Re:play

BULLETPROOF

You think you're bulletproof?

You think nothing can touch you?

Let's see.

Educational Resources

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About the Play

On January 14th 2009, the Belfast Telegraph ran with the front page headline "Pupils' Mental Health Shock: One in 10 need help we cannot give, say teachers." Although this article was not a 'shock' to Replay, it did however prove the much needed catalyst for a project that the company had long been contemplating but never quite realised. One year on and Replay will return to Northern Ireland's schools in January 2010 with 'Bulletproof'; a new theatre project for 14+ year olds. In response to the Bamford Review of Mental Health and Learning Disabilities (2007); to our own experience of working with the young people; and to the spotlight the media puts on the lives of these young people, Replay has commissioned award winning playwright Gary Owen to create a challenging, compassionate and educational work. In order to honour the 'voice' of young people and the sensitivity and complexity of the topic, this work has been created as verbatim theatre. Representative of real life experiences and attitudes, the work challenges stigmatisation whilst presenting the possibility of empowerment and support.

Seeing theatre should always be both an engaging and challenging experience. When theatre strongly advocates a social justice position, it brings with it not only opportunities for action but also potential risks. Young people's experience of mental health and their emotional wellbeing should not be glossed over and at times Bulletproof can dramatically present the raw experience, consequences and realities of mental illness.

Bulletproof commenced its life as a work specifically concerned with mental health and emotional wellbeing in young people. However, because it was important to garner young people's stories through a verbatim theatre process, more specific issues surfaced such as ADHD, Bi-polar Mood Disorder, suicide and coping with grief. These educational resources and activities include information about all of these specific content areas, however the scope of these notes cannot encompass all of them in detail. This is why some specific detailed 'Teacher Resources' are included on suicide prevention and grief, whereas there are other activities and information resources concerning ADHD and Bi-polar Mood Disorder in the body of the booklet. If teachers feel that a more in-depth session is required on any of these specific issues we would recommend the 'Further Study' section to assist with developing more educational activities.

About Replay

Replay is a theatre company inspired by the integrity of educational theatre and the power of storytelling.

Transforming spaces into theatres for a day, we want to give all of Northern Ireland's children and young people their first opportunity to experience live theatre.

At Replay, we believe that theatre finds truth in discussion. By empowering their authentic voice, we aim to grow the possibility and potential of our young audiences.

Based in Belfast, Replay has been touring to schools and venues throughout Northern Ireland since 1988.

Acknowledgements

This document draws together teacher resources and current publications on young people's mental health and wellbeing, from national and international sources. Acknowledgements and links to that material can be found throughout the document, in the endnotes, bibliography and appendices. This resource was compiled and written by David Fenton for Replay Productions, with editorial support and advice from Eimear Henry, Graham Logan (NIAMH), Caroline McCreight, Adele Thomas, Philip McTaggart (Pips Project) and Gayle Nixon (BELB).

Replay would like to thank New Lodge Arts, especially, Katrina Newell, Helen Coburn and the young people that participated during the development of this project; the OMAC & Young At Art Youth Panel; the Northern Ireland Association for Mental Health (NIAMH) and Pips Project.

Replay gratefully acknowledges the support of the Arts Council of Northern Ireland, National Lottery, Belfast City Council, Lloyds TSB Foundation for Northern Ireland and Ulster Garden Villages. Without the generous support of these organisations this project would not have been realised.

And finally we would like to thank all the young people who had the courage and generosity to share with us their stories and experiences. We hope that in producing Bulletproof, we have honoured your voice.

Credits

Cast (in order of appearance)

- **Michael:** Brian Markey
- **Alex:** Kerry Cleland

Production Team

- **Director:** David Fenton
- **Dramaturge:** Adele Thomas
- **Personal Development Coach:** Caroline McCreight
- **Designer:** Stuart Marshall
- **Composer:** Garth McConaghie
- **Lighting Designer:** Ciaran Bagnall
- **Production Manager:** Keith Ginty
- **Company Stage Manager:** Maureen Macauley
- **Workshop Facilitator:** Colin Ash (Creative Development One)
- **Stage Manger:** Kate Ferris (Creative Development Two)
- **Graphic Design:** Frank
- **Marketing Consultant:** Kirsty Atkinson
- **Workshop Consultant:** Jen Goddard
- **Animation:** Ray Pittman

For Replay Productions

- **Artistic Director:** David Fenton
- **Development Manager:** Eimear Henry
- **Operations Manager:** Fiona Bell
- **Administrative Officer:** Irene Swift

From the Playwright

"I have to be Bulletproof"
Anonymous Interviewee

One problem of promoting mental health in the young is that the phrase itself, 'mental health', has come to have negative associations. I sat with Caroline McCreight in New Lodge Youth Centre as she asked a succession of young people what words came to their minds when they heard the phrase 'mental health'. They said 'crazy', 'psycho', 'mad', 'need locking up'. And so it's common to hear people who want to promote good mental health stress that they are coming from the perspective of mental health as being a positive thing, wanting to get away from the discussion of mental health being always about mental illness.

I understand that desire completely - but I still think we need to talk about mental illness a lot more than we do.

Between January 2007 and December 2008 twenty-four young people from Bridgend, the county I grew up in, died by suicide.

As teenagers, my friends and I would talk about Bridgend as if it were the worst place in the world, a dreary hellhole from which we couldn't wait to escape. The reality is that Bridgend is not much different to any other small town. Some people are doing very well there, most people are doing alright, and some people – particularly in the villages outside Bridgend town itself – are living in severe deprivation. But again, this picture isn't anything out of the ordinary. We live in an unequal society, and pockets of wealth and deprivation exist alongside each other in towns and cities all over the UK. So why were young people in Bridgend killing themselves?

Early speculation blamed a suicide pact between the young people – but that turned out to be no more than speculation. The newspapers blamed the internet for spreading the suicide craze, and then everyone blamed the newspapers for whipping up hysteria. For a long time I wondered whether I should write anything about what was going on in my home town, afraid that to write about the problem might make things worse – that all this discussion of suicide was simply putting the idea in the kids' heads. But I've spent time since then talking to people like Darren, the director of Samaritans in Bridgend (whose volunteers are on the streets every weekend, where you can't help but bump into them and their big green van) and Paul, regional representative for Samaritans in Wales, about suicide clusters. These conversations have persuaded me that discussion of suicide isn't the problem. People in despair are led to think that suicide is a possible solution not because of talk about suicide - but because of the reality of someone within their community having died by suicide.

People take their own lives because they are stuck in situations they can't cope with, or because they are overwhelmed by feelings they can't bear, and they can see no other way out. It's very hard to talk about feeling so desperate: you worry that you'll look weak, you worry that you'll look stupid. Very often you worry about a person you are telling, because if they are someone that cares about you, it will probably break their heart to know you feel so awful you'd rather be dead. And so the worse you feel, the harder it becomes to ask for help. You spiral downwards, becoming lonelier, more isolated, more desperate: until finally, taking your own life starts to seem like maybe not a good option, but perhaps the only option you have. And if someone in your school, or your street, or your town has died by suicide, and you've seen the funeral, the night out in their memory, all the glowing tributes in the paper and on Facebook – that tells you 'suicide is allowed. It's alright. It's what the kids do, around here.'

We can intervene in this process. From an early age, children learn that it's perfectly normal to be physically ill from time to time – and that when we are ill, we get help. We need to be teaching children and young people the same lesson about mental health and emotional wellbeing. Most people are mentally healthy, most of the time: but all of us will have some experience of poor mental health, either ourselves or in our loved ones. And when we're ill, we get help. Young people need to understand that feelings of sadness, or despair - even suicidal feelings – are nothing to be ashamed of, nothing to be frightened of, and nothing to hide. They are horrible feelings – but they pass.

Gary Owen

From the Dramaturge

I may not be talking to everybody about it but

At least I'm sort of opening up to people
I've never met before

And being able to talk freely about it.

Which is a huge step.

Huge step for anyone who has to deal with

Something like that.

Alex, Bulletproof

Verbatim Theatre

As its name would suggest, Verbatim Theatre is written using the spoken or written words of real people on a particular subject. These words can come through a number of sources: through interviewing those directly involved in the event or subject covered in the play, by using transcripts of conversations, by using court documents or interviews amongst others. The writer acts as a kind of curator of those words, first engaging or collecting the original testimony and then in constructing and editing of this text to form a dramatic work.

Because Verbatim Theatre acts as authoritative voice - a form of documentary of the event or subject in question - it has historically had its roots in political and social issues and is regularly conceived of as a way of opening up debate within its audiences. Verbatim Theatre asks its audience to look upon and to judge 'the true' experiences of real people, conveyed through the real words of those directly involved.

Bulletproof and Verbatim Theatre

In using the Verbatim model as a means of addressing the issue of mental health, Bulletproof seeks to reflect some of the attitudes and experiences of young people in Northern Ireland. Following numerous drama workshops run by Replay and hours of interviews Gary conducted around the subject of mental health and emotional wellbeing, personal stories and private experiences started to emerge in which issues of mental health had often tragically affected the interviewees. The play's focus would be shaped by what these young people discussed with Gary in these interviews, and quite quickly the issues of suicide, self-harm and diagnosed cases of ADHD and Bipolar Disorder emerged as some key events affecting their lives. The words of those young people became, in Gary's hands, the voices of just two characters, Michael and Alex.

From the start of the writing process, Gary and David (the Director) have been careful to balance how much the play engages the audience with these two characters, while enabling the audience to retain enough critical distance to challenge their own pre-conceptions about mental health and emotional wellbeing. The monologue form, the direct address to the audience, the inter-cutting dialogue, the holding back of the characters' relationship with each other, the frankness and un-emotive manner in which the characters speak all invite us, as an audience, to question the characters' actions and behaviour rather than sit back and 'lose ourselves' in the story.

As the quote above suggests, we, as a society, shy away from discussing mental health. Within the play both Michael and Alex suggest that they have frequently locked away their anxiety with devastating results: Alex notes that Michael would never really open up to her, and Alex says that she herself tried to suppress her grief over her brother's death. With a reported 1 in 4 young people suffering from some form of mental health issue, the play, much like the Verbatim process itself, asks its audience to do the thing that these characters couldn't do in time: to speak up about this issue. The frankness and generosity with which the interviewees discussed their experiences speaks to the young people in the audience in their own language and will hopefully provide inspiration to do the same.

Adele Thomas

About this Educational Resource

Why a theatre project?

At Replay we believe that theatre has the phenomenal ability to engage and empower young people. Through dialogue with our audiences we seek to transfer information and present them with real life choices and possibilities.

Aim

- To create a theatre project that will encourage the promotion of positive mental health for young people.

Objectives of Bulletproof

What are the objectives of the programme?

- to honour the specificity of the young people's experiences of mental health and emotional wellbeing,
- to provide options for empowerment and support,
- to de-stigmatise the experiences of young people suffering mental health problems,
- to encourage learning by providing critical distance on the subject matter,
- to engage in an ethical and supportive manner with participants and audiences from a broad range of geographic and socio-economic areas throughout Northern Ireland,
- to create an authentic, compassionate and educational work.

Why an awareness programme?

Young people are especially susceptible to mental illness. Symptoms of severe, and chronic forms of mental illness like bipolar mood disorder, obsessive-compulsive disorder (OCD), schizophrenia, eating disorders, and panic disorder generally emerge between the ages of sixteen to twenty-four. As young people have the potential to either suffer from, or know someone suffering from, mental illness - accompanied with young people's emerging skills to navigate stress - a project that personalises their awareness of mental health and emotional wellbeing is essential.1

The Northern Ireland Association for Mental Health, Educational Reference Group argues strongly for a 'whole school' approach to concerns of mental health...

> There is a strong correlation between emotional problems in childhood and poor mental health and social functioning in adulthood. Promoting the emotional wellbeing of children is of particular importance. Promoting emotional health and wellbeing can contribute to improved life outcomes for pupils, as well as contributing to school goals and targets, and a more inclusive school community (NIAMH, 2009, p.4).

Curriculum Alignment

Bulletproof will support learning at Key Stage 4 in English, Drama and Learning for Life & Work. In particular, dramatic themes will explore Self Awareness, Personal Health & Relationships and Media Literacy.

What are the objectives of this Educational Resource?

When working through the activities and the workshop, in complement with the theatre production, students will…

- develop an understanding and informed attitude towards mental and emotional wellbeing,
- increase their awareness of factors, both positive and negative, which can affect their mental and emotional wellbeing,
- promote opportunities and strategies to understand and nurture personal resilience.

What does this pack contain?

This educational resource contains pre and post-show educational and evaluative activities to help teachers and workshop facilitators across Northern Ireland increase awareness about mental health and emotional wellbeing for young people.

The resources come equipped with ready to use pages that can be converted to PowerPoint, or handouts. Importantly these activities are essential in order to frame the students' and teachers' reception of Bulletproof. When carried out together these activities maximise student learning and support before, during and after seeing the show.

How to use this resource

Teachers can potentially have a significant impact upon framing and monitoring the health and wellbeing of their students. This is why Replay strongly recommends that these pre and post activities be conducted with student audiences to help augment that ongoing process. Each activity indicates the educational goal, materials, time allocation and instructions. Some activities have resources built in where as others reference resources in the appendices.

Before the Play

Pre-Show Activities

The pre-show educational activities outlined below are just suggestions, feel free to adapt and refine them. Accompanying these activities are teachers notes on the content area. The activities are not placed in a lesson format so that you may chop and change them, or spread them out as an isolated activity per lesson.

Ground Rules

The topics covered in Bulletproof may be upsetting for some students. Remember there are likely to be students in your class who are questioning their own mental health, or know someone who suffers from mental illness. Equally, you may have students who may self injure or know someone who does. You may also have students who are grieving. Therefore we STRONGLY RECOMMEND that due to the sensitivity of this topic you do not allow students to see the play without having a school counsellor on hand.

Please read this statement out at the beginning of the lesson/presentation:

> "In this session we will be covering some sensitive issues. You may be affected personally by the topic that we are addressing/seeing today, or you may know someone else who is. Please be respectful and thoughtful of others, and treat the subject responsibly. If you would like to talk to someone after the lesson/presentation, you can go to … (please give the contact person in the school, for example a School Counsellor)."

Creating a Safe Space

When engaging in activities around mental health and emotional wellbeing young people can feel threatened and may personalise the information. It is therefore best to create a safe space with clear ground rules concerning appropriateness, confidentiality and risk to facilitate learning. Here are some guidelines to assist in creating a safe environment for this work.

- Be clear in your language and clear as to the intent of the activity/ discussion/ workshop.
- Enlist participants in setting the ground rules for the work. Write them up on the wall so everyone sees and agrees. For example using 'I' statements and treating diverse opinions with respect and tolerance.
- Try dispelling nervousness by saying, to the whole group, the various words that people get fixated on concerning mental health conditions, so as to define their appropriateness.
- Offer definitions at the beginning of the workshop so everyone will know the proper language to use and will understand the concepts you are presenting.
- Stop people in the moment when they say something offensive. Often people speak without thinking and stopping them at the time can be very useful.
- Affirm during and at the end of the session that confidentiality is essential. However in a school context you may wish to emphasis that personal anecdotes may not be the best way to engage in the activity.

Activity 1: What do we know already?

Goal: Evaluating current knowledge and attitudes of your students towards mental health and emotional wellbeing.

Materials: Please use the pre-evaluation opposite for this activity

Time: 10 minutes

Teacher's Input:

One week before your school or community group sees the show we advise evaluating the young audience's general knowledge and attitudes towards the topic. We also advise that this is done before any pre-show activities. This pre-evaluation will assist teachers in verifying what the students have learned through a combination of the activities and the production. It is important to make sure you...

- communicate it is not a formal test,
- communicate the results by creating a summary,
- provide comments so that the feedback is not too formal.

Resource Sheet: Bulletproof Student pre-evaluation

Date: ______________________

School: ______________________

Teacher: ______________________

Subject: ______________________

Please indicate how much you feel you know about each of the following. Circle the number that best describes your knowledge.

Mental Health in general	1	2	3	4
How people cope with mental health problems	1	2	3	4
Different approaches to help persons with mental health problems	1	2	3	4
What it is like to have mental health problems	1	2	3	4
What it is like to have a family member with mental health problems	1	2	3	4
The cause of different forms of mental health problems	1	2	3	4
How to recognise signs of mental health problems	1	2	3	4

1 - None 2 - A little 3 - Some 4 - A lot

Please indicate whether you agree or disagree with the following statements by circling the appropriate number.

Most people with a serious mental health problems can, with treatment, get well and return to productive lives.	1	2	3	4
In most cases keeping up a 'normal' life in the community helps a person with mental health problems get better.	1	2	3	4
People with mental health problems are far less of a danger than people believe.	1	2	3	4
People with mental health problems are, by far, more dangerous than the general population.	1	2	3	4
It is easy to recognise someone who once had a mental health problem	1	2	3	4
The cause of different forms of mental health problems	1	2	3	4
The best way to handle someone with mental health problems is to keep them locked behind doors.	1	2	3	4

1 - Strongly Disagree 2 - Disagree 3 - Agree 4 - Strongly Agree

Background Reading for Activity 2 - Good Mental Health

What is Health?

According to the World Health Organisation (WHO) 'health' has been defined as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity."3

What is Mental and Emotional Wellbeing?

A soon to be published paper from the Northern Ireland Association for Mental Health, Educational Reference Group acknowledges the increasing use of the term 'emotional health'.

> One of the reasons for this is that traditionally 'mental health,' (as in mental health services) has the connotation of illness rather than health. This is an attempt to move away from the traditional term of 'mental health' with connotations of illness towards mental health, as wellbeing. Hence the tendency to refer to 'emotional wellbeing' or other alternatives such as 'positive mental health' or 'flourishing mental health' in literature. (NIAMH, 2009, p.9).

What is Mental Illness?

Mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.4

Activity 2: Free association exercise and discussion5

Goal: To establish that there is a difference between mental health and mental illness

Materials: Flipchart, markers

Time: 15 -20 minutes

Teacher's Input:

- Q: 'What words come to mind when you think of term mental health?'
- Sort into positive & negative.
- Give World Health Organisations definition of health (see notes above).
- Prompt:
  'Think of someone you know who you would describe as mentally healthy: list the words that describe that person.'
- Give definition of good mental health.
- Discussion Points:
  Q: 'Was anyone surprised by responses?'
- Q: 'What words come to mind when you hear the term Mental Illness?'
- Activity:
  In small groups of 4 ask the students to come up with their own definition of mental illness.
- Give definition of mental illness e.g. have it written on flipchart. (See notes above).
- Discussion Points:
  Q: 'What is the difference between mental health and mental illness?'

Background Reading for Activity 3 - Stigma

What is stigma?

The term stigma refers to any attribute, trait or disorder that causes a person to be labelled as unacceptably different from 'normal' people.6 Stigma is best defined as three things: Ignorance, Prejudice, Discrimination. 7

Professor Graham Thornicroft in his publication Actions Speak louder…says "stigma projects the fear and anxiety felt by members of the general population onto the person with the diagnosis. People with a diagnosis do not really carry a mark that sets them aside".8

How does stigma affect people's lives?

The Ontario based Centre for Addiction and Mental Health states,

> Commonly held misconceptions of people with mental illness include the following: people with mental illness are all potentially violent and dangerous, people with mental illness are somehow responsible for their condition, people with mental illness have nothing positive to contribute.9

These misconceptions promote social exclusion and discriminatory practice against people who experience mental illness. Importantly many young people who are questioning their mental and emotional wellbeing may also carry these misconceptions about themselves.

What is self-stigmatisation?

Disability Services at Victoria University of Wellington define self-stigmatisation as…

> When we experience discrimination it is hard not to take it on board, sometimes the stigma that comes from society can create an internalised stigma within ourselves. If we are told we are worthless by society then it is only a matter of time before we start to feel worthless.10

Stigmatistaion and self-stigmatisation work together creating discriminatory behavior that limits the life choices of people who experience mental health and emotional wellbeing problems.

Activity 3: What is stigma?

Goal: To get students to explore the concept of stigma, its causes and its impact.

Materials: Use Resource Sheet: What is stigma? (see opposite)

Time: 10 - 15 minutes

Teacher's Input:

Ask the following question and relate it back to the Activity 2 if necessary.

- **Q:** Can anyone tell me what Stigma is? Record Responses. Use Resource sheet to…
- Define Stigma – write it up on the board and give out handout
- Assure the students that everyone has discriminatory attitudes and thoughts.
- Confirm it is important to recognise these attitudes and thoughts
- It is important to examine where they come from.
- It is essential to work towards controlling and changing the hurtful behaviours that they cause.

Ask more of the following question and relate it back to the Activity 2 if necessary. Be focused on identifying negative stereotypes while also considering labels that are 'perceived' to be positive.

Discussion Points:

- Q: What are some of the negative things you have heard about people with mental illness?
- Q: What are some positive things you have heard about people with mental illness?
- Q: Why do you think people with mental illness are stigmatised?
- Q: Are there any other groups of people throughout history who have been stigmatised because of a social issue or health condition?
- Q: How do you think stigma effects the lives of people with mental illness?
- Q: Do you think people with mental illness may agree with some of these labels?
- Q: What do you think influences people's perceptions about mental health?

Resource Sheet:

What is stigma?

"A mark or sign of disgrace or discredit."

"A visible sign or characteristic of a disease."

http://dictionary.reference.com/browse/stigma

"An attribute which is deeply discrediting"

Goffman, E., Stigma: The management of spoiled identity. 1963

"…a mark of disgrace or infamy; a stain or reproach, as on one's reputation."

http://dictionary.reference.com/browse/stigma

Terms related to stigma

Stereotype:

"a person or thing that conforms to an un-justifiably fixed impression or attitude"

Prejudice:

"an unfavourable opinion or feeling formed beforehand or without knowledge, thought, or reason."

Discrimination:
"unfavourable treatment based on prejudice"
http://dictionary.reference.com/browse/prejudice

Primary Source:

http://www.camh.net/education/Resources_teachers_schools/TAMI/tami_teachersall.pdf

Activity 4: Famous people who have experienced mental illness

Goal: To affirm that mental illness is not a barrier to achievement.

Materials: Use Resource Sheet opposite

Time: 10 minutes

Teacher's Input:

Wordstorm – ask the students if they know anyone famous who has officially expressed that they have mental and emotional wellbeing problems. Using Resource sheet 'name that face' and explain that people who have mental and emotional wellbeing concerns can and do live productive lives like everybody else. That there is a continuum of 'function' for people who experience mental and emotional wellbeing issues, and that one of the significant factors in people being limited, or limiting themselves, is their fear of stigma associated with illness.

Resource Sheet:

Famous people known to have experienced mental health problems:

Activity 5: What is mental health? Fact or Fiction?

Goal: Correcting myths around mental illness

Materials: Resource Sheet opposite

Time: 15 - 20 minutes

Teacher's Input:

Use resource sheet, ask students to fill it in. Then read each statement one by one and ask for a student's opinion on 'true' or 'false'. Ask why? Discuss the correct answers using Answer Key.

Fact or fiction? Answer key

1. One person in 100 develops schizophrenia. True. One per cent of the general population develops schizophrenia.

2. A person who has one or both parents with mental illness is more likely to develop mental illness. True. Mental illness can be hereditary. For example, the rate of schizophrenia in the general population is one per cent. This rate rises to eight per cent if one parent has the disorder and to 37–46 per cent if both parents have it. One in 10 people in the general population has experienced depression, compared to one in four for people whose parents have experienced depression.

3. Mental illness is contagious. False. Mental illness is not contagious. Heredity can, and often does, play a factor in the development of the disease.

4. Mental illness tends to begin during adolescence. True. The first episode of a mental illness often occurs between the ages of 15 and 30 years. Early intervention is currently thought to be one of the most important factors related to recovery from mental illness. Embarrassment, fear, peer pressure and stigma often prevent young people from seeking out help.

5. Poor parenting causes schizophrenia. False. Childhood abuse or neglect does not cause mental illnesses such as schizophrenia. However, stressful or abusive environments may seriously impair a person's ability to cope with and later manage the illness.

6. Drug use causes mental illness. True and False. Alcohol and other drugs sometimes play a role in the development of some symptoms and disorders, but do not usually cause the illness. However, long-term drug and alcohol use can lead to the development of drug-induced psychosis, which has many of the same symptoms of organic mental illness. Alcohol and drugs are often used as a means to cope with the illness, although using alcohol and drugs can make the symptoms of mental illness worse.

7. Mental illness can be cured with willpower. False. Mental illness is associated with chemical imbalances in the brain and requires a comprehensive treatment plan.

8. People with mental illness never get better. False. With the right kind of help, many people with a mental illness do recover and go on to lead healthy, productive and satisfying lives. While the illness may not go away, the symptoms associated with it can be controlled. This usually allows the person to regain normal functioning. Medication, counselling and psychosocial rehabilitation are treatment options that can help people recover from mental illness.

9. People with mental illness tend to be violent. False. People who experience a mental illness acutely sometimes behave very differently from people who do not. While some of their behaviours may seem bizarre, people with mental illness are not more violent than the rest of the population.

10. All homeless people are mentally ill. False. Although studies have shown that between 17 and 70 per cent of people who are homeless have mental illnesses, it is clear that being homeless doesn't automatically indicate a mental illness.

11. Developmental disabilities are a form of mental illness. False. Mental illness is often confused with developmental disabilities, even though the two conditions are quite different. Mental illness does not affect an individual's intellectual capacity, whereas developmental disabilities do. However, people with developmental disabilities are more susceptible to developing mental illness.

12. People who are poor are more likely to have mental illness than people who are not. False. Income is not a factor in overall rates of mental health problems. However, people with lower incomes experience slightly higher rates of depression. People who live with major mental illnesses often end up in lower social classes because the illness may interfere with their ability to hold a job.

Resource Sheet:

Fact or fiction?

1. **One person in 100 develops schizophrenia.** TRUE / FALSE
2. **A person who has one or two parents with mental illness is more likely to develop mental illness.** TRUE / FALSE
3. **Mental illness is contagious.** TRUE / FALSE
4. **Mental illness tends to begin during adolescence.** TRUE / FALSE
5. **Poor parenting causes schizophrenia.** TRUE / FALSE
6. **Drug use causes mental illness.** TRUE / FALSE
7. **Mental illness can be cured with willpower.** TRUE / FALSE
8. **People with mental illness never get better.** TRUE / FALSE
9. **People with mental illness tend to be violent.** TRUE / FALSE
10. **All homeless people are mentally ill.** TRUE / FALSE
11. **Developmental disabilities are a form of mental illness.** TRUE / FALSE
12. **People who are poor are more likely to have mental illness than people who are not.** TRUE / FALSE

Activity 6: Mental Health statistics for Northern Ireland

Goal: To provide students with current statistics about mental health in Northern Ireland. The statistics can inspire further investigation and discussion in the classroom.

Materials: Resource Sheet opposite

Time: 10 minutes

Teacher's Input:

Give out hand out read and discuss. If students require further information related to these statistics, please refer them to the primary source material indicated in the document.

Resource Sheet:

Mental Health statistics for Northern Ireland

- 158,000 people in Northern Ireland suffer from a medically identified mental illness in the course of a year.
  (Accept Northern Ireland, 2000)

- Three million working days are lost to Northern Ireland industry each year due to mental illness at a cost of £2 billion.
  (Accept Northern Ireland, 2000)

- It is estimated that 10%-12% of children and teenagers have mental health problems severe enough to need help in overcoming them.
  (YoungMinds)

- In Northern Ireland there are 150 suicides each year with just over 35% of these being young men under 35 years old.
  (The Samaritans)

- 17% of men and 24% of women aged 35-44 show signs of depression.
  (Northern Ireland Health and Social Wellbeing Survey 2001)

- 20% of women and 14% of men in England have some form of mental illness.
  (Mental Health Foundation)

Prevalence of Mental Health problems

One person in four people in the world will suffer from a mental health problem at some point in their life (WHO, 2001). Mental health problems account for up to a third of all GP consultations in Europe (fact sheet on “Mental Health in the European Region”, WHO, 2003). One in four European adolescents shows one or more mental symptoms.

In the UK, 15% of pre-school children will have mild mental health problems and 7% will have severe mental health problems. `Six per cent of boys and 16% of girls aged 16-19 are thought to have some form of mental health problem.' (Mental Health Foundation)

www.niamh.co.uk/dispfactsheet

Activity 7: Understanding Mental Health

Goal: Your students will have heard of some mental health conditions but now here is the time to inform them with brief definitions from a medical perspective. This activity may produce more questions than answers and as such you may feel more comfortable inviting a medical professional in to the class to discuss these definitions, causes and treatments in more detail.

Materials: Resource Sheet: Definition of Mental Illnesses and Disorders

Time: About 15 minutes to go through each resource.

Teacher's Input:

Use Resource Sheet: Definition of Mental Illness to uncover the students' knowledge of types of mental illness. Ask students to name some types of mental illness. As you read through the definitions, be sure to remind students of the following:

- Everyone experiences feelings of sadness, agitation or confusion, but people with mental health problems experience these symptoms for extended periods of time; they experience a loss of ability to function and they are unable to bounce back without extensive medical attention and social support.
- Culture, age and gender influence each of these disorders, and different people may have different experiences with the illness.
- A person can experience one or more of these disorders at the same time.

Resource Sheet:

Definition of mental illness and disorders

Mental illness is a disturbance in thoughts and emotions that decreases a person's capacity to cope with the challenges of everyday life.

Depression is more severe and long lasting than normal sadness and is one of the most common mental health problems in adolescents. People can feel deeply unhappy, hope less and withdrawn. Some people may develop more serious or long-lasting depressive illnesses, maybe with changes in sleep or appetite, aches and pains, anxiety and poor concentration. In adolescents, feelings of depression sometimes occur as irritability or disruptive behaviour, rather than sadness.

Anxiety is normal when a person feels stressed or threatened and many young people feel temporarily anxious about relationships, special events, or school pressures. However, persistent or severe anxiety may indicate a disorder such as social phobia, panic disorder or obsessive-compulsive disorder. Around one in twenty people experience an anxiety disorder at some stage in life, often occurring for the first time in early adulthood.

Eating or Body Image Problems are often seen for the first time in young people. There is a preoccupation with control over food, eating and weight, with unrealistic body image ideals. Many young people have mild or transient difficulties with body image, but around two in every hundred teenage girls will develop anorexia nervosa, while up to three in a hundred experience bulimia. Increasingly, young men are also affected by unrealistic ideals and may become overly concerned with diet and exercise.

Psychosis is an experience which can occur in a number of mental illnesses, including schizophrenia. It involves false beliefs or sensations which are not shared by others, called delusions and hallucinations. Examples include hearing voices, seeing things, or believing (without reason) that someone is controlling you or trying to harm you. This is very real and distressing to the person who is ill and may cause them to behave in ways that others don't understand, creating fear and misconceptions in the community.

Schizophrenia is not a split personality, but is an illness in which people can experience psychotic symptoms. Schizophrenia and related diseases often occur for the first time in young people, causing them to lose touch with reality and suffer from hallucinations or delusions. This can be very frightening for the young person, and their family and friends.

Bipolar Mood Disorder was previously called Manic Depression. It is a mental illness in which people experience periods of elation and energy (mania), during which they may do everything in a 'larger than life' way, such as spending lots of money or making impulsive decisions. This mania is usually followed by depression and fatigue, and the illness is very disruptive for the person and their family.

Anxiety disorders are associated with feelings of anxiousness, combined with physiological symptoms that interfere with everyday activities. Obsessive-compulsive disorder, phobias and post-traumatic stress disorder are types of anxiety disorders.

Obsessive-compulsive disorder is marked by repeated obsessions and/or compulsions that are so severe they interfere with everyday activities. Obsessions are disturbing, intrusive thoughts, ideas, or images that cause marked anxiety or distress. Compulsions are repeated behaviours or mental acts intended to reduce anxiety.

Post-traumatic stress disorder is the re-experiencing of a very traumatic event, accompanied by feelings of extreme anxiety, increased excitability and the desire to avoid stimuli associated with the trauma. The trauma could be related to such incidents as military combat, sexual assault, physical attack, robbery, car accident or natural disaster.

Phobias are significant and persistent fears of objects or situations. Exposure to the object or situation causes extreme anxiety and interferes with everyday activities or social life. Specific phobias have to do with objects or situations — for example, germs or heights. Social phobias have to do with social situations or performance situations where embarrassment may occur — for example, public speaking or dating.

A personality disorder is a pattern of inner experience and behaviour that is significantly different from the individual's culture; is pervasive and inflexible; is stable over time; and leads to distress or impairment. Personality disorders usually begin in adolescence or early adulthood.

Disassociative identity disorder, formerly known as "multiple personality disorder," is the presence of two or more distinct identities that alternately control a person's behaviour. It reflects a failure to make connections between identity, memory and consciousness. Known by the general public as "split personality," there is now a controversy as to whether or not it is a real diagnosis.

ADHD is a clearly defined clinical condition and not just a label for naughty or badly brought up children. Attention Deficit Hyperactivity Disorder (ADHD) is diagnosed when a child exhibits abnormally high levels of:

- Inattention (short attention span, easily distracted, doesn't finish things, disorganised, forgetful etc)
- AND/OR; Hyperactivity and impulsiveness (fidgets, can't sit still, always on the go, talks too much, interrupts, can't wait their turn etc).

Primary source: http://www.camh.net/education/Resources_teachers_schools/TAMI/tami_teachersall.pdf

Secondary Resource: http://www.deni.gov.uk/adhd_-_a_practical_guide_for_schools.pdf

Activity 8: Contributing Factors?

Goal: To explore the factors contributing to the development of mental health problems

Materials:

- Teacher: Background Reading
- Resource Sheet: Prompts for Treatments of Mental Illness

Time: About 30 minutes to go through each resource.

Teacher's Input:

- Wordstorm 1 - In small groups ask students to write down and report back what they think are the factors contributing to the development of mental health problems.
- Wordstorm 2 - In small groups ask students to write down and report back what they think are the approaches to treating mental illness. Use Resource Sheet: Prompts for Treatment of mental Illnesses to get the students guessing.

TEACHER: BACKGROUND READING

Factors that may contribute to the development of mental illness

Discussion guide

Although there is currently no agreement about the exact causes of mental illness, the following factors are recognized as playing a role in the development of various mental illnesses:

Chemical imbalance

There is growing evidence that mental illness may be partially caused by a chemical imbalance in the brain. Many people respond well to medications that address such an imbalance and many of the symptoms of their illness are reduced or eliminated.

Substance use

There is no clear causal relationship between substance use and the development of mental illness. People who have mental illness may use alcohol and other drugs to relieve some symptoms of their illness. However, substance use may actually worsen symptoms and delay proper diagnosis and treatment. There are also cases in which substance use has induced psychotic behaviour, both because of the chemical effect of the drug and because the drug unmasks a pre-existing mental illness.

Traumatic life events

Similar to substance use, traumatic life events can, in some instances, make people more vulnerable to developing mental illness. Instead of recovering from a situational depression (e.g., grief following the death of a loved one), some people may go on to develop a more profound, clinical depression.

Heredity

We are learning more about the role heredity plays in the development of mental illness. Researchers have found that with certain diagnoses, the likelihood of a child developing a mental illness is greater if one or both parents have a mental illness. Examples of diseases thought to have a genetic component include schizophrenia, bipolar disorder, obsessive-compulsive disorder and depression.

Other illnesses

People with conditions such as Alzheimer's, Parkinson's, dementia and brain damage (from strokes or accidents) experience memory loss and confusion. People can also develop chronic depression in conjunction with debilitating physical illness, or illnesses that alter their level of functioning.

www.camh.net

Treatment of mental illness

Treatment of mental illness: Discussion guide
Treatments vary according to the particular illness and the severity of the illness. Different types of treatment include biological interventions, such as medications and electroconvulsive therapy; and psychosocial interventions, such as psychotherapy, family support and involvement, self-help, vocational, recreational and housing support. For most people with a serious mental illness, a combination of approaches tends to be most effective in relieving symptoms.

Biological treatments

Medication

The types of medications most commonly used to treat mental illness fall into four categories: antipsychotics, antidepressants, mood stabilizers, and anxiolytics, or anti-anxiety medication.

Electroconvulsive therapy (ect)

ECT, also referred to as "shock therapy," is a long standing, effective and often misunderstood treatment for acute depression. The patient is given an anaesthetic and a muscle relaxant, then an electric charge is applied to the brain, inducing a small seizure. ECT has been both condemned and promoted in the mental health field and the media. In its early days, ECT was a cruder procedure, which sometimes resulted in short- and long-term memory loss (although it usually resolved after six months).

Today, ECT is a much gentler intervention proven to be an effective treatment for major depression and bipolar depression or mania. Most people are unaware of the newer procedures and remain fearful of ECT, so they tend to try several medications before considering ECT as a treatment.

Psychosocial interventions

Psychotherapy

Psychotherapy is often used in conjunction with medication to treat mental illness. Psychotherapy is a general term used to describe a form of treatment based on "talking work" done with a therapist. The aim of talk therapy is to relieve distress by expressing feelings; to help change negative attitudes, behaviour and habits; and to promote constructive ways of coping. There are many different types of therapy, including short-term, long-term, individual and group. An essential component of any psychotherapy is a supportive, comfortable relationship with a trusted therapist.

Self-help groups

Self-help organizations, run by clients of the mental health system and their families, provide an important part of treatment for people with mental illness and their families. Self-help groups offer the chance to meet informally with other people who understand the same issues and challenges. These groups can reduce a sense of isolation and provide opportunities to learn from other group members' experiences. Volunteering and sharing the wisdom gained by living with mental illness can be an empowering experience for others.

Family support and involvement

Informal relationships with friends, family, co-workers and others play a vital role in supporting and maintaining mental health. Family members and friends of people with mental illness need as much information as possible so they can assist and support their loved ones, and deal with their own feelings.

Community support

People with serious mental illness need access to social services, education, public housing, social support and family services to maintain wellness. In addition to these services, there are networks of community groups and organizations that contribute to community life. Interest based groups (such as gardening and sports clubs), religious organizations and service clubs also provide the opportunity for meaningful involvement in the community.

www.camh.net

Resource Sheet:

Prompts for treatments of mental illness

Background Reading for Activities 9-12: Self-harm and Suicide

Self-harm

Broadly defined, self-harm refers to the deliberate attempt to physically injure oneself without causing death. The National Inquiry into Self-harm among Young People (2004)18 focuses specifically on self-mutilation (e.g. cutting behaviors), self-poisoning, burning, scalding, banging, and hair-pulling. Although clearly damaging, alcohol and drugs misuse, eating disorders, unsafe sex and other excessively risky behavior, such as dangerous driving, are not generally classified as self-harm.

Suicide

Suicide is an emotive and sensitive subject, and there is currently little evidence as to why people take their own lives. Risk factors include depression, alcohol and drug misuse, personality disorder, hopelessness, low self-esteem, bereavement, break-up of a relationship and social isolation. While no specific intervention has been found to be universally effective, it is important that interventions address these risk factors as part of a broader approach to promoting mental health and wellbeing.

What is self-stigmatisation?

Disability Services at Victoria University of Wellington define self-stigmatisation as…

When we experience discrimination it is hard not to take it on board, sometimes the stigma that comes from society can create an internalised stigma within ourselves. If we are told we are worthless by society then it is only a matter of time before we start to feel worthless.10

Stigmatistaion and self-stigmatisation work together creating discriminatory behavior that limits the life choices of people who experience mental health and emotional wellbeing problems.

Activity 9: Brainstorm

Goal: To introduce students to the concept of self-harm and to ascertain and acknowledge their current understanding of the subject.

Materials: NA

Time: 15 minutes

Teacher's Input: In small groups ask students to discuss their understanding of…

Q: What is self-injury?

Q: What do you know about it?

Q: Do you know any other words for it?

Q: What are the different ways people self injure?

Explain: Self-harm (self-injury) is when someone deliberately hurts or injures him or herself.

Activity 10: Case Study

Goal: Students now know what self-injury is and why people do it. This activity is aimed at learning how to support someone who self injures.

Materials: Use Resource Sheet: Rebecca's Letter

Time: 30 Minutes

Teacher's Input: Using Resource Sheet, read out Rebecca's Letter and lead a discussion about the students' reactions. Handout photocopies of the letter and ask students in small groups to answer these questions.

Q: How do you think that Rebecca is feeling?

Q: What underlying issues are going on in her life?

Q: Do you think that she is attention seeking?

Q: Could she be suicidal?

Q: If you asked Rebecca about the marks on her wrists do you think she'd tell you?

Q: If you asked Rebecca about her parents splitting up do you think she'd like to talk about that?

Explain: Self-Injury is a way of coping with pressure people feel inside. Often they prefer to talk about whatever is causing the pain than about the injury. Sometimes someone may feel very low and be thinking about suicide. If you think someone may be suicidal don't ignore it, ask them how they're feeling. If you need to, tell someone you are worried.

Resource Sheet:

Rebecca's Letter

Dear Kimi,

How is Tokyo? I hear it's cold. It's cold here too.

I've been writing to you for four years now since the student exchange and I miss you. It's lonely here. Mary-Francis is in London so I don't get much opportunity to chat to her. Not that me and my sister were ever close.

Dad's been away for a fortnight now. Mum says it's an extended business trip, like a conference or something, but I think he's not coming back for a while. Mum spends most of the time down the pub over the weekend. There is something wrong with our heater it's cold in the back rooms. So I'm in the kitchen with the gas rings on the stove.

I cut myself yesterday. Not deliberately. I broke a window by accident – I can't remember how but the cut wasn't deep. It leaves a funny mark.

I want to come to Tokyo. Do you think I can? I can save up the money and stay with you. I'm sure it will be fine. We can go to your school together and I can take Japanese lessons and everything. What do you think? I think it's a great idea. I'm going to look up flights right now.

You can be my real sister, my blood sister. Look, see that mark at the end of the page that's a drop of my blood. Gross hey? Do you think it's gross? This cut just keeps opening. I pick at it a bit, but just 'cause I want it to heal.

Love Bec

PS. Skype me.

Activity 11: Suicide Prevention Fact or Fiction

Goal: To dispel some common myths concerning suicide.

Materials: Use Resource Sheet: Suicide Prevention – Fact or Fiction?

Time: 15 Minutes

Teacher's Input: Conduct a Fact or Fiction session on dispelling the myths concerning suicide. Use Resource Sheet to follow up on crucial details to promote understanding and peer responsibility.

Explain: The warning signs of suicidal behaviour.

Answer Key

1. Question "The people who talk about it don't do it."

1. Answer: Mostly False - Studies have found that more than 75% of all completed suicides did things in the few weeks or months prior to their deaths to indicate to others that they were in deep despair. Anyone expressing suicidal feelings needs immediate attention.

2. Question "Anyone who tries to kill himself has got to be 'crazy'."

2. Answer: Partially False - Perhaps 10% of all suicidal people are psychotic or have delusional beliefs about reality. Most suicidal people suffer from the recognized mental illness of depression; but many depressed people adequately manage their daily affairs. The absence of emotional or mental ill health does not mean the absence of suicide risk.

3. Question "Those problems weren't enough to complete suicide over,"

3. Answer: False - This is often said by people who knew a completed suicide. You cannot assume that because you feel something is not worth being suicidal about, that the person you are with feels the same way. It is not how bad the problem is, but how badly it's hurting the person who has it.

4. Question "If someone is going to kill themselves, nothing can stop them."

4. Answer: False - The fact that a person is still alive is sufficient proof that part of him or her wants to remain alive. The suicidal person is ambivalent - part of them wants to live and part of them wants not so much death as they wants the pain to end. It is the part that wants to live that tells another "I feel suicidal." If a suicidal person turns to you it is likely that they believe that you are more caring, more informed about coping with misfortune, and more willing to protect their confidentiality. No matter how negative the manner and content of their talk, they're doing a positive thing and they have a positive view of you.

5. Question "Talking about it may give someone the ideas."

5. Answer: False - People already have the idea; suicide is constantly in the news media. If you ask a despairing person this question you are doing a good thing for them: you are showing them that you care about them, that you take him seriously, and that you are willing to let them share their pain with you. You are giving them further opportunity to discharge pent up and painful feelings. If the person is having thoughts of suicide, find out how far along their ideation has progressed.

www.pipsproject.com/howcanihelp.html

Resource Sheet:

Suicide prevention - fact or fiction?

1.	**The people who talk about it don't do it**	TRUE / FALSE
2.	**Anyone who tries to kill him/herself has got to be 'crazy'**	TRUE / FALSE
3.	**Often the problems weren't enough to complete suicide over**	TRUE / FALSE
4.	**If someone is going to kill themselves, nothing can stop them**	TRUE / FALSE
5.	**Talking about it may give someone the ideas**	TRUE / FALSE

www.pipsproject.com/howcanihelp.html

Activity 12: Resilience. Collage the Future

Goal: For students to imagine a fulfilling future and to focus on actions that can facilitate those aspirations.

Materials: A3 paper, blu-tack, glue, scissors, felt pens, and a collection of contemporary magazines. (Caution magazines should be carefully curated so as to provide a diversity of life options).

Time: 1 Hour (can be separated into two sessions)

Teacher's Input:

Step One: With several pieces of blank paper stuck to the wall students are encouraged to go around the room with a felt pen and write up a response to this question...
Q: What are the words that you would use to describe your 'happy' future as an adult?

Step Two: Individually students then take their own A3 piece of paper and draw a circle with the word "me" in it. Then using some of the words written on the wall from step one, radiating out from that circle draw spokes that have any of their words written on them – one word per spoke. (Limit them to six spokes).

Step Three: Ask students to cut and paste pictures around those spokes from the magazines to show what that adult 'happiness' may look like. If there is not a picture in the magazine encourages them to draw it. Allow students to work together and allow them to change their spokes if inspired by the content of other student.

Step Four: Ask student to write one thing they are doing daily to actively pursue that 'happiness spoke'. If they are not doing anything ask them to write what they could be doing.

Step Five: Place all the A3 collages up on the wall and ask the students to go around and tick the spokes that they like so much they would have wanted to include it on their paper. Allow students to discuss why.

Activity 13: Questioning the Characters. Casting a critical eye on the play's text

Goal: As a piece of verbatim theatre characters display inconsistent behaviour around mental and emotional wellbeing. The goal of this activity is to activate the student's critical thinking around the text of Bulletproof so that they can watch the production with both emotional engagement and critical distance.

Materials:

- Resource Sheet: Play Excerpt One – Michael talks about pushing himself to the limit.
- Resource Sheet: Play Excerpt Two – Alex talks about her time at Tech.
- Resource Sheet: Play Excerpt Three – Alex talks about trying to speak to Michael.
- Resource Sheet: Play Excerpt Four – Michael talks about his ADHD medication.

Time: 40 minutes

After exploring each excerpt divide the class into four groups that represent the issues featured in Excerpt 1, 2, 3 or 4. Give each group a quest. When watching the play members of each group must find two more examples that answer the questions above. After the play they must feedback their examples in discussion.

Resource Sheet:

Teacher's Input: Using Excerpt One, ask questions about the way that Michael is modelling behaviour around his own mental health problems. Give the students the extract and ask them these prompting questions. Use this to generate discussion.

Q: Is Michael choosing a healthy or potentially debilitating choice here?

Q: Where is there an example of that in the text?

Q: Why is he doing this – what might you do?

Excerpt one.

Michael:

I push myself to the limit, but

There'd be times when I would have to sit down,

Go away on my own

And just go, I can't, I can't handle this but

- what happened to me when that guy was struck down

I just

I think

If somebody's looking up to me like that

You know, I wouldn't want them in the position I was in.

So I'd be, nothing can shake me.

I want kids to sort of look at me and go -

I don't want them to be like me

I want them to take the same things that I took from -

And be stronger,

Be better

Be a better me

That can't be, that can't be shaken.

Resource Sheet:

Teacher's Input: Using Excerpt Two ask questions about the way Alex is dealing or not dealing with her grief. Give the students the extract and ask them these prompting questions. Use this to generate discussion.

Q: What strategies Alex is using to process her grief?

Q: Are they constructive or destructive strategies?

Q: What strategies might you suggest to her?

Excerpt two.

Alex:

I've kept busy.

I take every opportunity - do you
want to go for a coffee? with

Anyone of my friends who's available.

I think that's the best thing, then there's no time

To like sit around and cry and be sad and stuff like that.

What my brother taught me was life's too short.

Tomorrow you could wake up and you
could find your life's changed.

If you're happy with your life, enjoy it while you can.

Which is...

No I've just got on with it really.

The week after he died, two weeks, three weeks
- no it was almost a month and a half

After he died

I'm just going to tech as usual.

I just kept to my routine,

I just suddenly said to my course tutor,

I can't do this anymore, I really can't,
I need to take some time off

And then I was breaking down having

panic attacks and all this

And she was like, ahhh, what's going on?

Cause I hadn't told anyone in tech?

Nobody knew.

And then my dad had to phone in
and my course tutor was like

I had no idea! I had no idea!

Because I just hadn't said, or hadn't let
on, just getting on as normal.

Things like that take a while to sink in, they really do.

And

Some people think,

Oh, yeah, just get over it, it's been a month -

Oh, God.

Resource Sheet:

Teacher's Input: Using Excerpt Three ask questions about the strategies Alex used to talk to her brother. Give the students the extract and ask them these prompting questions. Use this to generate discussion.

Q: What else could she have done to help her brother discuss his problems?

Q: Is it her responsibility to help?

Q: Who else could Alex talk to about Michael? Should she?

Excerpt three.

Alex:

My brother, when we were younger,

Sometimes I would sleep in his bed

And we'd get food and like we'd just watch a DVD or something.

And I would tell me him all this stuff but like

He would never tell me anything.

If I said, so is there anything up with you?

He'd be like, no not really.

I'd be like, are you sure?

And he'd be like, mmm...

And I'd be like, och, tell me.

And he'd be like, no

And I'd be like, och go on tell me

And he'd be like, no, go away

And I'd just give up after a wee while

He would tell me really stupid things.

He wouldn't tell me like personal things.

I would tell him a lot of stuff but he would never really tell me anything.

Resource Sheet:

Teacher's Input: Using Excerpt Four ask questions about Michael's position on ADHD medication. Give the students the extract and ask them these prompting questions. Use this to generate discussion.

Q: What is Michael's attitude to his ADHD medication?

Q: Is Michael choosing a healthy or potentially debilitating choice when he talks about what the medication can make him do?

Q: What might a Michael's parent feel is they knew how he felt about his medication?

Excerpt four.

Michael:

I don't think I have ADHD.

My sisters have it and I just got put on the bandwagon.

They all think I have ADHD : I don't think I have it.

They all shout at me anytime I say that though, they all say, yes you do.

They say I'm all over the place. Erratic. Can't concentrate.

I can concentrate.

Just sometimes – first second third year I would choose not to.

The tablets are meant to stop you being angry and depressed but when I'm on them

I'm more, angry and depressed.

But they do

Make me good

At

Things.

Like physics. And history.

I don't know, I can concentrate better.

You need to show you're as good as you are.

In order to show I'm as good as I am

I have to be on them.

I'm not going to underperform just because

I can't deal with being a bit sad.

Or a bit angry.

It's okay.

I have an art teacher at school says, you're so stressed, you need to just chill out.

I say, I'M NOT STRESSED!!!

I think, I think they, I think the tablets

Change the way you direct your -

Mind control, they call them.

It's meant to stop you being angry as well.

I'm not angry when I'm not on it.

It's the medication makes me angry more than anything else.

I spend half the day going, so stupid, that's so stupid.

Why are people so stupid? Idiots.

The doctor called it poison, it is poison. You're not allowed to be on it forever.

You have to deal.

Swings and roundabouts.

When I'm on it - I noticed it especially on study leave

I can sit on my bed and work from nine till...

Nine?

Maybe nine till seven.

Just on the pills.

I can go work for hours and hours and hours on it.

I'm on a get a compulsion to work.

Turns you into a machine.

Amazing.

It's only for a short period of time.

When seeing the play

Preparing your students

It is important to go over a few basic ground rules with students before the play takes place. Remind students to use respectful language — terms like 'crazy', 'mental', 'psycho', and so on, are not acceptable when discussing the work.

Prepare students for the emotional content of the play. Some of the play's content and subsequent discussions may evoke discomfort for some students, and may lead them to question their own functioning.

Actors will be sharing the real life experience of interview subjects. Remind students that the actors are not representing their own perspective and that everyone has very different experience when it comes to emotional wellbeing. Importantly, the thoughts that these characters deliver are, at times, conflicting messages about mental health, but it is within these contradictions that the debate can be explored.

Students need to know that conflicting emotions are a natural reaction to the play. In post-discussions, teachers should establish a clear distinction between distress and illness, and clearly define processes for seeking help.

Preparation checklist for teachers

Before the presentation:

- Prepare students in advance by covering activities and material in classroom.
- Establish clear ground rules and expectations for students (e.g. respectful listening, privacy and confidentiality).

During the play:

- Have a guidance counsellor, social worker, or school nurse present.
- Observe students' reactions to the material.

After the presentation:

- Replay will conduct a 30 minute workshop run by accredited facilitators to debrief the students.
- Replay staff will distribute a postcard with contact details of local mental health services for students.
- It's recommended that teachers and workshop leaders follow up with any students who express concern.

Mental Health and the Media

After the Play: Post-Show Activities

Activity 1: What does the media say about mental and emotional wellbeing?

Goal: This activity is to examine media reporting on mental health in order to understand the influence it has upon young people's perceptions of mental and emotional wellbeing.

Materials: Resource Sheet: Mental Health in the Media, file cards, blu-tack and x2 coloured highlighters for each group.

Time: About 20 minutes

Teacher's Input: Assign students into small groups to examine one or two media statements from Resource 14. Ask them to highlight language that is potentially negative.

Ask students to report back by writing these negative phrases on file cards and sticking them to the wall. Ask them to categorise them and rephrase what might be more appropriate language for the media statements.

Resource Sheet:

Mental Health in the media

See the source link below to assist in analysing the media's portrayal of mental health.

'Maniac killed twin sisters.'

Front page headline, London Evening Standard, 18 April 2005 (England)

'Knife maniac freed to kill. Mental patient ran amok in the park.'

Front page headline, Daily Mail, 26 February 2005 (England)

'I grew up on a pre-war council estate in Wimbledon in the 1950s. Illness, other than cold or flu, or illness afflicting the elderly like gout, etc., was hardly spoken about. Madness and mental illness happened in the tabloids all of the time, often to sex perverts and murderers. Those 'nutters' that were, rightly or wrongly, locked away from society'.

Paul

'Violent, mad. So Docs set him free. New 'Community Care' scandal.'

The Sun, 26 February 2005 (England)

Self-harm disclosure. Olympic winner Kelly Holmes tells of hidden scars. Double-gold winning Olympic athlete Dame Kelly Holmes has revealed how she slashed her body with scissors just a year before she triumphed at the Athens games.

The Guardian, 30 May 2005, England.

'Ashes amid dust tell of ignored lives, deaths. 3489 urns of mental patients in Oregon. The urns hold the ashes of mental patients who died here from the late 1880s to the mid 1970s. The remains were unclaimed by families who had long abandoned their relatives, both when they were alive and after they were dead'.

Chicago Tribune, 18 March 2005, USA

'Newspapers label us all mad and dangerous; the only person I'm a danger to when ill is myself. But the stigma of the newspapers has me down as an axe murder because of my illness. I've never even hurt a fly let alone another person'.

Maria

Youtube, High-Speed Chase 27
http://www.youtube.com/watch?v=03ZCQy3vuO0

Source: Graham Thornicroft. Head, Health Service Research Department Institute of Psychiatry, London and Consultant Psychiatrist, South London and Maudsley NHS Trust, www.mentalhealthcare.org.uk

Support Strategies

Activity 2: What should I say, what should I do?

Goal: To encourage students to think about the language and behaviour they use concerning mental health and to encourage ways of promoting socially acceptable changes to that language and behaviour.

Time: About 40 minutes.

Teacher's Input: Brainstorm and Freeze Frames - In small groups of three ask students to brainstorm inappropriate and appropriate ways of talking to, and behaving with, people who have mental health and emotional wellbeing problems.

Place the list in a freeze frame.
In groups of three ask the students to come up with six freeze frames of a job interview for a mental health sufferer who has no visible signs of their condition.

- The first three freeze frames have one sentence each per person, and they feature the negative experience. For example the interviewee is forced to reveal their condition.
- The next three freeze frames have one sentence each per person, and they feature the positive experience. For example the interviewee may feel comfortable about revealing their condition and offer suggestions for on-the-job management of their condition.

Perform each, telling the story as minimally as possible with only three sentences each across the three freeze frames.

Use these structured improvisations to raise questions e.g. Q: 'Do we know enough about how people with mental and emotional wellbeing conditions are supported in the work place?' Ask students to do some research and report back using the 'Further Study' links in the appendices.

Activity 3: Support Strategies

Goal: The goal of this discussion is to provide students with strategies for supporting people with mental and emotional wellbeing problems, whether they be fellow students, family, friends or themselves.

Materials: Resource Sheet: Support Strategies, overhead projector, and or enough photocopies for each student (optional).

Time: About 5 minutes.

Teacher's Input: Ask students to imagine that they had a mental health problem. Then ask them to imagine how they would wish to be treated by others if they had that problem. Use this prompt to generate discussion about strategies for assisting yourself and others with mental and emotional wellbeing issues.

Resource Sheet:

Support Strategies

Here are some strategies for supporting someone with a mental health problem:

1. Be supportive and understanding.

2. Spend time with the person. Listen to him or her.

3. Never underestimate the person's abilities.

4. Encourage the person to follow his or her treatment plan and seek out support services.

5. Become informed about mental illness.

6. If you are a close friend or family member of someone who has a mental illness, make sure you get support as well. Crisis training, self-help and/or individual counselling will help you become a better support person.

7. Put the person's life before your friendship. If you think the person needs help, especially if she or he mentions having thoughts of suicide, don't keep it a secret (even if the person may have asked you to). Tell his or her parents or someone else who can help.

www.samaritans.org/pdf/F3UnderstandingSelf.pdf

Self-harm

Activity 4: Supporting someone who self injures

Goal: To learning how to support someone who self injures.

Materials: Resource Sheet: Supporting someone who self-Injures

Time: 30 minutes

Teacher's Input: Use the cards in Resource Sheet for this activity. Imagine that Alex told a friend that she was engaging in self-harm. Using this situation as a premise, ask individual students to choose a card. Thinking a bit more about our character, what might you say to her if she was your friend? We have a series of possible responses. Let a student pick one and read it out. Then discuss...Q: 'Is this a good thing to say to someone who self-harms and why?'

Summarise: There is no right or wrong way to let someone know you care. Just remember: **DON'T:** Ignore it or stop talking to her. **DO:** ask them how they're feeling, let them know you'll be there for them, talk when they're ready to talk, tell someone you trust if you need to.

Resource Sheet:

Supporting someone who self-injures

"Eughh! That's gross"

+ You've acknowledged the cutting

– You are letting your feelings get in the way and are making Alex feel worse

"Oh no, you should go to a doctor or the school counsellor knows about this stuff"

+ You're letting them know where there is support

– It might sound like you're saying, Talk to someone else - not me!

"If you tell me what's wrong, I swear I won't tell anyone"

+ You are encouraging her to talk about what's going on. You let her know she can trust you

– Some of what she says may be upsetting. You may worry this is serious and want to tell someone

"How are you feeling?"

+ You are encouraging her to talk about what's going on

– "I feel fine". She may not be ready to talk, let her know you will be there if she wants to.

"You're crazy, cutting yourself like that. Just pull yourself together and stop doing it"

+ You've acknowledged the cutting

– Is she really crazy? Is it really that easy just to stop?

"You wanna be careful, those cuts will get infected you know"

+ You've acknowledged the cutting

– You're avoiding the issue. Better to ask how she's feeling

www.samaritans.org/pdf/F3UnderstandingSelf.pdf

Resilience

Activity 5: Letters from the Future

Goal: This activity gives students an opportunity to reflect upon what is good about them right now.

Time: 30 minutes

Teacher's Input: Ask students to imagine that they are 30 years old. Ask that 30 year old to write a letter to their younger selves. Ask the older self to convey all the wisdom that they have learned during that time. And ask the older self to comment, with hindsight about what was good about their young selves, specially naming attributes about the younger self that they were proud of.

Once finished, ask those who wish, to read out their letters form the future. Draw out from those letters aspects that the individual sees as something to be proud of right now.

Activity 6: Seven Eleven Breathing Technique

Goal: To demonstrate the direct physiological link between breath and thought to generating calmer states of being.

Time: 20 minutes

Teacher's Input: This activity is best done in smaller groups. Sometimes to assist students to concentrate and focus it is best done at the end of a focusing game or where chairs are facing the wall to create a private space.

- Settle yourself comfortably somewhere that you won't be disturbed. Make sure your clothes are loose.
- Sit comfortably with your hands side by side in your lap, or your arms by your side and your legs uncrossed.
- Close your eyes.
- Now concentrate on becoming aware of your feet on the floor, of your legs and arms, wherever they are resting.
- Then begin to make each out-breath longer than your in-breath. (This works because the out-breath stimulates the body's natural relaxation response. By changing your pattern of breathing in this way your body automatically begins to relax.)
- A good way to do this is to breathe in to the count of 7, and then breathe out gently and more slowly to the count of 11. Do this about 10 or 20 times, knowing that you will relax more each time.
- Concentrate on the counting (don't let your mind wander off) and feel a sense of calm gradually flow in.
- Try and be aware of how more relaxed you feel, just by relaxing you're breathing and blocking out your worrying thoughts. This technique is good for instant relaxation too. Just do it a few times, wherever you are, if you feel so wound up that you can't make a simple decision, or are nervous. (If you find it easier, substitute 3/5 for 7/11. The important thing is that your out-breaths last longer than your in-breaths).

Activity 7: Post-Evaluation

Goal: To assist teachers in verifying what the students have learned through a combination of the activities, workshop and the production.

Materials: Please use the post-evaluation for this activity.

Time: 10 minutes

Teacher's Input: Soon after your school sees the show we advise evaluating the students' general knowledge and attitudes towards mental and emotional wellbeing. We also advise that this is done after all the post-show activities. It is important to make sure you...

- communicate it is not a formal test,
- communicate the results of the test by creating a summary,
- provide comments so that the feedback is not too formal.

Resource Sheet: Bulletproof Student post-evaluation

Date: ______________________

School: ______________________

Teacher: ______________________

Subject: ______________________

Grade: ______________________

Please indicate how much you feel you know about each of the following. Circle the number that best describes your knowledge.

Mental Health in general	1	2	3	4
How people cope with mental health problems	1	2	3	4
Different approaches to help persons with mental health problems	1	2	3	4
What it is like to have mental health problems	1	2	3	4
What it is like to have a family member with mental health problems	1	2	3	4
The cause of different forms of mental health problems	1	2	3	4
How to recognise signs of mental health problems	1	2	3	4

1 - None 2 - A little 3 - Some 4 - A lot

Please indicate whether you agree or disagree with the following statements by circling the appropriate number.

Most people with a serious mental health problems can, with treatment, get well and return to productive lives.	1	2	3	4
In most cases keeping up a 'normal' life in the community helps a person with mental health problems get better.	1	2	3	4
People with mental health problems are far less of a danger than people believe.	1	2	3	4
People with mental health problems are, by far, more dangerous than the general population.	1	2	3	4
It is easy to recognise someone who once had a mental health problem	1	2	3	4
The cause of different forms of mental health problems	1	2	3	4
The best way to handle someone with mental health problems is to keep them locked behind doors.	1	2	3	4

1 - Strongly Disagree 2 - Disagree 3 - Agree 4 - Strongly Agree

Teacher Feedback

Replay values the feedback of teachers to assist us with the evaluation of our work. Please take a moment to fill in the Teacher Evaluation and send it back to us so we can continue to make challenging, educational theatre for your students.

Additional Resources:

Appendix A: ADHD

ADHD is a clearly defined clinical condition and not just a label for naughty or badly brought up children. Attention Deficit Hyperactivity Disorder (ADHD) is diagnosed when a child exhibits abnormally high levels of:

- Inattention (short attention span, easily distracted, doesn't finish things, disorganised, forgetful etc)
- AND/OR; Hyperactivity and impulsiveness (fidgets, can't sit still, always on the go, talks too much, interrupts, can't wait their turn etc).

To qualify as true ADHD, these problems:

- Must be long-term - present for at least 6 months;
- Must be abnormal for the age and stage of development of the child (what's normal in a 2-year-old is not normal in a 10-year-old);
- Must have been present before the age of 7 and are nearly always seen before the age of 5 years. ADHD is a developmental disorder and doesn't appear suddenly;
- Must be genuinely disruptive to the child's everyday performance and wellbeing - mere naughtiness at home or not doing well at school is not enough;
- Must occur in more than one place, for example both at home and at school. Problems which are present just at home or just at school are likely to have other causes.

Subtypes

Not all children with ADHD are hyperactive. Some children only have problems with inattention and some (actually very few) only have problems with hyperactivity and impulsiveness, but many have a combination of both types of problem.

The term "Hyperkinetic Disorder" is also sometimes used to describe those children with the most severe ADHD, where there are symptoms of inattention and hyperactivity and impulsivity which are all seriously disrupting the lives of children at home, at school and in the community.

http://4patients.janssen-cilag.co.uk

What is school like for a child with ADHD?

When we understand the types of difficulties children with ADHD have to cope with, we can imagine how tough school life can be for them.

Children with ADHD have difficulty: -
Screening out unwanted stimuli
Everything screams for the attention of the child with ADHD: the hunger pangs in their stomach, the noise of the distant lawn mower, thoughts about the football match, the pencil dropped by the child behind them. The teacher's voice is only a small distraction! Imagine yourself sitting in an important lecture trying to concentrate on the speaker's voice while two of your favourite films are showing at full volume in the conference room, your mobile is ringing, your friend is waving through the window and the person next to you keeps chatting to you. This might help you to imagine how the distractions of a normal classroom affect the child with ADHD.

Monitoring and regulating their own behaviour
Children with ADHD are poor self-monitors. They often require high levels of feedback to let them know what they are doing right and wrong. When these children hear, "Stop that!" they may not actually know to which behaviour the teacher is referring.

Inhibiting inappropriate verbal and physical responses
It's not that the child did not know it was a bad idea to throw the paper aeroplane; it's just that they knew it after they threw it! The mechanisms that allow us to think before we speak or act are affected in ADHD.

Knowing how much concentration is needed for a task
We know that it requires greater effort to read an academic journal than it does to read a magazine and we allocate mental effort accordingly.
This is difficult for the child with ADHD.

Sustaining attention for prolonged periods
Children with ADHD may start an activity with great enthusiasm but they find this difficult to sustain.

Controlling activity level
Children with ADHD can have trouble adapting their activity level so that it is appropriate to the context. They may feel the need to move as much in the classroom as they do in the playground!

These difficulties have a number of consequences for children with ADHD. They may find it hard to make and sustain friendships. They could find that, despite their best efforts to manage their behaviour, they are often in trouble in school and underachieving in the curriculum. This can clearly cause stress and anxiety, reduce the child's self-esteem and lead to negative views of school.

School staff are in a powerful position to halt this negative spiral and make a huge impact on the quality of life for children with ADHD.

http://www.education-support.org.uk/parents/special-education/adhd/

Appendix A: Suicide Prevention

Conditions associated with increased risk of suicide

- Death or terminal illness of relative or friend.
- Divorce, separation, broken relationship, stress on family.
- Loss of health (real or imaginary).
- Loss of job, home, money, status, self-esteem, personal security.
- Alcohol or drug abuse.
- Depression. In the young depression may be masked by hyperactivity or acting out behaviour. In the elderly it may be incorrectly attributed to the natural effects of aging. Depression that seems to quickly disappear for no apparent reason is cause for concern. The early stages of recovery from depression can be a high risk period. Recent studies have associated anxiety disorders with increased risk for attempted suicide.

Emotional and behavioural changes associated with suicide

- Overwhelming Pain: pain that threatens to exceed the person's pain coping capacities. Suicidal feelings are often the result of longstanding problems that have been exacerbated by recent precipitating events. The precipitating factors may be new pain or the loss of pain coping resources.
- Hopelessness: the feeling that the pain will continue or get worse; things will never get better.
- Powerlessness: the feeling that one's resources for reducing pain are exhausted.
- Feelings of worthlessness, shame, guilt, self-hatred, "no one cares". Fears of losing control, harming self or others.
- Personality becomes sad, withdrawn, tired, apathetic, anxious, irritable, or prone to angry outbursts.
- Declining performance in school, work, or other activities. (Occasionally the reverse: someone who volunteers for extra duties because they need to fill up their time.)
- Social isolation; or association with a group that has different moral standards than those of the family.
- Declining interest in sex, friends, or activities previously enjoyed.
- Neglect of personal welfare, deteriorating physical appearance.
- Alterations in either direction in sleeping or eating habits.
- (Particularly in the elderly) Self-starvation, dietary mismanagement, disobeying medical instructions.
- Difficult times: holidays, anniversaries, and the first week after discharge from a hospital; just before and after diagnosis of a major illness; just before and during disciplinary proceedings. Undocumented status adds to the stress of a crisis.

Suicidal Behaviour

- Previous suicide attempts, "mini-attempts".
- Explicit statements of suicidal ideation or feelings.
- Development of suicidal plan, acquiring the means, "rehearsal" behaviour, setting a time for the attempt.
- Self-inflicted injuries, such as cuts, burns, or head banging.
- Reckless behaviour.
- Making out a will or giving away favourite possessions.
- Inappropriately saying goodbye.
- Verbal behaviour that is ambiguous or indirect: "I'm going away on a real long trip.", "You won't have to worry about me anymore.", "I want to go to sleep and never wake up.", "I'm so depressed, I justcan't go on.", "Does God punish suicides?", "Voices are telling me to do bad things.", requests for euthanasia information, inappropriate joking, stories or essays on morbid themes.

http://www.pipsproject.com/howcanihelp.html

Appendix A: The needs of bereaved young people

The following notes draw heavily on the work of William Worden as well as our own experience of working with bereaved young people. In "Children and Grief", (1996) Worden summarises the findings of the two year long Harvard bereavement study, which charted the impact of the death of a parent. Worden states that children and young people have ten needs:

1. Adequate information
If teenagers are not given enough information by the adults around them,they may fill in the gaps themselves, sometimes inaccurately. Young people sometimes think they know or understand more than they actually do. This may cause misunderstandings or rumours.

2. Fears and anxieties addressed
It can be especially difficult for teenagers to talk about their fears and anxieties because they may feel too vulnerable and may worry about being judged. Sometimes this results in angry, resentful or withdrawn behaviour. It is often helpful to find a quiet time to ask if there are any questions, thoughts or things that are worrying them. Sharing how you feel or how you might feel in their shoes may help.

3. Reassurance they are not to blame
Adults and children often feel that they could have done something differently that may have prevented a death. A natural part of teenagers' development is to over-emphasize their role in things. This may intensify their feelings of guilt and they need reassurance and explanations about why they are not to blame.

4. Careful listening and watching
Teenagers will sometimes find it easier to talk while you are doing something else, like washing up or preparing a meal. Perhaps this is because they feel less self-conscious. It is important to respond to their approaches positively. Sometimes it may be worth creating these opportunities, for instance by travelling somewhere together. Often it really helps to share something of our own experience first, without assuming that the young person will feel the same.

5. Validation of Individuals' feelings
Allow for individual differences both in feelings and in the expression of feelings. There is not one way to grieve; in fact there are as many ways to grieve as there are people.

6. Help with overwhelming feelings
Adults need to balance teenagers' need for consistent boundaries and expectations about their behaviour, with an acceptance that they may be less capable than you would usually expect from someone of their age.

7. Involvement and inclusion
Young people should be given an informed choice about their roles in rituals and activities which surround a death. This may include visiting a sick person before death, seeing the body after death, their involvement in the funeral and their opinions about memorials.

8. Continued Routine Activities
It is especially important following traumatic loss to provide as much stability and continuity as possible. The death of someone close is often very frightening. Continuity helps to re-establish stability and helps teenagers to realise that though life will never be the same there are still many things that remain constant.

9. Modelled grief behaviours
"Children (and young people) learn how to mourn by observing mourning behaviour in adults." (Worden 1996 p. 145). Adults can promote an environment where it is easy to talk about the deceased and to acknowledge good and bad memories. We should acknowledge that none of us have all the answers and there is no "right" way to grieve.

10. Opportunities to remember
When someone who played a significant part in our life dies there will be countless moments when we are reminded of their absence. When a family is able to speak about the deceased naturally, it helps a teenager to make sense of their own reality. At the same time it is important to respect that any individual may need to protect themselves from pain at times, and at times they may not want to talk about the deceased.

Primary Source: *Worden, W. (1996) 'Children and Grief', Guilford Press, New York.*

Secondary Source:
http://www.childhoodbereavementnetwork.org.uk/policyPractice_training.htm

Appendix B: Useful mental health-related Websites

http://www.healthyschools.gov.uk/
Linking good health, behaviour and achievement through a whole school approach.

http://www.youngminds.org.uk/
Promotes child and adolescent mental health and mental health services.

http://www.teachernet.gov.uk/teachingandlearning/library/self-harm/
This site carries information about teaching and learning: teaching strategy, teaching and learning tips, learning psychology, and links to thousands of resources.

http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm
This site carries information about young people's emotional well being with interactive resources

http://www.innerresilience-tidescenter.org/teachers.html
International site that cultivate the inner lives of students, teachers and schools by integrating social and emotional learning with contemplative practice.

http://www.responseability.org/site/index.cfm?display=134877
International site, Response Ability supports the exploration of relevant principles in teacher education programs, to better prepare teachers for their important roles in supporting the development and wellbeing of children and young people.

http://www.nhsdirect.nhs.uk/
NHS Direct provides expert health advice and information 24 hours a day 365 days a year. The health information professionals such as nurses, health advisors and dental advisors can deal with a wide range of health queries.

http://www.stampoutsuicide.org.uk/northern_ireland.aspx
This website contains pages concerned with suicide awareness and suicide prevention.

Appendix C: Youth Telephone Help-lines

Awareness NI
help@aware-ni.org | 08451 29 20 61

ChildLine homepage get help and advice about a wide range of issues.
www.childline.org.uk/
Childline is a free and confidential 24 hours helpline for children in distress or danger 0800 1111

Contact Youth provides counselling for young people
www.contactyouth.org | 0808 808 8000

Relate provide relationship counselling for couples, families and young people and also psychosexual therapy.
www.relateni.org | 0870 242 6091

Samaritans provide confidential emotional support 24 hours a day
www.samaritans.org.uk | 08457 90 90 90

Parentline Plus
0808 800 2222

PIPS Project
Public Initiative for the Prevention of Suicide and Self-Harm - Suicide Helpline
0808 808 8000 | www.pipsproject.com

PIPS Belfast
02890755070

PIPS Newry
07707039799

PIPS Ballynahinch
07818 222733

PIPS Downpatrick
07709 861310

PIPS Newcastle
07756 795044

Saneline
(for those experiencing mental health problems)
08457 678 000

Zest healing the hurt provides support and counselling for people concerned with suicide and self-harm.
www.zestni.org | 028 7126 6999

Appendix D: Further Study

Gary Owen
For the playwright's philosophy and the voice of young people:
http://www.gary-owen.co.uk/articles-writing_big_hopes.html

Other Verbatim plays of note:
- Black Watch by Gregory Burke
- Deep Cut by Phil Ralph
- Talking to Terrorists by Robin Soans
- The Girlfriend Experience by Alecky Blythe
- Bloody Sunday: Scenes from the Saville Inquiry by Richard Norton-Taylor's

ADHD
www.attention.com
www.helpforadd.com
www.adders.org
www.cdipage.com
www.add.org
www.livingwithadhd.co.uk

Self Harm
National Inquiry: www.selfharmUK.org
ChildLine: www.childline.org.uk
Mind: www.mind.org.uk
National Children's Bureau: www.selfharm.org.uk
National Self-Harm Network: www.nshn.co.uk
Young Minds: for professionals:
www.youngminds.org.uk/professionals/
Young Minds: for parents
www.youngminds.org.uk/parents/
Young Minds: for young people
www.youngminds.org.uk/young people/index.php

Suicide Prevention
www.stampoutsuicide.org.uk/northern_ireland.aspx

Media Guidelines for portrayal of Suicide
www.pipsproject.com/MediaGuidelines.pdf

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