of an intervention was drawn up and sent to participants via email. Following some minor amendments, a final outline description of the intervention was completed.

5.5. Overview of Findings from Consultations with Key Stakeholders

Whilst the purpose of the consultation process was to inform the development of an outline description of a PAI, it became apparent that the shape and content of the intervention in a real world context would largely be determined by the needs of the specific group. This was largely due to the positive mental health outcomes being accrued from a self-reflective process which can vary considerably between groups and compared to a physical activity or educational intervention for example ('maybe in [educational programme] you could say by Week 5 you should be on page 59 but that will not work for something like this’ Aine Community Health Worker). Therefore, whilst an outline description of an DST intervention is presented, it would likely need to be adapted to suit the needs of the specific group that is being targeted. The findings from this stage of the study are presented under three primary headings as they relate to the main aims of this stage of the study: (i) Opinions on Problems to Be Addressed and Interest in DST; (ii) Preferences for Approaches to Delivery; and, (iii) Preferences for Content and Features of Intervention. Section 5.6 explores stakeholders’ opinions on the problems to be addressed and presents their interest in the concept of DST. Stakeholders’ preferences for delivery of the DST intervention, including gender-sensitive
strategies and more practical considerations, are presented in Section 5.7. Finally, the preferences for the features and content of the intervention are presented in Section 5.8.

5.6. Opinions on Problems to Be Addressed and Interest in Digital Storytelling
There was a high level of agreement that the ‘problems to be addressed’ that were identified in Chapter 4 were pertinent issues to men in areas of high social disadvantage in Northern Ireland. There was also consensus that DST had the capacity to support men around these issues by enhancing connectedness, self-efficacy and emotional processing. Addressing isolation and self-efficacy were noted as common features in men’s health programmes but specifically targeting difficult life transitions through emotional processing was felt to be novel development (“that is something that I’m not seeing an awful lot of and is very much needed” Mary, Senior Lecturer). Indeed, in many cases, the men noted how DST would provide a medium to self-reflect on past experiences and have a cathartic effect:

“It would act as a form of therapy. It would be a relief to talk about certain experiences and to hear yourself talking about them out loud. It would definitely benefit my mental health...and there are loads of lads in the group that would benefit from it immensely”. Josh, 58, Men’s Group Member.

The concept of DST was well received by stakeholders and initial reactions were mostly positive. The men expressed a desire to participate in such a DST intervention and service providers that were unfamiliar with DST expressed their willingness to implement something similar with their own respective groups:
“I think it is just brilliant. I can think of about 10 lads who would love to get involved in this. The lads love telling stories...that’s what a shed is about, talking and sharing stories. This sort of captures that but in a more creative way through the arts”. Séan, 61, Men’s Group Member.

“I would love to have this as a programme in [Organisation]. I can think of the exact group that would have a ball doing this. What you are doing here is really on the button”. Kate, Men’s Shed Facilitator.

Indeed, DST was felt to align with a long tradition of storytelling in Northern Ireland and therefore represented an art form that was favourable among this group. Stakeholders felt that the visual and story-based nature of the art form meant it was an accessible to a broad proportion of society and was an innate feature of human life;

“There is huge strength to digital storytelling - its visual and story-based. It’s based on the universal idea that we all like to tell our stories and we are surrounded by visual stories all the time. As humans we are the accumulation of the stories in our lives. Particularly, on the island of Ireland we have a very strong tradition of storytellers, it is something we do and it is something that we are comfortable with”. Mary, Academic in Health Promotion.

Indeed, the fact that ‘everyone has a story to tell’ (Cormac, Men’s Health Practitioner) and the low skillset required to participate was highlighted as a key strength of DST. Finally, many stakeholders appreciated that the intervention was
evidence-based and included a rationale as to why it should be delivered. This was felt to support the delivery of the intervention;

“What I really like about this is that it is based on evidence. It’s really important to have the background of why we are doing the intervention. Some people think than you can just have a manual and run it [intervention], but you need to know the why”. Peter, Prison Mental Health Nurse.

Although DST was well received among stakeholders there were a few features and approaches to delivery that stakeholders felt might not work well with men. These were: a lack of action-orientated approaches in the early stages of the programme; the degree of vulnerability required to participate; literacy issues; and the need to provide extra support around low digital skills. Suggestions that were provided to overcome these barriers are discussed in the following sections.

5.7. Preferences for Approaches to Delivery

5.7.1. Gender-Sensitive Approaches
Although initial reactions to DST were positive among stakeholders many felt that a number of gender-sensitive approaches would have to be incorporated to enhance its acceptability among men. These are discussed in the subsequent sections.

5.7.1.1. Delivering DST to Existing Groups in a Familiar Space
Stakeholders noted that there is a degree of vulnerability required to participate in DST which could potentially clash with traditional masculine ideologies and act as a barrier to engagement. Indeed, Amy recounted the difficulty in convening new groups of men to engage in DST whilst recruiting established group proved to be a more fruitful approach. Therefore, stakeholders recommended delivering DST to an
existing group of men who have established trust and in an environment that is safe and familiar to the group:

“We tried to bring new groups of men together to do this... and it was just so difficult to get them in the door. We moved to recruiting more established groups and that worked much better. It helped to overcome a lot of the trust issues”. Amy, Research Fellow, Suicide Prevention.

“When delivering this, you would need to do it with an established group and in their space. There is a certain level of formation and trust and they have already been vulnerable with each other to some degree”. Aine, Community Health Worker.

Indeed, stakeholders highlighted the importance of the informal space and advised against using any resources or approaches that made the intervention feel like a formal learning process;

“I think it will work as long as you don’t make it like being back in school. A lot of the men would have had a poor experience in school and the arts was just not valued at the time. Once you make it a bit of craic and laidback I can see it working well”. Joey, Men’s Group Member.

The men’s shed network in Northern Ireland was cited as a potential site to deliver the intervention and to build its credibility before branching out to other groups. With regard to the amount of participants per class, it was noted that between six to twelve participants worked best. This was felt to allow sufficient one on one time with facilitators and to provide enough of a group context to enable the benefits of
peer support. In terms of creating safety through the content and features of the programme, stakeholders highlighted the importance of beginning with activities that did not require too much disclosure of personal information and graduating to more self-reflective topics that required more personal insight in order to ease men into the programme. This is discussed in more detail in Section 5.8.

5.7.1.2. Utilising Action-Orientated Approaches

Another concern among stakeholders was the lack of action-orientated approaches in the initial weeks of DST. Some noted that men might lose interest quite quickly if they were sitting around waiting for their turn to speak;

“If the lads are sitting around in circles waiting their turn to speak, it’s not gonna work. A guy is going to go for a cup of tea and not come back. It’s important to keep busy, holding cameras and stuff – get involved from the start. I suppose it will be a fine balancing act to get the stories out of guys whilst keeping them busy and not sitting around”. Josh, 58, Men’s Group Member.

However, stakeholders noted that once men became more deeply involved with the process the need for these action-orientated approaches becomes less important. Therefore, stakeholders suggested implementing some of the teaching of digital skills at the beginning of the intervention to give more of a hands-on experience early on. Stakeholders agreed that it was important to introduce what defines a digital story and the seven steps of DST. However, they recommended that this should be done through the screening of digital stories that are relatable to the target group and not through Powerpoint or reading materials. This would help the
men to conceptualise what they are being asked to do in more practical terms. Other more action-orientated suggestions included overlaying the storytelling processes with existing activities in the group, getting men to interview each other, and introducing ice-breaker activities that require greater movement around the room. These are discussed in more detail in Section 5.8.

5.7.1.3. Adopting Strengths-Based Approaches
Stakeholders recommended that the DST intervention should prioritise peer-led approaches and enable men with relevant proficiencies to lead components of sessions (e.g. men with photography experience leading image collection sessions). Capitalising on the existing capacities in the group was felt to build trust and confidence within the group and further contribute to peer support and connectedness:

“Different men have different skills so guys with more I.T. skills can help the other guys. That peer support is equally as important as the facilitation. We want to take every bit of goodness that is already in the shed to support this process. You recognise the strength of the group and that tends to work best to build the trust and confidence of the group”. Mary, Academic in Health Promotion.

“The story might be an individual thing but I think if you could make it more of a group thing it would work really well. One guy holding a camera, one helping with the audio, one guy doing something else. That would add a lot to it, it would encourage me to be more involved anyway”. Lee, 26, Men’s Group Member.
It was also recommended to maximise discussions around the positive values and strengths of men and to draw out positive lessons they may have learnt from overcoming difficult experiences. Furthermore, stakeholders felt the DST intervention should be framed around the altruistic tendencies of men to facilitate engagement. This could be operationalized as providing a “living legacy” or the “life-enhancing wisdom” that these men have to offer. This was felt to be an important incentive or “hook” for these men who were retired or lacking in self-esteem as it offered them an opportunity to be seen and to feel that they can contribute something useful;

“The hook here is the story of our best selves, our life-enhancing learnings - living legacy. We all want to leave something in life and I think that really speaks to men. A lot of these men feel they have become invisible but having the opportunity to speak to legacy and lessons learnt, that is very powerful, for a man to be seen. When men are asked to do something for the good, there are very few that will say no”. Liam, Men’s Health Practitioner.

Indeed, many stakeholders noted their success in engaging men in digital arts interventions when they were framed around altruism and giving back (“these guys were so motivated around the fact that they were giving something back” Peter, Prison Mental Health Nurse). With this in mind the name “Living Legacy” was suggested as the name of the intervention which was accepted by the stakeholders. Additional ‘hooks’ or incentives for men to engage in DST included: learning new skills particularly those relating to computer literacy; raising money for their respective men’s group through an open screening of the stories; having fun; being
‘a star for a day’; developing routine and structure; and having something to do. Perhaps not surprisingly key stakeholders stressed the importance of not advertising DST as a mental health or arts programme as it would likely drive men away;

“If you go down a mental health route or specifically advertised is a place to learn arts then it might throw boys off. But if you go down the route of what is a story you would like to tell, then I think you would get buy-in” Arnold, 59, Men’s Group Member.

5.7.1.4. Enabling Autonomy, Ownership and Flexibility in DST
Stakeholders highlighted the importance of building men’s autonomy and ownership in order to sustain their engagement in DST. There was broad agreement that the DST facilitators should consult with men before and during the intervention to identify what they would like to learn, to ensure it is meeting their expectations, and to adapt it to suit their needs. Ciara highlighted that although certain objectives will have to be met to meet the aims of a funding body, the intervention should be adapted to the needs of the group as much as possible;

“…as long as you incorporate their feedback into the programme, it usually works really well. I would also check-in at the end of each session to see if things are going the way they wanted them to... if there was anything they wanted to change. I always offered them the flexibility to change anything but I encouraged them to try it first. If there are funding objectives that have to be done then you need to get certain things done but suit the men as much as you can”. Ciara, Community Digital Artist.
Stakeholders noted that simply the act of offering ownership and opportunities for feedback was often enough to gain trust and buy-in from men. Introducing the programme in terms of hours rather than weeks (12 hour programme vs 6 week programme) and allowing men to choose how those hours are spent was another mechanism to offer ownership over the programme and can help to overcome issues associated with competition commitments. Indeed, flexibility with men’s participation was also deemed important. It was advised that there ought not to be any pressure to write a story, but rather participants could be involved with other aspects of the process like holding cameras, helping to record scripts, and helping other men to tell their story, if some did not wish to develop their own.

5.7.1.5. Prioritising Clear and Tangible Processes and Outcomes
Another gender-sensitive approach that was mentioned frequently was the need for all intervention processes and outcomes to be clear and tangible. Stakeholders highlighted the need for men to know what was expected of them in advance of the next session which was felt to facilitate sustained engagement. Having this clearly laid out was felt to make the intervention more approachable and manageable:

“You need to be very clear on what you are asking them to do. I would make sure at the end of every session they go away knowing what is expected of them the following week. That makes it easier to buy in to it. That makes the programme look manageable and approachable – you would think yeah I can do that”. Cormac, Men’s Health Practitioner.

In this regard the stakeholders appreciated the clear outputs for each primary activity within the intervention (e.g. 500 word script; 10-16 images; 3-5 minute
video). However, areas that stakeholders felt needed to be clearer were the prompts used to encourage men to ‘find their story’ and the ‘story-circle’ process. Some prompts that were suggested - such as “what are the things that add to your life?” - were felt to be too open to interpretation or “wooly” (Cormac). Stakeholders suggested that these prompts should be more tangible and relate to a specific timeframe within participants’ lives:

“Men might be put off by those type of prompts, they might think ‘what is the point of this’? There has to be a clear outcome or a clear story in relation to the question or prompt. Most males like to cut to the chase. So ask a question that is positive, tangible, and about a specific time. Pick a time in your life when you overcame an obstacle”. Aine, Community Health Worker.

Finally, many stakeholders noted the importance of giving lots of practical examples to men prior to beginning each task. This could include the facilitator’s own digital story, an example of a script or previous participants’ work;

“You will need to give lots of examples of what the men are working towards. Examples of videos, photographs, scripts and things like that. I think that would help a lot so you could see what you are working towards”. Joey, 53, Men’s Group Member.

5.7.1.6. Using “Male Friendly” Language
Many stakeholders cited the importance of using ‘male friendly’ language when facilitating the intervention and on all documents associated with the intervention. Stakeholders recommended avoiding language that sounded too formal or medical such as the phrases ‘intervention’ or ‘mental health outcomes’. Indeed, language
that could be interpreted as feminine by association with emotions or ‘touchy-feely words’ should also be avoided (Cormac, Men’s Health Practitioner). Therefore, stakeholders highlighted the need to change the name of the ‘story-circle’ as it could be perceived as feminine or as something for children;

“I think story circle might remind the lads of primary school or something for children. From my experience once the words sharing or story comes into it, its unnerving for some men. A less feminine name for it, something like discussing life experiences”. Joey, 53, Men’s Group Member.

It was felt that language reminiscent of school or that could be construed as reinforcing a sense of authority should be avoided. Against this backdrop, stakeholders recommended not using the words ‘group rules’, ‘group contract’ or ‘homework’ throughout the intervention and recommended using phrases like ‘group agreement’ and ‘tasks’ instead;

“These might be men who had a lot of rules in their life, men who may have had issues in school or with the authorities. So I would tend to use the phrase group agreement rather than rules or contract... I wouldn’t use the word homework either, a lot of the guys would not have had a good experience in school. Maybe something like tasks instead”. Aine, Community Health Worker.

Finally, stakeholders recommended removing any reference to ‘writing’ in the intervention. They noted that some men might have literacy issues and so would not participate in the intervention. Indeed, Cormac noted that writing was one of the biggest stumbling blocks for engaging men in health interventions. Therefore, in
addition to provided alternative exercises to writing a story, Liam suggested using alternative language like ‘develop your story’ rather than ‘write your story’;

“Some guys would have had literacy issues so when it came to writing or reading anything they would just disengage and a few dropped out. I realised it wasn’t they weren’t interested, it was just literacy issues but they never told me that”. Niamh, Community Digital Artist.

“I would take the word writing out of it, I would call it ‘developing your story’. Take out anything that looks like a barrier to literacy. Especially the men you are going to be reaching out to, they might have left school early or had a bad experience. It’s better if we use the language of story more than the language of writing a script”. Liam, Men’s Health Practitioner.

5.7.2. Practicalities of Delivering the Intervention – Duration, Facilitator and Resources
This section covers more practical aspects of the delivery of the intervention including the duration of the intervention, the skills required by potential facilitators and the resources needed. These are discussed in the subsequent three sections.

5.7.2.1. Duration of Intervention
All stakeholders noted that the standard digital storytelling format - a 3 day workshop lasting 6-8 hours per day - would not work well with men. Many like Joey felt that this would be too intense, too structured, and therefore could drive the men away;

“If you ran all this over 3 days it would be too intense and I think you would lose a lot of lads. You want a bit of flexibility as well, that you don’t have to
be down there at 9 in the morning, you might have grandkids to pick up”.

**Josh, 58, Men’s Group Member.**

Although stakeholders agreed that the intervention should be drawn out over a longer time period, there was some disagreement on the ideal duration for the intervention. Some stakeholders felt that 10 weeks was necessary to deliver the the intervention whilst others noted the difficulty in retaining men in once-off programmes lasting longer than 6 weeks;

“When I did something similar it took me 10 weeks. It depends on the group and if they are computer literate. That will take longer to teach. You could maybe turn it around in 6 weeks if you do a lot of editing yourself”. **Niamh, Community Digital Artist.**

“I agree the content is 10 weeks, to do it well, but maybe not for men who have never done anything like this before. Five to six weeks feels more appropriate to me. A guy can image five or six weeks”. **Liam, Men’s Health Practitioner.**

All of the men’s group members felt that ten weeks was too long and they would prefer a shorter intervention. Moreover, the digital storytelling experts in the USA confirmed that six week programmes can be effective if extra supports are provided for those who lack computer skills. Therefore, the stakeholders agreed via a follow up email on a six week intervention. However, this was proposed to be six weeks of ‘working time’ and would exclude the introductory session and the screening session. Stakeholders recommended that facilitators should make a judgement call on the digital proficiencies of the group and additional support may need to be
provided outside the hours of the intervention. Additionally, some stakeholders recommended that a separate computer skills class could be offered prior to commencing the intervention to accommodate those with additional needs. This could cover the basics of using the computer and/or phone and the editing software. Finally, all stakeholders agreed that sessions should be delivered once per week for two hours. However, as participants are likely to be articulating stories about difficult experiences; it was recommended that lots of comfort breaks are included. This would be consistent with the informal that men highlighted a preference for:

“Some men may be working at an intense level that they have not worked at before, I know men who have told stories to men’s groups but not to their closest friends. So free time is really important I think. Time to down tools and walk away for a while”. Arnold, 59, Men’s Group Member.

“A lot of tea breaks seem to be a thing with the men’s sheds [laughter]. I always did sessions that were about 2 hrs with a break in the middle of about 20 minutes”. Ciara, Community Digital Artist.

5.7.2.2. Skills and Qualities of the Facilitator
Stakeholders recommended that at least two facilitators should deliver this intervention, preferably with complementary skillsets/experience of DST and utilising gender-sensitive approaches to work with men around mental health. Some stakeholders highlighted the potential for men to become distressed through the DST process and thus supports should be provided. As a minimum, it was proposed that distress protocols should be available and facilitators should have the
capacity to refer participants to appropriate services. Facilitators with experience of supporting those in distress were also recommended. Having facilitators with complementary skillsets was seen as being helpful in terms of creating safety, responding to distress and ensuring that men were given every opportunity to complete a digital story;

“We also had facilitators who were strong in digital storytelling. Sometimes people would not be able to finish their stories and they would give that extra push to help to complete the final product”. Amy, Academic in Suicide Prevention.

“It should at the very least be co-facilitated. I think somewhere between 2-4. At the very least you should know how to appropriately refer people in distress and if at all have some capacity for counselling”. Mary, Academic in Health Promotion.

Moreover, having an adequate number of facilitators meant that individual support could be provided to those with literacy issues or who found it difficult to articulate their story. Indeed, as Niamh pointed out, these were often the stories that went unheard and so it was crucial to support such individuals;

“Having a few extra hands there too in case of literacy issues. We did that with a group of who had dyslexia and intellectual disabilities. So you can sit with people, listen to them and help them to form their narrative. The greatest value comes from taking the extra time to support people who normally wouldn’t get a chance to participate because of some of those limitations”. Niamh, Community Digital Artist.
In terms of personal qualities, it was felt that the facilitator should be someone who was encouraging, non-authoritative, empathetic, relatable, non-judgemental and “down to earth”. As Arnold highlighted, the facilitator should guide and move with the process, at a pace that was most suitable to the group, rather than being a ‘consummate leader’ who was overly focused on the outputs and timeframe.

Indeed the ability to adapt to the needs of the group was highlighted as a key skill that would be required by potential facilitators. The facilitator should model vulnerability where appropriate and could engage with the tasks alongside the men. This might help to build trust and rapport between the group and the facilitator, give men a greater understanding of the activity at hand, and build their confidence to develop their own story;

“The lead facilitator of our group had been in prison himself. So at the start he shared his own story and he joined in on the activities with the lads. From that point the lads instantly identified with him and he stopped being someone with a camera who just asked them questions, he was one of us sort of thing. It gave them the confidence to write their own story. Sometimes if you model something, people get an understanding of what is expected of them and off they go”. Peter, Prison Mental Health Nurse.

Finally, it was highlighted that facilitators should be mindful of the potential for embarrassment or shame when working with men around DST and limit this risk where possible. Some stakeholders noted that facilitators lacking experience of working with men could undertake training on how to engage men using gender sensitive approaches such as ENGAGE National Men’s Health Training (MHFI, 2021).
5.7.2.3. Resources Needed
Stakeholders noted that men from lower socio-economic communities might not have access to computers and so might need to be provided with laptops. Some stakeholders noted that they formed partnerships with local education training boards in order to gain access to computer suites;

“We linked our intervention with a local training organisation that allowed the guys to use their computers with the software already installed”. Amy, Academic, Suicide Prevention.

Conversely, it was noted that this might disrupt the ‘safe-space’ of a men’s group and represent a formal learning environment. Others reported that they supplied up to three laptops for use between the group and took turns editing videos and developing scripts. One suggestion was to use the video editing software WeVideo which can be used on mobile phones or tablets. As most participants had access to a smart phone, it was felt that this software could be used on their personal device. Stakeholders suggested using a mix of participants bringing in their own laptops, phones and tablets whilst also providing some laptops. Beyond these resources, it was noted that the facilitator needed a projector and their own laptop to screen videos.

5.8. Preferences for the Features and Content of the Intervention
5.8.1. Introductory Session
Stakeholders highlighted the importance of hosting an introductory session prior to delivering the programme. This should provide an overview of the intervention, clearly outline what would be expected of the men should they choose to participate, and give an indication that it is ‘safe’ to participate. Safety in this regard
related to feeling comfortable enough to discuss sensitive topics and not being afraid of looking silly or feel emasculated:

“Its important to have an introductory session. Laying it out to men, let them think about it and what it would be like to engage with it. The two most important things there are that men walk away from the session knowing they will be kept safe and knowing what they will be doing next week”. **Cormac, Men’s Health Practitioner.**

“I think most men will know what story they want to tell, but it is figuring out if it is safe to tell it. You need to create that safety early on. There is also safety in that digital storytelling is approachable and they [men] are not going to look silly. If you get that right, the intervention will look after itself”.

**Liam, Men’s Health Practitioner.**

There was broad agreement that this introductory session should last about 30 minutes and introduce men to the overarching ideas of the programme (‘a shorter session maybe 30mins to give the flavour of digital storytelling’, Ciara, Community Artist). Stakeholders noted that this session should sell the benefits of DST (i.e. the ‘hooks’ See Section 5.7.1.3) with a particular focus on the wisdom they can share with other men. It should be delivered informally and offer men opportunities to ask questions and adapt the programme to their needs. This would also serve to model how the intervention will be delivered:

“Have an introductory session separate, over a cup of tea and a sandwich – I think that would hold their interest. Explain what you are planning to do and ask them to be honest with you with feedback. Laying it out to them, what is
expected of them and let them have a bit of time to think about it. It also shows them that you interested in them and you will listen to what they have to say”. Josh, 58, Men’s Group Member.

5.8.2. Graduating Vulnerability to ‘Find the Story’
Many stakeholders noted the importance of graduating men’s exposure to discussing sensitive topics and being vulnerable in the group in order to ease them into the story development process. Firstly, stakeholders highlighted the importance of drawing up a group agreement based on the men’s suggestions. This should be signed by all participants and displayed for the duration of the intervention. This was felt to gain buy-in, build social cohesion within the group and with the facilitator and to offer men autonomy and ownership over the process from the outset.

Stakeholder also recommended beginning the story development process with ice-breaker activities that focused on participants discussing other men in their lives and graduating these activities to focus on more personal topics. One such introductory activity that was recommended was the ‘name game’ (say your name and why you are called that). This was felt to be a safe way to disclose personal information and might uncover some family history that could lead to the development of a story. Moreover, it ensured that everyone was afforded the opportunity to speak within the first 15 minutes of the programme which was felt to be crucial for creating open dialogue for the rest of the programme:

“You are straight away into a personal experience which can help with the stories for the rest of the process. In the first 15 minutes you have to hear
everybody’s voice in the room at least once”. Cormac, Men’s Health Practitioner.

Another suggested activity was for participants to discuss men that they admired, looked up to or that taught them a valuable lesson. This could be man in the public eye or personal friends and family. This not only acted as another way of graduating vulnerability but served to model the positive values of men. It was felt that this activity could act as a catalyst and source of inspiration for men to develop their own story;

“I would move on to stories about men that inspire us. You are keeping it one step away from them [participants]. Those stories might inspire or stimulate a story in themselves”. Liam, Men’s Health Practitioner.

“A lot of older men might have grown up trying to be heroes or were monsters that drank too much or were neglectful. Starting with the idea that these men are people of worth...you do not want to come out the other end of the project with a bunch of stories about their failings”. Kate, Men’s Health Facilitator.

Other activities that were suggested included call and response exercises to questions associated with positive masculinities (what good traits do men possess) and more visual exercises where participants select one image from a group of photos associated with men and explain why they chose the image. The group responses could be synthesised and displayed in the room to help stimulate ideas for personal stories later in the process. Finally, many noted that men often felt more comfortable talking about a personal object rather than themselves. As such,
it was recommended that a useful activity would be for men to bring in old photos to the group and to discuss them. These objects could also form the images when the digital video is being produced:

“You get more out of men when they having something to talk about rather than themselves. So we used that to our advantage and asked them to bring in photos and ask them questions about their item. We wrote all those things down and made a story out of that. Then you start to move into the more personal stuff”. Niamh, Community Digital Artist.

However, some stakeholders recommended caution with this approach as it had the potential for harm. Ciara explained how a participant dropped out of her DST intervention because bringing in old photos caused him distress due to the death of his daughter. Therefore, she recommends keeping this as broad as possible and to allow men to bring in any item they wished. All in all, stakeholders believed that these activities would ease men into the process of developing a personal and self-reflective story whilst also provided inspiration for what stories they would like to tell.

Stakeholders recommended that the next feature that should follow these ice-breaker activities is the development of the script. They highlighted that men may already have a story in mind but noted that it was important to provide a number of prompts to stimulate ideas (“prompts are necessary to kick start a story, to explore ideas” Mary, Academic, Health Promotion). In addition to ensuring that the prompts were clear and tangible, stakeholders stressed the importance of ensuring that they
were also strengths-based and focused on the positive outcomes from, or resilience shown in the face of, past difficulties:

“I would stay away from questions about mental health problems or coping. I would rephrase it to how did you overcome an obstacle or a difficulty in your life. You want to ensure that you are not getting stuck in bereavement, sadness or a lack of fulfilment. Those things might come up but you are looking through them with a lens of how you got past those things, the positive aspects of your life. You are looking after people that way, it is a lot less frightening”.

Liam, Men’s Health Practitioner.

With this in mind, stakeholders suggested a number of prompts which included:

- Tell me about a time when you learned an important life lesson.
- What would you tell your 18 year old self.
- Tell me about a time when you gave or received good advice.
- Tell me about a time when a belief you had changed.
- Tell me about a time when you overcame a challenge or obstacle.
- Tell me about a time you were resilient.
- Tell me about a time when you adapted to a difficult transition.
- Tell me about a time when you felt proud.
- Tell me about a time you were most happy.
- Write a thank you letter to someone you care about.

All in all, there was a positive response to these prompts from the men’s group members. Arnold highlighted how they provided a number of opportunities for men to tell a range of different stories about their life experiences:
“I think they are great and they would help the men tell their story. I could grab on to any number of those and think of a story in my own life”. Arnold, 59, Men’s Group Member.

Stakeholders highlighted the need for provide alternative approaches to writing to develop and refine the story. Many stakeholders suggested that men could audio-record their narratives in response to these prompts rather than writing them. These could then be refined through an iterative process of listening back and making changes to subsequent versions of the audio-file or through transcribing the document using the Google Docs voice-typing command. Alternatively, stakeholders suggested that men could pair up, interview and audio-record one another talking through some of the prompts or talking about the item or photographs they brought in. Finally, many suggested the need for sufficient time over lunch breaks and from session to session to self-reflect and de-brief on the story development process.

5.8.3. Re-Defining the “Story-Circle”
Stakeholders felt that the story circle lacked clear and tangible processes and adopted an approach to discussing sensitive topics that was too formal. However, stakeholders with experience of DST noted that the story circle should not be discarded as it is a crucial process for facilitating peer support and connectedness within the group. Conducting the story circle process over lunch was one suggestion to introduce a more informal flow. Stakeholders recommended framing the story circle process around the altruistic tendencies of men and highlighting that the purpose of the process is to help refine each other’s stories:
“Whenever and wherever there is coffee and tea I think that is when the story circle should happen. I would say something along the lines of ‘listen it would be good if every man got a bit of help here and not just a few, do you want to say something about your story and we will come in when you want’. It is important that men have the option and the choice and I think that is a better way to sell the story circle... it looks a bit more informal”.

Mary, Health Promotion Academic.

“It is tying it [story circle] to the altruistic tendencies of men. The idea of a man listening deeply so as to give support to another man to help him shape his story – that is something men are good at. They know the purpose of it, my time now is to help another. From that perspective, I think the story circle would work well with men”. Liam, Men’s Health Practitioner.

The story circle was highlighted as a process that needed to be approached with caution and care. Stakeholders noted that many men may already be experiencing low self-esteem with regard to negative experiences in their life and that care was needed not to cause additional distress. Therefore, it was suggested that the feedback process should be guided by the storytellers, who might request what parts of the story they would like feedback on. Indeed, feedback ought to be on the telling of the story and whether it conveys the message the storyteller wants to tell rather than the content of the story. It was also suggested to be more clear and direct with what was expected of men in the process. This might include giving men a time limit to share their experience or giving specific points to feedback on as Kate described;
“There might be other ways of going at it rather than have one man talk for 15 minutes and then the next men talk for 15 minutes. You might need a little more direction in sharing the story. What are the two or three reasons why you are sharing this story and have a bit of a time frame on it”. Kate, Men’s Shed Facilitator.

However, some stakeholders were reticent about adopting such an approach, fearing that it could have negative consequences for those men sharing their story for the first time by being cut short due to a time limit. They felt men should have unreserved time to tell their story in whatever way they wished. Therefore, stakeholders noted that it ought to be up to the facilitator to make a judgement call on which approach might be best for the specific group.

5.8.4. Bringing the Story to Life and Sharing the Story
The stakeholders had very little feedback on the sessions of the DST process that involved production, editing and sharing of the video. Almost all stakeholders felt that the men would enjoy this process and there were very little gender-sensitive approaches needed to deliver these aspects of the intervention. Some suggested that men could be given time to take photos of their local area or within the group as part of the image gathering session. Others suggested creating a physical storyboard where men could connect images with words from their script in order to see how it might look before moving to the editing software;

“I like the idea of a physical storyboard. It is a very tangible to bring in photos and stick them on a board. I think it would also get them to communicate on a different level with each other where they could ask each
Similarly, sessions were needed to show men how to use the video-editing software and that this ought to be determined by the digital competencies of the group. Stakeholders, noted that extra support should be offered to men who are finding it difficult to use computers or the software. It was acknowledged men should learn how to use the software by ‘doing’ and by creating digital stories rather than reading instruction manuals. The DST experts from the USA kindly shared specific materials from their own workshops with regard how to support participants to refine their script and edit their video. Finally, stakeholders stressed the importance of men having complete rights over how their video was to be shared, and that the onus was on the facilitator to highlight the permanency of sharing materials online. Some stakeholders noted that they held screening events that were open to the public which helped to raise money for their respective men’s groups.

5.9. Conclusion
This qualitative component helped to identify the preferences and opinions of key stakeholders with regard appropriate features, content, approaches to delivery and outcomes of a DST intervention to promote mental health among men in areas of high social disadvantage in Northern Ireland. There was broad agreement that the problems to be addressed among this group are social isolation, a lack of meaningful occupation, difficulty life transitions, and adverse childhood experiences. Stakeholders highlighted a number of gender-sensitive approaches to enhance the acceptability of the intervention among men as was as practical considerations relating to duration of the intervention, the background of the
facilitators and the resources needed. They also suggested a number of changes to the features and content of the intervention which mostly related to the introductory session, graduating men’s exposure to discussing sensitive topics and re-defining the “story-circle”. Few suggestions were made with regards changes to the production, editing and sharing of the videos. Through this iterative consultation process an outline description of the Living Legacy Programme was developed. This is outlined in Chapter 6.
Chapter 6: Living Legacy - A Digital Storytelling Intervention to Promote Mental Health Among Men in Areas of High Social Disadvantage in Northern Ireland
6.1. Introduction
The previous chapter described key stakeholders’ preferences for features, content, approaches to delivery and outcomes of a digital storytelling (DST) intervention to promote mental health among men in areas of high social disadvantage in Northern Ireland. This resulted in the development of the Living Legacy Intervention. A significant criticism of participatory arts interventions (PAIs) is the lack of clear intervention descriptions, theoretical underpinnings and logic models describing the mechanisms of action (Daykin et al., 2017; Dunphy et al., 2018; Sheppard & Broughton, 2020). Therefore, there is an identified need to provide clear descriptions of PAIs to encourage transparency and replicability and to aid future implementation and evaluation (Daykin et al., 2017; Dunphy et al., 2018). Therefore, this brief chapter provides an outline description of the proposed Living Legacy intervention. The integration of the findings from Chapter 2, 4 and 5 and how they relate to the existing literature will be discussed in Chapter 7.

6.2. Living Legacy: A Gender-Sensitive Digital Storytelling Intervention
The Living Legacy intervention was developed using a systematic evidence-based and user-informed intervention development approach. Although Stage 1 - Systematic Review was limited in drawing conclusions on men, it helped to establish the evidence-base, identify potential mechanisms underpinning positive mental health outcomes via PAIs and barriers and facilitators to engagement. This helped to inform the topic guides used in Stage 2(a) – Understanding Experiences. Stage 2(a) - Understanding Experiences helped to identify the key issues that the intervention should address, elucidated the gendered pathways through which men experience the mental health benefits of PAIs, pointed to a number of gender-
sensitive approaches to improve male engagement and informed the development of a draft logic model (see Figure 5, Section 4.9). It also helped to identify DST as a potential art form to promote mental health among men in areas of high social disadvantage in Northern Ireland. Finally, Stage 2(b) – Design of the Intervention served to refine a traditional DST intervention in order to suit the specific needs of men in areas of high social disadvantage in Northern Ireland. The information gathered in Stage 2(b) – Design of the Intervention also served to develop a logic model that is specific to the Living Legacy intervention. This is presented in Figure 6 below.

In line with the recommendations of the systematic review, the Living Legacy intervention is documenting using the Public Health England (PHE) Arts, Health and Wellbeing Evaluation Framework Reporting Tool (Daykin et al., 2017). A number of items on this tool cannot be reported on due to the infancy of the intervention. These include contact details for the project manager, funding source and duration, intervention delivery dates, quality assurance processes and project costs. Furthermore, the reporting tool calls for information on the evidence review and consultation process that have informed the development of the intervention. However, these have been described in-depth in the previous chapters and so will not be repeated here. Therefore, the following sections will report on the aims and objectives of the intervention, target population and recruitment, intervention timescale, equipment and resources, structure and content of the sessions, core staff competencies and mechanisms of change.
Figure 6: Living Legacy Logic Model

**Focus**

- Providing DST intervention to men in areas of high social disadvantage to address issues of:
  - Isolation
  - Lack of meaningful occupation
  - Difficult life transitions
  - Adverse childhood experiences

**Activities**

- 6 x 2hr DST sessions delivered once per week with at least two facilitators
- Delivered to an established group of 6-12 men in a familiar space.

**Input**

- Resources
  - Mobile phone and/or access to PC’s/laptops
  - Web/video classroom account
  - Internet access
  - Projector
  - Audio-recorder
  - 6 x 8” cards

- Facilitators (x2)
  - Complementary skill sets in gender-specific approaches and/or DST
  - Capacity to refer for professional support
  - Access to needs of group
  - Model vulnerability
  - Non-authoritative
  - Relatable
  - Non-judgemental

- Facilitator time:
  - 6 x 2hrs sessions (12hrs)
  - 30 mins introductory session
  - 2 hr screening session
  - Additional support if necessary (2-8hrs)

**Key Principles of DST**

- Self-revelatory - gaining new meaning from a past experience
- First person voice - personal reflection on subject.
- Photography Forward - more photos that videos, relaxed visual pace
- Soundtrack - ambient sounds or music to add meaning or emotion
- Restrained Length & Design - 3-5mins with simple editing techniques
- Intention - emotional expression and self-awareness take priority over concerns with regard audience or production value. Storyteller has control over process from beginning to end.

**Gender-Specific Approaches to Delivery**

- Delivered in space that is familiar to men
- Delivered to established group with existing trust
- Frame around the altruistic tendencies of men & wisdom they can share
- Consult with men in decision-making
- Enable flexibility with participation and emotional disclosure
- Focus on the strengths, resilience and existing capacities of men
- Clear and tangible processes and outcomes
- Prioritize of interactive and action-oriented approaches
- Graduate of men’s exposure to discussing sensitive topics
- Utilize “male-friendly” language and reduce literacy requirements

**Theories of Implementation:**

- Check-Mate Tool
- Theories on masculinities

**Outcomes**


  - Bonding Relationships (shared relatedness; belonging; social modeling; peer support)
  - Social Capital
  - Bonding Relationships
  - Mastery of New Skills
  - Mastery of "My Story"
  - Concentration
  - Routine & Purpose
  - Distraction (from emotions via absorption in tasks)

  - Cognitive Change
  - Bridging Relationships (screening to wider community; helping others)
  - Reappraisal of Emotional Stimulus (meaning-making of event)
  - Reappraisal of Emotional Response (sharing similar experiences)
  - Response Modulation (catharsis from emotional expression)

**Outcome Measures**

- Qualitative: Interviews
- Quantitative: Social Connectedness Scale (Lee et al., 2001); New General Self-Efficacy Scale (Chen et al., 2001); Emotion Regulation Strategies for Artistic Creative Activities Scale (Fancourt et al., 2019)

**Assumptions:**

- Support from existing men's groups; adequate recruitment; interest in DST; interest in learning new skills; wanting to occupy time and obtain a sense of purpose; openness to share story; facilitators with relevant skill set

**External Factors:**

- Social norms re masculinities, arts participation & sharing personal stories; interest in intervention; competing commitments; low self-efficacy; facilitator personality
6.2.1. Aims and Objectives of Living Legacy Intervention
The overarching aim of the Living Legacy intervention is to promote the mental health and wellbeing of men in areas of social disadvantage in Northern Ireland through DST. In order to achieve this aim the following objectives are proposed:

- Intervention Objective 1: To facilitate connectedness among men to address issues pertaining to social isolation.
- Intervention Objective 2: To enhance self-efficacy to address issues pertaining to a lack of meaningful occupation.
- Intervention Objective 3: To facilitate emotional processing of difficult life transitions and/or adverse childhood experiences.

6.2.2. Target Population
The target population for the Living Legacy intervention is men in areas of high social disadvantage in Northern Ireland. Due to the older age profile of the men that shaped the intervention, it is most likely suited to an older age group. This intervention should be delivered to an existing men’s group with established trust and rapport. Men will self-refer to this intervention. Contact should be made with existing men’s groups in areas of high social disadvantage in Northern Ireland via the facilitator of the group. If the group is interested in Living Legacy, a 30 minute face-to-face introductory session should be organised to explain the intervention in more detail. If the group wishes to participate, an appropriate time and date to start the first session should be organised. Six to twelve men should be recruited for each intervention.
6.2.3. Context and Setting  
This intervention should be delivered in an environment that is familiar to the men. The most ideal environment is the space already used by the group. The setting is a critical feature of this intervention. Delivering Living Legacy in other spaces such as local community halls or education training facilities might result in poor uptake among men. It is important for the intervention to feel informal and to avoid a formal learning environment. Particular features of the intervention such as “sharing your experience” (or “story circle”) should be delivered over lunch to achieve this aim. The final screening event should be conducted in a setting that is selected by the group. This could be a closed session in the men’s group building or it could be open to the public in another community venue.

6.2.4. Intervention Timescale  
The Living Legacy intervention is intended to be delivered for six weeks, once per week for two hours. This is preceded by a 30 minute introductory session and followed by a screening event lasting two hours. A 20 minute break should be provided during each two hour session. This break is important to allow men some ‘down-time’ within sessions. If the digital competencies of the target group are low, additional weeks and/or sessions might be needed. This should be decided through consultation with the group. The facilitator may alternatively wish to offer the intervention in terms of hours rather than weeks (12 hours vs 6 weeks) and let the men decide how and when that time should be used. This may be a helpful approach when there are numerous competing activities within the group.
6.2.5. Structure and Content of Sessions
The Living Legacy intervention consists of 8 sessions in total – one introductory session, six sessions to develop the digital story, and one screening event. The key output of the intervention is a 3-5 minute video that reflects on a lesson learned from a personal experience. It should contain 10-16 images and be guided by a script that is 300-500 words long. The proposed structure and content of each session is outlined in Table 12. It must be noted that this outline of the intervention content is a guide. More sessions might be needed depending on digital competencies and the structure and content might need to be adapted to suit the specific needs of the group. However, it is recommended that the facilitators make notes of any adaptions made.

6.2.6. Equipment and Resources
Each participant will need a laptop, tablet or smart mobile phone. It is recommended that at least three laptops are available to men who may not possess their own laptop, tablet, or smart phone. A WeVideo classroom subscription is also needed which can accommodate all participants at once. Moreover, one audio-recorder, a projector, a pack of 6” x 8” cards, pens and access to the internet are required.
### Table 12: Structure and Content of Living Legacy Intervention

<table>
<thead>
<tr>
<th>Session</th>
<th>Key Activities</th>
<th>Description of Activities</th>
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| Pre-Intervention Introduction  | Introduce concept of DST (15mins)   | DST is the practice of combining voice, sound, images and video to create a short first person movie about a moment in a person’s life. Digital stories can be about anything but are usually about a turning point or when a person learned an important lesson. Show examples of videos:  
  - Camaro Boy – Rob Kershaw [https://www.youtube.com/watch?v=_NPqbQdsWRc&t](https://www.youtube.com/watch?v=_NPqbQdsWRc&t)  
  - A Convex Mirror – David Fanning [https://www.youtube.com/watch?v=4Wyk0s1Zbos](https://www.youtube.com/watch?v=4Wyk0s1Zbos)  
  - Waiting – Nick Slie [https://www.youtube.com/watch?v=0QWB2IJ4MQ4](https://www.youtube.com/watch?v=0QWB2IJ4MQ4)  |
|                               | Sell ‘hooks’ of programme (5mins)   | • Pass on legacy, wisdom and life-enhancing lessons with others  
  • Capture life history to share with family, friends and community  
  • Tell a story that never got a chance to be told  
  • Learn new skills relating to computers, film, photography, communication and story development  
  • Have a bit of fun with the lads and be a star in your own movie  
  • Something enjoyable to do with time  
  • Learn more about the lives of the men in the group |
|                               | Allow men to ask questions and adapt to fit needs (10mins) | • Ask participants if they have any questions about the programme.  
  • The facilitator should highlight that they can adapt the process and/or timing of the programme to suit the needs of the group.  
  • It is crucial to remain open to feedback and to be flexible with men’s level of participation in order to maximise their ownership and autonomy over the intervention. |
<table>
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<tr>
<th>Session 1: What is DST and Introduction to WeVideo Software (2 hours)</th>
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</table>
| **Review programme agenda** (15mins) | Aim: To create a 2-5 minute video about a meaningful experience in your life over the next six weeks. To create this participants will:  
  - Identify an experience they would like to tell through ice-breaker activities and prompts  
  - Develop a short 300-500 word script outlining the story  
  - Share the story with the group and receive feedback  
  - Refine the script  
  - Take and/or collect photographs that suit the script  
  - Audio-record the script  
  - Identify music or sounds that would complement it;  
  - Piece together the voice, images and sound on video-editing software  
  - Add effects to blend them all together and produce a final digital story  
  - Share the video with the rest of the group.  
Ask participants what are there expectations for the programme and what they would like to learn. Do they have any stories that they would like to tell? |
| **Ice-breaker activity #1 - “Name Game”** (10mins) |  
  - Ask participants what is your name and why are they called that name. Is it a common name in their family? Does it have a meaning?  
The goal of this activity is to:  
  - Hear the voices of all participants – the longer people stay silent the less likely they are to contribute later on  
  - Get to know the names of the people in the room  
  - To potentially stimulate an idea for a story |
| **Introduction to seven steps** | Screen various stories and ask participants what they think makes a good digital story. Examples for videos are provided above. Additionally, the facilitator can access the StoryCenter website or |
YouTube account for more videos. Follow this with what is considered the key components of a digital story:

- **Self-Revelatory** – The stories feel as though the author is aware of new insight that is being shared through the story
- **First Person Voice** – The stories are personal reflections on an experience and convey emotion or deep meaning to the author
- **Experiential** – They are about a lived experience, a description of a moment, or moments, in time
- **Photos More than Moving Images** – The dominant approach is still images to create a relaxed visual pace against the aural narrative
- **Soundtrack** – The story relies on a soundtrack of music or ambient sound to add meaning and impact
- **Restrained Length & Design** – The story should be 2-5 minutes in length. This presents an achievable goal for beginners. To this end, digital editing software is used to a minimum. The emphasis is on a raw and more direct feel with some use of pans and zooms.
- **Intention** – The story prioritises self-expression and self-awareness - process over product. Participants have ultimate authorship and control of the contents of the story.

<table>
<thead>
<tr>
<th>Break for refreshments (20mins)</th>
<th>• Important to create an informal feel and allow men to de-brief.</th>
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<tbody>
<tr>
<td><strong>Group Agreement</strong> (15mins)</td>
<td>Establishing a group agreement can demonstrate a desire to share ownership and power, allow people to fully participate and protect their interests, ensure that opinions are heard from the outset, build trust and safety and ensure they people don’t feel forced down a route they don’t want to be on.</td>
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<td>• Start with a blank sheet of flip chart paper.</td>
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<td>• Ask participants to shout out things that should be included.</td>
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<td>• Display the agreement for the rest of the intervention.</td>
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</tbody>
</table>
| WeVideo Tutorial #1 – Downloading the app, logging-in and basic functions (30mins) | • How to download the WeVideo App on phone/tablet and/or how to access the WeVideo website on internet browser.  
• How to log-in with name and password.  
• Brief overview of main functions – selecting photos, videos and music from the resource library.  
• Ask participants to insert 1 photo, 1 video and 1 music file into the video timeline. |
|---|---|
| Brief introduction to prompts and Wrap-Up (5 mins) | Briefly introduce the prompts that will guide the story development process. Ask men to think about prompts and what stories they might have in relation to them for Session 2:  
• Tell me about a time when you learned an important life lesson.  
• What would you tell your 18 year old self.  
• Tell me about a time when you gave or received good advice.  
• Tell me about a time when a belief you had changed.  
• Tell me about a time when you overcame a challenge or obstacle.  
• Tell me about a time you were resilient.  
• Tell me about a time when you adapted to a difficult transition.  
• Tell me about a time when you felt proud.  
• Tell me about a time you were most happy.  
• Write a thank you letter to someone you care about.  
Finally, ask men to bring items next week that they have a story about or that are meaningful to them. It could be about where they got the item, what it means to them, who gave it to them. |
| Ice-Breaker #2 – ‘Role Models’ | Ask participants to:  
• Reflect on a man in their life that inspired them or that taught them an important lesson. This |
| Session 2: Idea Generation (2 hours) | (5mins) | could be anyone from a celebrity to a family member.  
- Finish the sentence “the man who inspired me is/was.....because... and this taught me to...”  
- Are there any common lessons or commonality between the men? What are the strengths of these men?  
- Ask participants if they can identify any other strengths that men possess. Write all of these on a piece of flip-chart paper and leave displayed for the rest of the intervention. |
|---|---|---|
| Ice-Breaker #3 - Bring in item to discuss (30mins) | (30mins) | Ask participants to place items they brought on a table. Instruct them to pick up an item that is not their own but reminds them of something in their life.  
- Ask each participant to say what the item they picked up reminded them of. Is there a story in that?  
- Ask the participants to guess who brought in what item.  
- Next – give the items back to the person they belong to and ask why they brought those items. Is there a story that goes with the item?  
- Remind participants that every item and every picture has a story. If they are having trouble finding a story, look around at everyday items in their house. Tell participants if an item sparks an emotion ask themselves why? |
| Refreshment break (20mins) | (20mins) | Important to create an informal feel and allow men to de-brief |
| Tricks and tips for audio-recording (10mins) | Show participants how to audio-record on their phone.  
- Highlight differences in recording while standing or sitting  
- Highlight importance of recording 20 seconds of ‘room tone’ to insert if there are silences needed in video  
- Demonstrate the ideal distance to have the phone away from the mouth, to angle it slightly to the side of the mouth and the ideal hand-placement to stop additional noise. |
| Responding to prompts (20mins) | Introduce the prompts again from Session 1.  
- Split participants into groups of 2 or 3. Ask them to take turn discussing some of the prompts |
with one another. Can they identify a particular story they would like to tell?
- Ask participants to audio-record 30 seconds of each other talking about one of the prompts.

| WeVideo Tutorial #2: Re-cap on logging-in; uploading audio-files and images (30mins) | Re-cap on how to log-in to the app and the basic functions.
- Show participants how to upload the audio-file they recorded in the previous activity.
- Ask participants to take pictures of the items they brought in using their mobile phones.
- Show participants how to upload the image to WeVideo. |
|---|---|
| Wrap-up (5mins) | Ask participants to come in next week with an idea of a story they would like to tell.
- They will be sharing this story with a small group of 3-6 men who will give them feedback on the story. They can write the story down if they wish or just tell it. It doesn’t have to be complete.
- Finally, ask participants if they are happy with how everything is going and if they want to change/add anything. |

**Session 3:** Sharing your Experience and Script Development (2 hours)

**Overview of how to conduct “sharing your experience” (5mins)**
- Wait until the storyteller is done before asking questions or making comments.
- Ask storyteller if there is anything they would specifically like feedback about.
- Share an appreciative comment first.
- Offer feedback as questions or conditional opinions “If it were my story, I might...” or “have you thought about...” or “When you were talking about X, is this what you meant...”
- Keep discussions on topic of story and storyteller not issues raised by story. It is important to relate to the storytellers’ story (“I experienced something similar and I know how tough that can be”) but not to take up the storytellers’ time by telling your own version of the story.

**Sharing Your experience – small group work where participants discuss their stories**
- Conduct this over refreshments (tea, coffee, biscuits).
- Split into smaller group of 3-6 people (one facilitator per group).
- Each person shares a verbal story or part of their script (this is only a rough draft)
- Ask the storyteller if they are ready to tell their story.
- Give each participant 10 minutes to tell their story and receive feedback. The facilitator may
(45 mins) wish to provide unreserved time to tell a story if they feel it is necessary for the group.
- Facilitator should open up the feedback to the collective group first before giving their opinion.
- The facilitator should be aware of the assertiveness or shyness in the room. Everyone should have an opportunity to contribute to the feedback. Manage those that speak too much and encourage those who don’t speak.
- Synthesis group feedback before moving on to the next person.

Goal of this process is to:
- Advance the development of the story from first draft to next iteration.
- Establish sense of community among workshop participants
- Assess relative preparedness of participants to tell their story

| Four C’s to developing a script (5 mins) | Connect – Jump to the scene of a decisive moment in a story and leave it hanging (100 words)  
| | Context – Give enough information to the listener so they can understand what is happening (250 words)  
| | Change – The change that happened or conclusion of the story (50 words)  
| | Closure - Exit the story with a summary statement or closure (50 words). |

| Refreshment break (10 mins) | This refreshment break is slightly shorter as participants will already have refreshments over the “sharing your experience” process. |

| Free time for refinement of script (40 mins) | Allow men some free time to further develop their script in response to the feedback. This can be done through writing; one-to-one support; Google Voice Typing; or men audio-recording each other to further refine the script.  
| | Encourage men to identify a specific moment that describes the essence or emotion of the story.  
| | Discuss approaches to script revision if the script is too long or too dry (lacking first person voice and is just describing a chain of events rather than the impact of the event). |
- Is the story buried? Make sure that the principle of the story is not padded out with other stories or extra information. Encourage the storyteller to only include the most important details.
- The storyteller should be encouraged to “show not tell” by illustrating general points with a detailed specific example. This can be a more economical way of illustrating the point that conveys more meaning. For example:
  **Tell:** My dad loved me a lot. He is one of the most caring and loving people I have ever known. **Show:** I remember when I gave my Dad the nickname Ba-Ba. He let me skip school that day because... Instead, we spent the day... and then he said “...” and that is how he got the nickname Ba-Ba.
- Use your own words. How people tell a story and how people write a story are very different. DST is more concerned with oral language. The storyteller might be encouraged to think about making phrases rather than sentences; ignoring punctuation; replacing long words that people don’t commonly say and avoiding long or overly descriptive sentences.
- Trust the story form and audience. It is important to have confidence that the listener has the ability to drop into your story. So there is often no need to give a lot of background context to place the story.

<table>
<thead>
<tr>
<th>Approaches to image selection and image gathering (10 mins)</th>
<th>Demonstrate these through screening different stories:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What do you want your photo to say? Explicit images are used to highlight the specifics of the story and establish context (e.g. person, place, time, object). Implicit images are used when conveying emotions/insight (e.g. rising sun to convey hope)</td>
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<tr>
<td>- Horizontal photos are better for digital storytelling because of the editing software</td>
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<tr>
<td>- What shot types do you want to use? Long shots – often used at the start of a story to set the scene. Medium shots - focus on a particular subject within the scene. Close ups – show portion or detail of subject. Each one can convey a different meaning.</td>
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<tr>
<td>Session 4: Editing Your Video (2 hours)</td>
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<tr>
<td><strong>WeVideo Tutorial #3: Re-cap and video editing basics (25mins)</strong></td>
<td></td>
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<tr>
<td>- Re-cap on how to select and insert images, videos and audio-files from the resource library.</td>
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<tr>
<td>- Re-cap on how to upload audio files and images from phone.</td>
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<tr>
<td>- Introduce basic on creating transitions, pans and zooms.</td>
<td></td>
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<tr>
<td><strong>Free time to edit video/audio-record script/ refine final script (20 mins)</strong></td>
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<tr>
<td>- Participants can begin to start editing their videos with support provided by the facilitators.</td>
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<tr>
<td>- Instruct participants to begin by uploading all the photos they would like to use.</td>
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<tr>
<td>- Participants who have not audio-recorded their script or who have yet to finalise a script can also do so during this time.</td>
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<tr>
<td><strong>Refreshment break (20mins)</strong></td>
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<tr>
<td>- Important to create an informal feel and allow men to de-brief.</td>
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<tr>
<td><strong>WeVideo tutorial #4:</strong></td>
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<tr>
<td>- Introduce more advanced techniques such as layering images over one another to create</td>
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<tr>
<td>Session 5: Editing Videos (2 hours)</td>
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<tr>
<td>Advanced transitions, layering and audio-levels (25 mins)</td>
<td>• Transitions, reducing the colours of photos and cropping images to the screen size. • Introduce how to add sound effects and manage the audio-levels across different audio-files.</td>
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<tr>
<td>Free time to edit video (25 mins)</td>
<td>• Free time to edit videos</td>
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<tr>
<td>Wrap-up (5 mins)</td>
<td>• Tell participants that they can continue to work on their story at home if they wish. • Tell participants that next week they will be asked to share a very rough draft of their story with 2-3 other men.</td>
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|  |
|-----------------|------------------------------------------------|
| Free time to edit video (40 mins) | • Free time to edit videos |
| Refreshment break (20 mins) | Important to create an informal feel and allow men to de-brief. |
| “Sharing your experience” #2 (30 mins) | • Ask men to split into small groups of 2-3 along with a facilitator for each group. • Reiterate how to conduct the “sharing your experience” process. • Ask men to share their story with one another and give feedback. |
| Free time to Edit Video (25 mins) | • Free time to edit videos |
| Wrap-Up (5 mins) | • Ask participants if they have any questions or anything else they would like to learn in the last week. |
| Free time to edit video (40 mins) | • Free time to edit videos |
| A note on sharing stories (15 mins) | • Storytellers must be provided with the information they need to make choices about the sharing of their stories |
| Session 6: Editing Video (2 hours) | • Storytellers have the right to withdraw their stories from public circulation at any time, recognising the technical constraints of removing digital material from electronic forms of distribution.  
• Consent is a process, not a one-time activity |
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<tbody>
<tr>
<td>Refreshment break (20mins)</td>
<td>• Important to create an informal feel and allow men to de-brief.</td>
</tr>
<tr>
<td>Free slot (40mins)</td>
<td>• Free time to edit videos or space held to cover anything else the participants would like to learn</td>
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<tr>
<td>Wrap-up (5mins)</td>
<td>• Decide on how to screen stories, who will be there and where it will take place.</td>
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<tr>
<th>Screening of Stories (2 hours)</th>
<th>• Screening of stories by men.</th>
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<tbody>
<tr>
<td>Screening of stories (40 mins)</td>
<td>• Important to create an informal feel and allow men to de-brief.</td>
</tr>
<tr>
<td>Refreshment Bbreak (20mins)</td>
<td>• Screening of stories by men.</td>
</tr>
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</table>
| Screening of stories (40mins)   | • Facilitators’ to synthesise the key messages from the digital stories.  
• Open discussion to men about what they got out of the process. Perhaps probe impact on connectedness, self-efficacy, life transitions and/or childhood adversities.  
• Thank participants for their time. |


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6.2.7. Approaches to Delivery and Core Competencies of Facilitators
The Living Legacy intervention is intended to be a facilitated, group-based process that is delivered face-to-face. At least two facilitators with complementary experience in working with men and/or DST should deliver the intervention. Having the capacity to provide professional support would be desirable, but at the very least, facilitators should have the capacity to refer participants for professional support when needed. Training in how to facilitate DST and/or how to engage men using gender-sensitive approaches would also be desirable. Facilitators should also be encouraging, non-authoritative, empathetic, relatable, non-judgemental, model vulnerability and share life experiences where appropriate and adapt to the needs of the group where possible. There are a number of general principles to follow when delivering DST intervention:

- Respect – every story matters even if you find aspects of the story outside your values and opinions. Take a non-judgemental approach and remain neutral in terms of the storytellers’ experiences. No one has the right to silence, intimidate, or control the voice of others.
- Power and Humility – The facilitator plays a supporting role. The storyteller is an expert in their experience; the facilitator is there to listen and to guide where possible. The facilitator must be aware of their position of power and how their feedback might change the storytellers’ story. It is more about asking “what can I help you with next” rather than “here is what I think you should do”.
• Collective Knowledge – The collective knowledge of the group is often greater than just one person. The group should be used to facilitate feedback where possible.

• Active Listening – The facilitator is not just listening with a critical ear to give feedback but also to find meaning in the story and to reflect that back to the storyteller.

Moreover, there a number of gender-sensitive approaches that are utilised within this intervention to improve male engagement and should be modelled by the facilitators where possible. These include:

• Using a familiar and informal environment.

• Framing the intervention around the altruistic tendencies of men and the ‘legacy’ and ‘wisdom’ they can pass on to future generations.

• Utilising action-orientated and interactive approaches to ease men into talking about sensitive topics and providing reciprocal peer support.

• Adopting a strengths-based approach that utilises existing capacities within the group and that highlights the positive values of men.

• Enabling men’s autonomy and ownership of the intervention where possible.

• Ensuring all processes and outputs are clear and tangible.

• Using ‘male friendly’ language that is informal and that avoids overly technical or ‘artsy’ language.

• Allowing men flexibility as to when and how they participate.
Consulting with men throughout the process and adapting the programme to suit their needs.

6.2.8. Potential Mechanisms of Change

Drawing on the data from Chapter 2, Chapter 4 and Chapter 5, the Living Legacy Intervention is proposed to support men’s mental health through enhanced connectedness, self-efficacy and emotional processing. Appropriate theories were identified in the literature to explain these potential mechanisms of change which are: social capital theory (Putnam, 2000); self-efficacy theory (Bandura, 1986); and, the process model of emotional regulation (Gross & Thompson, 2007). These theories were identified when discussing the findings from Stage 2(a) Understanding Experiences in relation to the wider literature on PAIs. This is discussed in more detail in Chapter 7 (see Section 7.2.4).

Men will experience connectedness through the mediator “social capital” via enhanced bonding [within group] and bridging relationships [across groups] (Putnam, 2000). Identification and engagement with a story is contingent on: (i) identification with the storyteller [realistic, likable, perceived as like self, empathetic]; (ii) an engaging story [appealing storyline and dramatic sequence]; and (iii) cultural resonance [familiar characters, cultural events, and language] (Larkey & Hecht, 2010). Therefore, delivering DST to men with shared circumstances and around a common theme of life lessons, men will be prompted to recognise themselves in the story, discuss similar experiences and reciprocate encouragement and peer support which will strengthen bonding relationships. Moreover, discussing and rehearsing personal experiences serves as a form of social modelling around the disclosure of personal content and emotions. This represents
an additional opportunity to normalise taboo issues within the group. Therefore, DST may shift masculine norms relating to the disclosure of personal content and emotions by capitalising on peer learning (Oliffe et al., 2019). Moreover, social proliferations of digital stories associated with men overcoming mental health issues could help to normalise taboo issues in the wider male population and form valuable connections outside the group (i.e. bridging relationships) (Hausknecht et al., 2018). This is similar to the concept known as the ‘Papageno Effect’ in suicide prevention. The concept relates to reductions in suicidal ideation following exposure to positive messages about others overcoming suicidal behaviour (Till et al., 2018).

Men will experience enhanced self-efficacy through the mediator “mastery experience”. This relates to an increase in an individual’s assessment of their own abilities following successful completion of a given task (Bandura, 1986). Men will experience the mastery of new technical skills relating to digital literacy, script writing, audio recording, photography, video editing and communication. The mastery of telling “your story” has also been reported as an empowering experience that facilitates a greater level of self-acceptance and closure relating to lived experience and identity (DiFulvio et al., 2016; Hausknecht et al., 2017; Rolbiecki et al., 2019). Finally, the creation of a tangible product that represents improved competencies and a sense of purpose and routine developed through regular attendance may also contribute to improved self-efficacy.

Finally, men will experience emotional processing through the mediators “attentional deployment”, “cognitive change” and “response modulation” as
articulated by the process model of emotional regulation (Moses and Barlow, 2006). Attentional deployment relates to the regulation of emotions through concentration (directing attention towards the emotions or consequences) or distraction (shifting attention away from or towards a different aspect of the situation; Gross & Thompson, 2007). Men will “concentrate” or identify the emotional resonance of their story during the script development process and also become “distracted” from their emotions when focusing on more practical tasks like learning digital skills and video-editing.

Cognitive change relates to changing the appraisal of an experience so as to alter its emotional meaning (Gross & Thompson, 2007). Reappraisal is an example of a cognitive change strategy which involves reinterpreting the meaning of an event so as to alter its emotional impact. Through the story development process, men will alter the emotional meaning of their story through re-appraisal of the emotional stimulus and the emotional response. Men will develop a digital story in response to the strengths-based prompts which may help them to gain new insight relating to past negative events. This represents reappraisal of the emotional stimulus. The peer support accrued both formally and informally in the intervention may normalise the emotions associated with experiences (i.e. others have experienced similar difficulties). This may prompt men to re-appraisal the emotional response. Finally, DST represents a unique opportunity for “response modulation” or emotional expression where men get their story “off their chest”, a process that has been found to be cathartic and therapeutic (DeVecchi et al., 2016; Hinyard & Kreuter, 2007; Pennebaker & Evans, 2014).
6.3. Conclusion
This chapter has presented an outline description of Living Legacy, a gender-sensitive DST intervention to promote mental health among men in areas of high social disadvantage communities in Northern Ireland. A clear intervention description and logic model are provided in order to promote transparency, replicability and to aid future implementation and evaluation. However, further refinement work is required to assess the acceptability of Living Legacy among the intended target group. The next and final chapter, Chapter 7, summarises the main findings of the research, highlights the key contributions to knowledge, the study limitations, and offers recommendations for future research and practice in the field of participatory arts and men’s health.
Chapter 7: Discussion
7.1. Introduction
The aim of this thesis was to develop a participatory arts intervention (PAI) to promote mental health among men in areas of high social disadvantage in Northern Ireland. The frameworks used to guide the study design was the Medical Research Council (MRC) guidance for developing complex interventions (Craig et al., 2008) and the taxonomy of approaches for intervention development (O’Cathain et al., 2019). The primary objectives of this thesis were:

1. To assess the evidence for effectiveness, acceptability and gender-responsiveness of PAIs among adults, particularly among men.
2. To identify the needs, preferences and opinions of men in areas of high social disadvantage and key service providers to develop an outline description of an acceptable PAI. More specifically:
   a. To identify the problem to be addressed among men in areas of high social disadvantage in Northern Ireland
   b. To explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland
   c. To identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland
   d. To explore the preferences and opinions of key stakeholders on potential intervention features, content, approaches to delivery and outcomes in order to develop an outline description of a PAI.
An iterative intervention development process was conducted that included a systematic review (Chapter 2), focus groups and interviews with men in areas of social disadvantage in Northern Ireland (Chapter 4) and online consultations both with men in areas of high social disadvantage and service providers with a remit for men’s health, mental health and digital arts (Chapter 5). This chapter will begin by summarising the main findings from Chapter 2, 4 and 5 and highlight the key contributions to knowledge (Section 7.2). This chapter will also detail the limitations of the thesis (Section 7.3), implications for future research (Section 7.4) and implications for practice and policy (Section 7.5). Finally, the overall thesis conclusions are presented in Section 7.6.

7.2. Key Contributions to Knowledge

7.2.1. Introduction
The modular approach taken in this thesis provides key contributions to knowledge across the fields of participatory arts, men’s health and suicide prevention. A DST intervention was developed to promote mental health among men in areas of high social disadvantage in Northern Ireland using a rigorous evidence-based and user-informed approach. The key contributions to knowledge generated through this process are discussed in greater detail in the subsequent sections 7.2.2 to 7.2.4.

7.2.2. The Effectiveness, Acceptability and Gender-Responsiveness of Participatory Arts Interventions
The mixed methods systematic review (Chapter 2) is the first in the literature to explore the effectiveness of all five primary participatory arts forms on the mental health and wellbeing of adults. Although other reviews have been conducted, they focused on specific art forms such as performance and visual arts (Sheppard &
Broughton, 2020; Tomlinson et al., 2018), included a focus solely on children (Zarobe & Bungay, 2017) and/or used rapid review methodologies (Stickley et al., 2018; Zarobe & Bungay, 2017). Therefore, this review was significant because it provided a deeper understanding on the effectiveness of a wider range of art forms in promoting mental health and wellbeing among adults. Moreover, no review to date had explored the acceptability or gender-responsiveness of PAIs.

The systematic review identified limited evidence of effectiveness for PAIs in improving mental health and wellbeing among adults due to a lack of experimental studies, heterogeneity between interventions and outcome measures, inconsistent reporting of intervention components and the methodological bias of the evidence as a whole. Similar issues and difficulties in drawing conclusions on evidence of effectiveness have been cited in several other “arts in health” reviews (Callinan and Coyne, 2018; Daykin et al., 2008; Leckey, 2011,).

Overall, PAIs appear to be an acceptable modality. The majority of studies that assessed acceptability focused on “perceived effectiveness” and retrospective acceptability. Nonetheless, PAIs were perceived effective in benefiting mental health and wellbeing via connectedness, emotional regulation, meaning-making and re-defining identity, and personal growth and empowerment. Whilst the evidence of effectiveness was limited, these themes provide a useful evaluative approach for further PAIs. Indeed, the findings reflect both the CHIME mental health recovery model (Connectedness; Hope; Identity; Meaning; Engagement) and the PERMA model of wellbeing (Positive Emotion, Engagement; Positive Relationships; Meaning; Achievement) (Leamy et al., 2011; Seligman, 2011). Brief
quantitative measures assessing each domain might help to standardise evaluation methods and build an evidence-base for effectiveness. Fewer studies reported on the theoretical framework of acceptability domains “burden”, “self-efficacy”, “affective attitude” and “ethicality” which primarily relate to barriers and facilitators to engagement in PAIs. Nonetheless, barriers to engagement included venue accessibility and reduced physical capabilities (burden), a perceived lack of artistic abilities (self-efficacy) and the femininity of choral singing (ethicality). Facilitators to engagement included flexibility with participation and disclosure of mental health issues (burden), strengths-based approaches (burden), no pressure to achieve high standard (self-efficacy), positive feedback (self-efficacy) and autonomy (self-efficacy).

Finally, assessing gender responsiveness was limited because only four studies focused on men – one on effectiveness and three on acceptability – and all were graded as methodologically weak. Just one study in the review adopted a gender-sensitive approach and intentionally targeted men (Irle and Lovell, 2014). The other three studies focused on population groups that disproportionately represent men (i.e. prisoners and homeless people). As such, little gender responsiveness insights were gained.

The limited evidence of effectiveness, absent or inconsistent reporting on intervention components, and limited information on gender responsive approaches, made it difficult to identify a potential PAI intervention that would be effective or acceptable amongst the target group of men. This finding emphasises the importance of the work contributing to this thesis. Nonetheless, the review
identifies important gaps in knowledge and provides insights on how to build the evidence for effectiveness and acceptability among adults. Therefore, Chapter 2 served to meet the first research objective to “Assess the evidence of acceptability, effectiveness and gender-responsiveness of participatory arts to promote mental health and wellbeing among adults and men in particular”.

7.2.3. Issues that Contribute to Psychological Distress Among Men In Areas of High Social Disadvantage in Northern Ireland

7.2.3.1. Introduction
The sources of psychological distress among men in areas of social disadvantage in Northern Ireland primarily related to: isolation; a lack of meaningful occupation; difficult life transitions and adverse childhood experiences. These are discussed in more detail in the subsequent sections.

7.2.3.2. Social Isolation
The findings support existing evidence that older adults experience social isolation as a result of narrowing social circles, bereavement, mobility issues, living alone, retirement and illness (Fakoya et al., 2020; Li & Ferraro, 2005; McPherson et al., 2006; SCIE, 2012). However, intergenerational poverty and community deprivation appeared to compound disconnection among this cohort with many feeling left behind by local government, socially-excluded based on income and generally looked down upon. This had a negative impact on men’s self-esteem, social inclusion and trust for statutory services. This is concerning, considering that social isolation and a lack of belonging are central elements in both Durkheim’s Theory of Egotistic Suicide and Joiner’s Interpersonal Theory of Suicide (Durkheim, 1897; Van Orden et al., 2010). Wider studies have also reported that structural neglect among
those in areas of high social disadvantage can result in negative experiences and mistrust of health and/or educational institutions which can act as a deterrent to seeking care (Becker & Newsom, 2003; Kierans et al., 2007; Lefkowich et al., 2015). This raises important considerations regarding “how” to engage this group which is discussed in further detail in Section 7.2.5.

Whilst many men felt compelled to address their issue of isolation, negative connotations were associated with men’s groups, such as the idea that they are for retired men or men with mental health problems. These pre-conceived prejudices or judgements acted as an additional barrier to seeking support. Even though many men attending were retired or had mental health problems, seeking support for these was seen as compounding their perceived vulnerability and shifting masculine identity. Therefore, a more palatable option was to suppress psychological distress. This often resulted in many reaching a crisis point before seeking support. Moreover, fewer social opportunities and/or experiences of psychological distress resulted in many men losing their social confidence and further withdrawing from social encounters. The evidences lends insights to findings of similar studies that identified men as being less likely to join community-based social groups (Devine et al., 2017), the social stigma of men’s groups (O’Donnell & Richardson, 2020) and withdrawing from social scenarios as a form of coping (Grace et al., 2016).

7.2.3.3. Lack of Meaningful Occupation and Difficult Life Transitions
The transcripts were dominated by men’s accounts of loss relating to various transitions in later life such as retirement/unemployment, bereavement, marriage breakdown, physical illness and cognitive deterioration. A lack of meaningful occupation following retirement/unemployment resulted in a loss of routines and
daily habits which challenged men’s sense of purpose, control and workman identity. Oliffe et al. (2013) has highlighted similar links between a ‘workman identity’, retirement and psychological distress among older men. However, it appears the ties between work and masculinity are more deeply entrenched among men in areas of high social disadvantage. There was also evidence of a more acute awareness of vulnerability represented by an ailing physical body and a decline in cognitive functioning. Masculinity appeared to be inextricably linked to independence and ‘doing’. However, faced with the ignominy of an impaired body and mind no longer able to “do”, there was a sense of relinquishing control and independence. Such transitions challenged the personal and societal expectations the men felt they ought to achieve in life. With many struggling to re-calibrate their masculine identity beyond the sphere of work and within the confines of their ageing body and mind, defeatist attitudes about the future inevitably began to creep in. Moreover, increased time spent “sitting around the house” copper-fastened this lack of purpose and shifting identity, which ultimately made some men feel useless.

These findings are notable in the context of the Integrated Motivational-Volitional [IMV] Model of suicidal behaviour. This model suggests that experiences of defeat [failed struggle, powerlessness, losing social status] and negative social comparisons can lead to feelings of entrapment and suicidal behaviour (Gilbert, 2000, O’Connor and Kirtley, 2018, Wetherall et al., 2019). A lack of goal re-engagement and absence of positive future thinking are key factors that increase the likelihood of escalating entrapment to suicidal ideation (O’Connor and Kirtley,
This highlights the need to support men in areas of high social disadvantage in Northern Ireland to redefine or expand on their masculine identity in order to more successfully negotiate difficult life transitions. Re-igniting a sense of purpose, goal re-engagement and meaningful occupation among this cohort may be a useful place to start. Previous research has also highlighted the links between re-igniting a sense of purpose and addressing issues of isolation among older men (Neville et al., 2018).

7.2.3.4. Adverse Childhood Experiences
Finally, a number of men who experienced mental health issues as adults identified adverse experiences in childhood as a key contributing factor to their psychological distress. This ranged from more chronic factors such as exposure to political violence (i.e. The Troubles) and severe deprivation to instances of corporal punishment in school, alcoholic and violent fathers, witnessing parental suicide attempts and sexual abuse. Indeed, such adverse childhood experiences are considered to increase the likelihood of a suicide attempt in adulthood (Felitti et al., 1998), with individuals with low socioeconomic status being more likely to be exposed to such adverse experiences (Bjorkenstrom et al., 2013).

7.2.3.5. Conclusion
By virtue of being male and living in an area of high social disadvantage in Northern Ireland, men experienced varying degrees of isolation, a lack of meaningful occupation, found it difficult to adapt to life transitions and were troubled by past childhood experiences. These issues did not exist in isolation; rather, they intersected and compounded one another, creating knock-on and multiplicative effects. These findings provide insights into the key issues facing this cohort of “at
risk” men, for whom the PAI has been developed. These findings serve to answer research objective 2(a) which was to “explore the issues that contribute to psychological distress among men in areas of high social disadvantage in Northern Ireland”.

7.2.4. Impact of Participatory Arts on the Mental Health of Men Living in Areas of High Social Disadvantage

7.2.4.1. Introduction
Participatory arts support men’s mental health by facilitating connection, self-efficacy and personal growth, and emotional processing. These findings reflect many of themes identified under the acceptability domain of “perceived effectiveness” in the systematic review (i.e. connectedness, emotional regulation, meaning-making and re-defining identity; personal growth and empowerment). However, this study adds new knowledge in that it elucidates the “gendered” pathways through which men experience the mental health benefits of participatory arts. This adds empirical credibility to using Connell’s (1995) masculinities framework to guide the development of gender-responsive interventions to support men’s mental health.

7.2.4.2. Participatory Arts Improves Connectedness
Participatory arts offer men a route to flourishing friendships and extended social networks which provided social support and alleviated feelings of disconnection. Whilst these outcomes could, arguably, be attributed to the men’s group rather than the artistic activity, unique aspects of participatory arts appear to facilitate and strengthen connectedness. Putnam’s concept of “bonding” and “bridging” social capital is a particularly relevant frame to unpack these pathways (Putnam,
Participatory arts helps to facilitate connectedness within this cohort of men (i.e. “bonding” relationships) through three primary routes: (i) it represents a shared interest around which friendships were formed and which provides men with a “reason” to socialise; (ii) it helps to strengthen a sense of collective identity through physical synchrony and working towards a collective goal; and (iii) it facilitates a comfortable space for men to engage in casual conversations and reciprocate peer support around mental health issues. Indeed, because the focus is on the activity and not the conversation, connection or emotional support are ‘bi-products’ of shared activities rather than explicit objectives. This can help to preserve a masculine identity and lessen perceptions of men’s own need and vulnerability (Carroll et al., 2014; Galdas et al., 2014). The focus on the shared collective effort towards an action-orientated goal is also noted as a key route to facilitating male rapport (see Section 7.2.5.6). Moreover, “bridging” relationships were formed with the wider community through the gifting of arts products or public performances which brought retired men into the world from which they felt disconnected. The cultivation and maintenance of such connectedness can increase resilience and act as a protective factor against the risk of suicide (WHO, 2014). Indeed, resilience gained from social support is noted as a mitigating factor against suicide risk associated with childhood traumas, which may be particularly relevant to this cohort (Sarachiapone et al., 2011).

Through consistent exposure to social contact over time, the group dynamic appeared to unlock men’s inherent but latent ability to be sociable. This had a knock-on effect by forming friendships within the wider community. Through these
bonding and bridging relationships men re-connected with well-functioning parts of themselves and grew more self-accepting. This is similar to the “Journey to Connection” theme articulated in the Men on the MOVE evaluation report. This theme highlights how men connect with others which had a catalysing effect on their connection with themselves (Carroll et al., 2019). The social rehearsal of reciprocal peer support around sensitive topics appeared to normalise taboo issues in the group with many signposting health services and even assisting peers to mental health appointments. This illuminates the power of facilitating ‘permission’ among men to normalise conversations around health topics and, by doing so, transgressing traditional linkages between masculinities and mental health (Seaton et al., 2017; Olliffe et al., 2019). Therefore, PAIs should not shy away from discussions around mental health but use the creative process to enable men to reciprocate stories and support around their lived experiences. However, flexibility is needed so that men do not feel pressured to disclose information, and that they feel reassured that they can listen or participate without having to share (Galdas et al., 2014).

7.2.4.3. Participatory Arts Enhances Self-Efficacy
Participatory arts assisted with re-igniting a sense of purpose, routine and self-efficacy by being seen as a meaningful, constructive and positive activity and a worthwhile use of their time. The development of a routine and purpose resonates with the masculine concepts of discipline and control where men can (re)gain control and order that may have been previously associated with employment (Courtenay, 2004; MacDonald 2011; Robertson et al., 2013a). The importance of sense of purpose also aligns with Atchley’s (1989) continuity theory which notes
that adjustment to ageing in life depends on the extent to which an individual can continue to carry out preferred routines, roles, habits and activities. The acquisition of new artistic skills and knowledge was a particularly rewarding experience that elicited a sense of achievement and a self-realisation that the men were capable of personal growth. This improved sense of self-esteem and self-efficacy which was copper-fastened by the production of a tangible art product that personified increased competencies. This aligns with the concept of “mastery experience” where self-efficacy is improved through the successful completion of given tasks (Bandura, 1986). In broader contexts, improved self-esteem, sense of purpose and self-efficacy are cited as protective factors against suicide (WHO, 2014).

Moreover, performing for others or gifting art products provided a sense of affirmation and validation that helped men to feel “useful” again. Similar benefits were accrued from receiving positive feedback from peers and facilitators on artwork produced. Indeed, feelings of usefulness have also been identified as crucial to successful ageing among older men in Northern Ireland (Devine et al., 2017). Therefore, PAIs should ensure that men experience the “mastery” of learning new skills that leads to the development of a tangible product that could potentially benefit others. This would serve to enhance feelings of self-efficacy and personal growth. Moreover, opportunities for informal and formal feedback on art-work should be incorporated to accrue further benefits associated with validation and affirmation.

7.2.4.4. Participatory Arts Provides an Outlet for Emotional Processing
Finally participatory arts provide men with an outlet for emotional processing. These findings align closely with the process model of emotional regulation
particularly the constructs ‘attentional deployment’, ‘cognitive change’ and ‘response modulation’ (Gross & Thompson, 2007). Participatory art provided a ‘distraction’ from difficult emotions/situations and put men in a ‘reverie’ through complete absorption in a task. This resonates with the construct ‘attentional deployment’ wherein concentration (directing attention towards the emotions or consequences) or distraction (shifting attention away from or towards a different aspect of the situation) can support emotional processing (Gross & Thompson, 2007). Participatory arts also provided men with an opportunity to self-reflect and to attach new and deeper meanings to emotions/experiences. This provided men with an alternative outlet to express emotions and to ‘take off the mask’ which acted as a form of therapeutic catharsis. This resonates with ‘cognitive change’, relating to the appraisal of an experience so as to alter its emotional meaning, and ‘response modulation’, where emotions are released or vented to change previous emotional states (Gross & Thompson, 2007). Therefore, PAIs should include opportunities for men to develop artistic products through self-reflective processes and enable them to communicate their emotions and thoughts. This holds unique opportunities for men to appraise and attach new meanings to past experiences, current transitions and shifting masculine identities. Indeed, previous research has highlighted that redefining, or at least expanding, personal views of what it means to be a man, is critical for the transition to successful ageing (Oliffe et al., 2013).

7.1.4.5. Conclusion
In conclusion, participatory arts can develop social capital among men through bonding and bridging relationships whilst a sense of relatedness and the social rehearsal of emotional disclosure can normalise taboo issues and facilitate peer
support. The mastery of new skills, the creation of artistic products, and the development of routines facilitate a sense of achievement, personal growth and self-efficacy among men. Finally participatory arts can facilitate emotional processing through attention deployment (distraction), cognitive change (meaning-making), and response modulation (emotional expression). This could support men to self-reflect on, and attach new meanings to, past experiences, current transitions and a shifting masculine identity. Therefore, Chapter 4 helped to meet research objective 2(b) - “to explore the impact of extant PAIs on the mental health of men in areas of high social disadvantage in Northern Ireland.

7.2.5. Improving Male Engagement in Participatory Arts

7.2.5.1. Introduction
The systematic review identified a significant gap in PAIs with regard the barriers and facilitators to male engagement. Formative research with men in areas of high social disadvantage in Northern Ireland (Chapter 4) and consultations with these men and service providers with a remit for men’s health, mental health, and participatory arts (Chapter 5) have helped to fill this gap. These barriers and facilitators have been synthesised as key “Lessons” to improve male engagement and are discussed below.

7.2.5.2. Lesson One: Embed PAIs in community spaces that are informal, comfortable and familiar to men
Men favour participatory arts that are embedded in the community setting and that feel familiar, informal and relaxed. Humour, ‘banter’ and light-hearted ‘slagging’ are vital in promoting such a relaxed and comfortable atmosphere where telling jokes and stories over activities and cups of tea act as a lynchpin to male bonding. These
environments should be specifically advertised as “male spaces” which helps to create a sense of safety and trust. This is consistent with wider literature that notes greater acceptability of health interventions among men if they are delivered in environments that engender trust and familiarity (Hunt et al., 2014; Robertson et al., 2013; Robertson et al., 2015; Seaton, 2017).

7.2.5.3. Lesson Two: Convene PAIs with existing men’s group or with men who have shared social backgrounds and/or mental health experiences
A strong sense of relatedness and trust among men, predominately stemming from shared social backgrounds and/or mental health experiences, is crucial for sustained engagement and enjoyment in PAIs. Most importantly, this is important for overcoming fears of feeling silly or emasculated through engagement in what might be construed as effeminate activities such as participatory arts. These findings are consistent with wider literature that identifies homogeneity with respect to shared social backgrounds as important for group safety, enjoyment and sustained engagement (Galdas et al., 2014; Carroll et al., 2014; Robertson et al., 2018). Delivering PAIs to existing groups of men or men who share similar social backgrounds might be a useful starting point to building the credibility and acceptability of PAIs among men. Indeed, this may be particularly important for men in areas of high social disadvantage in Northern Ireland considering their reported mistrust of health and educational institutions. It also reinforces the need to consult with men in the development process in order to build mutual respect and overcome suspicions (Heenan et al., 2004; Kierans et al., 2007; Lefkowich et al., 2015).
7.2.5.4. Lesson Three: Frame PAIs around male interests and values rather than “mental health” or “participatory arts”

The perception that art is effeminate and men’s groups are for those who are retired or who have mental health problems are significant barriers to engagement. To overcome these issues, it is important to work with and not against cultural ideals of masculinity (Galdas et al., 2014). Therefore, PAIs should be framed around male interests rather than concepts such as “health” or “creativity”. This could also serve to move beyond the stigmatising labels associated with the group. Indeed, reaching out to more diverse aspects of wellness may allow an intervention to cast a wider net and appeal to men at different intersections of their identity (Lefkowich et al., 2015). Identifying these male interests is often termed ‘finding the hook’. One ‘hook’ identified for participatory arts is creating artistic products that benefit others which ties to the masculine ideologies of ‘altruism’ and ‘the provider role’. More research is needed to identify additional masculine interests around which to frame PAIs.

In seeking to identify such interests, it is crucial to avoid reinforcing hegemonic masculine stereotypes [e.g. competition, aggression, physicality] that perpetuate inequalities between males and females and within groups of males. Indeed, there have been calls to incorporate gender-transformative approaches in men’s health interventions that aim to promote gender equality and healthy masculinities whilst challenging hegemonic masculinities (Paretz & Dworkin, 2018). Participatory arts hold unique opportunities to adopt such gender-transformative approaches to challenge hegemonic ideals and promote positive masculinities. However, gaining
trust through gender-specific approaches before shifting to gender-transformative approaches is recommended.

7.2.5.5. Lesson Four: Adopt strengths-based approaches to build men’s confidence to participate and their overall self-efficacy
Men reported low self-confidence, self-esteem and self-efficacy which had an impact on their perceived capabilities to do participatory arts. Therefore, facilitators delivering PAIs should adopt strengths-based approaches that emphasise the existing strengths, capacities, emotions, and virtues of men in order to encourage their potential and promote wellbeing (Isacco et al., 2012; Englar-Carlson & Kiselica, 2013). This might include activities and discussions that highlight the strengths and values of men and utilising existing capacities within the group through peer-led approaches. Indeed, many men favoured activities that were collaborative and enabled them to share knowledge with peers. Although it might be tempting to create a competitive environment to align with supposed masculine ideologies, this might do more harm than good for group dynamics (Lefkowich et al., 2015). Other approaches that build men’s self-efficacy include a focus on the process rather than the product and selecting an art form that requires no previous experience or existing skill level to participate (i.e. drumming activity versus a guitar lesson). This can help to alleviate concerns of a perceived lack of artistic skill and to manage expectations with regard to the quality of the product.

7.2.5.6. Lesson Five: Utilise interactive and action-orientated approaches
Men highlighted their preference for “doing” and action-orientated activities rather than “sitting around talking about your problems”. As such, active rather than passive participation in arts activities might work best with this cohort of men. This
resonates with previous men’s health research that calls for more interactive and action-orientated approaches to engaging men in health promotion programme (Englar-Carlson & Kiselica, 2013; Robertson et al., 2015). Another example of implementing action-orientated approaches might include learning skills through practice rather than demonstrations. However, service providers highlighted that the need for action-orientated approaches lessens as men gain trust in the programme. Therefore, re-ordering activities might be a worthwhile approach when elements of an intervention cannot be exclusively action-orientated. Indeed, it must be noted that action-orientated approaches should not be used as an alternative to talking approaches but rather a tool to facilitate connection.

7.2.5.7. Lesson Six: Enable autonomy and ownership through a structured programme that has inbuilt mechanisms to allow for adaption and flexibility

It is important to strike a balance between structure and flexibility within a PAI to enable autonomy and ownership among men. This can be operationalized by consulting with men in the development process, incorporating feedback loops into PAIs and by being flexible with the arrangements of the session (e.g. timing, competing commitments, and activities). Indeed, such approaches have been found to build trust and maximise the acceptability of intervention content (Heenan et al., 2004; Pringle et al., 2013; Robertson et al., 2013b; Seaton, 2017; Lefkowich et al., 2015). This also highlights the usefulness of the partnership methodologies used in this thesis. Other mediums that facilitated autonomy and ownership included the creation of a group agreement led by men’s suggestions and flexibility with regard to participation. This latter can act as bridge for men to dabble in participatory arts without feeling a need to fully commit. This may mean allowing men the
opportunity to observe rather than to participate or to remove themselves from certain parts of the creative process if they wish (e.g. public exhibitions or displays of art work). This may better accommodate men who had a propensity to drop in/out due to mental health problems and is consistent with fostering an informal environment that men favour (Gray et al., 2009; Robertson et al., 2013b).

7.2.5.8. Lesson Seven: Use male-friendly language
Careful attention should be paid to “male friendly” language which primarily relates to informal, non-medical, non-technical language. Language that is reminiscent of school, that reinforces a sense of authority or that could be interpreted as effeminate, by association with emotions, should also be minimised.

7.2.5.9. Lesson Eight: Ensure process and outcomes are clear and tangible
PAIs should have clear and tangible processes and outcomes to sustain men’s engagement. Men tended to perceive themselves as outcome-orientated and more likely to participate if they could imagine what the end product was and how they would create it. Ill-defined activities with no tangible output were felt to impede men’s engagement. A modular approach where each session has a defined outcome and which contribute to an overall goal may make PAIs more acceptable among this cohort. This also resonates with previous recommendations for men’s mental health promotion interventions to adopt solution-focused or problem-solving approaches (Galdas et al., 2014; Robertson et al., 2018).

7.2.5.10. Lesson Nine: Adopt an informal facilitation style and lead alongside the group
Men and service providers noted that facilitators should be encouraging, non-hierarchical, empathetic, relatable, non-judgemental, ‘down to earth’ and fit in with
the informal and relaxed environment. Indeed, adapting to the needs of the group and leading alongside the group rather than being an authoritative figure was felt crucial to creating trust, confidence to engage in participatory arts and a positive group dynamic. Similar personal qualities deemed desirable in a men’s health facilitator have been reported elsewhere (Carroll et al., 2014; Galdas et al., 2014; Lefkowich et al., 2015; Pringle et al., 2013; Robertson, et al., 2015; Robertson et al., 2018).

7.2.5.11. Conclusion
In summary, these nine lessons respond to calls for further investigation into improving male engagement in participatory arts (Daykin et al., 2018; Sheppard & Broughton, 2020) and for identifying the “active ingredients” that make health interventions acceptable and accessible to men (Galdas et al., 2014). Whilst men may perceive themselves as being at risk of relinquishing masculine capital by engaging in participatory arts, using these gender-specific approaches can help to counter this by enabling the performance of masculine ideals and thus facilitating engagement. It is encouraging to note that these findings share similarities with lessons learnt from other men’s health interventions concerned with sport and physical activity (Lefkowich et al., 2015; Pringle et al., 2013; Robertson et al., 2018). They also align with many of the guidelines in the Check-Mate Tool for incorporating gender-related influences in men’s mental health promotion programmes (Struik et al., 2019). All in all, these findings provide a useful response to the research objective 2(c) – “to identify contextual barriers and facilitators to engagement in PAIs among men in areas of high social disadvantage in Northern Ireland”.

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7.2.6. Development of a Gender-Specific Digital Storytelling Intervention to Promote Mental Health Among Men in Areas of High Social Disadvantage in Northern Ireland

7.2.6.1. Introduction
Key stakeholders expressed a range of preferences for features, content, approaches to delivery and outcomes of a digital storytelling (DST) intervention. This resulted in the development of the Living Legacy intervention, a gender-sensitive DST intervention to promote mental health among men in areas of high social disadvantage in Northern Ireland. This responds to previous calls to explore approaches that might recruit more men to participate in DST (Hausknecht et al., 2018). This section highlights key changes to the format, delivery and content of a traditional DST intervention. It also gives an indication on the prospective acceptability of the Living Legacy intervention.

7.2.6.2. Changes to Delivery of Traditional DST Intervention
Stakeholders indicated a preference for a 6-10 week intervention delivered once per week for two hours rather than the traditional three day (six hours per day) format. The traditional format was felt to lack flexibility with regard to emotional disclosure and participation which would likely deter men. Similar to Hausknecht et al. (2018), additional sessions on digital skills should be delivered if the digital proficiencies of the group are low. Previous research notes that participants do not need to know each other in DST intervention and “defensive masks could be removed through the common purpose of making art” (Reed & Hill, 2010; De Vecchi et al., 2017, p8). However, stakeholders disagreed with such an approach and urged a strong need to deliver DST to an existing group of men for whom trust had already been established. Although the Living Legacy approach differs, it aligns with
wider approaches utilised in the field of men’s health (Hunt et al, 2014; Robertson et al., 2013) and recommendations that DST interventions should prioritise an encouraging and safe group environment (De Vecchi et al., 2016; McDonough & Colucci, 2019).

The level of openness achieved in DST is largely dependent on the degree of trust, rapport and safety participants feel towards facilitators (Guillemin & Drew, 2010). Stakeholders highlighted the need for facilitators to adapt to the needs of the group, model vulnerability where appropriate and be encouraging, non-hierarchical, empathetic, relatable and non-judgemental. It was felt that at least two facilitators with experience of working with men and/or DST and that facilitators should have the capacity to provide or at least refer to professional support if needed. Similar recommendations with regard the backgrounds and number of facilitators have been made by De Vecchi et al. (2017). Phrases such as “story circle”, “homework” or “group rules/contract” should be avoided. Facilitators should also avoid overly medical or formal language.

7.2.6.3. Changes to Features and Content of Traditional DST Intervention
In terms of the intervention features and content, stakeholders highlighted the importance of hosting an introductory session but disagreed with holding “brief lecture” type presentations as has been recommended (Gubrium et al., 2014). Instead, the introductory session should teach DST core elements through the screening of digital stories and interactive activities. The introductory session should also highlight what is expected of men if they participate in clear and tangible terms (3-5min video, 10-16 images, 2hrs per week), model how the
programme will be delivered, and frame the intervention around the altruistic tendencies of men and the wisdom they can pass to future generations.

DST interventions for men should incorporate more action-orientated approaches and graduate men’s exposure to discussing sensitive topics. Teaching digital skills throughout the programme rather than just at the end and incorporating ice-breaker activities that move men from talking about others to discussing more personal experiences are recommended. Examples of ice-breaker activities included discussing male role models, the name game and bringing in old photos or items to discuss with the group. The latter has been found to better facilitate the sharing of emotional experiences and helps to break down verbal barriers (Rolbiecki et al., 2016; Rolbiecki et al., 2017; Teti et al., 2016). Discussing an “artefact” might also help men to legitimise discussing personal experiences because the focus is on the item and not themselves. This graduated approach was also felt to better stimulate ideas for stories among men and would serve to ease them into the “story-circle” process.

Prompts should also be provided to help men develop their story. These prompts should focus on the strengths and positivity of men rather than on their deficits and mistakes. Previous research has identified that a focus on wellness may limit participants’ need to express emotional vulnerability in DST workshops (De Vecchi et al., 2017). It could be argued that this approach is avoiding vulnerability and reinforcing a masculine stereotype (i.e. that men do not want to discuss sensitive topics). However, the approach in the Living Legacy intervention encourages participants to view mistakes and failures through the lens of resilience and self-
efficacy rather than avoiding difficult topics. This aligns with a strengths-based approach to engaging men and was highlighted as an approach to creating a safer and more manageable environment for participants and facilitators alike. A more direct approach to discussing mistakes and deficits may be employed once significant trust is built with the group. In order to overcome literacy issues and promote a more interactive approach, stakeholders highlighted the need to provide alternatives to writing scripts. These could include men audio-recording each other talking about their stories in small groups, men taking notes for those who have literacy issues, or one-on-one support from a facilitator. These more collaborative approaches would also help to leverage the existing capacities in the group and could offer roles for men who do not wish to make their own story.

Stakeholders felt that the name, form and placement of the ‘story circle’ should be changed. Therefore, the ‘story-circle’ should be called ‘sharing your experience’, be placed after an initial script development process rather than before, and be conducted over lunch in an informal space. These changes were felt to remove many of the factors that made the process feel effeminate, childish and/or too formal. Moreover, attempts should be made to drawn linkages between the ‘sharing your experience’ process and the altruistic tendencies of men in order to re-frame it as a masculine practice. Directing men to share their story within specific parameters such as a time limit or 2-3 key points in order may help the process to feel more tangible was recommended by participants which has been reported elsewhere (Cunsolo Wilox et al., 2012). Finally, stakeholders recommended minimising the amount of reading that was required when learning
digital skills. Although this contrasts with Lambert’s (2010) recommendations to teach digital skills in DST through written instructions, this was felt to better align with the learning styles favoured by men and better accommodate those with lower literacy levels. Therefore, the teaching of all digital skills should be implemented through ‘doing’ and discussions rather than lecture style presentations and written instructions.

7.2.6.4. Indication on Prospective Acceptability of Living Legacy Intervention

The consultations with stakeholders indicated that ‘Living Legacy’ may be an acceptable intervention to deliver to men in areas of high social disadvantage in Northern Ireland. Stakeholders described key domains of the TFA, mainly “affective attitude”, “ethicality”, “self-efficacy” and “perceived effectiveness”. The domain “affective attitude” was represented by the positive response to the concept of DST. Indeed, all men that contributed to the consultations expressed a desire to participate in the Living Legacy intervention. DST was felt to align with a long tradition of storytelling in Northern Ireland, particularly among older adults, indicating that it fits with the value system of the intended target group (e.g. ethicality). Moreover, stakeholders felt that it was quite accessible due to there being no requirement for pre-existing skillsets and the fact that everyone has a story to tell. Finally, stakeholders perceived that the intervention would be effective in promoting connectedness, self-efficacy and emotional processing among the target group. Indeed, many men highlight how it would be a form of catharsis and a release from stories they have held in for years. However, these insights were gleaned from a very small number of men involved in the brief consultation phase (n=5) therefore further testing is required. Moreover, due to the iterative
development process, stakeholders were giving feedback on an evolving intervention.

7.2.6.5. Conclusion
Consultations with key stakeholders on their preferences for content and delivery of a DST intervention resulted in the development of the Living Legacy intervention. A logic model has been developed that outlines the key issues to be addressed, gender-specific content and approaches to delivery and proposed mechanisms of change (See Chapter 6, Figure 6). Although the focus of the consultations was on preferences for content and delivery of the intervention, there is some indication that this intervention is acceptable among men in areas of high social disadvantage in Northern Ireland. This is encouraging to note and a useful indication that it is worthwhile continuing with the intervention development process. There is a need to further assess the acceptability of the intervention before it is ready for the next stage in the MRC framework (i.e. feasibility/pilot-testing). This is discussed in more detail in Section 7.2. These findings address the final research objective 2(d) - "to explore the preferences and opinions of key stakeholders on potential intervention features, content, approaches to delivery and outcomes in order to develop an outline description of a PAI."
7.3. Limitations
The primary limitation of this thesis is the impact of COVID-19 on the progress of the work, mostly on the conduct of Stage 2(b) –Design of the Intervention. It was anticipated that a small group of men would participate in the intervention and offer feedback but significant delays due to COVID-19 made this unfeasible. Therefore, the acceptability of the intervention is yet to be established. Whilst an outline description of the intervention has been developed, it was not possible to reach beyond the “Development” stage of the MRC guidance (Craig et al., 2008). There is some indication that the intervention is acceptable among the target group but this requires further investigation. Moreover, public health restrictions made it unfeasible to conduct face to face co-design workshops and the furlough of “gatekeepers” significantly challenged the recruitment of men. A limitation of the online consultations was the absence of shared decision-making and problem-solving processes between “end-users” and service providers due to the individual nature of the consultations. Capitalising on this group dynamic could have resulted in a more refined, timely and/or acceptable intervention. However, the decision to conduct individual consultations was made due to the drawn out recruitment process and men’s preference not to participate in the group format with service providers. The group’s mistrust for health and/or educational institutions could be an explanatory factor. It may be possible that the format of group online consultations with service providers is not favourable among men in areas of high social disadvantage but this requires further investigation. Although the individual approach moved away from a typical co-design approach, the principle of partnership working was maintained by ensuring equal decision-making between
the stakeholders and researcher and by circulating the intervention description for feedback following the consultations. However, the latter received few responses. Moreover, all consultations were recorded and transcribed to support analysis and to give a further indication of group consensus on certain topics.

Despite these limitations, the conduct of online individual consultations also provided a number of advantages such as diminished costs, a more geographically diverse consultation group and the option to “screen share” so intervention content and delivery features could be updated in real time during consultations. Moreover, men who participated in online consultations appeared to be extremely open to discussing sensitive topics, although this was not the focus of the consultations. This could be a result of being in the safe home environment which has been found to facilitate discussions around sensitive topics elsewhere (Dodds & Hess, 2020). Therefore, using online technologies could hold value in discussing health topics with men. However, significant caution is needed due to the lack of support structures that can be provided to participants when using such approaches.

Another limitation of this thesis was the sole use of qualitative research to develop the intervention. Participants may have withheld information due to the sensitive nature of the topic or in order to avoid embarrassment or shame within the group or in front of the researcher. Indeed, many men appeared to speak more freely about experiences of isolation, unemployment, a lack of purpose and health issues. However, particular issues such as adverse childhood experiences and the Troubles were not discussed in depth despite the researcher’s best efforts to probe these
topics further. This is similar to findings from Chandler (2021) who highlighted that some topics – sexual assault, theft from family members, physical violence – elicited stronger feelings of shame and are more “unsayable than others”. Therefore, it may be likely that men withhold information from the researcher in order to avoid such shame, and as some point out, may be an attempt to maintain gendered power relations (Chandler, 2021; De Boise & Hearn, 2017).

Alternative methods for gaining consensus such as the Delphi method could have been used. However, such an approach would not enable stakeholders to elaborate on their views or to unpack why they think certain features of DST may or may not work. The need for continued commitment of a participant group that was already difficult to retain was another reason why this method was not used. Whilst the study sought to include the voices of a range of men in areas of high social disadvantage, the average age of men in the cohort was 65 years old and they were almost exclusively white British/Irish. Moreover, their sexual orientation was not recorded. Therefore, the findings cannot purport to be inclusive or ‘representative’ of all men in areas of high social disadvantage. Indeed, the study may have benefited from recruiting greater numbers of men that were of a younger age and that represented a wider range of ethnicities and sexualities. Furthermore, men were recruited based on representing a socio-demographic group that places them at a higher risk of suicide rather than having experience of suicidal behaviour. This study may have been enriched by the inclusion of more men that had direct experiences of suicide. Nonetheless, eleven out of the 41 men that participated in Stage 2(a) spoke of having either experienced suicide ideation or attempted suicide.
It is also not possible to generalise these findings to other men “at risk” of suicide and/or men in areas of high social disadvantage in other countries. However, it must be noted that the primary aim of the thesis was to develop the Living Legacy intervention, rather than generalize findings.

7.4. Implications for Research

7.4.1. Further Research to Build the Evidence of Acceptability and Effectiveness for Participatory Arts Interventions to Promote Mental Health

The field of “arts in health” sits at the interdisciplinary cross-roads of health, social science and art research. Therefore, it is comprised of individuals from a range of disciplines, working in a range of settings, with different understandings of key concepts and that use varied terminology. This has considerable implications when conducting a systematic review in the field. Indeed, such an endeavour has been noted as a “cumbersome process that requires persistence” (Raw et al., 2012, p14). In order to overcome these issues in the systematic review, clear definitions were provided for “participatory arts”, “intervention”, “common mental health problems” and a classification framework was utilised to limit art forms that were included. Further reviews should adopt such an approach and be clear about the art forms, intervention types and domain of health under investigation. The review made a clear distinction between participatory arts and those conducted in clinical settings. This served to delineate away from a biomedical model of health and find a “conceptual home” for participatory arts within the social determinants model of health (South, 2004). This was felt to provide a tighter frame of evidence and theories in which to position and discuss the review findings. This served to provide a clear theoretical underpinning which may orientate future research. Indeed,
future PAI research should clearly outline the underpinning theoretical framework and ideally align with the social determinants model of health.

Further research is needed to develop a rigorous evidence base for PAIs to promote mental health and wellbeing. There is a need for more controlled studies with longitudinal outcomes. However, it must be noted that many PAIs are once off or have limited potential for scale. Therefore, building qualitative acceptability evaluations in PAIs that assess the range of TFA domains and graduating those with appropriate end-user volume to more experimental designs may appropriately establish the evidence of effectiveness. PAIs that assess perceived effectiveness should map their findings to relevant theories in order to elucidate potential mechanisms of action underpinning positive outcomes. Brief quantitative measures could then assess appropriate theoretical constructs in order to build the evidence of effectiveness. There is also a clear need for more qualitative research that focuses on the optimal mechanisms for engagement, particularly for population groups that are underrepresented in participatory arts research such as men, those from a low socio-economic background and ethnic minority groups (Sheppard & Broughton, 2020). The methodology quality of qualitative PAI studies needs attention. Utilising existing guidelines for the conduct of qualitative research such as the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007) is recommended. A high proportion of the literature is concerned with performance-, multimodal- and visual arts. Future research would benefit from exploring other art forms that are underrepresented such as digital, online and electronic arts and literature.
7.4.2. Need for Further Understanding of the Gendered Pathways to Engagement and Positive Mental Health Outcomes in Participatory Arts among Men

There is a need for more PAIs that specifically target men. This requires the intentional targeting of males through PAIs that incorporate gender-responsive approaches. Failure to consider gender in mental health promotion work may lead to negative views about the likelihood of engaging men and contribute to self-fulfilling failures (Robertson et al., 2018). However, as evidenced in this thesis, taking time to understand gender in a nuanced way, can help to elucidate approaches that facilitate male engagement in participatory arts and potential mechanisms that underpin positive mental health outcomes.

This thesis has begun to articulate gender-specific approaches that could facilitate men’s engagement with PAIs. However, these approaches are relevant to a specific group of “at risk” men in Northern Ireland that may not be generalizable beyond this context. Additional research is needed to explore if these approaches are relevant to a wider male population and if different approaches are required to engage other men “at risk” of suicide. Moreover, these are broad principles and further research is needed to explore how these approaches could be operationalized within different art forms. Indeed, a greater understanding of how to frame specific art forms around male interests would be beneficial. Finally, this thesis set out to recruit men who were actively engaged in PAIs and thus does not encapsulate the views of men who chose not to participate in PAIs. Further research with these men might help to elucidate further barriers to male engagement in participatory arts. Nonetheless, these findings coupled with the Check-Mate Tool, a set of guidelines for incorporating gender-related influences in
men’s mental health promotion programmes, could provide a basis for the development of further gender-specific PAIs targeting men (Struik et al., 2019). Involving men in the intervention development process and assessing the prospective acceptability of emerging PAIs might be a useful starting point to building the evidence of acceptability.

The use of Connell’s (1995) social construction of masculinities theory helped to elucidate the gendered pathways through which PAIs positively impact the mental health of men in areas of high social disadvantage. This is one of the only studies in the PAI literature that has adopted such an approach. Further research should use this frame to broaden the evidence base on the mechanisms of action underpinning the positive mental health outcomes of PAIs among the wider male population and other “at risk” groups of men. This thesis drew on social capital theory (Putnam, 2000), social cognitive theory (Bandura, 1986) and the process model of emotional regulation (Gross & Thompson, 2007) to explore the positive impact of PAIs on this cohort’s mental health. Further research should explore the utility of these theoretical constructs to interpret and gauge the impact of PAIs using quantitative measures such as the Social Connectedness Scale (Lee et al., 2001), the New General Self-Efficacy Scale (Chen et al., 2001) and the Emotion Regulation Strategies for Artistic Creative Activities Scale (Fancourt et al., 2019). Moreover, this thesis drew on experiences from men who engaged in a wide range of participatory arts activities in their respective groups. Further research on the mental health impact of specific art forms among men would be useful in order to ascertain whether some are more effective or acceptable than others, and for whom.
7.4.3. Further Development and Evaluation of the Living Legacy Intervention
This thesis resulted in the development of Living Legacy, a gender-sensitive DST intervention to promote mental health among men in areas of high social disadvantage in Northern Ireland. There is a need to assess the acceptability of the intervention prior to conducting pilot testing/feasibility studies. The intervention should be delivered to a small group of the intended target group and a mixed methods study should be conducted to further assess the retrospective acceptability of the intervention format, content, delivery and outcome measures in advance of feasibility studies or pilot of an RCT. Qualitative interviews should explore participants’ experience of the intervention, the barriers and facilitators to sustained engagement, and positive outcomes accrued from participation. The topic guide for these interviews should be informed by the seven domains of the TFA and attendance should be taken as an additional measure of acceptability. This study should also explore possible outcome measures that could be used in the future evaluation of the intervention such as the Social Connectedness Scale (Lee et al., 2001), the New General Self-Efficacy Scale (Chen et al., 2001) and the Emotion Regulation Strategies for Artistic Creative Activities Scale (Fancourt et al., 2019). Finally, attempts should be made to follow-up with participants who drop-out of the intervention in order to determine further barriers to participation. Facilitators delivering the intervention should record personal reflections at the end of each session, making note of what was changed to suit the needs of the group, what went well, what didn’t, and what could be improved for next time. The intervention should be adapted accordingly, and if it is deemed acceptable, feasibility studies and a pilot RCT are recommended. These studies might assess the
recruitment and retention of participants in preparation for a future RCT, the completion and appropriateness of outcome measures and acceptability of the research procedures.

Finally, further studies could also assess the acceptability and adaption of the intervention to suit the needs of other men considered “at risk” of suicide. Indeed, Traveller men on the island of Ireland have a suicide rate that is seven times higher than the national male average (AITHS, 2010). There is also a strong oral tradition of storytelling, song, and recitation that is particular to Traveller culture. Therefore, DST might represent an acceptable non-clinical modality to promote mental health among this population group but further research is needed. Further studies might also assess the impact of screening digital stories - which describe resilience and self-care in overcoming suicidal behaviour - on intention to seek help and the stigma of suicide among men. Indeed, such studies could also assess the impact of the stories on suicide ideation which could help to expand the suicide prevention literature on the “Papegeno Effect” (Hill et al., 2018).

7.5. Implications for Policy and Practice
The quest to find a magic formula to address the high suicide rate of men in areas of high social disadvantage in Northern Ireland will remain on the agenda, due to the complexity and interplay of risk factors for suicide. Generally suicide prevention policies have placed insufficient emphasis on area level suicide prevention programmes, specifically targeting men in areas of high social disadvantage (Pirkis et al., 2017). There is a need for suicide prevention policies to consider area-level, systems approaches that comprise of universal (whole of
population), selective (specific ‘at risk’ populations) and indicated interventions (individuals displayed suicidal behaviour). This thesis has elucidated that isolation, a lack of meaningful occupation, difficult life transitions, and adverse childhood experiences, in particular, contribute to psychological distress among this cohort. This responds to Objective 10 in the Northern Ireland suicide prevention strategy to strengthen local evidence on suicide risk (Department of Health, 2019). These findings could inform key interventions to address suicide risk among men in areas of high social disadvantage in Northern Ireland. For example, direct, gender-specific, interventions aimed at developing interpersonal connections and providing meaningful occupation among men in these communities are needed. This thesis also highlighted a number of key transitional points in men’s lives – such as divorce, unemployment, retirement, and the onset of illness - where men in areas of high social disadvantage appear to be at higher risk of psychological distress. In terms of practical implications, healthcare providers, employers, and local mental health services should be aware, and respond to, their increased mental health needs during these times. Although much of the existing focus of health policy is on increasing personal capacity to effect change, it is imperative that policy also accounts for the wider social determinants of health that, in the context of this study, result in circumstances that contribute to psychological distress among this cohort.

The thesis has identified that PAIs may improve the mental health of men in areas of high social disadvantage by enhancing connectedness, self-efficacy and personal growth, and emotional processing. However, there is insufficient emphasis on using...
PAIs to improve men’s mental health across Northern Ireland. Therefore, community and voluntary organisations with a remit for men’s health and mental health may wish to partner with arts organisations to deliver PAIs to “at risk” groups of men across the region. The key lessons presented in Section 7.2.5 with regard improving male engagement in PAIs will also benefit a range of community artists. This included recommendations on the setting, the group, personal traits of the facilitator, and a number of gender-specific approaches that may enhance the acceptability of PAIs.

Finally, this thesis has practical implications for the development of wider men’s health programmes and/or PAIs in general. This thesis was heavily informed by the approach taken in the “If I were Jack” film-based intervention about teenage men and unintended pregnancy (Aventin et al., 2015). This thesis echos conclusions by Aventin et al. (2015) on the importance of bringing together researchers, programmers and a range of stakeholders to develop evidence-based and user-informed interventions. The intervention development processes and components in this thesis can help to bridge the gap between research and interventions and inspire the development of similar programmes within the field of men’s health and participatory arts. Indeed, the Living Legacy intervention has already inspired the development of an intervention by Pavee Point (National Irish Traveller Association) and the National Centre for Men’s Health in Ireland. This proposal will explore the impact of digital storytelling among Traveller men with experience of suicide and will result in several Traveller representatives being trained in DST facilitation.
Therefore, the Living Legacy could be an exemplar which others might utilise, modify and improve.

7.6. Conclusion
This thesis describes how the MRC guidance (Craig et al., 2008) and the taxonomy of approaches for intervention development (O’Cathain et al., 2019) were applied to develop an evidence-based and user-informed intervention. The Living Legacy intervention is a DST intervention designed to improve the mental health of men in areas of high social disadvantage in Northern Ireland by enhancing connectedness, self-efficacy and emotional processing. The intervention was systematically developed by conducting a systematic review (Chapter 2), focus group and interviews with men in areas of high social disadvantage in Northern Ireland (Chapter 4) and online consultations with key stakeholders (Chapter 5). Chapter 2 highlighted that PAIs are acceptable among adults. However, methodological issues limit the conclusions that can be drawn with regard to evidence of effectiveness. There is a dearth of studies in the literature that focus on men and more research is needed to identify mechanisms of action that highlights how PAIs support men’s mental health, the barriers and facilitators to male engagement in PAIs, and the overall acceptability of particular PAIs among men. Chapter 4 identified that isolation, a lack of meaningful occupation, difficult life transitions and childhood experiences were the key factors contributing to psychological distress among men in areas of high social disadvantage in Northern Ireland. However, PAIs can address some of these issues by enhancing connectedness, self-efficacy and personal growth, and emotional processing.
Chapter 4 and 5 highlighted a number of approaches that may improve male engagement in PAIs. These included the need for PAIs to: (i) be delivered in a space that is familiar and desirable to men; (ii) be delivered to an existing group that shares a sense of relatedness; (iii) be framed around male interests and values versus “health” or “creativity”; (iv) adopt strengths-based approaches that build men’s confidence and self-efficacy; (v) utilise action-orientated and interactive approaches; (vi) enable autonomy and ownership in a structured programme that allows for flexibility; (vi) use male-friendly language; (vii) ensure process and outcomes are clear and tangible; (ix) be led by facilitators that are informal and non-hierarchical. Finally, Chapter 5 elucidated a number of preferences and practical considerations to develop a gender-sensitive DST intervention. This resulted in the development of Living Legacy. Further research is now required to assess the acceptability of Living Legacy and to refine the intervention components before implementation into practice.
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Organisation.

https://www.who.int/gender/documents/Engaging_men_boys.pdf


## Appendix 1: Data Extraction Form

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## Appendix 2: Quality Appraisal for Qualitative Studies

<p>| First Author &amp; Year | Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*) | Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components) | 1. Is the qualitative approach appropriate to answer the research question? | 2. Are the qualitative data collection methods adequate to address the research question? | 3. Are the findings adequately derived from the data? | 4. Is the interpretation of the results sufficiently substantiated by data? | 5. Is there coherence between qualitative data sources, collection, analysis &amp; interpretation? | Grade |
|---------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Giaver (2016)       | Yes                                                               | Yes                                                               | Can’t tell                                                                                      | Can’t tell                                                                                      | Yes                                                               | No                                                               | Can’t tell                                                                                      | Weak |
| Lawson (2014)       | Yes                                                               | Yes                                                               | Yes                                                                                           | Yes                                                                                           | Yes                                                               | Yes                                                               | Yes                                                                                           | Strong |
| Makin (2011)        | Yes                                                               | Yes                                                               | Yes                                                                                           | Yes                                                                                           | Yes                                                               | Yes                                                               | Yes                                                                                           | Strong |
| Horhagen (2014)     | Yes                                                               | Yes                                                               | Yes                                                                                           |                                                                                              |                                                                   |                                                                   |                                                                                               | Moderate |
| Marie-Heard (2013)  | Yes                                                               | No                                                                | Yes                                                                                           | No                                                                                           | No                                                               | No                                                                | No                                                                                           | Weak |
| Nagji (2013)        | Yes                                                               | Yes                                                               | Yes                                                                                           | Yes                                                                                           | No                                                               | No                                                                | No                                                                                           | Weak |
| Perkins (2016)      | Yes                                                               | Yes                                                               | Yes                                                                                           | Yes                                                                                           | Yes                                                               | Yes                                                               | Yes                                                                                           | Strong |
| Stickley (2012b)    | Yes                                                               | Yes                                                               | Yes                                                                                           | Yes                                                                                           | No                                                                | Can’t tell                                                        | Yes                                                                                           | Moderate |
| Stickey (2013)      | Yes                                                               | Can’t tell                                                        | No                                                                                           | Yes                                                                                           | Yes                                                               | Yes                                                               | Yes                                                                                           | Moderate |</p>
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### Appendix 3: Quality Appraisal for Randomised Control Trials

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<th>First Author &amp; Year</th>
<th>Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?</th>
<th>Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).</th>
<th>Is randomisation appropriately performed?</th>
<th>Are the groups comparable at baseline?</th>
<th>Are there complete outcome data?</th>
<th>Are outcome assessors blinded by the intervention provided?</th>
<th>Did participants adhere to the assigned intervention?</th>
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Appendix 4: Quality Appraisal for Non-Randomised Studies

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<th>1. Are participants representative of the target population?</th>
<th>2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?</th>
<th>3. Are there complete outcome data?</th>
<th>4. Are the confounders accounted for in the design and analysis?</th>
<th>5. During the study period, is the intervention administered (or exposure occurred) as intended?</th>
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### Appendix 5: Quality Appraisal for Mixed Method Studies

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<th>Is there an adequate rationale for using a mixed methods design to answer the research question?</th>
<th>Are the different components of the study effectively integrated to answer the research question?</th>
<th>Are the outputs of the integration of qualitative and quantitative components adequately interpreted?</th>
<th>Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?</th>
<th>Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?</th>
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## Appendix: 6: Coding Framework for Systematic Review

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<td>Routes to connection</td>
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<td>Caring for and being cared for; reciprocal social support; sharing problems; reciprocal feedback on artwork; sharing &amp; learning from others</td>
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<td>Emotional regulation</td>
<td>Distraction and absorption</td>
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<td>Distraction from mental health issues; peace of mind; absorption; letting go of thoughts; flow states; fullness of time; distorted sense of time</td>
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<td>Relaxing and relief</td>
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<td>Relaxing; stress relieving; therapeutic; realising tension</td>
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<td>Generating</td>
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<td>Lifting mood; fun; enjoyable; energising; creating memories; feeling good about self; increased confidence</td>
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<td>Self-discovery and self-knowledge</td>
<td>Changing self-perception; self-discovery; self-exploration; self-knowledge; self-understanding; greater awareness of self</td>
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<td>Agency, control and independence</td>
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<td>Structure and stimulation</td>
<td>Structure; routine; consistency; stimulation; purpose; something to look forward to; sense of everyday occupation</td>
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<td>Stepping stone to other opportunities; springboard effect; catalyst for change; inspiration to continue art-making; engaging in new activities; hope about future; instilling hope &amp; belief</td>
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<td>Maintaining, creating and re-connecting with identity</td>
<td>Re-connecting with self; re-connecting with previous interests &amp; achievements; feeling normal &amp; not identified based on label; identifying as new role; shift in self-perception; building new identities</td>
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<td>Creation and achievement</td>
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<td></td>
<td>Acquisition of skills &amp; knowledge</td>
<td>New skills; personal development; improved abilities; improved knowledge; problem solving skills; art skills; increased confidence with skills</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Responding to challenges</td>
<td>Overcoming challenges; rewarding challenges; making mistakes; achievement in mastering difficult task</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unintended Adverse Effects</td>
<td>Accessibility &amp; group tensions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Frustration with quality of work; disappointment; need for follow on activities; sense of longing with cessation of PAIs; clash of personalities with group; clash with facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Burden</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alleviators of Burden</td>
<td>Flexibility in participation; no pressure to discuss mental health; acceptance of emotional behaviours; treated like normal person; focusing on capabilities; focus on art not mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Burdensome Factors Associated with PAIs</td>
<td>Accessibility of venue; long commute; physical fatigue; family commitments</td>
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<tr>
<td></td>
<td></td>
<td>Self-efficacy</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitators of Self-Efficacy</td>
<td>Equally valuing contributions; everyone able to make contribution; no pressure to be ‘good; no expectations; dissolution of fault with mistakes; encouraging mistakes; guidance &amp; autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeling Incapable</td>
<td>Worry of making mistake; lack of perceived artistic skills</td>
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<td>Affective attitude</td>
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<td></td>
<td></td>
<td></td>
<td>Enjoyable PAI; prized experience</td>
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<td></td>
<td></td>
<td>Effectiveness</td>
<td>Mental wellbeing &amp; quality of life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
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<td></td>
<td></td>
<td></td>
<td>Mental wellbeing; positive affect; quality of life; life satisfaction</td>
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<td></td>
<td>Common mental health problems and psychological distress</td>
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<td></td>
<td></td>
<td></td>
<td>Depression; anxiety; psychological distress</td>
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<tr>
<td>Social relationships</td>
<td>N/A</td>
<td>N/A</td>
<td>Social support; social connectedness; social inclusion</td>
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<tr>
<td>----------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Empowerment</td>
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<td>N/A</td>
<td>Empowerment</td>
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</table>
### Appendix 7: Topic Guide for Stage 2(a) – Understanding Experiences

<table>
<thead>
<tr>
<th>Topic</th>
<th>Questions</th>
<th>Prompts</th>
</tr>
</thead>
</table>
| Mental Health Experiences     | • What does it mean to be mentally well? When you feel like that spark is there, what does that look/feel like.  
• What sort of things do you need to, or makes you, feel well?  
• Have you ever felt mentally unwell or sort of lost that spark? Could you tell me a little bit about that experience?  
• What sort of things made you feel unwell?  
• Did living in this community contribute to some of those issues? | Social, emotional, physical, spiritual.  
Financial stress, loss (jobs, opportunities, friends, relationships), the Troubles, childhood, changes in health. |
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What art activities work well?</td>
</tr>
<tr>
<td></td>
<td>• What would stop you or other men from becoming involved in creative activities? What would make you want to become involved?</td>
</tr>
</tbody>
</table>
Appendix 8: Stage (a) Participant Information Sheet

Arts-Based Interventions to Promote Mental Health and Reduce Suicide Risk among Men

We need your help in our research:

Hello,

- We are a research team from Queen’s University Belfast and we want to promote mental health and reduce the suicide risk of men in Northern Ireland.
- We are developing an arts-based intervention to try and tackle this issue but we need men to help us create it. **This research is being undertaken by Shane O’Donnell as part of his PhD research programme.**
- We need your help to develop this intervention to ensure it is wanted and useful for men.
- This would require you to participate in a focus group or an interview to share your thoughts on your mental health experiences and engagement in creative activities.
- **This study has been reviewed by the School of Nursing and Midwifery Research Ethics Committee.**

If you would like to help:

- If you think you would like to help please continue to read this information sheet which gives some more details about the research, what you would do if you took part and how we will protect your privacy if you take part.
- You will also have the chance to meet the researcher before agreeing to take part so you can find out more about what you will be doing and ask any questions you may have.

<table>
<thead>
<tr>
<th>Researcher Contact Details</th>
<th>Support Organisations Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead Researcher</strong></td>
<td><strong>SanarBans</strong></td>
</tr>
<tr>
<td>Shane O’Donnell</td>
<td>116 123</td>
</tr>
<tr>
<td><a href="mailto:share.oddonell@qub.ac.uk">share.oddonell@qub.ac.uk</a></td>
<td>0808 808 8000</td>
</tr>
<tr>
<td>+44 (0)28 909 7 5761</td>
<td><strong>LifeLine (NI)</strong></td>
</tr>
<tr>
<td><strong>Chief Investigator</strong></td>
<td>116 123</td>
</tr>
<tr>
<td>Karen Galway</td>
<td>0808 808 8000</td>
</tr>
<tr>
<td><a href="mailto:k.galway@qub.ac.uk">k.galway@qub.ac.uk</a></td>
<td><strong>Pieta House (IRL)</strong></td>
</tr>
<tr>
<td><strong>Chair of Ethics Committee</strong></td>
<td><strong>Pieta House (IRL)</strong></td>
</tr>
<tr>
<td>Dr Oliver Peria</td>
<td><a href="https://www.pieta.ie/contact-us">https://www.pieta.ie/contact-us</a> to find your nearest service.</td>
</tr>
</tbody>
</table>
Why are you doing this study?

- The male suicide rate in Northern Ireland is three times higher than the female suicide rate.
- Art-based interventions have shown promise in promoting mental health but many of these interventions don’t consider men’s needs when they are being developed.
- This may lead to men feeling that the intervention is not for them and may decide not to participate.
- So, we want to develop an arts-based intervention for men that is created by men.

Why are you asking me to help?

- You reside in a community that has been significantly affected by suicide in recent years.
- We value your opinion and feel that you have the greatest insight into what is best for men’s mental health in your area.

What will I do if I take part?

- You would participate in a focus group with other men from your group or an individual interview with the researcher. The men’s group facilitator will be on site to support you if you become distressed.
- You would discuss issues that have affected your men’s mental health and your experiences of participatory arts.

Do I have to take part?

- No – it is totally up to you if you want to take part.
- If you do decide to take part at the start you can change your mind at any time and not take part anymore. You don’t have to give a reason why.
- You don’t have to answer any questions you don’t want to.

Will my identity be kept?

- Yes – your name or anything that could identify you will not be used in the research in order to keep your identity private. Instead we will use made up names and say we were helped from men in communities affected by suicide in Northern Ireland.
Will things I say be kept private?

- Yes – only the researcher or the men in the group will know what you say.
- BUT there are two reasons where we cannot keep the things you say private: (1) If you tell us something that indicates that you or a person you know is in danger we may have to pass this information to the authorities to ensure your/other’s safety. (2) If you tell us about things you have done that could be considered a crime we may have to pass that information onto the authorities.
- You can change your mind at any time and not take part in the study. You don’t have to give a reason why.

What will happen to the info I give you?

- All data will be confidential and stored in a locked cabinet, a password protected computer in Queen’s University and/or on a cloud storage service which only the researchers can access. This will be held for 5 yrs from the point of collection & then destroyed.
- The results of this study will be presented in a PhD thesis and will be seen by a team of supervisors and external examiners. It may be published in an academic journal and presented at conferences. We may use some of your quotes or share themes you discussed with other researchers, but it will all remain anonymous.

Are there any downsides to taking

- As we will touch on the topics mental health and suicide some conversations might be difficult to talk about.
- You don’t have to talk about anything you don’t want to.
- You can remove yourself from the interview at any time and a facilitator will support you.
- If you would like professional help following the interview we can support you to contact a professional. With your permission, we can contact them for you.
- The phone numbers for local and national services are also listed above if you wish to seek help at any time.

What if I have a complaint?

- If you have any complaint about the study you can contact Shane who will be happy to resolve the issue. If you are unable to resolve the complaint, you can contact Dr Oliver Perra, chair of the School of Nursing and Midwifery Ethics Committee.
Appendix 9: Stage 2(a) - Informed Consent

Art-Based Interventions to Promote Mental Health and Reduce Suicide Risk Among Men

Informed Consent Sheet: Stage 2(a)

Please put your initials in the box if you agree to the following information:

1. I have read and/or have had the information sheet read to me and I understand that I am being invited to participate in this PhD study titled above. I have had the opportunity to ask questions and I am satisfied with the answers.

2. I understand that the data and/or personal information held about me will only be available to the researchers, held on a password protected computer and that it will be protected in line with the new General Data Protection Regulations (GDPR).

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

4. I understand that everything I say in the focus group or interview will be anonymous and kept strictly confidential (unless information needs to be passed on as a safe-guarding matter). I understand that direct quotes may be used in the PhD thesis or in published reports or articles but it will all be completely anonymous.

5. I understand that if I withdraw or can no longer continue in the study, any information I have already given will be retained, as it would be difficult to separate this from the groups’ view.

6. I agree to focus group or interview being audiotaped.

7. I agree to participate in this study.

_________________________    ___________    ________________________
Name of Participant        Date          Signature

_________________________    ___________    ________________________
Researcher           Date          Signature
Appendix 10: Stage 2(b) – Topic Guide

Topic Guide – Stage 2(b) Co-Design of intervention

1. What are your initial thoughts on digital storytelling? Is it something you could see working well or not? Why or why not?
2. Is it something that you could see yourself participating in? Why or why not?
3. What elements did you like and not like about digital storytelling?
4. What elements of it do you think should change?
5. Do you think this ABI would be useful for promoting mental health? Why or why not?
6. How many sessions do you think there should be in the ABI? How long should each session last?
7. What should each session(s) consist of?
8. Who do you think should deliver the ABI?
9. What type of setting should the ABI take place in?
10. How should we get men in the door for the first session?
11. How do we keep men engaged through the ABI and ensure they want to keep coming back?
12. Do you see any potential downsides or risk of participating in this ABI? How can we avoid them?
13. What kind of resources would be necessary to deliver this ABI?
14. What do you see as the main challenges to delivering this ABI? How could we overcome those challenges? What opportunities are out there that might assist with the delivery of this ABI?
15. Are there any wider environmental barriers or threats to this ABI? How could we overcome these?
Appendix 11: Stage 2(b) – Participant Information Sheet

Arts-Based Interventions to Promote Mental Health and Reduce Suicide Risk among Men

Hello,

- We are a research team from Queen’s University Belfast and we want to promote mental health and reduce the suicide risk of men in Northern Ireland and Ireland.
- We are developing an arts-based intervention to try and tackle this issue but we need men to help us create it. This research is being undertaken by Shane O’Donnell as part of his PhD research programme.
- We need your help to develop this intervention to ensure it is wanted and useful for men.
- This would require you to participate in up to three online focus groups via Microsoft Teams, share feedback and suggest other creative activities that men in your area might like which could promote mental health.
- This study has been reviewed by the Faculty of Medicine, Health and Life Sciences Ethics Committee at Queen’s University Belfast.

If you would like to help:

- If you think you would like to help please continue to read this information sheet which gives some more details about the research, what you would do if you took part and how we will protect your privacy if you take part.
- You will also have the chance to meet the researcher before agreeing to take part so you can find out more about what you will be doing and ask any questions you may have.

---

**Researcher Contact Details**

<table>
<thead>
<tr>
<th>Lead Researcher</th>
<th>Chief Investigator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shane O’Donnell</td>
<td>Karen Galway</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Samaritans</th>
<th>Lifeline (NI)</th>
</tr>
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<tr>
<td>116 123</td>
<td>0808 808 8000</td>
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</table>

**Support Organisations Contact Details**

<table>
<thead>
<tr>
<th>Pietà House (IRL)</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="https://www.pieta.ie/contact-us">https://www.pieta.ie/contact-us</a> to find your nearest service.</td>
</tr>
</tbody>
</table>

---
Why are you doing this study?

- The male suicide is Northern Ireland and Ireland is three to four times higher than the female suicide rate.
- Art-based interventions have shown promise in promoting mental health but many of these interventions don’t consider men’s needs when they are being developed.
- This may lead to men feeling that the intervention is not for them and may decide not to participate.
- So, we want to develop an arts-based intervention for men that is created by men.

Why are you asking me to help?

- You reside in a community that has been significantly affected by suicide in recent years.
- We value your opinion and feel that you have the greatest insight into what is best for men’s mental health in your area.

What will I do if I take part?

- You would participate in up to three online focus groups lasting up to 2hrs via Microsoft Teams with other men from your area, the researcher and another member who will support you if you become distressed.
- You would suggest what art activities might be useful for men in your area to benefit their mental health.
- You would give feedback on activities designed by the group as a whole.
- You would suggest approaches that might be best to delivering such activities targeted at men in your area.

Do I have to take part?

- No – it is totally up to you if you want to take part.
- If you do decide to take part at the start you can change your mind at any time and not take part anymore. You don’t have to give a reason why.
- You don’t have to answer any questions you don’t want to.

Will my identity be kept private?

- Yes – your name or anything that could identify you will not be used in the research in order to keep your identity private. Instead we will use made up names and say we were helped from men in communities affected by suicide in Northern Ireland and Ireland.
Will things I say be kept private?

- Yes – only the other men in the group, the researchers and facilitators will know what you say.
- **BUT** there are two reasons where we cannot keep the things you say private: (1) If you tell us something that indicates that you or a person you know is in danger we may have to pass this information to the authorities to ensure your/other’s safety, (2) if you tell us about things you have done that could be considered a crime we may have to pass that information onto the authorities.
- You can change your mind at any time and not take part in the study. You don’t have to give a reason why.
- You don’t have to answer any questions you don’t want to.

What will happen the info I give you?

- The online focus group will be video-recorded. If you only to be audio recorded you have the right to turn off your video camera during the online focus group. The audio of the video will be transferred to a word document and the video will be deleted.
- All data will be confidential and stored on a password protected computer in Queen’s University and/or on a cloud storage service which only the researchers can access. This will be held for 5 years from the point of collection & then destroyed.
- The results of this study will be presented in a PhD thesis and seen by a team of supervisors and external examiners. It may be published in an academic journal and presented at conferences. We may use some of your quotes or share themes you discussed with other researchers, but it will all remain anonymous.

Are there any downsides to taking part?

- You don’t have to talk about anything you don’t want to.
- You can remove yourself from the online focus group at any time and a facilitator will support you.
- If you would like professional help following the online focus group, we can support you to contact a professional. With your permission, we can contact them for you.
- The phone numbers for local and national services are also listed above if you wish to seek help at any time.

What if I have a complaint about the study?

- If you have any complaint about the study you can contact Shane who will be happy to resolve the issue. If you are unable to resolve the complaint, you can contact Mrs Louise Dunlop, Head of Research, Governance, Ethics & Integrity.

What if I want to find out more?

- If you would like to participate please contact the person who informed you about the study who can contact the researcher on your behalf or you can contact the researcher directly.
Appendix 12: Stage 2(b) – Informed Consent

Art-Based Interventions to Promote Mental Health and Reduce Suicide Risk Among Men

Informed Consent Sheet: Stage 2(b) Men

Please put your initials in the box if you agree to the following information:

1. I have read and/or have had the information sheet read to me and I understand that I am being invited to participate in this PhD study titled above. I have had the opportunity to ask questions and I am satisfied with the answers.

2. I understand that the data and/or personal information held about me will only be available to the researchers, held on a password protected computer and that it will be protected in line with the new General Data Protection Regulations (GDPR).

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

4. I understand that everything I say in the group will be anonymous and kept strictly confidential (unless information needs to be passed on as a safeguarding matter). I understand that direct quotes may be used in the PhD thesis or in published reports or articles but it will all be completely anonymous.

5. I understand that if I withdraw or can no longer continue in the study, any information I have already given will be retained, as it would be difficult to separate this from the group’s view.

6. I agree to the online focus groups being video-recorded. However, I understand if I wish only to be audio-recorded I have the right to turn my camera off.

7. I agree to participate in this study.

Name of Participant ___________________________ Date __________ Signature ___________________________

Researcher ___________________________ Date __________ Signature ___________________________
Appendix 13: Ethical Approval

27 November 2018

Mr Shane O’Donnell
School of Nursing and Midwifery
Queen’s University Belfast
Medical Biology Centre
97 Lisburn Road
BELFAST BT9 7BL
Belfast
Northern Ireland
Tel: 028 9097 2233/2061
Fax: 028 9097 2328
nursing@qub.ac.uk
www.qub.ac.uk/mur

Dear Mr O’Donnell,

SCHOOL RESEARCH ETHICS COMMITTEE

RE: Arts-Based Interventions as a Vehicle for Mental Health Promotion and Suicide Risk Reduction among Men

Thank you for your recent submission to the School of Nursing and Midwifery Research Ethics Committee. I wish to advise you that your application has been approved and you can now commence with your study. This approval has been given by Chair’s Action as agreed at the last meeting.

To complete the Research Governance process, you should complete the Gov 3 form (request for sponsorship of a research project) and forward this along with your protocol to Ms Louise Dunlop at the Research Governance Policy Office. In addition, please ensure the project is recorded on the PURE system.

Yours sincerely

[Signature]

Dr Oliver Perra
Chair, School Research Ethics Committee
School of Nursing & Midwifery

cc File copy
Appendix 14: Ethical Amendment Approval

Date: 06 August 2020
To: Professor Maria Lohan / Dr Karen Galway / Mr Shane O’Donnell
Faculty REC Reference Number: PREC 09.18.M1.V2
Full Title: Arts-Based Interventions as a Vehicle for Mental Health Promotion and Suicide Risk Reduction among Men
Decision: AMENDMENT 2 - APPROVED

Thank you for your request for an amendment to the above study to allow for the Focus Groups and Interviews to be conducted online, received on 27 July 2020.
The amendment has been considered and has been given approval.
The following study documents have been reviewed as part of this amendment and approved for use:

<table>
<thead>
<tr>
<th>Documentation Received</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of Amendment Form – Amendment 2</td>
<td>6</td>
<td>08 July 2020</td>
</tr>
<tr>
<td>Research Protocol</td>
<td>8</td>
<td>Received 27 July 2020</td>
</tr>
<tr>
<td>Proposed Amendments Documents</td>
<td></td>
<td></td>
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<tr>
<td>Cover Letter</td>
<td>2</td>
<td>07 July 2020</td>
</tr>
<tr>
<td>Distress Protocol</td>
<td>2</td>
<td>Received 08 July 2020</td>
</tr>
<tr>
<td>Topic Guide</td>
<td>2</td>
<td>Received 08 July 2020</td>
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<tr>
<td>Information Sheet Step 2(b) Co-Design Men</td>
<td>6</td>
<td>Received 27 July 2020</td>
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<tr>
<td>Information Sheet Stage 2(b) CVSP</td>
<td>6</td>
<td>Received 27 July 2020</td>
</tr>
<tr>
<td>Information Sheet Stage 2(c) Men</td>
<td>6</td>
<td>Received 27 July 2020</td>
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<tr>
<td>Consent Form Stage 2(b) Men</td>
<td>5</td>
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<td>Received 27 July 2020</td>
</tr>
</tbody>
</table>

If you would like to discuss this further please contact the Research Ethics Officer, Mr Stefan Curran, at facultysrec@qub.ac.uk or by telephone on 028 90972529.

Yours sincerely

pp Professor Michelle McKinley
Chair, MHL5 Faculty REC
Appendix 15: Distress Procedure

Before the Focus Group/Workshop:

- Participants will be reminded:
  - (a) that participation is voluntary and they can withdraw at any time
  - (b) that they do not have to answer any question they do not want to
  - (c) that potentially upsetting discussions may occur
  - (d) of the supports available to them should they become distressed before and/or during the focus group/workshop

An Individual Becomes Distressed:

- They are asked would they like to continue?
  - If Yes, The researcher continues
  - If No, The researcher stops the focus group/workshop

The individual appears to be no longer distressed:

- The researcher "checks in" with the individual in private at the end of the focus group/workshop and asks them if they require additional support.

The individual remains significantly distressed:

- The "support facilitator" or researcher offers support to the individual and verbally recomends that they make contact with appropriate local/national support services.
  - The "support facilitator" or researcher shows the individual the supports services available which are outlined on the bottom of the information sheet.
  - The individual is asked if they would like assistance in contacting the support services.
    - If Yes, The "support facilitator" or the researcher contacts the local and/or national support service on the individual's behalf as chosen by them and explains how the distressing event occurred.
    - If No, The "support facilitator" or the researcher respects the individual's right to self-refer.
  - The researcher will draw attention to the support services and to the researcher contact details on the information sheet.

Indicent is recorded in the safeguarding concerns log (Appendix 21).
## Appendix 17: Coding Framework for Stage 2(a) – Understanding Experiences

<table>
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<th>Theme</th>
<th>Subtheme</th>
<th>Categories</th>
<th>Example of Codes</th>
</tr>
</thead>
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<td><strong>Theme 1: From Isolation to Connection</strong></td>
<td>Isolation and Barriers to Engagement</td>
<td>Isolation and Withdrawal</td>
<td>Isolation; social withdrawal; narrowing friendships with older age; retirement and isolation; loneliness; ageing and isolation; physical illness and isolation; health condition limiting social contact</td>
</tr>
<tr>
<td></td>
<td>Lack of Social Confidence &amp; ‘Shyness’ to Engage</td>
<td>Lack of Social Confidence &amp; ‘Shyness’ to Engage</td>
<td>Masculinity and lack of social confidence/opportunities; men too shy to join group; shyness in opening up; shyness and social anxiety; social ineptitudes; men not wanting to socialise</td>
</tr>
<tr>
<td></td>
<td>Negative Associations with Men’s Groups &amp; Community Groups</td>
<td>Negative Associations with Men’s Groups &amp; Community Groups</td>
<td>Men’s group for retired men; men’s groups associated with mental health problems</td>
</tr>
<tr>
<td>Routes to Connectedness</td>
<td>Outreach from Men’s Groups</td>
<td>Outreach from Men’s Groups</td>
<td>Face to face outreach; show &amp; tell; recruiting via women’s groups; show men what they can be involved in; encouragement from current members; word of mouth</td>
</tr>
<tr>
<td></td>
<td>Crisis Point</td>
<td>Crisis Point</td>
<td>Reaching point of crisis and readiness to engage</td>
</tr>
<tr>
<td>Belonging, Friendships and Peer Support</td>
<td>Connectedness</td>
<td>Social contact; friendships; shared interests; trust; reduced social contact; social support; meeting new people; getting to know the community; physical synchrony; social confidence; pulling together</td>
<td></td>
</tr>
<tr>
<td>Peer Support</td>
<td>Relatedness of mental health experiences; trust &amp; confidentiality; shared struggles &amp; feeling supported; sharing problems; comfort of talking about mental health issues; protective factor against on-going struggles; informal &amp; indirect peer support; no pressure to talk</td>
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<tr>
<td>Accessing Support Groups</td>
<td>Signposting to formal services; help to access counselling</td>
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<tr>
<td>Feeling Accepted</td>
<td>Feeling valued; part of a group; sense of belonging; feeling listened to and cared for; acceptance</td>
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<tr>
<td><strong>Theme 2: Creative Activities &amp; Personal Growth</strong></td>
<td>Lack of Stimulation</td>
<td>Lack of stimulation; boredom; repetitiveness of life; idleness; rumination; retirement and being at a loose end</td>
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<td></td>
<td>Loss of Role &amp; Purpose</td>
<td>Loss of role; lack of purpose;</td>
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<tr>
<td>Life Transitions</td>
<td>Self-Efficacy and Altruism</td>
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<tr>
<td>Relationship Problems</td>
<td>Achievement</td>
<td></td>
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<tr>
<td>Divorce; relationship problems; difficult home life</td>
<td>Pride in product; achievement; product representing capabilities; achievement in developing new skills</td>
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<tr>
<td>Deteriorating Physical Health &amp; Ageing</td>
<td>Purpose &amp; Meaningful Occupation</td>
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<tr>
<td>Lack of mobility; physical injury; cognitive decline; health condition limited expression of masculine body; death of spouse; death of friends</td>
<td>Sense of purpose; reason to get up in the morning; worthwhile pursuit; occupying mind; something to focus on; overcoming challenges; self-efficacy; self-esteem; self-confidence</td>
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<tr>
<td>Failure to Live Up to Expectations</td>
<td>Giving Back &amp; Feeling Useful</td>
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<tr>
<td>Loss of future; expectations; feeling useless; failure to achieve.</td>
<td>Giving back to community; usefulness of product; reciprocity of learning/teaching skills; altruism</td>
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<td>Cognitive Functioning</td>
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<td>Widened functioning of brain;</td>
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<tr>
<td>Theme 3: Emotional Regulation</td>
<td>Troubled Past</td>
<td>N/A</td>
<td>Corporal punishment; sexual abuse; flashbacks; exposure to violence/self-harm; physical violent father; childhood poverty &amp; low self-esteem; feeling inferior and poverty; deprivation</td>
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<tr>
<td>Negating Negative Emotions and Generating Positive Emotions</td>
<td>Distraction &amp; Absorption</td>
<td>Distraction from mental health issues; distraction from environment; solace; absorption; reverie; distorted sense of time; groundedness</td>
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<tr>
<td>Calming &amp; Therapeutic</td>
<td>Calming; relaxing; therapeutic; stress-relieving.</td>
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<tr>
<td>Positive Emotions</td>
<td>Uplifting; enjoyable; living again; new experiences; fun; life-enhancing</td>
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<tr>
<td>Emotional Expression</td>
<td>Emotional Expression</td>
<td>Self-expression; remove mask; greater meaning; outward expression offsets insularity of depression; telling your story; sharing yourself; communication</td>
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<tr>
<td>Theme 4: Dynamics of Engaging Men in Participatory Arts</td>
<td></td>
<td></td>
<td>Art process over product; no pressure or criticism; building trust with facilitator; lack of authoritative leadership;</td>
</tr>
</tbody>
</table>
removing fear of failure; lower skill threshold for participation; accessible engagement; easy level of entry; adapting to skill level; flexibility in participation; meeting men where they are at; no pressure approach; autonomy and ownership over process
Appendix 18: Study Outputs and Achievements

**Publications**


**Conference and Seminar Presentations**


**Seminars Organised**


**Funding**

2020 – Athena Swan Funding for Transgender Awareness Training - £750
2020 – Athena Swan Funding for Men’s Health Training - £750

2018-2021 – Marie-Curie Fellowship to Conduct PhD