

THE



PERSPECTIVE

THE

MALE

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YOUNG MEN'S OUTLOOK ON LIFE



BORD SLÁINTE
AN MHEÁN-IARTHAIR

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THIS STUDY WAS UNDERTAKEN IN PARTNERSHIP BETWEEN THE
MID-WESTERN HEALTH BOARD, THE NATIONAL SUICIDE REVIEW GROUP, AND
THE NATIONAL SUICIDE RESEARCH FOUNDATION.

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FOREWORD

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Since the late 1980s our suicide rate has grown steadily. In more recent years the number of suicides in Ireland has surpassed the number of road traffic deaths and young Irish men now have one of the highest suicide rates in the world. In 1993, the Criminal Law (Suicide) Act was passed, meaning that suicide ceased to be a crime in this country. In 1995, a National Task Force on Suicide was established, which was effectively a first national declaration that suicide is a major public health problem. Taken together, these developments signify a commitment on behalf of Irish institutions to tackle the burden of suicidal behaviour.

This study of young men is an important one. It is a first step towards the development of male focused health and social care strategies that will attempt to prevent further suicide deaths. The partnership approach between the key organisations engaging in this study reflects the key message of the study findings, i.e. that the promotion of young men's health and suicide prevention depends on the collective response of a wide range of organisations and agencies.

We welcome this report as the first attempt to face up these difficult and sensitive issues in consultation with young men themselves. Only by talking to the group that are at highest risk of suicidal behaviour in the general population can effective supports and services be developed to help in the reduction of suicide in Ireland. Finally, this report positions the problem of suicidal behaviour in a broad social and political context and it is from this perspective that society as a whole must face up to the challenge of suicide prevention.

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INTRODUCTION

The number of young men dying by suicide in Ireland has grown considerably in recent years with the rate for men under 35 years currently being between 30-35 per 100,000 population. In real terms, this represents around 190 suicide deaths each year among men less than 35 years of age. While accounting for 27% of the overall population in Ireland, this group of men account for over 40% of all suicides each year.

Death by suicide is primarily a male phenomenon in this country, and is reflected in the fact that for every female suicide, between four and five men kill themselves. Although, a single cause of suicide has never been found, a combination of biological, psychological and sociological factors have been identified. Addressing this serious and complex public health issue in men is a significant challenge. Clearly, a first step in suicide prevention for young men is to gain an understanding of their outlook on life and living.

INTRODUCTION

Therefore, this report examines attitudes among young men in relation to life and living in contemporary Ireland. The focus is on health issues such as help-seeking behaviour, ways of coping and approaches to problem solving. A key objective has been to develop recommendations for the health and social services in tackling young male suicide, built on meaningful consultation with young men. While other recent studies such as Men Talking have consulted with Irish men in relation to health in the broader sense, this is the first population study of young Irish men (i.e. those at highest risk) that has its main focus on mental health issues, including suicide.

The difficulty associated with engaging young men with health services was highlighted by the recent report Suicide in Ireland: a national study. However, by understanding the felt needs of young men, a framework for acceptable ways to improve access to, and uptake of, caring and supportive services might be developed.

From a sociological perspective, a sense of community (social integration) and shared values (social regulation) can influence the behaviour and actions of individuals. In this context, the social changes that have occurred in Ireland in recent years merit investigation in terms of their impact on men's sense of personal worth and belonging in our modern society. Previous research has speculated that sociocultural changes in Western societies in recent years have adversely affected men more than women and that a gender difference has emerged in terms of how "the self is seen or construed". Furthermore, increased individualism may be contributing to a greater sense of isolation for young men as women tend to remain more socially connected and to view the self as interdependent with others whereas men are more likely to view the self as separate.

Psychologically, the individual's perceived sense of control is also important in determining how problems are dealt with and challenges in life are met. By clarifying young men's existing sense of control, realistic and meaningful health promotion strategies may be identified.

At the outset, the report provides some background findings from previous research on men and mental health. It sets the scene in terms of the suicide problem in Ireland and in the Mid West and outlines the response to the problem to date. The study methodology and results are then presented before a discussion of the main points. Finally, practical recommendations are made in relation to prevention suicidal behaviour among young men.

BACKGROUND

SOCIAL CHANGE AND ANOMIE

Social change, including changes in traditional gender roles, may help us to understand the increase in young male suicide. It has been suggested that a male pessimism about society has emerged, resulting from socio-economic changes and changes in our social values. More generally, men's dissatisfaction with life in terms of opportunities, health services and social networks has also been identified. Such findings tell us that prevention strategies for young men need to consider both their internal and external worlds in terms of coping skills, attitudes and a sense of belonging. In this context it should be remembered that the rate of change in Irish society and the Irish economy (the external world) has been especially dramatic as characterised by changes in family structures, working life and religious practice.

A concept that has been applied to the understanding of changes in suicide rates is the concept of anomie. Anomie describes the unbalancing of social forces that affect individual action. It implies an upsetting of the balance or normality in a previously accepted way of life. It is based on the notion that society usually exercises control over individual behaviour and desire through social rules and norms and when these rules and norms break down individual behaviour is no longer regulated by society. At an individual level it can be described as a personal feeling of not being part of, or responsible to, society.

Underlying the notion of anomie is the belief that human desire is basically infinite, human beings will always want more unless society controls desires through the existence of everyday shared values and institutionalised rules or laws. Without a sense of

accepted social values individual behaviour or desire may not be controlled or regulated and the level of so-called deviant or unacceptable behaviour, including suicide, increases.

At an individual level, changes in personal circumstances can lead to uncertainty or can upset the normal way of life. For example, by winning a large sum of money an individual may be forced to question values and desires that were previously taken for granted as new opportunities present themselves. Similarly, negative events such as job loss or divorce can upset the balance or equilibrium that previously governed an individual's way of life.

Anomie is also related to the values and expectations in a society and the means to achieve these expectations. When there is a discrepancy between expectations and means to achieve them then the level of anomie increases. For example, in Irish society home ownership is something that is valued and is associated with independence and passage into adulthood. However, the means to achieve home ownership are not readily available to the majority of young people attempting to make the transition from adolescence to adulthood. The resulting situation may be that an individual is achieving societal expectations on some levels, e.g. in terms of career, but not on other levels such as home ownership.

While anomie contributes to our overall understanding of suicide as a social problem, as a symptom of social transition, it may be difficult to apply to the understanding of individual deaths by suicide. However, by examining the narratives, the tragic stories

surrounding these deaths, the conditions of anomie are often related, for example among young men who would seem to have had so much going for them and appeared to be 'in good form' .

MEN AND MENTAL HEALTH

Research into men and mental health issues has produced some worrying findings. For example, men have been found to be less likely to recognise a mental health problem than women , less likely to confide in family members about emotional matters , and much less likely to report a personal vulnerability to depression .

They are also less concerned about access to mental health services, and less likely to be in contact with them even if they are suicidal . Indeed, young men who kill themselves have been reported to be less likely to contact their GP in both the week and month prior to their death, than older male suicides 2. This tendency towards poor help-seeking behaviour is all the worse given the relatively high reported rates of suicidal ideation among young men .

Further studies have found that younger Irish men were much more likely to view those with depressive symptoms as "feeling sorry for themselves", would find it difficult to offer advice to someone who was depressed or suicidal and show greater reluctance to engage the services of a GP, psychologist or the Samaritans for depression or other psychological conditions , , .

COPING AND PRESSURES

Pressures reported by young Irish men in a recent study include alcohol misuse, social pressures, relationship problems, having few/no friends, and low self-esteem . Changes in gender roles, pressure to fulfil the role of provider, and an inability to value themselves outside of work have also been put forward as key influences on men's well being in this country2, . These self-reported stressors support the notion that a social change model as outlined above in terms of anomie can help us to understand changes in rates of suicide and self-harm among young men.

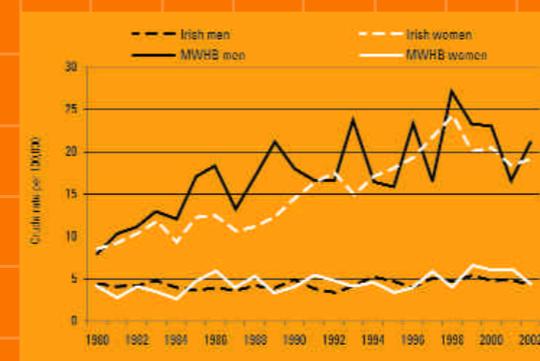
The ability to adapt and respond positively to life stressors (i.e. to cope) is associated with personality traits. Although it may be difficult to separate mental state factors from personality traits in young people, anxiety, impulsivity, neuroticism, and an external locus of control may predispose a person to suicidal behaviour. Internal locus of control refers to the extent to which an individual feels that the events in their lives are a consequence of their own behaviour and are therefore, potentially under their control. In this context a belief in one's ability to achieve a desirable outcome will promote perseverance even when faced with major difficulties . A number of studies have demonstrated that suicidal individuals are characterised by an external locus of control with lethality of attempt associated with a greater external locus of control . External locus of control has been found to be a useful predictor of risk for suicidal behaviour .

RATES AND NUMBERS

The World Health Organisation (WHO) has estimated that around 1 million people die by suicide each year and up to 20 million suicide attempts are made. In Ireland, there are around 450 suicide deaths each year*. This figure represents around 1.5% of all deaths in Ireland each year. The number of hospital-treated cases of parasuicide or deliberate self-harm, is estimated at around 10,000 .

In Ireland, more people die by suicide each year than in road accidents (in 2002 there were 451 suicides registered by the Central Statistics Office (CSO) compared with 349 vehicle accident deaths (E810-829, ICD9)[World Health Organisation, 1978 #52] and, for young Irish adults, suicide is now the leading cause of death. Suicide is therefore a major public health problem.

This study is set in the Mid-Western Health Board (MWHB) region of Ireland, 1 of 10 regional health board areas, with a total population of 339,930 (2002 census) covering counties Clare and Limerick and Tipperary, North Riding. The study targets 18-34 year old men, a group with a population of just over 40,000. Rates of suicide in the Mid West region reflect national trends. In terms of actual numbers, an average of around 43 such deaths are reported in the region each year (based on figures registered in 1998-2002). The rise in the suicide rate in the MWHB and nationally is shown in Figure 1.



Note: 2001 and 2002 rates are based on year of registration figures

Figure 1. Rate of suicide in the MWHB region and nationally, 1980-2002, by gender

AGE AND GENDER

More men die by suicide than women. However, the ratio of male to female suicide varies from country to country. In 2002, the gender ratio for Irish suicide was over 4:1 (371 male deaths, 80 female). This ratio appears to be increased for the younger age groups. For example, looking at data for the past 5 years, for those aged less than 35 years, the ratio was nearly 6:1, men to women.

It is important to note that in most other countries that return data to the WHO, the suicide rate increases with age. In Ireland, the rate of suicide peaks among young men (Figure 2) and in this way trends in Irish suicide are fairly unique. It is also important to stress that suicide becomes far more common after the late teenage years – i.e. men in the 20s and 30s are particularly vulnerable in Ireland.

In the Mid West in recent years, the male suicide rate for men in their early twenties was 45 per 100,000 population, which is more than 80% higher than the overall male suicide rate for the region and about one third higher than the rate of 33 per 100,000 for 20-24 year-old men in Ireland as a whole.

In summary, suicide rates are highest among young men in their 20s and prevention efforts must be targeted accordingly.

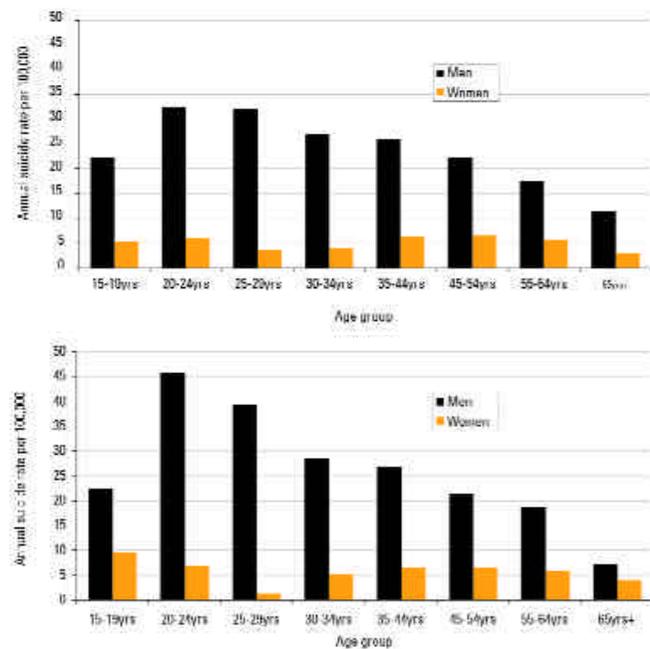


Figure 2 Suicide rates by age and gender in Ireland (left) and in the Mid West (right) based on 1998-2002 registered data

SUICIDE METHOD

The relevance of briefly considering suicide method lies in the potential to restrict access to commonly used means of self-harm. Impulsive suicidal behaviour might be prevented in this way.

The prevalence of certain methods appears to be related to culture and environment. For example, by far the most common method of suicide in the United States is by firearms where guns are more freely available. In Ireland, hanging is the most common method followed by drowning and it is difficult to restrict access to such means. However, the percentage of suicides by firearms has increased in recent years, especially among younger people. Figure 3 shows that almost 20% of recent suicides by men under 18 yrs in Ireland and in the Mid West involved firearms. This is an issue that warrants ongoing monitoring, as it may be necessary to impose further restrictions on gun licensing and to promote safer storage of firearms. However, hanging is by far the most common method of suicide in men and restricting access is not feasible. For men in the country as a whole as well as in the region under study, it can be clearly seen that hanging becomes less common as a suicide method with increasing age and this is also the case with guns as a method. The opposite is true for poisoning and drowning.

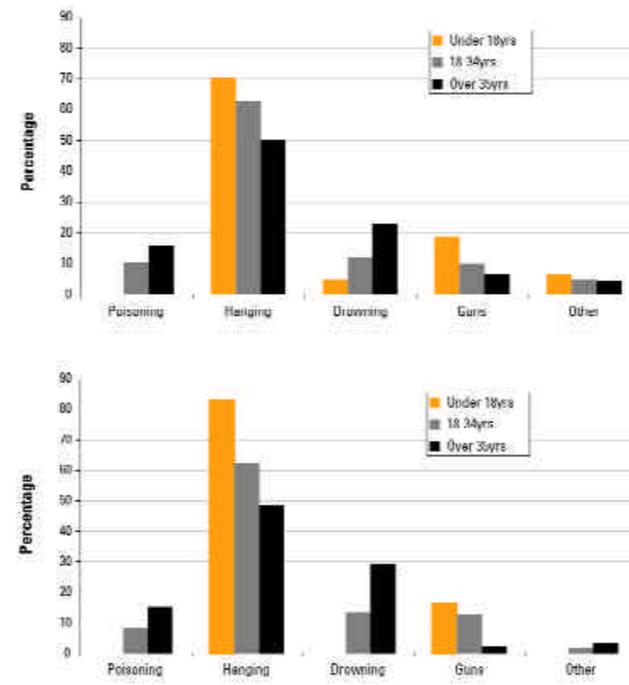


Figure 3. Methods of suicide used by men in Ireland (left) and in the Mid West (right) based on 1998-2002 registered data

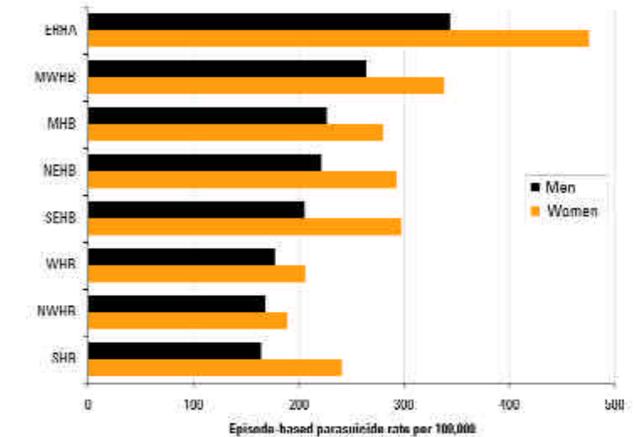
PARASUICIDE

It is appropriate to broaden our view of suicidal behaviour to include non-fatal acts of self-harm. This is especially true in the Mid Western region, where the rate of hospital treated parasuicide is the second highest nationally (Figure 4). The rate of episodes per 100,000 population per year is 261 and the rate is concentrated among younger age groups. While the rate is slightly higher among women, the rate for men is highest in the 18-34 year old age group, at almost 400 per 100,000. These rates are higher than previously reported European averages.

Certain medication has been commonly used in cases of parasuicide, in particular paracetamol. In terms of restricting common means of self-harm, restrictions on the sale of paracetamol came into effect in October 2001 following the introduction of a statutory instrument by the Minister for Health and Children (Medicinal Products (Control of Paracetamol) Regulations 2001, Statutory Instrument No. 150 of 2001). Restrictions cover the quantity sold, point of sale and the packaging used. The National Parasuicide Registry (NPR) will monitor the impact of these restrictions on the rate of parasuicide and levels of dosage.

Note: Rates are estimated for the ERHA due to incomplete coverage of ERHA hospitals.

Figure 4. Annual Episode-Based Parasuicide Rates in Ireland by Health Board/Authority (based on National Parasuicide Registry data for January-June, 2002)



THE RESPONSE

NATIONALLY

Ireland was the last country in Europe to decriminalise suicide with the passing of the Criminal Law (Suicide) Act in 1993. This facilitated efforts to research suicide openly and to develop strategies for suicide prevention.

The following timeline sketches some of the major developments in suicide prevention in Ireland in recent years:

- 1995: a National Task Force on Suicide was appointed
- 1995: the National Suicide Research Foundation (NSRF) was established with the aim of investigating the extent of suicidal behaviour and its possible causes
- 1996: the Irish Association of Suicidology (IAS) was established to promote public and professional awareness of suicide prevention
- 1998: the Final Report of the Task Force was published making 86 recommendations
- 1998: the National Suicide Review Group (NSRG) was appointed by the Chief Executive Officers of the Health Boards
- 1998: Health Boards began appointing Resource Officers for Suicide Prevention, supported by Regional Steering Committees
- 2000: the National Parasuicide Registry was implemented by the NSRF
- 2001: Suicide in Ireland: a national study 2 was published providing in-depth information on 2 years of suicide data in Ireland
- 2001: the Health (Miscellaneous Provisions) Act 2001 was passed, requiring the Minister for Health and Children to report annually on the activities of Health Boards in the area of suicide prevention

In addition:

- To date, 62 regional and national suicide prevention projects have been selected for Department of Health and Children funding through the NSRG
- A number of the Health Boards have published regional suicide prevention strategies
- Core funding has been approved for the IAS, NSRF and NSRG in the area of suicide prevention, through the Department of Health and Children
- Suicide bereavement support groups have been established throughout the country, linking in with the National Suicide Bereavement Support Network (NSBSN)

REGIONALLY

Since October 1999, the Mid-Western Health Board in collaboration with voluntary, statutory and community organisations have established the following services/ support structures and projects as part of its suicide prevention programme:

- Since 1995, in collaboration with the National Suicide Research Foundation parasuicide has been monitored as part of the National Parasuicide Registry (NPR) in order to inform service development
- The Healthlines Directory of voluntary and statutory support organisations was published in 2000

- The 'Living Links' outreach support services for the suicide bereaved has been established providing home support, healing programmes and support group services
- In collaboration with the Garda Síochána, the information booklet You Are Not Alone has been distributed to those bereaved by suicide offering guidelines on how to cope with the immediate aftermath of a suicide death
- The guidelines A Student Dies, A School Responds and crisis school team training for post-primary schools have been developed
- A 'problem solving intervention' research project providing specialised therapy for individuals attempting suicide is being conducted in collaboration with the Southern Health Board
- The Youthwise Guide and companion pocketbook for parents supporting vulnerable young people has been developed
- Good practice guidelines for staff responding to suspected suicide deaths have been published
- Give Depression the Boot in Older Persons project with primary care nursing staff is being developed
- A staff training on risk management project (STORM) for mental health professionals as part of an international research project in responding and managing suicidal behaviours is being conducted
- Public awareness is promoted through annual public conferences, regional community training events and gatekeeper courses

There has been a considerable mobilisation of resources nationally and regionally in the area of suicide prevention given the relatively short time frame involved. However, given the persistently high rate of suicide among young men, there is clearly a need to re-focus these resources if meaningful prevention policy is to be developed.

STUDY AIMS

The structures that have been established in the area of suicide prevention have made this particular project possible and it is hoped that this study can:

- Enhance the existing database of knowledge on suicide and suicide prevention in Ireland
- Examine attitudes to and perceptions of recent changes in Irish society
- Make recommendations that will inform service planning in a practical way
- Focus the attention of suicide prevention efforts on young men

There were two parts to this study - a community-based survey and a series of focus groups with young men. Ethical approval was sought and obtained from the Ethics Committee of the Mid-Western Health Board. During the fieldwork, support measures were put in place for the researchers and participants. Information on the relevant health board services and the telephone number of the MWHB Suicide Prevention Strategy Co-ordinator was made available to every participant.

COMMUNITY-BASED SURVEY

The questionnaire was administered to a convenience sample of fourteen men, known to the project team, from various backgrounds within the target age range. Following feedback, minor adjustments relating to formatting and phrasing of some questions were made.

In June 2002 a postal survey of 2,534 men was undertaken. However, because of a poor response rate (less than 20%), the researchers opted to complete a second, door-to-door survey, in order to capture a more representative sample of young men in the area.

The second survey utilized a door-to-door approach to survey a new group of young men aged 18-34 years and was conducted in early December 2002. Precision Marketing Information Ltd facilitated the fieldwork for this survey.

A target sample of 350 respondents was set. Thirty-five sampling points were selected across the urban and rural areas of the counties incorporating the MWHB region, namely Clare, Limerick and North Tipperary. These sampling points were either single or grouped electoral divisions or wards. Respondents were recruited at their homes if they met the criteria of being male, aged 18-34 years and permanently resident in the area. Quota controls were employed by age and social class to reflect the characteristics of the 18-34 year-old male population of the region. The details of the survey were explained to every eligible participant. Those willing to participate were given a self-seal envelope containing the questionnaire, an information leaflet outlining current health board services relating to suicide prevention and an explanatory letter from the MWHB. The participants were asked to complete the

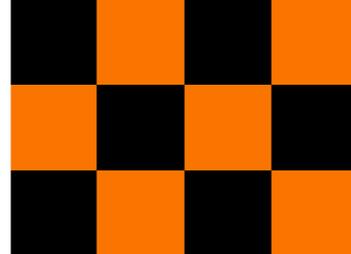
self-report questionnaire in private and return it in the sealed envelope when the interviewer returned to the house.

In total 423 people were approached who met the inclusion criteria. Of these, 363 completed the questionnaire, yielding a highly satisfactory response rate of 86%. The response rate varied by county from 79% (91/115) in Clare to 83% (151/182) in Limerick and 88% (111/126) in North Tipperary. Ten respondents (3.6%) did not indicate county of residence when completing the questionnaire.

Questionnaire

In addition to open-ended questions, a variety of multiple choice questions were included examining sociodemographic variables, perceived stressors, social support, coping styles, attitudes to suicide and suicidal behaviour, protective factors and health service utilisation. The majority of items included were either taken directly or adapted from established instruments. These instruments included the following, which are reproduced in Appendix 1:

- The Anomie Scale (Srole, 1951) . This measures the degree of social regulation of an individual and the extent to which he/she looks to society for 'terms of reference'.
- The Locus of Control Scale (Sapp & Harrod, 1993) . This measures the extent to which people view their life circumstances as governed by external factors (e.g. chance) or whether they feel in control of their lives.



- A series of questions enquiring about the individuals' experience of thoughts about suicide were adapted from Paykel, Myers, Lindenthal et al. (1974) . This measures the level of suicidal thoughts present in individuals, ranging from vague suicidal thoughts to concrete, specific plans about taking their own life.

STATISTICAL ANALYSIS

Descriptive statistical analysis results are reported. Percentages are presented that are adjusted for missing values. Between-group differences are reported based on the results of Chi-square tests and Student's t-tests as appropriate (p values are indicated). Comparisons were made between the following sub-groups:

- 18-24yrs and 25-34yrs
- urban and rural
- employed and not employed
- living with parent(s) and not living with parent(s)
- attitude toward the preventability of suicide: very positive and not very positive
- lifetime experience of suicidal ideation: yes and no
- lifetime experience of the suicide of another: yes and no (or none and one and more than one)

Only significant differences are reported. Therefore the percentages reported for the overall sample would fairly represent the percentages in subgroups where there were no significant differences.

FOCUS GROUPS

Rationale

The aims of the focus group interviews were to clarify and expand on the survey data, and, most importantly, to incorporate the 'lived experience' of young men into the study. Accordingly, it was deemed appropriate to purposively sample participants according to membership of a variety of sub-groups in this cohort. In addition to allowing a diversity of views to be expressed, this method also sought to target sub-groups that are thought to be at increased risk.

Participants

It was originally intended to interview nine groups, but despite several attempts, the research team did not succeed in interviewing the following: prisoners, farmers, IT sector employees, a gay group and an inner-city support group. The four groups that were successfully interviewed were university students, trainee Gardaí, GAA club members and a group from the probation services. Groups of between 6 and 10 were sought. In total, 35 men were interviewed. While all were in the age range of 18 to 34 years, the majority were younger than 25 years. Each county of the Mid-Western Health Board was represented. Almost half of the men lived at home with their parent(s) and there was an even distribution of students and the employed and unemployed.

Procedure

Focus group interviews were conducted at venues familiar to the men and at a time and date convenient to them, in the months of June and July 2002. The focus group sessions lasted between 1_ and 2 hours with the

option of a 15-minute break. They were conducted with the use of a discussion guide constructed following a review of the literature. This consisted of a schedule of relevant questions for flexible use in the discussion. It was the role of the lead facilitator to time the discussion of the various issues and to manage a spread of participation among the group. After welcoming everyone to the discussion, the lead facilitator gave an overview of the topic, established some house-keeping rules and addressed issues around confidentiality before beginning with the first question.

The series of guiding questions were as follows:

1. How is life different today compared with your father or uncles' time?
2. What are the positive things about being a young man in Ireland today?
3. What are the negative things about being a young man in Ireland today?
4. What would you do to cope with psychological problems given that the standard advice is to go to a general hospital or your GP if you think you need help (this was explained in more detail to the participants)?
5. How do you cope in general with the type of problems we have been discussing?
6. What range of supports are in place to help cope with these problems?
7. For what kind of psychological problems would you seek help?
8. What kind of health services could be developed that young men would use?

Anonymity, consent and support

Informed consent was obtained from all participants whereby the voluntary, confidential and anonymous nature of the interview was outlined. Furthermore, all participants were offered the opportunity of follow-up counselling support. With the men's permission, all interviews were audio taped.

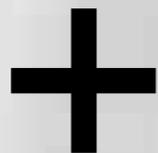
Group facilitation

The same three male researchers were involved in conducting each of the four groups. The researchers were of a similar age to the participants. The lead facilitator guided the group through the interview schedule, allowing and encouraging elaboration of themes as appropriate. The other researchers took detailed notes, monitored group dynamics, operated the tape-recorder and flip-chart, provided summaries of the discussion as required, ensured the smooth changeover of tapes and dealt with interruptions.

Focus Group Analysis

Transcripts based on the researchers' notes were used in the analysis of the focus groups. The lead facilitator bracketed the content of each focus group discussion into the main discussion guide themes by listening and reviewing the tapes and notes. Further sub themes were developed inductively. A composite report was then prepared outlining the main recurrent themes, experiences and perspectives, while also paying attention to divergent views. The research team reviewed this report and agreement was then reached as to the main themes that had emerged.

SURVEY RESULTS



DEMOGRAPHIC PROFILE

All 363 respondents were men aged between 18 and 34 years who resided in the MWHB region.

All percentages presented below are adjusted for missing values.

Almost two-thirds (221, 63.9%) of the respondents indicated that they lived in an urban area. Urban was defined by the researchers based on the area of residence being in a county borough (Limerick city) or Urban District Council (UDC). The geographical make-up of the sample was as follows:

- one in eight (44, 12.5%) were Limerick city residents;
- a further 30.3% (107) lived in Limerick county;
- one in four (91, 25.8%) lived in Clare;
- 31.4% (111) lived in North Tipperary.

Living situation

As illustrated in Figure 5, almost half (166, 49.3%) of the sample were living with their parent(s), a further one in four (89, 26.4%) were living with their partner (whether with or without children) while the remaining quarter were either living alone (12, 3.6%), with a friend/friends (56, 16.6%) or in another living situation such as a flat or a hostel (14, 4.2%).

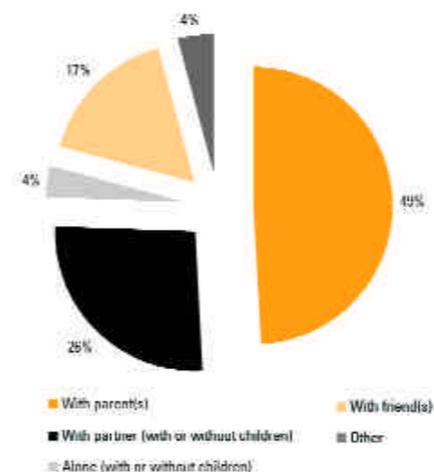


Figure 5. Living situation of respondents

Employment Status

Employment status was not stated for over 30% of the men (113, 31.1%). It may be that unemployed respondents were less likely to respond to this question. Where it was known, the majority (147, 58.8%) indicated that they were employed. Over a quarter (69, 27.6%) were students, 10.8% (27) were unemployed and a small number (7, 2.8%) were of another employment status (e.g. vocational training scheme).

Age Group

A slight majority of the men (186, 53.0%) were aged 18-24 years, while 165 (47.0%) were aged 25-34 years.

Parenting Status

One in four of the men (87, 24.7%) indicated that they were fathers. For almost one quarter of these fathers (21, 24.1%), their children were not living with them most of the time.

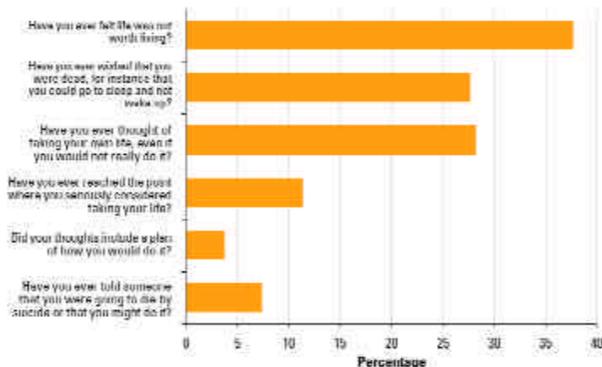
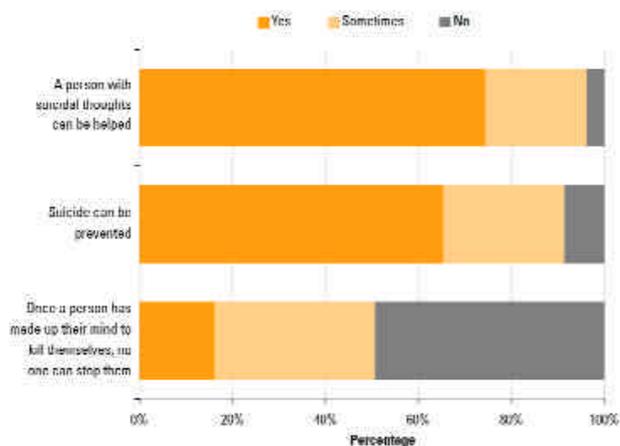
Medical Card / Insurance

Just over half of the men (177, 52.4%) indicated that they had health insurance while about one in five (73, 21.0%) had a medical card.

SUICIDAL BEHAVIOUR

Attitudes Towards Suicide

The men were asked to indicate their agreement with three statements relating to suicide and suicide prevention (Figure 6). **Virtually all of the men (331, 96%) felt that at least sometimes a person with suicidal thoughts can be helped and suicide can be prevented.** Just one in seven men (55, 16%) agreed with the statement "once a person has made up their mind to kill themselves, no one can stop them". A further one in three (118, 34.6%) felt that this is sometimes the case. Almost 2 out of 5 (130, 38.8%) men gave the most positive set of responses to the three statements regarding the preventability of suicide.



Experience of Suicidal Behaviour

Sixteen men (4.6%) indicated that they had deliberately taken an overdose or tried to harm themselves in some way, three of whom indicated that they had a history of multiple deliberate self-harm acts. Just six of these 16 men (37.5%) had been treated in hospital as a consequence of their self-harming behaviour therefore indicating that the majority of deliberate self-harm acts by young men are not hospital-treated. However, we have no details of what was done in these acts and consequently we cannot assess lethality or the level of intent motivating them.

Three of the six who were treated in hospital following an act of self-harm were dissatisfied with their treatment, citing a lack of follow-up support.

More than three-quarters of the men (272, 77.7%) knew someone who had died by suicide (Figure 8). Indeed over 40% (148, 42.3%) knew more than one person.

Almost 1 in 5 of the men (61, 17.4%) had a close friend who died by suicide while over 60% (213, 60.9%) were acquainted with someone who died by suicide. One in twenty (17, 4.9%) had lost a close relative to suicide, whereas a more distant relative of 14 men (4.0%) had died by suicide.

Suicidal Ideation

A further series of questions investigated lifetime experience of thoughts relating to death and suicide (Figure 7). **Almost 40% (129, 37.7%) indicated that they had at some point felt that life was not worth living while more than one in four had at some point wished that they were dead (95, 27.7%) and a similar proportion had thought of taking their life although not necessarily with any intent (97, 28.2%).** One in nine (39, 11.4%) had seriously considered suicide at some point while 13 (3.8%) indicated that their thoughts included a plan of how they would carry out their suicide. Twenty-five men (7.4%) had at some time told someone that they were going to die by suicide or that they might do it. **Almost half of the men (162, 47.0%) experienced at least one form of suicidal ideation**, although the most common positive response was to the question 'Have you ever felt life was not worth living?' (37.7%).

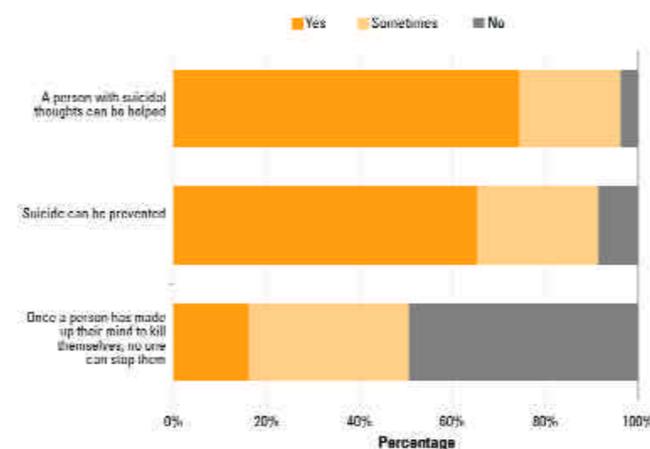


Figure 8. Relationship to people who died by suicide

Comparison by demographic characteristics

A very positive attitude towards the preventability of suicide was less likely among men who were living with their parent(s) (50, 32.9% vs. 74, 45.1%; $p = 0.026$) and among men who were employed (50, 36.0% vs. 48, 51.6%; $p = 0.018$).

Employed men reported a lower prevalence of thoughts of death and suicide (63, 44.4%) when compared to those who are not in employment (56, 56.6%) though this difference was only marginally significant ($p = 0.062$).

Men aged 25-34 years had experienced greater exposure to the suicides of others ($p = 0.022$) with half of them (80, 50.0%) personally knowing more than one suicide compared to just over one-third (66, 35.9%) of the 18-24 year-old men. There is obviously an age bias in this finding.

SOURCES OF SUPPORT

Participants were asked to indicate on a provided checklist who or what they turned to for support (Figure 9). **Almost 60% of the men indicated that they would turn to their mother for support (207, 59.7%).** That is far higher than the proportion that would turn to their father (122, 36.9%). Just over half of the men (183, 50.8%) indicated that a friend was a source of support while **just over 40% of the men with partners (136, 42.0%) turned to their partners.** This is slightly higher than the proportion that would turn to a sibling (128, 36.7%). A smaller number would turn to health professionals (42, 11.7%) or a work colleague (36, 10.0%). Thirteen men (3.8%) indicated the 'other' category. Religion/God and relatives accounted for the majority of these other sources of support. Fifteen men (4.2%) indicated that they do not turn to a close relative, partner or friend for support.

Note: The percentages illustrated were calculated with adjustment for those whose mother or father had died and for those with no siblings or partner.

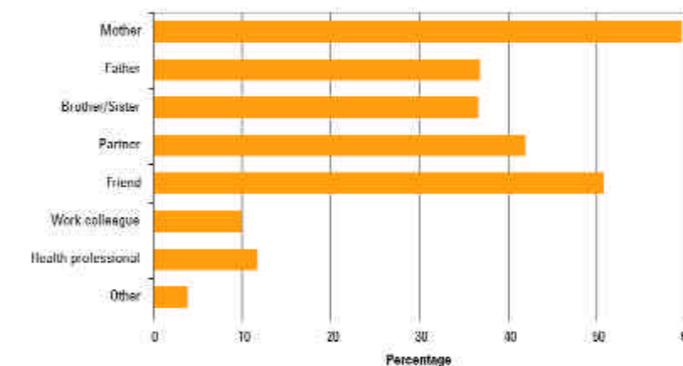


Figure 9. In general, who or what do you turn to for support?

Comparison by demographic characteristics and attitudes towards / experience of suicidal behaviour

The younger men (18-24 year-olds) were more likely to say that they turn to their mothers for support (121, 66.5% vs. 81, 52.9%; $p = 0.012$) as were those living with their parents (112, 68.7% vs. 78, 49.1%; $p < 0.001$).

The likelihood of indicating their mother as someone the men would turn to for support was not associated with their attitudes towards the preventability of suicide, their experience of suicidal ideation or their exposure to suicide.

None of the men's demographic characteristics were significantly associated with their likelihood of choosing their father as a potential source of support.

However, **men who had experienced at least one form of suicidal ideation were significantly less likely to have included their father as someone they turn to for support** (44, 29.9% vs. 72, 43.1%; $p = 0.016$).

The likelihood of turning to a sibling for support was not associated with any of the demographic or suicide-related factors.

The proportion of men who turn to their partner for support was significantly higher among the employed (74, 53.6% vs. 22, 26.2%; $p < 0.001$). A higher proportion of the men who were not employed (a group predominantly made up of students) indicated that they would turn to a friend for support (56, 54.9% vs. 61, 41.5%; $p = 0.037$). Of course this finding may be confounded by the reduced likelihood of students being married or in long term relationships.

A health professional as a source of support was indicated by almost one in five of those (22, 19.0%) who knew one person who died by suicide compared to just 5% of those not exposed to suicide (4, 5.1%) and 8% of those who knew more than one suicide (12, 8.3%; $p = 0.005$).

The older men (25, 15.4% vs. 14, 7.6%; $p = 0.021$) and the employed were more inclined to turn to a health professional (22, 15.1% vs. 6, 5.9%; $p = 0.024$).

COPING

Figure 10 summarises the frequency with which the men utilised a range of six selected coping mechanisms when worried or upset. **Nearly 90% of men at least sometimes "talk to someone" when worried or upset.** A similarly proportion said that they "get angry" sometimes or often. **About 70% of the men indicated that they sometimes or often "have a drink" when worried or upset whereas two-thirds would at least sometimes "avoid the problem by not thinking about it".** Thus, while talking seems to be a common coping mechanism, so too are getting angry, having a drink and avoidance (see Figure 10).

The men were also asked which coping mechanism they find most useful. By far the most common response, given by over two-thirds of the men who responded (150, 69.1%), was "talk to someone". "Have a drink" was given by 16 (7.4%) of the men; nine (4.1%) said they "think about how they dealt with similar situations" and another nine (4.1%) said they "think/work it out for themselves".

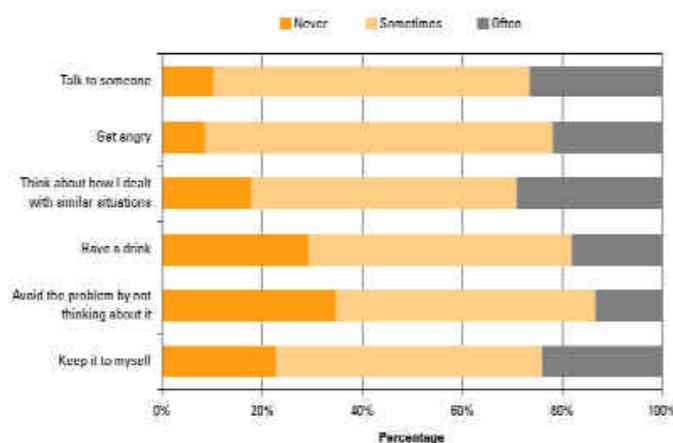


Figure 10. When you are worried/upset, how often do you do any of the following?

Comparison by demographic characteristics and attitudes towards / experience of suicidal behaviour

Men living in urban areas were less likely to say that they never "have a drink" when worried or upset (46, 24.7% vs. 41, 39.4%; $p = 0.032$).

Men with a very positive attitude towards the preventability of suicide were far less likely to say that they often "had a drink" when worried or upset (6, 5.7% vs. 44, 24.2%; $p < 0.001$). They were also more likely to say that they never "avoid the problem by not thinking about it" when worried or upset (50, 46.3% vs. 53, 29.8%; $p = 0.013$).

Those with a history of suicidal ideation were almost twice as likely to say that they often "get angry" when worried or upset (44, 30.1% vs. 25, 15.9%; $p = 0.001$) and they were twice as likely to say that they often "avoid the problem by not thinking about it" when worried or upset (27, 19.7% vs. 13, 8.6%; $p = 0.024$).

Those who had been exposed to the suicide of one person they knew were more likely (36.6%) to say that they often "talked to someone" when worried or upset compared to those who knew more than one person who died by suicide and those who did not know any suicide.

SENSE OF ANOMIE OR SOCIAL REGULATION

Figure 11 illustrates the level of agreement with the nine statements on perceived social regulation that make up the adapted Anomie Scale. Each statement is an indicator of anomie and hence agreement with a statement indicates support for the presence of anomie. The highest level of agreement (73.8%) was found for the statement regarding the disinterest of public office in the problems of the average man. About 60% of the men agreed that "the lot of the average man is getting worse" and that nowadays we must "live for today and let tomorrow take care of itself". The lowest agreement

was for the statements "it is hardly fair to bring children into the world with the way things look for the future" (27.0%) and "you sometimes can't help wondering whether making an effort is worthwhile anymore" (35.7%).

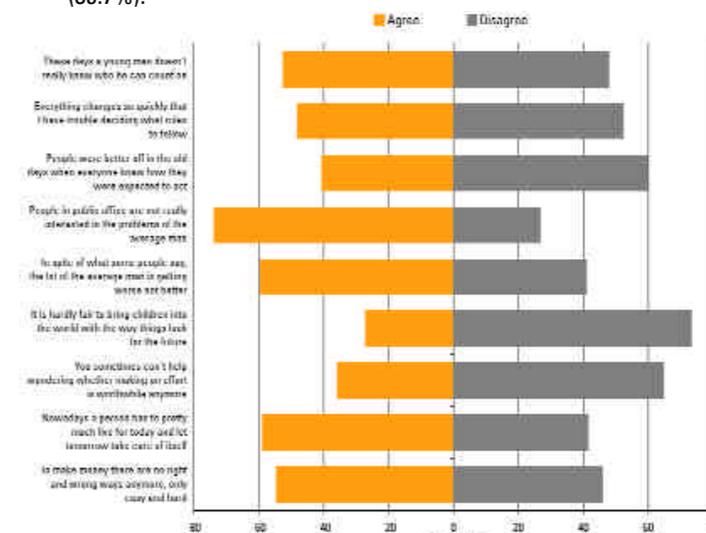


Figure 11. Level of agreement with the Anomie Scale statements

Comparison by demographic characteristics and attitudes towards / experience of suicidal behaviour

An overall score for the Anomie Scale was calculated by assigning the values -1, 0 and +1 to the responses agree, don't know and disagree, respectively for each statement. Thus, the scale score ranged from -9 to +9. The more negative the score the stronger the perception of anomie or social deregulation.

Men living with their parent(s) perceived greater anomie (mean score = -0.67 vs. +0.67, $p = 0.011$).

Perception of anomie varied highly significantly depending on whether the men had experienced at least one form of suicidal ideation. Those who had, perceived greater anomie (mean score = -0.95 vs. +1.07, $p < 0.001$).

SENSE OF CONTROL

The level of agreement with the seven statements of the Locus of Control Scale is summarised in Figure 12. Between 70 and 80% of the men agreed with each of the three positive statements. More than one in four (27%) of the men agreed both that they “have little control over the things that happen to them” and that “there is really no way that they can solve some of the problems they have”. Almost 40% agreed that they sometimes feel that they are “being pushed around in life” while half agreed that they “have often felt helpless in dealing with the problems in life”.

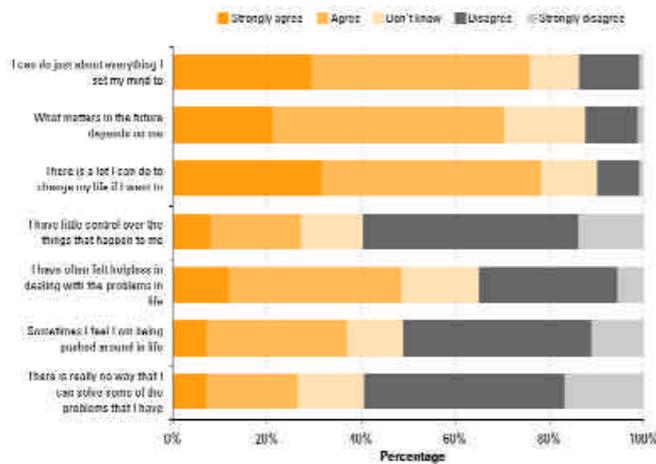


Figure 12. Level of agreement with seven statements relating to sense of control

Comparison by demographic characteristics and attitudes towards / experience of suicidal behaviour

An overall score for the Locus of Control Scale was calculated by assigning the values 5 through 1 to the responses ‘Strongly agree’ through to ‘Strongly disagree’ for the positive statements and the reverse for the negative statements. Thus, the scale score ranged from 7 to 35. The higher the score the greater the sense of internal control felt by the respondent.

Men living in rural areas had, on average, a marginally significant greater sense of internal control than urban men (mean score = 25.1 vs. 24.2, $p = 0.070$) as did men who were not living with their parent(s) compared to those who were (mean score = 25.0 vs. 24.0, $p = 0.046$).

Having a very positive attitude towards the preventability of suicide was associated with a highly significant greater sense of internal control (mean score = 25.8 vs. 23.8, $p < 0.001$).

Those who had experienced suicidal ideation had a highly significant lower sense of control over their lives (mean score = 23.2 vs. 25.7, $p < 0.001$).

HELP-SEEKING & HEALTH SERVICE UTILISATION

Type of Problems to Seek Help For

When the respondents were asked (open-ended question) about what psychological problems they would seek help for, 199 (54.8%) of the men left the question unanswered. Of the 164 men who did respond, mental health/psychological problems and particularly depression, was by far the most frequently cited type of problem for which they would seek help (41.5%). One third of the men indicated problems related to coping behaviours. Interpersonal problems were cited by almost one in ten. Nearly 7% of the men indicated that there were no psychological problems for which they would get help.

Table 1. For what psychological problems would you seek professional help?

	No.	%
Mental health/psychological problems	97	59.2
Depression	68	41.5
Mental/ psychological problems	16	9.8
Serious problems (including suicide)	8	4.9
Nervous breakdown	5	3.0
Coping behaviours	53	32.3
Drink and other addictions	18	11.0
Stress/ anxiety	11	6.7
Bereavement	10	6.1
Bad temper	8	4.9
Anger/ violence	6	3.7
Interpersonal problems	15	9.1
Relationship problems	10	6.1
Family problems	5	3.0
None	11	6.7
Other	26	15.8

Barriers to Seeking Help

In a further open-ended question, the participants were asked about the barriers to accessing professional help for psychological problems. Again, more than half of the men did not respond (211, 58.1%). Among those who did respond, the most common barriers to getting professional help for psychological problems were their dislike of talking to strangers about problems, the cost, the embarrassment and shame, concerns about confidentiality / people finding out and stigma.

Table 2. What would put you off getting professional help for psychological problems?

	No.	%
Dislike talking to strangers re: problems	26	17.1
The cost	23	15.1
Embarrassment and shame	21	13.8
Confidentiality/ people finding out	19	12.5
Stigma	11	7.2
Prefer to sort myself out	10	6.6
Dislike medication/ drugs	6	3.9
Too many questions	4	2.6
Time/ waiting for help	4	2.6
Fear something wrong/ admitting problem exists	4	2.6
Possible lack of understanding	4	2.6
Peer pressure	3	2.0
Talking to someone I know	3	2.0
Hassle and inconvenience	3	2.0
Other	29	9.9

Experience of Problems

When asked about serious personal, emotional, behavioural or mental health problems, more than 80% of the men (286, 83%) reported having few or no such problems in the past year (Figure 13). One in eight (40, 12%) men reported having a problem in the past year for which they felt they needed professional help but they didn't try to get help. This is a worrying finding and suggests that the health services need to become more acceptable and accessible. Just 4% (13) of the total sample of men did have such a problem for which they did get professional help. A further 1% (4 men) reported that they asked for professional help but did not get it.

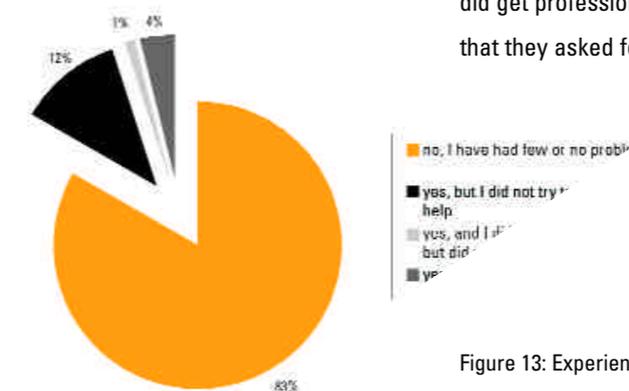


Figure 13: Experience of Mental Health Problems

Of the 40 (12%) men who did not try to get professional help despite having a problem in the preceding year for which they felt they needed such help, 29 (73%) indicated why they did not try. Among those men the barriers were primarily personal with the reasons cited including “I can handle it myself”, “no one can help me” and “I didn’t want to”. However, the most common reason cited was more of an institutional barrier, i.e. 5 of the 29 giving a reason said that help is “too expensive”.

Of the 13 (4%) men who indicated that they had a problem in the preceding year and did avail of professional help, 7 specified the professional help received. A range of supports was indicated including General Practice, social work, psychiatry and psychology services.

Using the Services

Twenty-four (7%) of the total sample had at some point used the health services for support with psychological problems. Fifteen (63%) of these men indicated what they liked about these services and fifteen (63%) indicated what they disliked about them (Figure 13). On the positive side, confidentiality and helpfulness were the characteristics most commonly cited. There was greater variation in the aspects of the services that the men disliked. The most common dislikes related to the administration of the services, e.g. waiting times and bureaucracy.



Figure 13: Perception of Services

How the Services could improve

Fourteen of the 24 men who had experience of the health services for psychological support and 14 who had never used these services responded, when asked about how the health services could be improved for men.

The most common recommendation was that more information should be available. Three of those who had no experience of using psychological support services recommended that there should be no charge, although none of those who had accessed such services made this recommendation. Other recommendations related to improving access, guaranteeing confidentiality and removing stigma.

Reasons for not needing Help

The men who have previously had or currently have problems but have never felt the need for professional help were asked to explain why. Sixty-four men (18%) responded to this question and the reasons given are summarised in Table 5 below. The most common reasons by far were that the men sorted the problems out themselves and that they talked to friends. The responses highlight an emphasis on either self-reliance or reliance on close social supports. There also seemed to be a lack of knowledge about services and a lack of confidence in them.

Table 5. If you have had, or now have, problems, but have never felt the need for professional help, please explain why?

	No.	%
Sort problems out myself	20	31.3
Talk to friends	17	26.6
Problem not serious enough for help	5	7.8
Don't know where to go	2	3.1
Never considered it	2	3.1
Cost	2	3.1
Not confidential enough - fear family or friends find out	2	3.1
Problem sorted out with time	2	3.1
Other	12	18.7

SUMMARY OF SURVEY FINDINGS

- One in four indicated they were fathers. For one in four of these their children were not living with them.
- Virtually all the men felt that, at least sometimes a person with suicidal thoughts can be helped and that suicide can be prevented.
- Almost half of the men experienced at least one form of suicide ideation. 4% had actually planned their suicide.
- Over three-quarters of the men knew someone who had died by suicide. (17% close friend, 5% close relative)
- Almost 60% of the men indicated that they turn to their mother for support which is far higher than the 37% who turn to their father.
- The majority of men with partners indicated that do not turn to them for support.
- Twelve per cent of the men said that they turn to a health professional for support when they have problems. Men who knew one person who died by suicide were more likely to say that they turn to a health professional for support. However, knowing more than one suicide actually reduced the level of profession help seeking.
- Nearly 90% of men at least sometimes “talk to someone” when worried or upset. A similarly proportion said that they “get angry” sometimes or often. About 70% of the men indicated that they

sometimes or often “have a drink” when worried or upset whereas two-thirds would at least sometimes “avoid the problem by not thinking about it”. Over two-thirds of the men indicated that talking to someone was the most useful coping mechanism.

- About 60% of the men agreed that “the lot of the average man is getting worse” and that nowadays we must “live for today and let tomorrow take care of itself”.
- More than one in four (27%) of the men agreed both that they “have little control over the things that happen to them” and that “there is really no way that they can solve some of the problems they have”. Almost 40% agreed that they sometimes feel that they are “being pushed around in life” while half agreed that they “have often felt helpless in dealing with the problems in life”.
- When asked questions regarding the types of psychological problems for which they would seek professional help and what would put them off getting such help, the majority did not respond. This may reflect the importance (or lack thereof) that young men give to the area of psychological problems.
- Mental health/psychological problems (59%), and particularly depression (42%), was by far the most frequently cited type of problem for which the men would seek help. This was followed by difficulties relating to coping behaviours (32%) and interpersonal problems (9%).

- A strong theme emerged from the responses of the men when they were asked what would put them off getting professional help for psychological problems. They appeared to have the attitude that they disliked the idea of talking to strangers about their problems, that they felt embarrassment, shame and stigma and they were concerned about confidentiality and people finding out, thereby preferring to sort things out themselves. A key challenge in the prevention of suicidal behaviour in young men is to change this attitude.
- The vast majority of the men (83%) reported that they had few or no serious personal, emotional, behavioural or mental health problems in the past year. Of the men who reported having a problem in the past year for which they felt they needed professional help, 70% did not try to get help.
- Men who had used the health services for support for psychological problems liked that the service was confidential and helpful. Their most common dislikes related to bureaucracy.
- In terms of improving the services, the most common recommendation was that more information should be available.
- Men who had problems but never felt the need for professional help chose instead to rely on themselves and talk to their peers.

The following survey findings relate specifically to comparisons between those men who had and had not engaged in some form of suicidal ideation:

- Men who had experienced at least one form of suicidal ideation were significantly less likely to have included their father as someone they turn to for support.
- Thoughts of death and suicide were more common in men who were not in employment.
- Those with a history of suicidal ideation were almost twice as likely to say that they often “get angry” when worried or upset and they were twice as likely to say that they often “avoid the problem by not thinking about it”.
- Men who had experienced at least one form of suicidal ideation perceived greater anomie.
- Those who had experienced suicidal ideation had a lower sense of control over their lives.

FOCUS GROUP INTERVIEW FINDINGS



PROCESS

The experience of conducting the focus groups was a positive one for the facilitators and for the participants. Despite the traditional stereotyping of Irish men as being unwilling to talk openly about serious issues the facilitators/moderator found that these groups of young men had plenty to say for themselves.

In terms of the group interaction, there didn't tend to be any particular individual dominating any of the discussions. However, in all of the groups one or two of the young men tended not to speak very much. There was usually agreement on most of the points raised apart from one group, the third level students, where there was some debate regarding perceptions of social life.

DEVELOPING THEMES

The main emphasis of this aspect of the research study was to engage young men in discussion concerning four broad themes: experience of life and living, identifying problems, help-seeking behaviour and attitude to suicidal behaviour. The key questions were only used to stimulate conversation while the facilitator's involvement was primarily focused on summarising and clarifying agreement of the key issues raised by participants. The key quotes and interpretation of them are presented below under the two broad headings: Life Issues and Health Issues. The following sub-themes have been used to categorise the key quotes.

Main Themes	Sub-themes
Life Issues	<ul style="list-style-type: none"> • Social change • Working life • Education • Family life • Religion • Positive changes • Negative changes
Health Issues	<ul style="list-style-type: none"> • Help-seeking and coping with problems • Attitudes to mental health and suicide • Stigma • Negative impressions of health services • Positive impressions of health services • Experiences of using the services • Suggestions for more acceptable services

LIFE ISSUES

Social change

According to the respondents, life today for young men is vastly different from that of their fathers and uncles. A distinction was made between the different types of pressures facing young men today and those in past Irish society. The young men said that life today is physically easier but mentally tougher than in the past: *"It's a rough question...(as)...everything's changed."*
"Life is easier (now)." – is there a more elaborate quote?



Although physical and social conditions appear to have improved, respondents felt that levels of expectations have risen accordingly, leading to pressure in the domains of working life, education, and family life: “(There are) more expectations today.”

The changing nature of working life was highlighted in terms of the move away from predominantly physical labour, increased opportunity and also in terms of the increased levels of expectation:

“There is less hardship nowadays...less physical labour.”

“(They) had it tougher, for example, gathering turf...”

“They (parents) worked harder so their children could get an education”

“Nowadays people don’t need to emigrate.”

“Before having a trade meant you were set up (for life)...but there’s a lot more to it today.”

“If you don’t have one (a job) then you’re the ultimate loser.”

The increased pressure to succeed in education was also highlighted:

“(In the past) you just got your Leaving (Cert).”

“No-one respects a degree anymore.”

Family life was seen as more stressful today than in the past. This might be seen in the context of the transition from the extended family as the traditional unit in the past to the more nuclear family associated with increased urbanisation and the increase of family breakdown and single parent families (where the father is usually excluded):

“(There’s)...more stress in family life (today).”

“The expense (today) of having even one kid is a pressure.”

With regard to the comparative impact of religion on current and past Irish society, respondents felt that attitudes to religion and religious practice had changed dramatically. There were both negative and positive interpretations of the decline in religious belief and practice, with the comment “nowadays all the concentration is going somewhere else” perhaps being indicative of the breakdown in the moral framework or value system associated with anomie. It was difficult for the respondents to determine where that “somewhere else” is.

“(Religion has) a major role in the way society is changing.”

“Opinion of the church has gone down...people have stopped going (to mass).”

“Before, Sunday was a special day...today people are asking ‘why?’ ”

“(Going to mass) was drilled into them in the past...(now) Sunday morning you’re hungover.”

However, there was also a sense of religious belief and practice expressed by some of the young men:

“It’s not just about going to mass.”

“Young people...still pray.”

Positive Change

The positive aspects of being a young man in Ireland today were expressed in terms of increased openness:

“(Society today is) more open...more is accepted...there are more open attitudes.”

“...the women are easier.”

Opportunities were seen as having greatly improved:

“(Social life) – we have one, they didn’t.”

“(Access to) a world class education.”

“You can be 35 and still travelling the world.”

“You can literally do what you want.”

“(There is) a wide choice of drugs, drink and sex.”

“There were no drugs available (then)...it was all barn dances and lemonade.”

When discussing positive change an emphasis on a material set of values was expressed:

“It’s a reasonably modern country.”

“Very affluent.”

“We have more money than they would have had.”

Among some participants however, this openness and sense of opportunity presented problems:

“The best things (drugs, drink, sex) become the worst things.”

“(There is) Too much choice if anything.”

“(Extra disposable income) - the money’s burning a hole in people’s pockets and leading to...alcoholism.”

Negative Change

The discussion around negative changes in Irish society concentrated in particular around leisure and social life, especially alcohol and drug use. Recently, many social commentators and politicians have been outspoken in their condemnation of the excessive use of alcohol and drugs amongst young people. It would seem that those young men most associated with this excess are acutely aware of this problem, and that it is associated with an intrinsic link between alcohol and social life:

“There’s an over-emphasis on alcohol.”

“Social life for us (young men) means we’ll meet in the local (pub).”

“There is a lack of things to do...you can see it in (the extent of) under-age drinking.”

“Drinking is totally out of hand, especially for young people.”

“There’s no such thing as going out and having 4 or 5 pints...you have to get loaded – it’s a given.”

“We must have the highest consumption of (vodka and) Red Bull in the world!”

“Heroin and cocaine are available everywhere, even in small towns.”

“...even hash is too easy to get.”

“...it all goes back to peer-pressure...if your friends do it, you will.”

Other negative aspects of social change were expressed in terms of a negative sense of community with an underlying theme of increased expectation to be successful in the context of modern Ireland, i.e. materially successful:

“...(People are) repeating exams to get an extra 25 points.”

“The pace of the country is picking up.”

“(There is) pressure to settle down...to buy a house.”

“Keeping up with other people”

“This knocking down...it’s an Irish thing.”

“Everyone’s always looking over their shoulders.”

HEALTH ISSUES

Help-seeking and Coping with Problems

Attitudes to help-seeking revealed a reliance on the self or on tight social relationships rather than a willingness to engage the health services, which would seem to carry a certain stigma:

“(However) if it’s you, then you’d say things will only get better.”

“Seeking help is the hard part.”

“(There’s the mentality that)...no matter what the problem is, you can always sort it out yourself.”

“(Young men are) more likely to say ‘nah, nah, I’ll get through this’...”



"It's just that it's better to rely on your friends than the health services..."

"By seeing a professional you are admitting that you have a problem."

[Re: depression] "It takes men longer to admit to a problem as it is seen as a sign of weakness."

With regard to the coping strategies adopted by the men for dealing with problems, the preference expressed was for talking and having some form of social support from friends, a girlfriend, family, or through playing sport. An interesting finding from the groups was the participant's willingness to talk about serious problems, reflected below in the statement that young men talk about more than people think.

A coping strategy that might be culturally specific was referred to in a number of the groups, that is the expression of concerns with mock-sarcasm (tongue-in-cheek), e.g. "sure I'm a bit depressed but what harm". An awareness of the plight of others also seemed to be helpful in the sense that there is comfort in knowing that there is always someone worse off than yourself.

"Talk to friends and just get on with it."

"If you can talk (to a friend) you are less likely to need help."

"Good friends will know if you have a problem."

"We (young men) talk about more than people think we do."

"For real problems you'd phone your friends, but for financial problems you would phone your parents."

"You would talk to a girlfriend before any of the lads."

"Sport is a great way of coping...the rest of it will go to the back of your mind."

"Serious issues are usually brought up in a jokey way."

"You could say 'I'm depressed' (tongue-in-cheek) and

this would be laughed off...it's a way of talking without losing credit."

"...being conscious of other people's problems helps."

Other coping strategies discussed by the respondents included getting drunk or smoking cannabis. However, some of the respondents pointed out the negative aspects of such escapism, realising that the problem will still be there the next day – the fact that they continue to do so perhaps indicating a level of problem drinking. An interesting coping strategy that was mentioned was avoiding being alone. The researchers perceived that there was a sense a fear of being left alone to think about problems among the participants.

"Having a smoke (cannabis) and forgetting about it...recreational drugs...get stoned and forget about it."

"Getting pissed and (only) then talking."

"When you come down it's (the problem) still there."

"You need stimulation, distraction...on your own you just think and think."

Attitudes to mental health and suicide

The men generally felt that they would not seek help if they were suicidal, although many could not even imagine being in that frame of mind. There was also some scepticism towards the communication of suicidal intent by others although other responses suggested an understanding of the continuum of suicidal ideation.

Overall, attitudes to suicide were varied.

"95% of people who are suicidal would have gone too far to get help."

"you can only prevent it (suicide) by educating people at an early age."

"If you lose the will to live it's too late."

"What can a psychologist do?" (rhetorically)

"Can you take suicide threats seriously?"

"Considering it and going through with it are vastly different."

A number of respondents discussed the link between pressures to succeed (especially exam pressure), depression and suicide. It was also felt that alcohol didn't necessarily play a causal role in the suicide of young men. The unpredictability and impulsive nature of suicide was alluded to in particular. One implication of this is that for some men at least, you don't even consider getting help if you are suicidal.

"You can never pick out someone who will die by suicide."

"He had everything going for him' is the first thing you hear after a suicide"

"(Suicide is linked) to the pressure to do well."

"...difficulty in seeing it (suicide) coming."

(Re: local suicide of young man around exam time) "It's not just drink...he didn't leave any signs...you'd never have thought there was anything wrong with him."

"(You'd say) that guy is sound...you'd never pick him out of a crowd to do it."

Stigma

While mental health service providers wish to encourage people in suicidal crisis to engage help, the barrier of stigma around mental health issues remains. This stigma seems to apply to both the services and to individuals who are labelled as having mental health difficulties. The young men again expressed a negative sense of community in relation to the judgemental perspective of others.

"support groups should be sensitive to the impressions of society."

[Re: calling the Samaritans] "But then....(you give the impression that)..you're really in a bad way."

"Small minded Ireland."

"the problem of social labelling...(being called) 'mad' or 'crazy'...society should be more informed."

Negative Impressions of Services

When asked about their impressions of the health services and voluntary support available a lot of negative opinions were expressed especially in relation to confidentiality issues, appropriateness of services and availability of services:

"A shrink is the last person in the world you would talk to."

"[Re: discharge from psychiatric care] They put them into care and when they come out there are no services or resources to look after them."

"...for young lads with psychological problems, care or help isn't there."

"You might be embarrassed going to a GP (for psychological problems)."

"A GP will drug you out of it."

"GPs are money mad."

"He'll (GP) just refer you on or give you leaflets."

"Your putting your life in their (Samaritans) hands."

[Re: Samaritans] "(You'd say) I'm not that sad a case"

"You don't know who is listening."

"[Re: relationship difficulties] "Nobody knows how available they (counsellors) are."

[Re: treatment and care] "...it's meant to be confidential but it's not – in a town this size there are no secrets."

[Re: compromised anonymity] "...the GP's secretary would know you so they'd know your business."

"pills are no good."

[Re: sexual health] "We're all worried about catching something, but you wouldn't go to the doctor."

"You wouldn't go to a 'mental health' centre"



"All the services can be there but if the stigma is there...(you won't use them)".

"...waiting rooms are a bad thing, people watching each other."

Accessibility

One of the greatest perceived difficulties in engaging services related to accessibility. This is an issue that has been raised by the Task Force on Suicide:

"People don't know where to go for help."

"No-one knows where to go."

"They need to increase awareness of them (psychological problems and coping) right across society...telling people 'this is where to get help'"

"99 out of a hundred people in a work setting wouldn't know the steps to get help for a colleague."

"...a lot of people suffer from it (depression) but might not even recognise it."

The men were also asked about the type of problem for which they might get help and as we found in the quantitative survey the young men identified the issue of alcohol abuse:

[Re: alcohol/drugs] "You'd go to family and friends first...then AA."

"Addiction is something you have to see a professional for."

[Re: alcohol problems] "I'd be pig-headed and try to overcome the problem myself."

"You would get support, maybe AA"

Positive Impressions of Services

There were some positive impressions of available supports and some willingness to engage with the mental health services:

"Mental illness isn't a prerequisite for seeing a psychoanalyst."

"Counselling is a worthwhile option."

"They (Samaritans) might be good for people in rural areas."

"Depending on the extent of the problem (you would call) the Samaritans."

Experience

In one focus group in particular (from the probation service) a number of respondents had been engaged with the health services and, in general, the experience had been negative:

[Re: Counsellors/therapists] "...they mentally kick the shit out of you by asking questions."

"No-one can see into your brain...they try to break you down."

"I 'gave' myself depression to get anti-depressants"

"pumping pills is no good...it's better to go away for a while."

"...if you are on medication you might as well take cocaine or speed instead."

[Re: friend of respondent who later committed suicide]

"...they refused to admit him into the hospital...they don't have to give a reason."

"Social workers are wankers....she nearly sent me around the bend."

"...it was depressing me that I was on anti-depressants."

Not all of the experiences had been negative, especially in relation to services for substance abuse:

[Respondent in recovery following drug problems attending Narcotics Anonymous] "I can't get enough meetings...after the meeting I'm charged up."

"I got involved in a detox programme through my GP...and it helped me."

Men's Suggestions

Throughout the course of the discussions, the men occasionally made recommendations as to how the services might be more accessible or acceptable. At the conclusion of each discussion this question was put to each of the groups:

"There should be mandatory screening by a counsellor before anti-depressants can be prescribed."

"A sort of one-stop health shop – something like the youth services but for older men."

[RE: need and demand for such services] "Gardaí would tell you, doctors would tell you."

"Institutions are very off-putting...a walk-in centre...rather than throw someone in at the deep end."

"Something like YouthReach...(because) it builds self-esteem away from the problem...they give the person something to distract them."

"Group situations are better but maybe the right type of counselling is good....you need choice."

Before long, the issues of anonymity, confidentiality and stigma were again raised, and how these would necessarily have an impact on whether or not young men would access mental health services. One participant gave the example of a condom machine as a health service that is acceptable to men because it is discreet. Use of resources such as the Internet or helplines were seen by the respondents as ways to negotiate the problem of anonymity and confidentiality. The Internet was suggested to be particularly user-friendly:

[Re: preference for internet] "...because of the lack of personal contact"

"It's easier to express everything when you are writing - with the Internet you can really describe your problems."

While some of the respondents would not like to use helplines, others expressed a preference for talking to a stranger through a helpline, emphasising the need for choice when developing services:

"...maybe it's better to talk to someone who doesn't know you, as it would be easier to talk openly."

[Re: helplines] "I'd say it's brilliant."

"I'd prefer to talk to a stranger....because it would be objective."

The point was also stressed that health services need to come to young men, rather than vice versa. In this context the present focus group discussions were seen by some of the men as a positive initiative by the Health Board. It was also suggested that targeting young men through sport is a viable method of mental health promotion, especially as there might be a ripple effect, the men involved in sport will be able to influence attitudes to health and the health services of their friends that don't play sport.

(Through sport) "It's a good way of reaching people."

"...you'd laugh it off at first but it would be good to know – 1 or 2 out of 20 might be interested." (on a football team)

"Every guy who plays sport will have 10 or 15 friends who don't, who he could help."

Another relatively consistent view was of the necessity of introducing mental health promotion and education at a young age.

"Simple relaxation courses could be brought into secondary school."

"It goes back to education."

SUMMARY

The key findings emerging from the focus groups were:

- Life was seen to have changed dramatically for young Irish men in comparison to the previous generation
 - Irish society is very open today, with a wealth of opportunities and experiences available to young men. Such conditions, however, were seen by the men to increase expectations and lead to increased perceived pressures, as well as problems such as alcoholism.
 - While psychological problems such as depression were acknowledged and seen as widespread, the men broadly agreed that they would try not to resort to getting professional help.
 - Most of the men indicated that they would be most likely to avail of social support for problems from friends, family or partners.
 - Women were perceived to be more open and better at coping with psychological problems than men, and there was the view that men should be more like them in this regard.
 - With regard to feeling suicidal and accessing professional help, many men felt those who were suicidal were too far gone to be helped, were sceptical about the expression of suicidal intent, and viewed suicide as a very unpredictable event.
- Attitudes toward the health services for dealing with psychological problems were broadly negative. The main concerns were an over-reliance on medication by doctors, stigma, and concerns about anonymity and confidentiality. Other barriers mentioned were the lack of awareness of such services and knowledge on how to access them.
 - Support services that were endorsed by the men were Alcoholics Anonymous, Samaritans, and helplines.
 - The Internet was suggested as a practical medium for help seeking and suicide prevention, in that it helped to overcome concerns about stigma and confidentiality.



discussion

HELLO YOU DON'T WANT TO
MASCULINE EXPERIENCE
SUICIDE RESOLVE
ME

d i s c u s s i o n

Suicide is a serious public health problem in Ireland especially among young men in their twenties and thirties. Having had a very low suicide rate, Ireland's young now have the second highest suicide rate of the 30 OECD member countries. This increase has occurred during a period of rapid social transformation. Ireland has changed from being a traditional society guided by strong moral values and sense of community to a more open society with an emphasis on individual responsibility and material gain. Ireland's experience is similar to other western industrialised societies in the manner described by Eckersley[Eckersley, 1993 #53], whereby our culture "may be failing to provide its young with a sense of belonging and purpose and so a sense of meaning and self-worth". The cultural changes experienced in Ireland have impacted on the individual's ability to enjoy life, cope with everyday stress, and seek help when appropriate.

The men in this study clearly recognised that life in Ireland had changed dramatically. They saw Irish society as being very open today, with a wealth of opportunities and experiences available to them. However, with these positive changes, the men also felt an increase in expectations and pressure to be successful. This pressure was felt in the areas of education, "where the pressures start", employment "if you don't have a job, you're the ultimate loser" and family life where there is "pressure to settle down...to buy a house and to keep up with other people".

Overall, the men's perception of life today was quite negative with more than half of those surveyed feeling that "the lot of the average man is getting worse" and that nowadays we must "live for today and let tomorrow take care of itself". This negative perception of life today was most pronounced in the young men who were still living with their parents, a group that

comprised half of those surveyed. Their negative attitude may be seen in the context that they recognise the pressures to succeed but have yet to achieve independence from their parents. These young men may well be living in that space between social goals and social means, where despite the expectation to be all you can be, to individuate and become an adult, the means of achieving such independence is unavailable.

Along with young men's perceptions of society and social expectations, the survey examined perceptions of self-control. The vast majority of the men surveyed (75%) agreed that "I can do just about everything I set my mind to". However, more than one in four agreed that "I have little control over the things that happen to me" and that "there is really no way that I can solve some of the problems that I have". Almost 40% agreed that they sometimes feel that they are "being pushed around in life" while half agreed that they "have often felt helpless in dealing with the problems in life". Thus, while the majority of 18-34 year-old men feel relatively confident with living in today's society, there is a significant minority who identify themselves as being vulnerable and ill equipped to cope with life.

These vulnerabilities may be reflected in the prevalence of thoughts of death and suicide found in the survey. The severity of suicidal ideation reported ranged from thoughts without intent (38%), to seriously considering suicide (11%) and to actually making a suicide plan (4%). Overall, almost half of the men reported having some form of suicidal ideation in their lifetime. Nearly 1 in 20 (16, 4.6%) reported having engaged in deliberate self-harm in the past, most of whom were not treated in hospital.

As might be expected, a clear association between a lower sense of perceived internal control and suicidal

ideation was found ($p < 0.001$). Men who had thought about suicide were more inclined to feel that luck, chance or "others" had more of an influence on their lives than their own personal actions.

Over three quarters of the men (78%) knew someone who took their own life and 20% indicated that they had a close friend who died by suicide. This reflects the increased numbers of young people dying by suicide in Ireland. The impact of the suicide of a close friend may be difficult to establish but it should be noted that such an experience increased the likelihood that men would seek professional support for psychological problems. Such findings really underline the potential positive impact of suicide bereavement support for young men, possibly in a peer group setting. The services available at present should be reviewed in order to ensure that acceptable and appropriate bereavement support services specifically targeting young people are readily available.

In general, a positive response to the concept of suicide prevention was reported as almost all of the respondents agreed that suicide can be prevented and that a person with suicidal thoughts can be helped. A positive attitude in society towards suicide prevention will greatly increase the chances of prevention strategies being effective and therefore these findings are welcome.

When the men in the survey were specifically asked who or what they turn to for support, almost 60% indicated that they turn to their mother whereas only 37% turn to their father. This highlights the importance of the mother-son relationship and the absence of a supportive relationship between young men and their fathers. Family structure in Ireland has changed significantly in recent years with increased separation

and divorce, generally resulting in a diminished role for fathers. This is reflected in the profile of the men surveyed whereby one in four of those who were fathers did not live with their children. Thus, the next generation of young men may be even less likely to have their fathers as a source of support. The alienation of fathers from the family may also have a negative impact on the fathers themselves. As one father put it: "not getting to see your kids is a very negative thing". Through the campaigning of groups such as The Unmarried Fathers of Ireland, the possible link between access to children / custody rights and suicide has been highlighted recently.

Only 40% of men with partners indicated that they turn to their partner for support whereas half of those surveyed turn to a friend. This implies that for young men, who may be in the early stages of a relationship, friends are more often used as a source of support. Less than one in eight men said that they turn to a health professional for support. If mothers and friends are the most common sources of support for young men, then there is a need to consider how they may be equipped to provide the most appropriate support. One approach in relation to friends might be to develop peer support programmes in schools, colleges and in the work place.

Despite the limitations in their support network, nearly 90% of the men indicated that they at least sometimes "talk to someone" when worried or upset and over two-thirds indicated that this was the most useful coping mechanism. However, almost 90% said that they sometimes or often "get angry" when upset or worried and about 70% sometimes or often "have a drink" whereas two-thirds would at least sometimes "avoid the problem by not thinking about it". The findings suggest that there is no one particularly dominant

d i s c u s s i o n

copied mechanism, but a range of positive and negative ways that men use to deal with problems. Therefore, while men do talk to others about their problems and they recognise the benefits of doing so, they may need support in dealing with their negative reactions such as getting angry, avoiding the problem and drinking alcohol. This is emphasised by the finding that those with suicidal ideation were significantly more likely to cope by getting angry, and were twice as likely to avoid problems.

Tackling the possible links between alcohol misuse and suicide will require vision given the deep-rooted unhealthy drinking style prevalent in Irish society which seems to have become worse among younger people. In the course of one of the focus groups a typical night out drinking was described as follows: "there's no such thing as going out and having 4 or 5 pints...you have to get loaded...it's a given." The reasons why alcohol abuse seems to be increasing could be related to a more general malaise among young people with obvious detrimental knock-on effects.

When asked questions regarding the types of psychological problems for which they would seek professional help and what would put them off getting such help, the majority did not respond. This may reflect the importance (or lack thereof) that young men give to the area of psychological problems. A mental health/psychological problem (59%), and particularly depression (42%), was by far the most frequently cited type of problem for which the men would seek help. This was followed by difficulties relating to coping behaviours (32%) and interpersonal problems (9%). However, it was clear from the focus groups that professional help was seen as a last resort with the attitude predominating that "no matter what the problem is, you can always sort it out yourself".

A strong theme emerged from the responses of the men when they were asked what would put them off getting professional help for psychological problems. They had the attitude that they disliked the idea of talking to strangers about their problems, that they felt embarrassment, shame and stigma and they were concerned about confidentiality and people finding out. A key challenge in the prevention of suicidal behaviour in young men is to change this attitude. Central to this challenge is the need to improve knowledge and understanding of what type of treatments and therapies are offered by the mental health services so as to answer questions such as "what can a psychologist do?" as was asked in one focus group.

One in six men (17%) reported that they had a serious personal, emotional, behavioural or mental health problem in the past year for which they felt they needed professional help. However 70% of these men did not try to get help. It is particularly worrying that even when a young man recognises that he has a serious problem for which he needs professional help, no effort is made to access such help in the majority of cases. This is very relevant to suicidal behaviour in Ireland as it has been found that the majority of young men who die by suicide have not been in contact with health services in the month prior to death.[Public Health Departments, 2001 #39]

For the small number of men that did access the health services, the aspects that they liked were confidentiality, helpful attitude and kindness. It was suggested by the young men that the health services could improve by being more flexible, by reducing administrative red tape and by making the service more accessible.

CONCLUSION

There are aspects of the suicide problem in Ireland that differ from most other countries, for example the gender ratio between men and women is among the highest in the world and the suicide rate peaks in the younger age groups. This is not the case in most countries where the risk of suicide increases with older age.

To address this problem it is beneficial to engage young men in research. In doing so, the following issues have been identified in the present report:

- Avoidance of problems
- Tendency to get angry
- Over use of alcohol
- Negative impression of Irish society
- Over reliance on the self
- Limited use of social support networks
- Limited consideration of their mental health
- Lack of knowledge about existing services
- Distrust of existing services

In addition to these general problems the study also identified that there is a significant minority of young men who are particularly vulnerable. This group of young men identified themselves through their responses to the anomie scale, the external locus of control scale, and in their reported levels of suicidal ideation and reluctance to get professional help, even when they recognise that they need it. These findings seem to support Eckersley's hypothesis that youth suicide is only the 'tip of the iceberg' of unhappiness rather than an 'island of misery in an ocean of happiness'.

Clearly, the promotion of men's emotional health requires a broad partnership approach beyond the specialist mental health services. Education services and primary healthcare services must also address the emotional needs of men. The problem of young male suicide and self-harm cannot be removed from the wider family, social and political context in which this behaviour is occurring with increased regularity.

To improve men's outlook on life in the 21st century, we need to consider the fundamental changes that have occurred in our culture and society. Social changes related to family, community and working life appear to have had a particularly negative impact on young Irish men.

A challenge, particularly relevant to suicide prevention in young men, is to overcome their tendency to rely on themselves when in difficulty. From a young age boys should be encouraged to access support from family and friends. In conjunction with this there is a need for more general information being available on mental health issues and support services. In this way parents and peers may be better equipped to provide appropriate support.

Finally, suicide prevention has come a long way in Ireland in a short space of time, from being a taboo subject towards being openly and honestly recognised as a serious social and public health problem. By further developing broad-based suicide prevention strategies Irish society more generally may become a better society to live in for everyone, including those most vulnerable.

RESEARCH

- Suicide prevention and research should have a gendered focus since the epidemiology of suicide and parasuicide differs significantly between the genders. In particular, prevention should focus on men in the age-range captured by the present study (18-34 years) as they account for around 40% of all suicides in Ireland each year.
- Further research into imitation and clustering of suicide among young men who were known to each other should be conducted. The CASE study (Child and Adolescent Suicide in Europe) being conducted by the NSRF will provide an indication of the extent to which deliberate self-harm in young people is influenced by their friends and wider peer group. Research into clustering of suicide deaths could be planned in the context of the development of a national action plan for suicide prevention.
- Bereaved men should be interviewed and asked about their bereavement and the type of supports, if any, they benefited from or that they feel they would have benefited from. Again this research might be conducted as part of the development of a national action plan for suicide prevention.
- Measures of external locus of control should be further investigated as possible predictors of vulnerability towards suicidal behaviour so that interventions with vulnerable men, for example following an episode of deliberate self-harm, might address issues related to men's sense of control over what happens to them.
- Research should be conducted into hanging as a method of suicide in order to determine any common ligatures and ligature points used in suicide in the community and explore the possibility of preventing such deaths in the future.

Health Service Development

- Support the development of General Practice settings to incorporate mental health professionals as part of a multi-disciplinary primary care team. While there are increasing numbers of practice nurses being appointed an initiative in the SHB has led to the appointment of a mental health nurse in a GP setting. This project is due for evaluation. The mental health needs of families may benefit from such improved access to mental health support at primary care level.
- Improve access to support services for young people by introducing the availability of a school mental health nurse service to primary and secondary schools and by further developing the National Educational Psychology Service.
- Clockwork- a young persons health service in Victoria, Australia should be reviewed as a possible means of improving access to health services for younger people. This is a youth focused service run by GPs, youth workers, nurses and psychologists aimed at promoting the accessibility, relevance and quality of health care for young people.
- The viability of providing a user friendly, one-stop shop service, providing health information, advice and support that is acceptable to men should be researched. Such a service, if considered viable, should be available to adult men and not targeted at young people only as 'health cafes' tend to be.
- Parents should be supported when a family member has attempted suicide by informing at least one family member of each aspect of treatment and referral and by letting them know about ongoing services that are available to support them should they feel they need it and the family member that has harmed him or herself.
- General parenting courses should be developed that focus on the emotional needs of parents and young people. Youth services, schools, community groups and health boards should work in co-operation to develop such courses.
- A more skills-based educational programme that provides parents with knowledge and skills concerning suicidal behaviour and how to respond in a crisis should be developed. Such a training programme should, ideally, be developed in collaboration with parents and be transferable as a parent led training initiative in the long-term. Such a pilot project is being developed in the WHB area, which could be reviewed by other service areas when the evaluation report becomes available through the NSRG.
- Consideration should be given to the preferences of young men when developing suicide bereavement support services. Many of these services have been developed with a strong pastoral and sometimes spiritual or religious theme. This approach may not be appropriate for young men who are increasingly likely to be atheist (over 200,000 people categorised as 'No Religion' or 'Not Stated' in 2002 Census).
- Supports should be put in place for fathers who don't get to see their children. Although such supports are often community-based where they exist, the statutory services should provide guidance and practical help to any such groups that need it bearing in mind the negative emotional impact of being alienated from the family unit.

Awareness

- Parents need to be made aware of the mental health services /resources available in their region and how and when to access them. This may require large-scale mail shots of well-researched information leaflets, public meetings and further use of the media.
- The MWHB Youthwise Guide and companion pocket book are examples of resources that provide key tips for promoting mental health in young people while also outlining the available voluntary and statutory resources. The guide and/or the booklet should be distributed to every house in the MWHB area
- Although a sustained programme for parents in relation to providing support for vulnerable children and adolescents is preferable, a once-off seminar entitled “Promoting Emotional Health in Teenagers” held in the WHB and MWHB regions might be replicated in other health board areas as a first step in creating awareness among parents of mental health issues and how to respond if they have concerns about a young person.
- The impact of alcohol and drug abuse in perpetuating impulsive behaviour should form part of a public awareness campaign focussing on mental health issues in general. The media is a positive resource in communicating the value of social drinking and the relationship between excess and loss of impulse control and suicidal acts to men.
- Any media campaigns aimed at improving the mental health and coping behaviours of young men should highlight both the benefit of existing positive coping strategies (talking especially) and the damaging impact of negative coping behaviours such as getting angry, avoiding problems and drinking.

Education setting

- Young people need to be made aware, from a young age, of where and when to get help if they feel they have problems. This awareness should be built in the context of the Social, Personal and Health Education module in schools through a step-wise programme that is offered throughout the primary and secondary school system. The ‘LifeSkills MindMatters’ module developed by the Centre for Health Promotion Studies in NUIG has been evaluated and could be considered for implementation nationally.
- Young people should be encouraged to help friends and siblings get help if they feel they have problems. Again this encouragement should be formally built into existing schools programmes such as the SPHE module
- Develop or adapt educational programmes for children to teach them about dealing with loss, whether through bereavement or changing family circumstances. The ‘Seasons for Growth’ 8-week schools based model developed in Australia may provide the template for an Irish programme.
- The two guidelines publications for schools developed by the IAS and by the MWHB should be available to and acted upon by all secondary schools in order to develop protocols of response if staff members are concerned about students or if a suicide occurs in a school.

Policy issues

- Given that young men are more likely to use firearms as a suicide method and that this method is becoming more common, safer storage of firearms should become mandatory through the introduction of gun safes. A Garda directive was recently overturned, on appeal, in the High Court but it should be followed up, if necessary by supplementing the cost of installing these safes for gun owners.
- The NARGC (representing nearly 900 gun clubs around the country) should be consulted in the development of suicide prevention strategies to ensure that their members are given every possible encouragement to ensure safe and separate storage of firearms and ammunition.
- A doctor other than the family doctor should be required to determine the medical fitness of applicants for gun licences or license renewal as it may be more difficult for a family doctor to maintain absolute objectivity, especially in smaller communities.
- Local authority housing schemes and government supported housing incentives should take into consideration the potentially negative impact emotionally and mentally on young men of not being able to attain independence in living circumstances.

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Mid-Western Health Board Men's Health Questionnaire

Everyone has problems at some time or another, and sometimes they may try to get help

1. In general, who or what do you turn to for support	Yes	No	Please tick if applicable
Mother.....	<input type="checkbox"/>	<input type="checkbox"/>	Mother deceased <input type="checkbox"/>
Father.....	<input type="checkbox"/>	<input type="checkbox"/>	Father deceased <input type="checkbox"/>
Brother or Sister.....	<input type="checkbox"/>	<input type="checkbox"/>	Have no siblings <input type="checkbox"/>
Partner.....	<input type="checkbox"/>	<input type="checkbox"/>	Have no partner <input type="checkbox"/>
Friend.....	<input type="checkbox"/>	<input type="checkbox"/>	
Work Colleague.....	<input type="checkbox"/>	<input type="checkbox"/>	
Health professional (GP, social worker, psychologist)...	<input type="checkbox"/>	<input type="checkbox"/>	
Other source.....	<input type="checkbox"/>	<input type="checkbox"/>	

If other source, please specify:

2. When you are worried or upset how often do you do any of the following things?	Never	Sometimes	Often
Talk to someone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get angry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Think about how I have dealt with similar situations.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a drink.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid the problem by not thinking about it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep it to myself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you find most helpful?

We are interested in finding out more about what the experiences, difficulties and attitudes associated with being a young man in Ireland are at the moment

3. Please indicate your agreement with these general statements:	Agree	Don't Know	Disagree
These days a young male doesn't really know who he can count on.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Everything changes so quickly that I have trouble deciding what rules to follow.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People were better off in the old days when everyone knew how they were expected to act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People in public offices are not really interested in the problems of the average man.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In spite of what some people say, the lot of the average man is getting worse not better.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It's hardly fair to bring children into the world with the way things look for the future.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You sometimes cant help wondering whether making an effort is worthwhile anymore.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nowadays a person has to pretty much live for today and let tomorrow take care of itself...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To make money there are no right and wrong ways anymore, only easy and hard.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please indicate your agreement with these personal statements:	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
I can do just about everything I set my mind to.....	<input type="checkbox"/>				
I have little control over the things that happen to me.....	<input type="checkbox"/>				
What matters in the future depends on me.....	<input type="checkbox"/>				
I have often felt helpless in dealing with the problems I life.....	<input type="checkbox"/>				
Sometimes I feel I am being pushed around in life.....	<input type="checkbox"/>				

There is really no way I can solve some of the problems that I have

There is a lot I can do to change my life if I want to.....

The following section relates to your attitude towards, and experience of, the health services.
 (if you would like to respond in greater detail, there is extra space on the last page of the questionnaire)

5. For what psychological problems would you seek professional help?

6. What are the things that would put you off getting professional help for psychological problems?

7. Have you in the past year had any serious personal, emotional, behavioural or mental health problem for which you felt you needed professional help (eg. A GP, social worker, youth worker, teacher, counsellor, psychologist, psychiatrist, telephone help-line)? Please tick one box

No, I have had few or no problems

Yes, but I did not try to get professional help?

Why didn't you try to get professional help?

Yes, and I did ask for professional help but did not get any

Why didn't you get the help you asked for?

Yes, and I did get professional help

Please specify the professional help you received

8. Have you ever used the health services for support with psychological problems? Yes No

a. What were the things that you liked about those services ?

b. What were the things that you disliked about those services?

c. How could the health services be improved for men?

9. If you have had, or now have, problems but have never felt the need for professional help, please explain why

if you would like to respond in greater detail, there is extra space on the last page of the questionnaire

The following questions concern your opinion about, and experience of suicide. There are no right or wrong answers. We are interested in your feelings about the topic.

10. A person with suicidal thoughts can be helped Yes No Sometimes

Suicide can be prevented

Once a person has made up their mind to kill themselves, no one can stop them

11. Yes No

Have you ever felt life was not worth living?

Have you ever wished that you were dead, for instance that you could go to sleep and not wake up?

Have you ever thought of taking your own life, even if you would not really do it?

Have you ever reached the point where you seriously considered taking your life?

If so, did your thoughts include a plan of how you would do it?

Have you ever told someone that you were going to die by suicide or that you might do it?

12a. Have you ever deliberately taken an overdose (eg. Of pills or other medication) or tried to harm yourself in some other way (such as cut yourself)?

Please tick the box that applies to you:

No Yes, once Yes, more than once

12b. if yes, were you ever treated in hospital following such an incident? Yes No

12c. if yes, were you satisfied with the treatment you received? Yes No

12d. please indicate why/why not:

13a. Did you know anybody who died by suicide? Please tick the box below that applies to you:

No yes, one person yes, more than one person

13b. if you knew one or more persons who died by suicide, please indicate whether he/she/they were:

close friends? acquaintances?

Close relatives? Other relatives?

AND FINALLY.....You will remain anonymous but we would be grateful if you could answer these questions:

14. Where do you live? Urban area Rural area

15. Is that in: Limerick city? Limerick county? Clare? North Tipperary?

16. Who do you live with most of the time? (Tick one)

- With parent(s)
- With partner (with or without children)
- Alone (with or without children)
- With a friend(s)
- Other

17. Are you primarily:

- A student?
- Employed?
- Unemployed?
- Other?

18. How old are you (in years)?

19. Are you a father? Yes No

20. If yes, does your child/children
Live with you most of the time? Yes No

21. Do you have a medical card? Yes No

22. Do you have health insurance (VHI/BUPA) Yes No

THANK YOU FOR YOUR HELP

In answering a questionnaire like this there are many reasons why some people may not be able or wish to be fully honest. In looking over your responses, should we:

- Accept them as fully honest
- Accept them but with some reservation
- Probably disregard them
- Disregard them as not valid

Please use the box provided below if you wish to add to any of the responses you gave earlier.
Please indicate the question number to which the response applies.