



# Young Men & Suicide Project



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A Report on the All-Ireland  
Young Men and Suicide Project



Prepared by Noel Richardson,  
Nicholas Clarke and Colin Fowler

# Ministerial Foreword

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Addressing suicide on the island of Ireland is a challenging task. The scale and breadth of factors that are associated with suicide and attempted suicide - and the complex interplay of these factors - underscores the magnitude of the challenge associated with suicide prevention.

Suicide is now a major cause of death among young males in both Northern Ireland and the Republic of Ireland, and trends are worrying and a cause for real concern. The economic downturn, and rising levels of unemployment, demand increased focus on prevention efforts. The loss of life for young people, so many of whom are male, is devastating to family and friends, and impinges on concepts and notions of community, solidarity and social cohesion.

On the island of Ireland, we have established a clear policy mandate for action in this area with the publication of 'Reach Out - The National Strategy for Action on Suicide Prevention' in the Republic of Ireland and 'Protect Life: the Northern Ireland Suicide Prevention Strategy and Action Plan'.

These policies need to be supported with effort and initiative by different agencies and sectors to make an impact and, in this instance, we are delighted that the Public Health Agency and the National Office for Suicide Prevention combined forces to support this particular initiative to identify a range of possible means to promote positive mental health among young men on the island of Ireland.

The work was undertaken by the Men's Health Forum in Ireland and was supported by the Institute of Public Health in Ireland.

This initiative, entitled the 'Young Men and Suicide Project', had four distinct phases:

- A thorough literature review to identify effective mental health promotion and suicide prevention work.
- Surveys to establish service provider perspectives.
- Focus group consultations.
- Pilot initiatives.

This report on the project is testimony to the endeavour and commitment of all who were involved. The pilot projects show promise, and the literature review is a valuable legacy for anyone seeking a greater understanding of the effectiveness of prevention strategies.

We would like to compliment the National Office for Suicide Prevention and the Public Health Agency for enabling the work to take place, and congratulate the Men's Health Forum in Ireland and the Institute of Public Health in Ireland for taking on board this difficult and demanding issue with real compassion and commitment.

We will make use of this work in our continued efforts to make a difference and save lives.



**Dr James Reilly**  
Minister for Health



**Mr Edwin Poots**  
Minister for Health,  
Social Services and Public Safety

# Thanks and Acknowledgements

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# Glossary and List of Abbreviations

Abbreviation	Meaning
<b>ASIST</b>	Applied Suicide Intervention Skills Training
<b>CBT</b>	Cognitive Behavioural Therapy
<b>CNP</b>	Colin Neighbourhood Partnership
<b>CSO</b>	Central Statistics Office
<b>DHSSPS</b>	Department of Health, Social Services and Public Safety
<b>DSH</b>	Deliberate Self Harm
<b>EU</b>	European Union
<b>GHQ-12</b>	General Health Questionnaire - 12 item scale
<b>GLBTIQ</b>	Gay, Lesbian, Bisexual, Transgender, Intersex and Queer
<b>GP</b>	General Practitioner
<b>HSE</b>	Health Service Executive
<b>IAS</b>	Irish Association of Suicidology
<b>ICGP</b>	Irish College of General Practitioners
<b>Inspire</b>	Inspire Ireland Foundation
<b>IPH</b>	Institute of Public Health in Ireland
<b>IT Carlow</b>	Institute of Technology Carlow
<b>LAS</b>	Life Attitudes Schedule
<b>LGBT</b>	Lesbian, Gay, Bisexual and Transgender
<b>MHFI</b>	Men's Health Forum in Ireland
<b>MY</b>	Mind Yourself
<b>NI</b>	Northern Ireland
<b>NISRA</b>	Northern Ireland Statistics and Research Agency
<b>North</b>	Northern Ireland
<b>NOSP</b>	National Office for Suicide Prevention
<b>NRDSH</b>	National Registry of Deliberate Self Harm
<b>NSRF</b>	National Suicide Research Foundation
<b>OSPI Europe</b>	Optimising Suicide Prevention programmes and their Implementation in Europe
<b>PDMU</b>	Personal Development and Mutual Understanding
<b>PHA</b>	Public Health Agency
<b>RCT</b>	Randomised Clinical Trial
<b>RoI</b>	Republic of Ireland
<b>SEHSCT</b>	South Eastern Health and Social Care Trust
<b>SMS</b>	Short Message Service
<b>SOFA</b>	Symptoms of Fatigue and Anergia
<b>South</b>	Republic of Ireland
<b>SPA</b>	Suicide Prevention Australia
<b>SPHE</b>	Social, Personal and Health Education
<b>UK</b>	United Kingdom
<b>USA</b>	United States of America
<b>WEMWBS</b>	Warwick-Edinburgh Mental Well-Being Scale
<b>WHO</b>	World Health Organisation
<b>YMSP</b>	Young Men and Suicide Project



**Young  
Men &  
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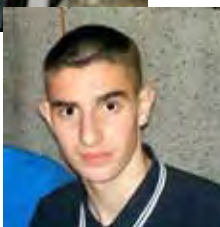
**An Executive Summary Report  
on the All-Ireland  
Young Men & Suicide Project**





# Young Men & Suicide Project

## Executive Summary



## Young Men & Suicide

Suicide is a major cause of death among young males on the island of Ireland. Over the past ten years, the rate of deaths from suicide has been five times higher in males than in females. Although the rate of male suicide in Ireland is relatively low within the overall European Union (EU) context, the rate among young males is amongst the highest in the EU. The recent spike in suicide rates among young males in both Northern Ireland and the Republic of Ireland coincides with the economic downturn and increasing levels of unemployment. On the island of Ireland, hanging is the most frequent method of suicide; particularly among young men. Although rates of attempted suicide and deliberate self harm (DSH) have, overall, been traditionally higher among females, rates of DSH are now higher among younger males than younger females.

## Policy Responses

Policy responses in the North (Northern Ireland) and the South (Republic of Ireland) are based on a public health model, and adopt both a general population approach and a targeted approach. These policies distinguish between strategies at a Primary Level (suicide awareness, skills based enhancement and restriction of lethal means) and at a Secondary Level (screening for vulnerable adolescents, gatekeeper training, media education, crisis intervention, crisis centres and suicide hotlines). The case, therefore, for an increased focus on mental health promotion and suicide prevention among boys and young men is unequivocal, and is underpinned by a strong evidence base and a clear policy mandate. The All-Island Suicide Prevention Action Plan identified the Men's Health Forum in Ireland (MHFI), in partnership with the National Office for Suicide Prevention (NOSP), as being well positioned to develop and implement relevant actions relating to suicide prevention in young men. This prompted MHFI to develop a proposal which led to the establishment of the Young Men and Suicide Project (YMSP).

## Aim of YMSP

The aim of the Young Men and Suicide Project (YMSP) was to identify a range of possible means to promote positive mental health among young men on the island of Ireland, and to assess the efficacy of these approaches.

## Objectives of YMSP

There were four key objectives to this project:

- Review existing mental health promotion and suicide prevention services and programmes (both national and international), in order to identify principles of effective practice when encouraging positive mental health among young men.
- Coordinate a stakeholder engagement process to share best practice - both online and face-to-face.
- Develop and pilot two practical initiatives which utilise the information generated.
- Report on the learning gleaned, and offer recommendations to inform future programmes / campaigns which focus on the mental health of young men in Ireland.

## Phases of YMSP

The YMSP had four discrete phases:

**Phase 1 ...** A thorough search of both the academic literature and the 'grey literature' to identify evidence of effective mental health promotion and suicide prevention work with boys and young men.

**Phase 2 ...** An online survey comprising two questionnaires; each one targeting a discrete service provider group:

### Survey 1

This survey was used with mental health service providers, and sought to explore: (i) the extent and nature of current mental health promotion and suicide prevention work on the



island of Ireland among boys and young men; and (ii) service providers' perspectives on the challenges and opportunities when working with the target group. This was set within the context of the issues raised in the literature review.

### Survey 2

This survey was used with organisations who work generally with young men and sought to map, more broadly, the type of work that is being carried out on the island of Ireland with young men and boys - not just in the area of suicide prevention, but in the areas of personal development, community development and social inclusion etc.

**Phase 3** ... Involved focus group consultations with: (i) key stakeholders from across the island of Ireland; and (ii) young men from the target age group.

**Phase 4** ... Comprised two practical pilot initiatives (one North and one South) that were based upon learning from the literature review and stakeholder engagement phases of the YMSP.

Ethical approval was granted by the Ethics Committee in the Institute of Technology Carlow prior to undertaking the research.

## Risk Factors for Suicide in Young Men

The key factors that influence youth and adolescent suicide are categorised into individual, familial and socio-demographic risk factors. The factors most consistently associated with the rise in young male suicide are income inequality, family relationship difficulties, peer relationship problems, school failure, low self esteem and violence. Gender has also been implicated in increased suicide risk among young men.

### The key factors that mediate the relationship between gender and suicide include:

- Methods used - men are more likely to use violent methods.
- Mental illness - whilst there are higher rates of mental illness diagnosed in

women, men are less likely to seek help; with male depression often being suppressed and manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour.

- Alcohol and substance misuse - these tend to be higher in young males, and are associated with increased suicide risk.
- Use of health care - men tend to access services less frequently than women. The main reasons cited by young men for not getting help with a problem include embarrassment, shame, stigma, confidentiality, and the fear of others finding out.
- Sexuality - some men experience stigma and shame associated with being gay, and higher rates of suicide are common among gay men.
- Social and community factors - such as rapid societal change, changing gender roles, and the socio-economic impact of recession.
- Marital and parental status - there is a higher risk in divorced and widowed men.
- Other social and community factors - including living and working conditions, unemployment and socio-economic status.

In the context of the more recent spike in suicide rates in Ireland, an examination of time series data reveals a causal link between rising unemployment and higher levels of alcohol consumption and increased suicide mortality among younger males. Other factors that are associated with increased suicide risk in young men include:

- Relationship breakdown.
- The accumulation of stress.
- Unhappiness, panic and anger that has remained unresolved over a long period of time.
- Impulsive behaviour associated with alcohol use.
- Awareness of a suicide script.
- Bullying and problems with identity.
- Being tied to the maintenance of a traditional masculine identity.



It has also been documented that whilst the problems that sometimes burden young men might be regarded by others as trivial, they may in fact be perceived and experienced as major problems for young men themselves. An Irish study, involving young men who had recently attempted suicide, reported high levels of emotional distress, and a difficulty among study participants in identifying symptoms of and managing emotional distress. Young men need to see emotional expression as a skill that improves with practice, and need to build an emotional vocabulary and be able to access the vulnerable feelings that are likely to underpin expressions of anger.

### Within the Northern Ireland context, a number of gaps have been identified in relation to supporting young men who may be at risk of suicide and self harm, including:

- A general absence of work that specifically targets young men.
- A lack of support in terms of raising awareness of the particular considerations for work with young men and for designing effective interventions with them.
- The absence of work focused on personal development and mental health promotion with young men.
- The absence of robust evaluation on 'what works' with young men.

The scale and breadth of factors that are associated with increased suicide risk, and the complex interplay of these factors, underscores the magnitude of the challenge associated with suicide prevention.

## Tackling the Complexity of Suicide Prevention in Young Men



A number of additional factors that contribute to the complexity of tackling suicide in young men must also be considered. These include:

- The need for a multi-dimensional whole of government approach, and for a truly comprehensive partnership model to suicide prevention work with young men.
- The difficulty with measuring effectiveness of interventions - in light of the base rates in populations being low. This makes it difficult to extrapolate differences in rates before and after interventions.
- Other methodological limitations that continue to hamper the development of 'evidence-based' interventions.
- (Young) men's reluctance to seek help and to access conventional health services.
- The challenge of reducing means to harm.
- Problems associated with transferring good practice from one setting to another - whilst it is tempting and understandable to wish to do so, it may not, necessarily, result in the desired outcomes because suicide is so intrinsically linked to socio-cultural factors.
- The rush 'to do something about the problem' - whilst often politically expedient, this may not always be backed up by good evidence.

## Suicide Prevention & Young Men – What Works?

The two key factors that are known to be effective in reducing suicide rates are physician education in depression recognition and treatment, and restricting access to lethal means of suicide.

Efforts to reduce suicide through limitation of access to methods can be categorised into endeavours that limit physical access to suicide methods, and those that attempt to reduce the cognitive availability of suicide. Other interventions - such as influencing how the media report suicide, pharmacotherapy, screening for at risk individuals, chain of care after a suicide attempt and psychotherapy - require further testing and evaluation to understand their short and long-term outcomes in relation to reducing suicide rates.

The efficacy of community education programmes has been found to be limited - in large part because such programmes often fail to reach the target groups who are most at risk. However, long-term programmes that utilise a commitment of the society at multiple levels, and that succeed in establishing a community support network, have been shown to effectively reduce suicide rates. Early intervention in childhood has been shown to be particularly effective. There is also encouraging evidence in relation to the use of sport in promoting positive mental health among young men - as well as enhancing protection against depression and suicidal behaviour.

One of the key challenges is to interrupt the cycle of alcohol / substance abuse, depression, and developmental failure that is associated with an exponential rise in suicide among more vulnerable groups of young men.

Suicide Prevention Australia reports that universal youth suicide prevention programmes (such as restricting access to means, anti-bullying programmes, and physical health promotion) offer the best value-for-

money in reducing suicide risk among young people. However, it stresses that a comprehensive approach - which combines universal, selective (e.g. gatekeeper training, suicide screening), and indicated initiatives (e.g. crisis support services, early intervention programmes) - will have the most effect in preventing youth suicide.

## Effective Practice

The following is a list of ten key principles for effectively engaging with young men in suicide prevention work:

- i. Focus on mind health or mental fitness not mental health.
- ii. Plan services and programmes with young men in mind, and work on developing trust and safety through the creation of non-threatening and male-friendly environments.
- iii. Consult and involve young men in programme development and programme delivery.
- iv. Find a 'hook', and look for avenues that appeal to young men.
- v. Target programmes early.
- vi. Target programmes to those young men most in need.
- vii. Use language that is positive and solution-focused.
- viii. Consider the use of role models and marketing in suicide prevention work with young men.
- ix. Consider the potential of peer support and mentoring.
- x. Evaluate what type of suicide prevention interventions work with young men.

Some examples of effective practice interventions that have been highlighted in the YMSP Full Report include Mind Yourself, Back of the Net, Frameworks, Alive and Kicking Goals, OSPI Europe, MoodGym, Coach the Coach and Incolink.



## Outcome of Online Stakeholder Surveys

Respondent organisations worked across a broad range of settings, and offered a spectrum of prevention and intervention work - with training, health promotion and suicide awareness raising being the most prevalent. Just over one third of these organisations reported that they specifically targeted young men as part of their work. A broad breadth of work was identified by the organisations that reported specifically targeting young men. This included:

- Work with a personal development focus - such as physical and emotional health training in schools, mental and emotional wellbeing, resilience building, and mentoring programmes.
- Counselling and group work, including the provision of outreach and crisis support, youth work, and work with young gay men.
- A range of education, advocacy and suicide prevention awareness programmes.
- Promoting improved access to services through enhanced signposting and referral mechanisms, and encouraging help-seeking.
- Tackling violence, criminal behaviour and working with criminal justice referrals.

Although just over half of respondents reported being effective across a range of capacity defining measures in delivering suicide prevention and mental health awareness work to young men, it was acknowledged, nevertheless, that there was significant scope for enhancing and supporting the capacity of service providers to effectively engage with young men. The key barriers to effectively engaging with young men that were cited included: lack of knowledge and expertise; insufficient funding; lack of training; the absence of partnerships.

In terms of organisational and structural barriers associated with successfully targeting young men, respondents cited: young men's inability to communicate effectively about mental health and emotional wellbeing; inadequacies within existing services; shortfalls in communicating effectively with boys / young men; the need for early intervention; lack of research on creating effective partnerships; lack of follow-up on research recommendations.

Whilst between a half and two-thirds of respondents reported being effective across a range of measures in reaching out to young men, a number of key challenges and barriers to working with young men were identified. These included: issues relating to communication, disclosure and seeking help; accessing, engaging and sustaining commitment; problems relating to alcohol and substance abuse; unemployment, lack of opportunities and disadvantage.

The key organisational needs required to engage with young men were seen as being increased resources, training and partnerships, and the provision of relevant, effective and targeted programmes. Conversely, respondents cited a number of factors that were found to work well in suicide prevention and mental health promotion work. These included:

- Activities or programmes with a personal development focus and with a strong emphasis on developing open communication, trusting relationships, and promoting help seeking behaviour.
- The importance of good staff and role modelling.
- Building relationships between services, and creating good networks and liaisons with effective referral.
- Client developed and led services.



### In summary, the respondents 'top priorities' were:

- Awareness raising and signposting - recognising signs and symptoms, and knowing where and how to access support.
- Resources - funding and staff to carry out such work.
- Age and gender specific community-based services.
- Mental health promotion and personal development for young men - with a focus on building resilience, reducing stigma, teaching positive life skills, and encouraging emotional communication.
- Training for frontline staff on all aspects of suicide prevention and the most up-to-date examples of effective practice.
- Challenging masculine ideology and improving young men's help seeking behaviour.
- Early intervention, and the provision of appropriate services for those most at risk.

## Feedback from Stakeholder Focus Groups

Among the most pertinent issues highlighted in the stakeholder focus groups were:

- The perceived challenges associated with communicating with young men.
- How to encourage help seeking behaviour amongst young men.
- Overcoming what is regarded as a persistent stigma attached to mental illness and mental health.
- Addressing young men's awareness of mental health / well-being, and their lack of 'life skills'.
- The paucity of services that specifically address young men's needs.

Stakeholders also discussed what they felt had worked - from their perspective - and what was needed in relation to the development of suicide prevention and mental health promotion work with young men. Of particular note, was the significance of: 'a life takes over' approach; taking advantage of 'windows of opportunity' for engaging with young men; the importance of persistence and perseverance in working with young men.

**The key issues which arose in the focus group with young men included:**

- Young men's fears and struggles.
- Negative perceptions of young men at a societal level.
- The 'pros and cons' of online technologies.
- The negative connotations associated with 'mental health'.
- Problems associated with bullying - particularly in schools.
- The challenge of disclosure within a macho culture.

Among their suggestions for improving the mental health of young men were: the need for early interventions; the importance of open, respectful, two-way communication; the need to develop confidence in dealing with disclosure.

## Pilot Interventions

Based upon learning from the literature review and the stakeholder engagement process, the YMSP Advisory Group agreed that the two pilot initiatives should focus upon ...

- A 'whole community approach' in Northern Ireland.
- The use of online communications / social media with young men in the Republic of Ireland.

The Northern Ireland intervention was called 'First Instinct' - the underlying goal being to encourage and foster a first instinct in young men which is to seek help and support at times of difficulty rather than taking their own lives or engaging in other self-destructive behaviours. It was based in the Colin area - situated between Lisburn and West Belfast. There were four main elements to this intervention:

- Training for Trainers was offered to local practitioners to enable them to deliver the 'Mind Yourself' (an evaluated, brief, mental health intervention aimed at adolescents) programme in schools.
- Specialist support was offered to enable the Colin Neighbourhood Partnership to develop a Young Men's Advisory / Reference Group for the area.

- Local practitioners were offered priority places at training / workshops / seminars which focused upon developing work with men and boys.
- A range of off-the-shelf group work resources / reference materials were acquired to help practitioners to better understand the world in which young men live, and offer them practical suggestions for group work activities with young men.

The pilot intervention in the Republic of Ireland focused upon the development of an online mental fitness programme for young men called 'Work Out'. This initiative was undertaken in collaboration with the Inspire Ireland Foundation. The Work Out programme was modelled on an application which was originally developed by the Inspire Foundation in Australia - working collaboratively with the Australian Brain and Mind Research Institute. The materials within it were chosen because of the strong evidence base which indicated that they can have a positive impact upon the mental health of young men. The programme addresses four main areas:

- Being Practical
- Building Confidence
- Taking Control
- Being a Team Player





## Conclusion & Recommendations

In conclusion, there can be no quick-fix solutions to tackling the extensive and complex causes and risk factors that underpin the very grave statistics on suicide in young men. These causes and risk factors are diverse and intersecting. The challenge of reducing suicide rates in young men demands a very comprehensive and multi-layered response that seeks to intervene at a number of different levels, and that involves a range of key stakeholders.

There can no room for inertia or ambivalence - there is both a public health and a moral requirement to act. It is not enough to be seen to act. There needs to be more concerted efforts to engage more effectively and in a more sustained way with young men, and to act in accordance with the best evidence that is available.

The report on the YMSP provides a blueprint and a roadmap for action that, it is hoped, will act as a catalyst for more focused efforts in tackling suicide in young men in the years ahead. The key recommendations from the report are:

- R1 Develop and promote positive models of mental health that are specifically targeted at boys and young men.**
- R2 Adopt a whole of government, joined-up approach, to young men's mental health.**
- R3 Plan services and programmes for and with young men, and work on developing trust and safety through the creation of non-threatening and male-friendly environments.**
- R4 Target early intervention and the provision of appropriate services at those most at risk.**
- R5 Expand interventions that tackle alcohol and substance misuse in young men.**
- R6 Challenge traditional masculine ideology that is associated with impaired help seeking behaviour in young men.**
- R7 Incorporate role models and marketing into suicide prevention work with young men.**
- R8 Have a more explicit focus on peer support and mentoring in suicide prevention work with young men.**
- R9 Promote and encourage the use of safe and responsible online resources in mental health promotion and suicide prevention work with young men.**
- R10 Develop a one day training programme for all frontline staff on how to effectively engage with young men.**
- R11 Ensure that research underpins all on-going and future work in the area of suicide prevention with young men.**
- R12 Identify and nominate a body to coordinate and oversee future developments in mental health promotion work with young men.**




**Adopt a whole of government, joined-up approach, to young men's mental health.**

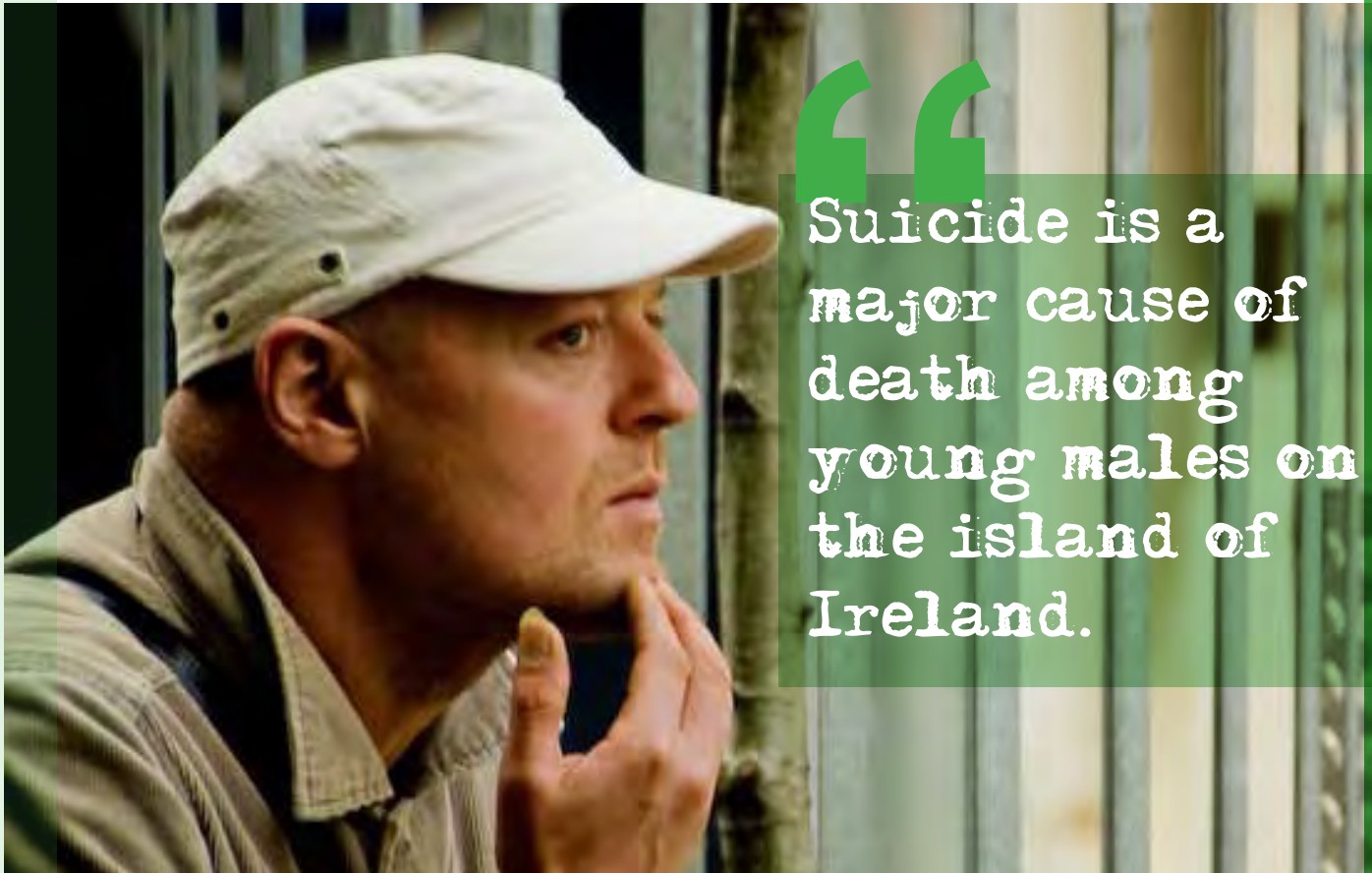




# Young Men & Suicide Project

**A Report on the All-Ireland  
Young Men & Suicide Project**





### 1. Overview of the Young Men and Suicide Project

#### 1.1 The Men's Health Forum in Ireland

The Men's Health Forum in Ireland (MHFI) is a diverse network of individuals and organisations, men and women, from both Northern Ireland (NI) and the Republic of Ireland (RoI). The Forum was established in 1999, and operates on an all-island basis. It is, primarily, structured, organised and run using the expertise, resources and enthusiasm of volunteers. See [www.mhfi.org](http://www.mhfi.org) for more details on MHFI's work.

MHFI is a charitable organisation which is registered as a Company Limited by Guarantee. The Forum seeks to promote all aspects of the health and well-being of men and boys on the island of Ireland through research, training, networking, practical health initiatives and advocacy. It is managed by a Board of Trustees.

#### 1.2 Origins of the Young Men and Suicide Project

The idea for the Young Men and Suicide Project (YMSP) was developed by MHFI in 2006. MHFI had, even before this time, recognised suicide as one of the biggest threats to young men's health, and had sought to bring stakeholders together to address this issue.

This drive by MHFI coincided with an increasing recognition among statutory bodies that male suicide is an important cross-Border issue which requires cooperation and partnership working:

- *'Reach Out - National Strategy for Action on Suicide Prevention'* (Department of Health and Children, 2005), had outlined three actions relating specifically to young men: review recent

research and service initiatives for men's health in Ireland and internationally; develop pilot mental health promotion and support initiatives for young men; provide support for young men through the voluntary sector and in community settings.

- Work with young males constituted a specific action area within *'Protect Life: A Shared Vision - the Northern Ireland Suicide Prevention Strategy and Action Plan'* (Department of Health, Social Services and Public Safety, 2006): ensure that targeted outreach programmes for young males, who may be at risk of suicide and self-harm, are available in local communities and in all Health and Social Service Trusts; implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly; enhance the role of the community / voluntary sector concerning the provision of mentoring support for young people at risk of suicide and self-harm.
- The *'National Men's Health Policy'* (Department of Health and Children, 2009) in the Republic of Ireland called for a stronger focus on mental health promotion, and for a gendered approach in the development of community-based mental health services.
- The *'All-Island Suicide Prevention Action Plan'* (2007) identified MHFI, in partnership with the National Office for Suicide Prevention (NOSP), as being well positioned to develop and implement relevant actions in the Republic of Ireland, while the 2006 *'Protect Life: A Shared Vision'* document also emphasised the potential for mutually beneficial North-South working ...

### 1.3 Funding for YMSP

MHFI applied to NOSP (Republic of Ireland) and the Public Health Agency (PHA, Northern Ireland) for joint project funding to develop an initiative. This was secured in 2011 - with two thirds of the total budget coming from the Republic of Ireland and one third from Northern Ireland. The funding was channelled to MHFI through the Institute of Public Health in Ireland (IPH), who was the grant-holder.

### 1.4 Aim of Project

The aim of YMSP was to identify a range of possible means to promote positive mental health among young men on the island of Ireland, and to assess the efficacy of these approaches.

### 1.5 Objectives

**There were four key objectives to this project:**

- Review existing mental health promotion and suicide prevention services and programmes (both national and international), in order to identify principles of effective practice when encouraging positive mental health among young men.
- Coordinate a stakeholder engagement process to share best practice - both online and face-to-face.
- Develop and pilot two practical initiatives which utilise the information generated.
- Report on the learning gleaned, and offer recommendations to inform future programmes / campaigns which focus on the mental health of young men in Ireland.

## 1.6 Advisory Group

To support the development of YMSP, an Advisory Group was established. This body was comprised of representatives from the lead partners / funders in this initiative, as well as a number of other organisations with specific experience in this field. The group comprised:

- Owen Metcalfe (Grant Holder) - Institute of Public Health in Ireland (IPH)
- Michael Lynch (Chairperson), Colin Fowler (Director of Operations) and Noel Richardson (Board of Trustees) - Men's Health Forum in Ireland (MHFI)
- Susan Kenny - National Office for Suicide Prevention (NOSP)
- Madeleine Heaney (and, in her absence, Michael Owen) - Public Health Agency (PHA)
- Martin Bell - Department of Health, Social Services and Public Safety (DHSSPS)
- Biddy O'Neill - Health Service Executive (HSE)
- Derek Chambers - Inspire Ireland Foundation
- Michael McKenna - YouthAction NI Work with Young Men Team

The role of the Advisory Group was to ...

- Offer a broad range of experience, contacts, ideas, research and resources to achieve the aims of this initiative.
- Help to guide the overall direction of the project.
- Suggest the means to achieve the operational goals.
- Promote and raise awareness of the project.
- Provide support to MHFI to meet the objectives set.
- Help MHFI to review progress.

The Advisory Group met nine times during this project, and conducted additional ongoing business via email, teleconferencing and sub-group meetings.

## 1.7 Key Achievements

The YMSP fully met all of the objectives that were set at the outset, and did so within the agreed timescale. The key achievements included ...

- A comprehensive review of international, national and regional literature on men and mental health / suicide was undertaken. This led to increased understanding of the context of the subject matter. It also helped to identify and establish key principles and models of effective practice in promoting positive mental health with young men.
- Local stakeholder input (both online and face-to-face) on 'what works' in relation to young men and mental health services / support was generated and collated. This helped to expand our understanding of the range of practical experience and expertise on the island of Ireland.
- Two pilot interventions (one in Northern Ireland and the other in the Republic of Ireland) were delivered and evaluated. The nature and location of these initiatives was informed by learning from the earlier stages of the project. The Northern Ireland initiative centred upon delivering the 'Mind Yourself' programme to Year 12 pupils in a High School, while the Republic of Ireland concentrated upon the development and launch of an online mental fitness programme for young men titled 'Work Out'.
- A final report on the various areas of learning (this document) was produced. It is hoped that the conclusions and recommendations in this paper will help to inform future policy, practice and service delivery in this field.

## 1.8 Focus of Pilot Interventions

Based upon learning from the literature review and stakeholder engagement phases of YMSP, the Advisory Group agreed that the two pilot initiatives should focus upon:

- A whole community approach in Northern Ireland (similar to the 'Frameworks / Connect' model developed in the USA).
- The use of online communications / social media with young men in the Republic of Ireland.

### Northern Ireland Intervention

The area targeted for the Northern Ireland intervention was the geographic catchment of 'Colin' - situated between Lisburn and West Belfast. Colin is comprised of the housing developments of Poleglass, Twinbrook, Lagmore and Kilwee, and has a population of approximately 30,000 people. This locality had been identified by both the DHSSPS and the PHA as the preferred target area due to the high levels of male suicide within it, the level of health inequalities, and its disadvantaged status.

The key local partners were the Colin Suicide Prevention Task Group (which included staff from the South Eastern Health and Social Care Trust - SEHSCT) and Colin Neighbourhood Partnership (CNP).

#### **There were four main elements to this intervention:**

- *'Mind Yourself'*: Training for Trainers was delivered to local facilitators in order to equip them to deliver the 'Mind Yourself' programme in schools. Mind Yourself is an evaluated brief intervention aimed at improving the mental health of adolescents. The programme was then delivered to all Year 12 pupils in St. Colm's High School, Twinbrook.
- *Young Men's Advisory / Reference Group*: In order to give a platform to the experiences of local young men, a group work programme was offered - wherein the young male participants were encouraged and supported to feel comfortable and confident about sharing their life experiences and expectations. Local youth leaders in the Colin area participated as co-workers and, in so doing, expanded their own insights and skills.
- *Training / Workshops / Seminars*: Workers from the Colin area were offered priority places at training / workshops / seminars organised by MHFI which focused upon engaging or working with men. In this way, practitioners gained a more in-depth understanding of what constitutes a 'man's world'.
- *Resources for Working with Young Men*: MHFI researched, identified and purchased a range of off-the-shelf group work resources / reference materials which could: (i) help practitioners in the Colin area to better understand the world in which young men live, and (ii) offer them practical suggestions for group work activities. These resources formed the basis of a locally-based mini-library on working with young men.



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## Republic of Ireland Intervention

The pilot intervention in the Republic of Ireland focused upon the development of an online mental fitness resource for young men called 'Work Out'. This initiative was undertaken in collaboration with the Inspire Ireland Foundation (Inspire).

The Work Out programme was modelled on an application which was originally developed by the Inspire Foundation in Australia. The materials within it were chosen because of the strong evidence base which indicated that they can have a positive impact upon the mental health of young men.

Work Out is free and easy to access. It is based upon a series of brief online interventions (called 'Missions') which utilise the principles of Cognitive Behavioural Therapy. During Work Out, young men are invited to:

- Register for an account.
- Take a comprehensive test to assess their strengths and weaknesses.
- Undertake a series of practical missions to improve their mental fitness.
- Use online reports to check (at any time) how they are improving.

The 'Work Out' programme addresses four main areas:

- Being Practical
- Building Confidence
- Taking Control
- Being a Team Player

## 1.9 Main Stages of Development

The YMSP began in March 2011 and lasted until the end of August 2012. The key stages included ...

### **March 2011: Setting-up the Infrastructure**

- Identify members for the YMSP Advisory Group.
- Issue an 'Invitation to Tender' for a research consultant.
- Appoint a research team, and begin the research contract.

### **April - June 2011: Literature Review**

- Review international literature on men's health and suicide.
- Determine the principles of effective practice in promoting positive mental health with young men.
- Identify models of effective practice for suicide prevention work with young men.
- Produce a draft report on both the principles and models of effective practice.
- Recruit members for the Advisory Group and convene the first meeting.

### **May - August 2011: Online Stakeholder Engagement**

- Draft and agree two stakeholder questionnaires: one (detailed) for people who work explicitly in the field of mental health / suicide prevention; one (shorter) for those who work with young men on a broad range of issues.
- Set-up a 'Survey Monkey' account and questionnaire template.

- Recruit participants to complete the online questionnaire.
- Conduct online stakeholder research.
- Invite suggestions on 'what works' in mental health promotion with young men.
- Analyse the data generated, and produce a draft report.

### **August - November 2011: Stakeholder Meetings and Determination of Pilot Interventions**

- Meet with a young men's stakeholder group in Cork.
- Conduct two practitioner stakeholder meetings - one in Belfast and one in Dublin.
- Analyse the data generated, and produce a draft report.
- Synthesise the key findings from the literature review and stakeholder consultation phase in order to determine the nature and location of the two pilot interventions.
- Agree that the main foci of the pilot projects should be: (i) a whole community approach - similar to the 'Frameworks Model' - in Northern Ireland, and (ii) the use of social media / networking with young men in the Republic of Ireland.
- Hold a range of meetings / teleconferences with key personnel from the PHA, NOSP, DHSSPS, HSE, Health Trusts, Youth Service, voluntary sector bodies ... to determine the most beneficial location in which to site the projects.
- Agree the partner bodies for the pilot interventions i.e. Inspire Ireland Foundation (Republic of Ireland) and Colin Suicide Prevention Task Group / Colin Neighbourhood Partnership (Northern Ireland).
- Finalise the nature of the interventions i.e. the development of an online 'Work Out' mental fitness programme for young men in the Republic of Ireland, and a package of support centred upon the introduction of the critically evaluated 'Mind Yourself' programme to pupils in St. Colm's High School, in the Colin neighbourhood.

### **December 2011 - May 2012: Roll-out Pilot Interventions and Conduct Impact Evaluation**

- Negotiate with the Inspire Australia Foundation about the use of their copyrighted Work Out materials.
  - Field-test the Australian Work Out resource with three groups of young men from Ireland - based in Carlow, Belfast and Armagh.
  - Issue / widely circulate an Invitation to Tender document for an Irish website developer to create a customised local version of the Work Out website.
  - Determine the content / feel / user journey ... of the Irish Work Out programme, and work with the website developer to operationalise this concept.
  - Meet with local youth service providers in the Colin area to explain the concept of the proposed Young Men's Forum / Reference Group.
  - Recruit participants for the Young Men's Group, and run a programme with them.
  - Offer a range of 'men's work' seminars / workshops to service providers and community activists in the Colin area.
  - Identify potential local facilitators for the Mind Yourself programme, and offer them a two day Train the Trainer programme, led by staff from the National Suicide Research Foundation (NSRF).
  - Offer additional support / skills practice days to the facilitators after the Train the Trainer programme ended.
  - Roll-out the Mind Yourself programme to every Year 12 pupil in St. Colm's High School in Twinbrook.
  - Conduct a baseline and post-programme evaluation with all participants in the Mind Yourself initiative.
- Identify group work resources suitable for engaging young men in the Colin area.

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### **June - August 2012: Test Work Out Website and Collate Evaluation Data**

- Fine tune the Work Out website's architecture / features / branding.
- Field-test the Work Out site with two groups of young men, members of the Advisory Group, and the MHFI Management Committee.
- Work alongside NSRF to determine the coding / scoring matrix for the Mind Yourself evaluation questionnaire.
- Input the data from the Mind Yourself questionnaires.
- Conduct a Focus Group with members of the Mind Yourself facilitation team, to collate their experience of delivering the programme, and their thoughts on how it could be amended for use in less formal settings.
- Prepare a report on the work undertaken to establish a Young Men's Advisory Group in the Colin area.

### **August - September 2012: Write Report and Establish Mini-Men's Work Library**

- Produce a draft report on the overall YMSP.
- Hand-over the young men's group work resource materials to Colin Neighbourhood Partnership.

### **September - October 2012: Launch Website and Finalise Report**

- Finalise and launch a 'Beta' version of the Work Out website.
- Final meetings of the YMSP Advisory Group.
- Complete and sign-off the YMSP final report - ready to design and print.

## 1.10 Methodology

The YMSP comprised four discrete phases:

### PHASE 1

This phase entailed a thorough search of both academic literature and 'grey literature' on evidence of effective mental health promotion and suicide prevention work with boys and young men:

- The research team had access to IT Carlow's library of electronic databases. A search was conducted using the most relevant databases (Pub Med, Medline, CINAHL and Scopus) using key search words ('suicide' AND 'boys'; 'suicide' AND 'young men'; 'suicide prevention' AND 'boys'; 'suicide prevention' AND 'young men'; 'mental health promotion' AND 'boys'; 'mental health promotion' AND 'young men'; 'suicide intervention' AND 'boys'; 'suicide intervention' AND 'young men'; 'suicide' AND 'policy' AND 'boys'; 'suicide' AND 'policy' AND 'young men'). Both researchers conducted independent searches, and cross-checked results prior to agreeing the final list of publications for inclusion in the literature review. Only research papers from reputable peer-reviewed publications were considered.
- A review of the 'grey literature' was also conducted using Advanced Google Search. The same key search words were used. Once again, both researchers conducted independent searches, and cross-checked results prior to commencing the review. There was a particular focus on seeking out evidence of policy responses and evaluated interventions (national and international) in the area of mental health promotion and suicide prevention with boys and young men.



## PHASE 2

Phase 2 of the research entailed an online survey comprised of two questionnaires - each targeting a discrete service provider group. The design of the questionnaires was informed by the preliminary findings and results from the literature review and via consultation with the YMSP Advisory Group.

Survey 1 targeted stakeholders, North and South, who were deemed to have an explicit brief in relation to mental health promotion and suicide prevention work with boys and young men. The participant database for the Republic of Ireland was built through a search of stakeholder organisations listed in the NOSP Annual Reports, and was verified by NOSP - with some additional suggestions for participant inclusion (totalling 107

organisations). In Northern Ireland, the stakeholder participant list was sent, by proxy, to the Suicide Strategy Implementation Group and the Mental Health Promotion Network (totalling 100 organisations). Therefore, a total of 207 stakeholder organisations were surveyed.

Survey 2 was a much shorter survey, and targeted organisations, North and South, with a broader remit in relation to social inclusion and community development. These organisations were chosen on the basis of their focus on communities experiencing disadvantage - with a view to establishing some insights into work taking place with boys and young men in these communities. In the Republic of Ireland, the survey was sent to Community Development Projects and Family Resource Centres. In addition, the MHFI Director of Operations emailed the survey link to the MHFI database of stakeholders, and included a short article and link in a number of electronic newsletters to community and voluntary groups in both the North and South of Ireland.

The questionnaires were constructed so that they were clear, easy to understand, and easy to fill in - so, minimising the amount of time required by respondents to complete them. They were constructed using fixed response questions, including Likert scales, and open-ended questions where appropriate.

Survey 1 sought to explore: (i) the extent and nature of current work in the area of mental health promotion and suicide prevention on the island of Ireland among boys and young men, and (2) service providers' perspectives on the challenges and opportunities in working with the target group (set within the context of the issues raised in the literature).

Survey 2 sought to map, more broadly, the types of work that are being carried out on the island of Ireland with young men and boys - not just in the area of suicide prevention, but in the areas of personal development, community development and social inclusion etc.

The questionnaires were completed online using 'Survey Monkey'. Data were downloaded into SPSS and Excel for analysis. Confidentiality was guaranteed to all participants who took part in the survey. All online data transferred between recipients and researchers was encrypted to ensure data security. Both questionnaires were developed following an initial drafting phase with the MHFI Management Committee, and they were then piloted with a small number of relevant stakeholders.



## PHASE 3

This phase of the research involved focus group consultations: (i) with some key stakeholders North and South, and (ii) young men from the target age group. The stakeholder consultations aimed to explore issues - at an organisational level - which were revealed in the findings from the online survey phase. The consultations with young men explored, in depth, issues of engagement, mental health in young men, and interventions which could help to prevent suicide.

## PHASE 4

Based upon the learning from the literature review, online surveys, and stakeholder focus groups, two practical pilot initiatives were developed - one in Northern Ireland and one in the Republic of Ireland. A full description of these interventions is provided in Section 11.

### 1.11 Ethical Approval

Ethical approval was granted by the Institute of Technology Carlow's Ethics Committee prior to undertaking the research elements of this project.

### 1.12 Input of Volunteers

Although funding was secured from NOSP and PHA to underwrite the key elements of YMSP, the success of the overall project also relied very heavily upon the goodwill, generosity and voluntary contributions of a broad range of individuals and organisations. In some cases, these people offered their input because they work in a related field - although they did not receive any recompense from this project for their time - but often contributors were, in the truest sense of the word, volunteers.

Given the varied and complex nature of the 'volunteer hours' tendered, it would be impossible to assign an exact financial value to these contributions. However, it is important to get a basic overview of the added value that these people brought to the project.

The table which follows provides a snapshot of some of the voluntary contributions that were offered.






Who	What
YMSP Advisory Group members, and those who deputised for them	Attended meetings and contributed to additional ongoing business via email, teleconferencing and sub-group meetings
MHFI Management Committee	Reviewed progress at Board meetings and contributed to proofing / testing resources
Contributors to online Stakeholder research	Completed a 'Survey Monkey' questionnaire
Attendees at Stakeholder meetings	Attended meetings in either Dublin or Belfast
Young Men's Group in Cork	Participated in a Focus Group on young men's needs
Individuals from PHA, HSE, Health Trusts, Youth Service, voluntary sector groups ...	Offered advice and guidance on possible locations for the two pilot interventions
Staff from Colin Neighbourhood Partnership	Contributed to preparation and progress meetings, as well as conducting ongoing business by email and telephone
Kevin Bailey (SEHSCT)	Recruited 'Mind Yourself' facilitators, coordinated additional team training, and oversaw the implementation of the programme in St. Colm's High School
Mind Yourself facilitators	Participated in a two day Train the Trainer programme, attended skills refresher training, supervised the two evaluation sessions, delivered two Mind Yourself programmes, and contributed to an evaluation Focus Group
Principal, teachers, and technical staff in St. Colm's High School	Were involved in the planning for / roll-out of the 'Mind Yourself' programme and two evaluation sessions with pupils
Paula Kinsella (MSc Student, IT Carlow)	Participated in the Mind Yourself Train the Trainer programme, and conducted an impact evaluation of the Mind Yourself programme with the pupils
Noel Richardson and Nick Clarke (IT Carlow)	Supervised and supported the Mind Yourself evaluation
Youth organisations in the Colin Area	Attended a briefing meeting about recruitment for the proposed Young Men's Advisory Group
Umberto Scappaticci (CNP)	Co-facilitated the Young Men's Advisory Group programme
Youth Initiatives staff	Contributed to five sessions of the Young Men's Advisory Group programme
Colin Area Youth Strategy Implementation Sub-Group	Attended a briefing meeting on progress in the locality
Staff from NSRF	Provided technical advice and support for the evaluation of the Mind Yourself programme
Inspire Ireland CEO, staff and Board members	Coordinated the development and testing of the Work Out website and planned / implemented a launch strategy
Jonny Ashe from YouthAction NI	Attended planning meetings and supervised the worker facilitating the young men's programme in the Colin area
Young Men's Groups	Tested both the Australian and Irish versions of the Work Out website, and offered feedback for improvements

Although it is not possible to give a completely accurate overview of what these contributions entailed, it is (conservatively) estimated that this volunteer input involved:

- 232 individuals
- 153 different organisations
- 2,009 volunteer hours

Please Note: These figures do not include the contribution of the pupils from St. Colm's High School in Twinbrook who took part in both the 'Mind Yourself' programme and the evaluation of it.



Focus on mind  
health or  
mental fitness  
not mental  
health.

## 2. Context of the Young Men and Suicide Project

### 2.1 Suicide in Young Men

Suicide is a major cause of death among young males (aged 15-24 years) on the island of Ireland<sup>73, 81</sup>. Over the past ten years, the rate of male deaths among 15-24 year olds has been, on average, five times that of the female rate. Although the rate of male suicide in Ireland (North and South) is relatively low within the overall EU context, the suicide rate among young males is amongst the highest in the EU<sup>73</sup>. Indeed, the Republic of Ireland experienced one of the fastest rising suicide rates in the world during the 1980s and 1990s (Department of Health and Children, 2005a), with the rate of increase being particularly prominent among young males. Similar increases were reported within the Northern Ireland context during the late 1990s and early 2000s (Department of Health, Social Services and Public Safety, 2006).

The more recent spike in suicide rates among young males (North and South) coincides with the economic downturn and increasing levels of unemployment. Although rates of attempted suicide and deliberate self harm (DSH) have been traditionally higher among females, this gap has begun to narrow in recent years. Indeed, the rates of DSH are 20% higher among 20-29 year old males in the Republic of Ireland (NRDSH, 2011), with higher rates also being recorded among males aged 15-19 and 25-29 in Northern Ireland<sup>51</sup>.

The causes and risk factors associated with suicide in young males are both multi-factoral and intersecting. The factors most consistently associated with the rise in young male suicide are income inequality, family relationship difficulties, peer relationship problems, school failure, low self esteem and violence (Fortune, 2006; Gunnell et al, 2003). Increasing suicide rates have also been linked to a lack of connectedness to the social fabric of life (Ryan, 2003).

In the context of designing suicide prevention strategies, Gunnell et al (2003) stress the importance of considering the experiences of older and younger individuals separately in the design of more targeted public health and social policy initiatives. For example, Stanistreet et al (2004) report that relatively few young men consult their GP during the period before death from suicide. Similarly, Fortune et al (2006) reported that engagement between services and young people who had attempted suicide, was also poor.

One of the key challenges in reaching young men is to overcome cultural taboos associated with acknowledging vulnerability and seeking help. The literature points to significant gender differences in relation to emotional and mental health and patterns of help seeking. Previous studies have also shown that male depression is often suppressed and manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour (Brooks, 2001), whilst men's unwillingness to seek help reinforces the social construction of their invulnerability to depression (Courtenay, 2000). With depression being implicated in over half of suicides (Moller-Leimkuhler, 2003), Winkler et al (2006) highlight the anomaly that although women are diagnosed with depression about twice as often as men, men are approximately twice as likely to die from suicide.

This highlights the need for a more 'language-sensitive and culturally-sensitive' approach to attending to young men's accounts of mental distress (McQueen and Henwood, 2002, p1493). Suicide prevention strategies must, therefore, consider other ways to reach out to young men and to support them when they are experiencing emotional distress.

## 2.2 The Complexity of Suicide Prevention

The scale and breadth of factors that are associated with both increased suicide risk and protecting against suicide - and the complex interplay of these factors - underscores the scale of the challenge associated with suicide prevention. Within the context of the YMSP, a number of key considerations informed both the overall ethos and the specific direction of the project:

### **The need for a multi-dimensional whole of government approach**

All of the evidence points to the need for interventions at multiple levels, and for a truly comprehensive and partnership approach to suicide prevention work with young men ...

*"The premise that the causes of suicide among young people are complex in their origins and need to be addressed on multiple levels remains the basic starting point"* (Australian Institute of Family Studies, 2000, p102<sup>65</sup>).

### **Difficulty in measuring effectiveness**

The difficulty with evaluating the effectiveness of prevention strategies and interventions is that suicide base rates in populations (even high risk populations such as those with mental illness) are low. This, therefore, makes it difficult to extrapolate differences in rates before and after interventions. In 2010, the World Health Organisation (WHO)<sup>i</sup> stated that relatively few suicide prevention programmes have been rigorously evaluated for their effectiveness in reducing suicide and related risk factors.

### **'Evidence-based' interventions are hampered by methodological limitations**

A raft of methodological limitations have been identified with previous interventions. These include a lack of control groups, the need for large sample sizes to gain sufficient statistical

power, and short funding cycles - all of which mean that it is hard to demonstrate their impact upon suicide rates. In a systematic review of suicide prevention strategies, the authors of this report acknowledge that whilst the relative impact of different strategies on national suicide rates is important for planning, it is difficult to gauge which components of particular interventions are associated with changes in suicide rates:

*“Many universal or targeted educational interventions are multifaceted, and it is not known which components produce the desired outcome, or there may be longer term trends in suicide rates that are not captured by the studies”* (Mann et al, 2005, p2070<sup>6</sup>).

Other interventions - beyond those known to decrease rates (such as reduction of means to harm and physician education programmes) - require further testing and evaluation to understand their short and long-term outcomes in relation to reducing suicide rates.

### **Young men tend not to access conventional health services**

As highlighted in this report, men tend to be reluctant to both seek help and to access conventional health services. This calls for more creative approaches to engaging with men that go beyond the approach of ‘the services are there, men can use them’.

### **Challenges associated with reducing means to harm**

One prevention strategy known to reduce suicide rates is the reduction of means to harm. However, young men in Ireland (and elsewhere) are more likely to use hanging as a means to end their lives. Limiting or restricting access to hanging is one of the most difficult suicide prevention strategies - as it is impossible to remove ligature points or potential ligatures in the natural environment or within people’s homes (Florentine, Crane, 2010, Värnik et al, 2009). In this regard, strategies to reduce hanging have focused on institutional environments such as prisons and hospitals, through the removal of potential ligature points both indoors and outdoors - even though this population only accounts for 10% of all hangings (Gunnell et al, 2005).

Efforts to reduce suicide through limitation of access to methods can be categorised into two approaches:

- Efforts that limit physical access to suicide methods.
- Efforts that attempt to reduce the cognitive availability of suicide - particularly in relation to responsible media coverage.

### **Transferring good practice from one setting to another**

Endeavours to transfer good practice from one setting to another - whilst tempting and understandable - may not, necessarily, result in the desired outcomes. Bertolote (2004) highlighted that because suicide is so intrinsically linked to socio-cultural factors, it is not, necessarily, the case that what has worked in one place will be effective elsewhere<sup>8</sup>. Therefore, initiating or transplanting prevention programmes that have worked in other settings is often problematic.

### **The rush ‘to do something about the problem’**

Within the Republic of Ireland context, Walsh (2007) has posited that the diversity of causes that lead a person to suicide is so great that any search for a generic solution is futile:

*“The understandable wish ‘to do something’ about the problem of suicide has led to a flurry of activity, little of it evidence sustainable, but most of it politically acceptable” (Walsh, 2007, p75<sup>9</sup>).*

The same author points to a lack of political will to progress the preventive measure which has the most potential to impact on youth suicide i.e. the implementation of the recommendations of the Strategic Task Force on Alcohol.

## 2.3 The Policy Context

The call for action on suicide prevention - particularly in young males - is underpinned by a clear policy mandate in both Northern Ireland and the Republic of Ireland:

- The Republic of Ireland’s National Men’s Health Policy<sup>64</sup> calls for “a stronger focus on mental health promotion” and for “a gendered approach in the development of community-based mental health services” (Department of Health and Children, 2008, p72<sup>64</sup>).
- The National Suicide Prevention Strategy, Reach Out<sup>1</sup>, outlined three actions relating specifically to young men:

- 20.1 Review recent research and service initiatives for men’s health in Ireland and internationally.
- 20.2 Develop pilot mental health promotion and support initiatives for young men.
- 20.3 Provide support for young men through the voluntary sector and in community settings.

- ‘Young Males’ also constitute a specific Action Area within the Northern Ireland Suicide Prevention Strategy and Action Plan, Protect Life<sup>2</sup>:

- To ensure that targeted outreach programmes for young males, who may be at risk of suicide and self-harm, are available in local communities and in all Health and Social Service Trusts.
- To implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly.
- To enhance the role of the community / voluntary sector concerning the provision of mentoring support for young people at risk of suicide and self-harm.

- The All-Island Suicide Prevention Action Plan<sup>82</sup> identifies the Men’s Health Forum in Ireland (MHFI), in partnership with the National Office for Suicide Prevention (NOSP), as being well positioned to develop and implement relevant actions relating to suicide prevention in young men. The Northern Ireland Suicide Prevention Strategy and Action Plan<sup>2</sup> also emphasises the potential for “mutually beneficial North / South working”.

The case for an increased focus on mental health promotion and suicide prevention among boys and young men is, therefore, unequivocal, and is underpinned by a strong evidence base and a clear policy mandate.



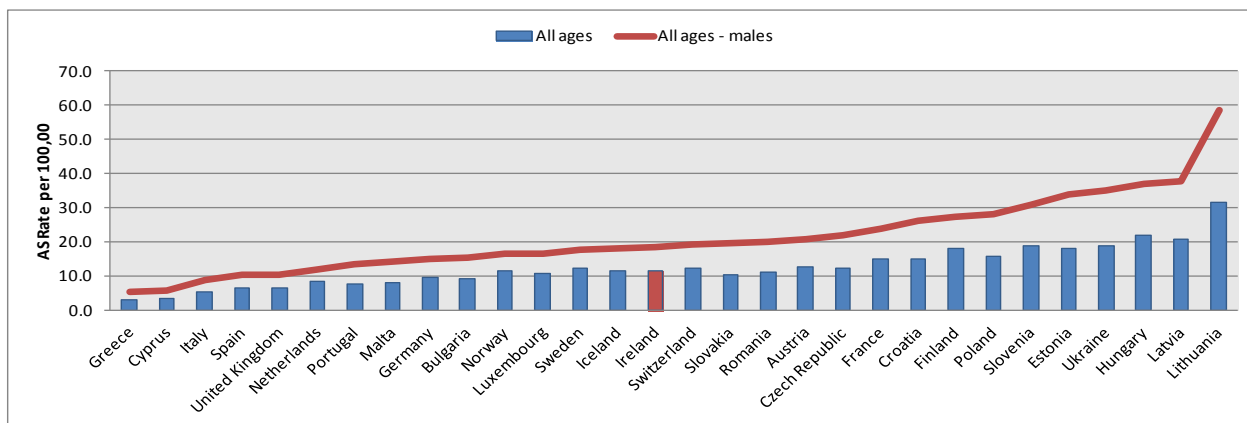


### 3. Suicide Statistics

According to the World Health Organisation, approximately one million people worldwide died from suicide in the year 2000, with those who attempted suicide estimated to be 10 to 20 times higher than this number<sup>72</sup>. In all countries, suicide is one of the three leading causes of death among 15-44 year olds, particularly among males<sup>72</sup>. Across the 27 member states in the European Union in 2007, a total of 54,756 people took their lives - 76% of whom were men - with suicide accounting for 1.75% of all male deaths in comparison to 0.54% of all female deaths<sup>83</sup>. Whilst death rates from suicide decreased by 15% between the years 2000 to 2007, a reversal of this pattern coincided with the onset of recession in 2008, when suicide rates began to increase in Europe<sup>84</sup>. While researchers only have data for a limited number of European countries, the results of their work reveal that the countries with the highest suicide rate increases were those most affected by the recession; namely Greece and Ireland (17% and 13% increases respectively)<sup>84</sup>.

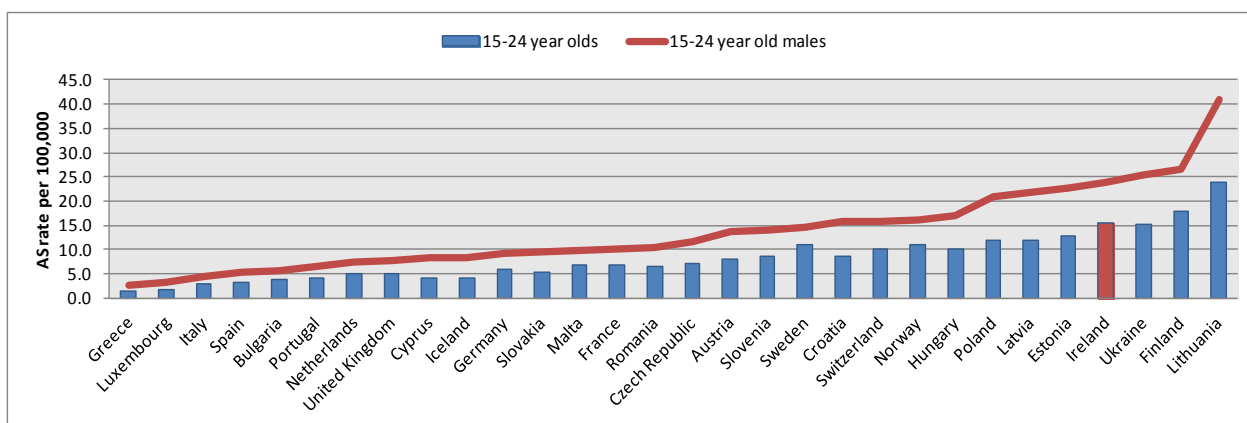
The epidemiology of suicide in Europe and, indeed, worldwide, indicates that completed suicide follows a gender related pattern; with developed countries having a male to female suicide ratio of between two and four to one<sup>17, 18</sup>. Although the rate of male suicide in Ireland is relatively low within the overall EU context (Figure 1), the suicide rate among young males is amongst the highest in the EU (Figure 2).

Figure 1: Total suicide and intentional self-harm death rates per 100,000 in the European region, 2009



Source: European Mortality Database, accessed August 2012

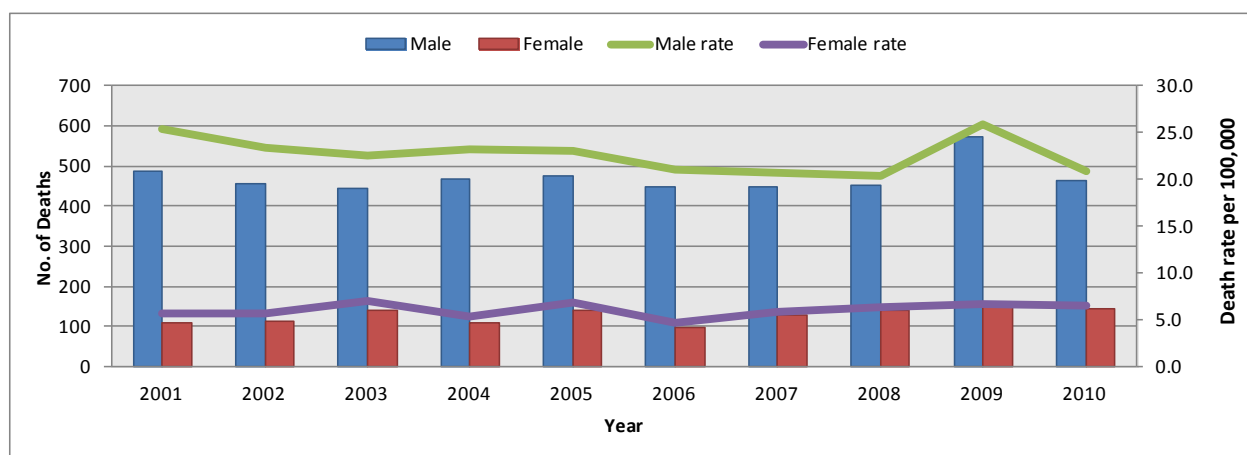
Figure 2: Total suicide and intentional self-harm death rates per 100,000 for 15-29 year olds in the European region, 2009



Source: European Mortality Database, accessed August 2012

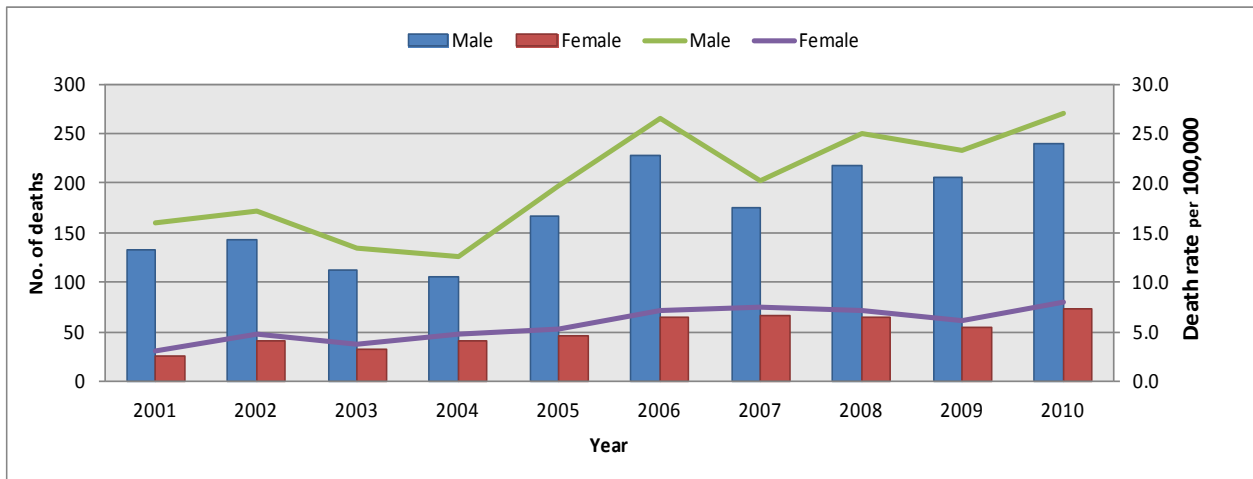
Figures 3 and 4 illustrate the numbers and rates per 100,000 of suicide and undetermined death for males and females, over the ten year period 2001 to 2010, for the Republic of Ireland and Northern Ireland respectively. As can be seen, male deaths and death rates are typically three to four times higher than female deaths and death rates.

Figure 3: Suicide and undetermined death - Number of deaths and death rate per 100,000 by sex in the Republic of Ireland, 2001-2010



Source: CSO

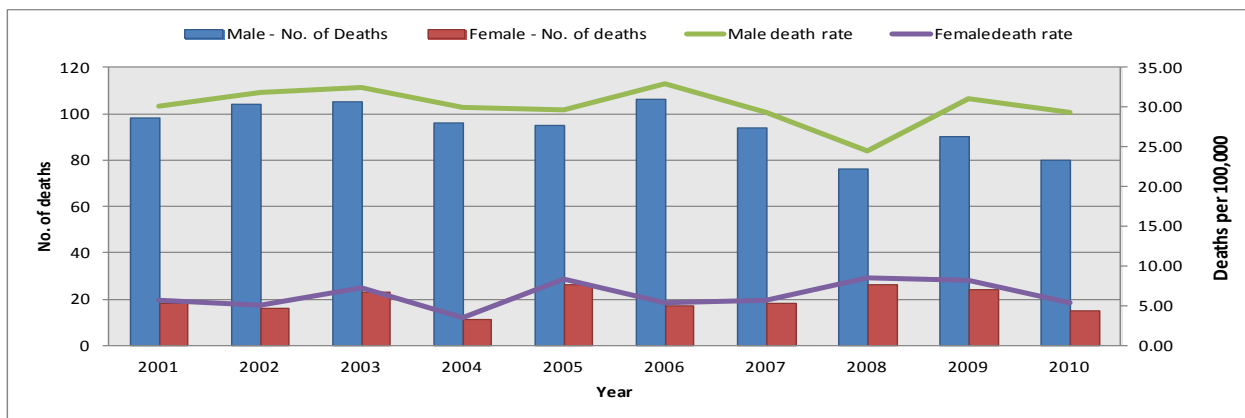
Figure 4: Suicide and undetermined death - Number of deaths and death rate per 100,000 by sex in Northern Ireland, 2001-2010



Source: NISRA

Over the same ten year period in the Republic of Ireland, the rate of male deaths among 15-24 year olds was, on average, five times that of the female rate - increasing to 8.5 times the female rate in 2004, dropping to three times the female rate in 2008, and returning to five times the female rate in 2010 (Figure 5).

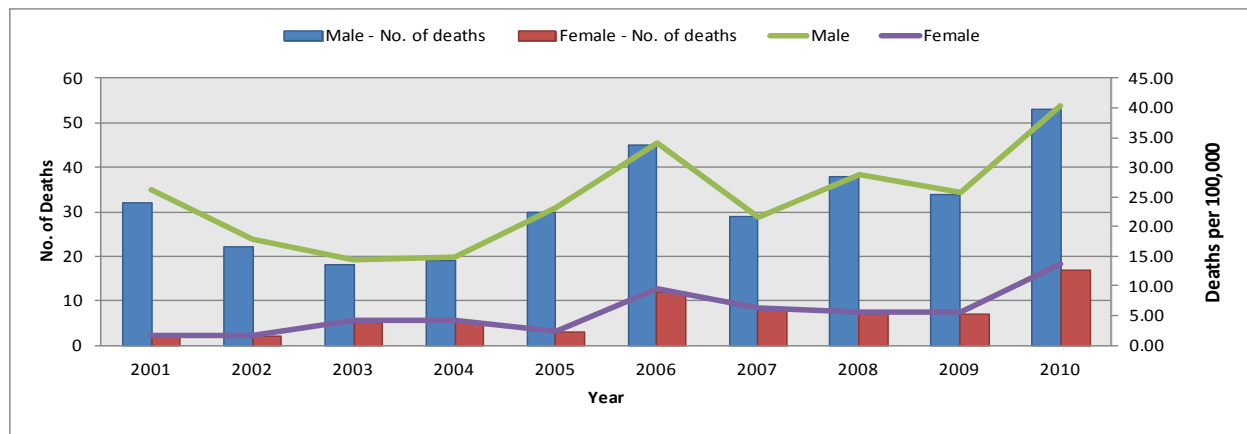
Figure 5: Suicide and undetermined death - Number of deaths and death rate per 100,000 for 15-24 year olds, by sex, in the Republic of Ireland, 2001-2010



Source: CSO

In Northern Ireland, suicide death rates among 15-24 year old males and females vary to a much greater degree. In 2001, the rate of suicide among 15-24 year old males was almost 16 times that of the female rate, decreasing to 9.5 times the female rate in 2005, and was three times the female rate in 2010 (Figure 6). This closing of the gap between male and female suicide rates among young people in Northern Ireland is not reflective of a decrease in the actual number of male suicides. Rather, there has been a proportionately greater increase in the rate of suicide among young females; with both the numbers and rates having increased in both sexes overall. For example, in 2001 only two female suicides in the 15-24 year old age group were registered in Northern Ireland. However by 2010, 17 female suicides were registered in this age group. Among 15-24 year old males, 32 suicides were registered in 2001, with 53 suicides registered in 2010.

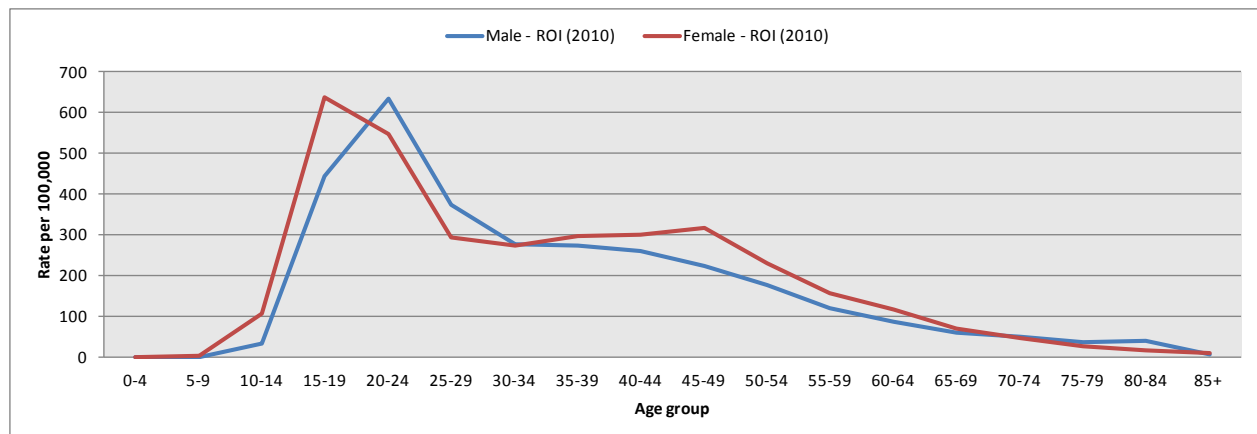
Figure 6: Suicide and undetermined death - Number of deaths and death rate per 100,000 for 15-24 year olds, by sex, in Northern Ireland, 2001-2010



Source: NISRA

Whilst the majority of suicides are carried out by males, the rate of attempted suicide and deliberate self harm (DSH) - which are more prevalent overall - have tended to be higher in females. Although the gap in DSH has more recently begun to narrow between the sexes (see Figures 7 and 8), in the Republic of Ireland the overall rate of DSH is still significantly higher among females<sup>31</sup>. However, among 20-29 year old males in the Republic of Ireland, the rate of DSH is 20% higher than in females in the same age group<sup>31</sup> (Figure 7), with higher rates also recorded among males aged 15-19 and 25-29 in Northern Ireland (Figure 8).

Figure 7: European age standardised rates for deliberate self harm by 5 year age group and sex, for 2010, in Republic of Ireland



Source: National Suicide Research Foundation (2011). National Registry of Deliberate Self Harm Annual Report 2010<sup>49</sup>

The National Registry of Deliberate Self Harm has reported that DSH among males in the Republic of Ireland has increased year on year since 2007<sup>49</sup>. DSH rose by 27% among males during this period compared to 7% in females.

The Registry suggests that the economic recession is likely to be a key contributor to this pattern of increase. In addition, the most striking increase in DSH rates was among 20-24 year old males and females; increasing by 19% for males and 30% for females over this period.

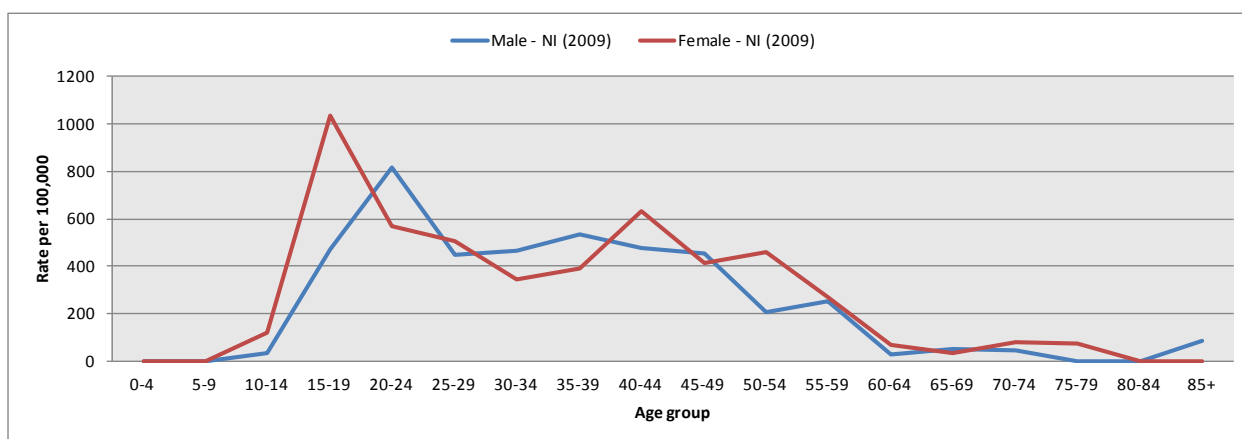
The overall gender difference in DSH has narrowed from 37% in 2004-2005 to 13% in 2009-2010<sup>49</sup>. For the first time, in 2009, a higher rate of DSH was recorded in men compared to women

in the Republic of Ireland. This apparent trend towards increasing DSH in males, coincides with increasing suicide rates, and may be indicative of increasing destabilisation in young men's mental health<sup>31</sup>.

Increases recorded by the National Registry of Deliberate Self Harm show that certain counties may warrant particular attention in relation to rises in male DSH - namely Leitrim, Monaghan, Mayo, and Cork City and County. Recorded increases in DSH in these counties of 131%, 73%, 69%, and 55% respectively are a source of particular concern<sup>50</sup>.

In contrast, the recording of DSH in the Western area in Northern Ireland<sup>ii</sup> has revealed a drop of 13.2% in the rates for males and 16.1% for females<sup>51</sup>. However, peak rates in males - like those recorded in the Republic of Ireland - show that 20-24 year olds are most at risk, and have higher rates than their female counterparts (Figure 8). Notably, the rate in Derry / Londonderry was 38% higher than in the Western region as a whole; with male rates being almost double that of the other neighbouring districts of Limavady, Omagh, Fermanagh and Strabane<sup>51</sup>.

Figure 8: European age standardised rates for deliberate self harm by 5 year age group and sex, 2009, Western Area, Northern Ireland

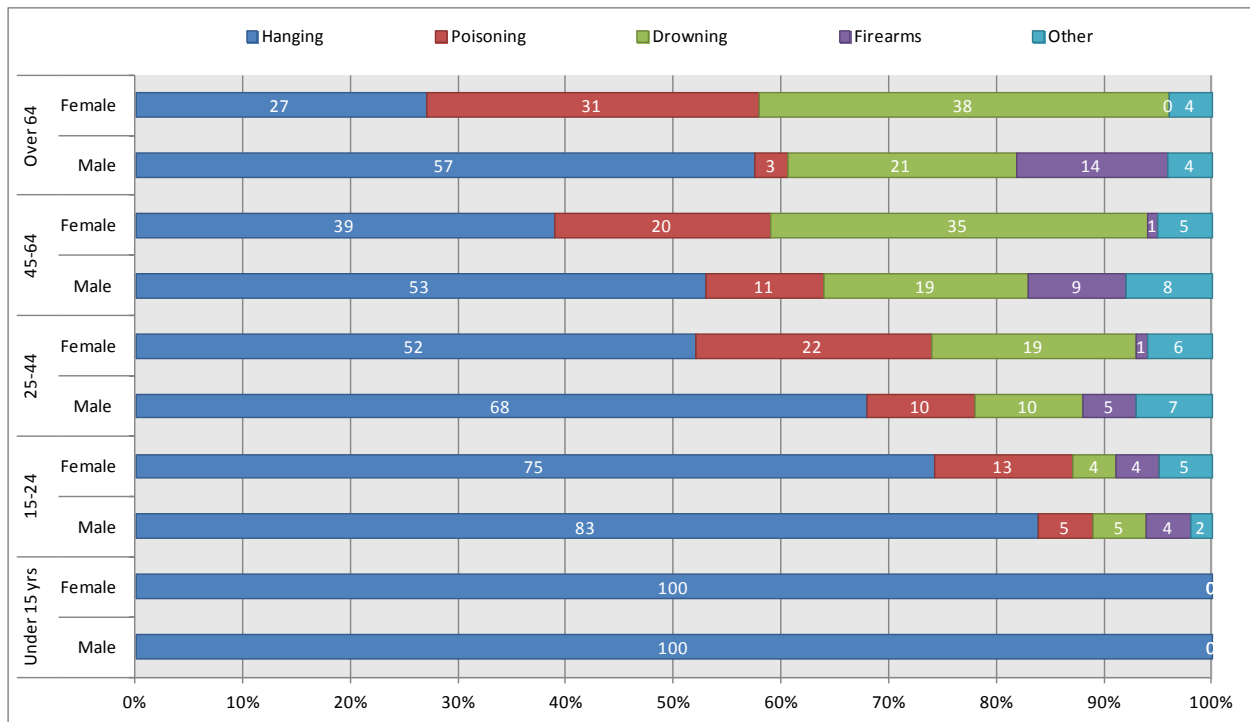


Source: Northern Ireland Registry of Deliberate Self Harm

On the island of Ireland and, indeed, throughout much of Europe, hanging is the most frequent method of suicide among men and women; followed by firearm use, poisoning by drugs, and jumping<sup>35</sup>. This pattern can be seen in both the Republic of Ireland<sup>31</sup> and Northern Ireland<sup>32</sup>. In the Republic of Ireland, 83% of young men between the ages of 15-25 used hanging as method of completed suicide in the years 2004-2008<sup>73</sup> (Figure 9). In a study of suicide methods in Derry / Londonderry, Northern Ireland, it was found that hanging was the most frequent method of suicide among 20-29 year olds<sup>33</sup>. Across Europe, hanging is also the most common method of suicide; with 54% of males and 36% of females using this method<sup>35</sup>. Hanging is a highly lethal method of suicide. Studies have found that around 70% of attempted suicides by this method result in death<sup>34</sup>.



Figure 9: Methods of suicide by sex and age category, 2004-2008, Republic of Ireland



Source: NOSP Annual Report 2010

## 4. Suicide - Causes and Risk Factors

Factors influencing youth and adolescent suicide are categorised into individual, familial, socio-demographic and life stressors, and can be further classified into high, medium and low risk levels<sup>20</sup>. In a psychological autopsy study<sup>22</sup> of young people who died by suicide in the United Kingdom, 70% had been diagnosed with psychiatric disorders (55% with depressive disorders) and 55% with personality disorders. While substance abuse disorders were uncommon, a substantial proportion had problems with alcohol or drug misuse. In addition, co-morbidity disorders were found in a third of the subjects. Relationship and legal difficulties were also found to be a relatively common contributory factor to suicide. The authors concluded that:

*“The process leading to suicide in young people is often long term, with untreated depression in the context of personality and/or relationship difficulties being a common picture at the time of death”* (Houston et al, 2001, p159<sup>22</sup>).

Gender has also been implicated in increased suicide risk among young men. In a review of the relationship between gender and suicide, Payne et al highlight that although gender roles have shifted, male gender roles remain more toxic and more limiting in terms of health potential<sup>16</sup>. In relation to suicide, the authors state that:

*“‘Doing masculinity’ may be associated with an increased risk of suicide compared with ‘doing femininity’”* (Payne et al, 2008 p26<sup>16</sup>).

The authors considered the key factors that mediate the relationship between gender and suicide. These include:

- **Methods used** - men are more likely to use violent methods which are intrinsically linked with hegemonic roles, and where survival is less acceptable for men with lethality linked to mastery or masculine expression.

- **Mental illness** - whilst there are higher rates of mental illness diagnosed in women, men are less likely to seek help. This begs the question: is there a male depressive syndrome?
- **Alcohol and substance misuse** - there are strong links between alcohol consumption and suicide. Particular patterns of drinking (such as binge drinking) can be a mechanism for young men, in particular, to define or assert their masculinity.
- **Use of health care** - men tend to access services less frequently than women do, and may also be more reluctant to seek help during times of distress.
- **Sexuality** - some men experience stigma and shame associated with being gay, and higher rates of suicide are common among gay men.
- **Social and community factors** - such as rapid societal change, changing gender roles, and the socio-economic impact of recession.
- **Marital and parental status** - there is a higher risk in divorced and widowed men.
- **Other social and community factors** - including living and working conditions, unemployment and socio-economic status<sup>16</sup>.

Factors known to contribute to youth suicide, and factors known to protect or reduce suicide risk, have been examined by a number of researchers internationally, and are outlined in Tables 1 and 2.

Table 1: Risk factors influencing youth and adolescent suicide

Individual Risk Factors	Familial Risk Factors	Socio-Environmental Risk Factors
Gender	Family history of suicidal behaviour (modelling or inheritance)	Socially disadvantaged background
Genetics	Parental psychopathology: <ul style="list-style-type: none"> <li>• Depression</li> <li>• Substance abuse</li> <li>• Anti-social behaviour</li> <li>• Divorce</li> <li>• Non-intact homes</li> </ul>	Indigenous status
Mental health	Less frequent and satisfying communication with parents	Problems at school or at work
Alcohol / substance abuse	Family / childhood adversities	Media coverage
History of abuse	Loss of a parent (before age 12 association with repeat attempters)	Non-school attendees (feelings of worthlessness)
History of prior suicide attempt / DSH	Physical or sexual abuse in childhood or adolescence	Death of an adolescent peer
Relationship break-up		GLBT
Abnormalities in functioning of serotonin		Access to means
Personality traits: <ul style="list-style-type: none"> <li>• High levels of neuroticism</li> <li>• Low self-esteem</li> <li>• External locus of control</li> <li>• Hopelessness</li> <li>• Impulsivity</li> <li>• Aggression</li> <li>• Introversion</li> </ul>		The impact of increasing unemployment on suicide rates tends to be more pronounced in higher level income countries
Restricted help-seeking		

Table 2: Protective factors in youth and adolescent suicide

Individual Factors	Social Factors	Contextual Factors
Good coping skills	Family connectedness and support	Access to appropriate services
Personal resilience	Positive school environment	Economic security
Problem solving skills	Social and community inclusion	Non-discriminatory environments
Optimism	Protection from adverse life events	Appropriate housing
Social and emotional well-being		
Ability and desire to seek help		

The scale and breadth of factors associated with both increased suicide risk and protection against suicide - and the complex interplay of these factors - underscores the scale of the challenge associated with suicide prevention. Indeed, this can be compounded by variability within specific risk factors. For example, most evidence has shown that same sex sexuality is a marker for increased risk of suicide among males beginning adolescence<sup>23, 24</sup>. However, other studies have shown that this risk does not continue into adulthood - indicating that it is during the adolescent period that homosexual men are at greatest risk of suicidality<sup>25</sup>. It is argued that contemporary masculinity and heteronormativity are compounded for gay and bisexual boys as their sexual awareness develops; in particular with young men 'coming out' at younger ages<sup>25</sup>.

The recent economic recession has resulted in an increase in suicide rates. This follows a period during the boom years, from 1999 to 2007, when suicide rates decreased. However, this trend reversed from 2008 on. According to the Central Statistics Office (CSO), 552 deaths from suicide occurred in 2009 - a 9% increase on the 2008 figure of 506 suicide deaths<sup>85</sup>. Males accounted for the total increase in suicide deaths in 2009. This represented a 15% increase in male suicide deaths from the previous year<sup>85</sup>.

An examination of time series data reveals a causal link between rising unemployment and higher levels of alcohol consumption and increased suicide mortality among younger males<sup>39</sup>. Indeed, the authors point out that, overall, the influence of alcohol on male suicide rates in Ireland has been much larger than the influence of unemployment rates. However, decreasing consumption of alcohol has moderated the rise in suicide rates during the recession when unemployment increased. Walsh<sup>9</sup> concludes several points in relation to suicide patterns and prevention strategies in Ireland which have a particular resonance in the context of young men:

- Alcohol consumption and alcohol abuse - which facilitate both completed suicide and deliberate self-harm - have trebled in Ireland over the last half century, and have shown the same historical 'long wave' changes as suicide rates.
- There are no unequivocal evidence-based measures to reduce suicide or repeat DSH other than reducing alcohol consumption by young persons.
- The understandable wish 'to do something' about the problem of suicide has led to a flurry of activity; little of it evidence sustainable, but most of it politically acceptable.
- There is little will to progress the preventive measure with most potential to impact upon youth suicide - namely the implementation of the recommendations of the Strategic Task Force on Alcohol.

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Waldvogel et al<sup>20</sup> suggest that it may be better to create strategies that treat risk factors instead of identifying at risk adolescents. They distinguish between strategies at a primary level (suicide awareness, skills based enhancement and restriction of lethal means) and at a secondary level (screening for vulnerable adolescents, gatekeeper training, media education, crisis intervention, crisis centres and suicide hotlines)<sup>20</sup>.

Langhinrichsen-Rohlin et al<sup>21</sup> advocate screening for at risk adolescents through direct screening methods such as the LAS (Life Attitudes Schedule); a measure of suicide proneness. However, this study relates to ethnic diversity within populations. The study does suggest that cultural expectations provide scripts for individuals to display certain suicidal behaviours, while providing a means to evaluate the suicidal behaviour of others. In terms of young people who are developing their personal identities, these scripts may be of importance in terms of suicidal behaviour<sup>21</sup>.

A study, aimed at gaining a greater understanding of young men's outlook on life in Ireland in the face of high rates of suicide, found that negative perceptions of life were particularly pronounced among young men who still lived with their parents<sup>40</sup>. For many such men, there was the ongoing dilemma between striving for independence and having the means to do so:

*“These young men may well be living in that space between 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”* (Begley et al, 2003, p38<sup>40</sup>).

The study also reported that among the participants (n=363): 38% reported suicidal thoughts without intent; 11% reported seriously considering suicide; 4% reported actually making a suicide plan; 4.6% reported engaging in deliberate self harm; 78% reported knowing someone who had died by suicide. In addition, men who thought about suicide believed that others had more of an influence on their lives than they did themselves.

The vast majority of the men surveyed (90%) stated that they would talk to someone when worried or upset. However, becoming angry (90%) and drinking (70%) were also cited as likely responses. Two-thirds of respondents stated that they would at least sometimes avoid the problem by not thinking about it. The main reasons cited for not getting help with a problem included embarrassment, shame, stigma, confidentiality, and fear of others finding out.

In summary, the main issues identified in the report in relation to young men included:

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

Research on problems experienced by young men and attitudes to help seeking in a rural community, found that both young men and key informants (Gardai, teachers, health board personnel, GPs, voluntary workers and sports coaches) believed that the greatest difficulties facing young men were misuse of alcohol, peer or social pressures, and problems associated



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with higher risk of suicide<sup>41</sup>. The same study found that young men had a strong preference to approach a friend in a time of difficulty; with a concurrent reluctance to approach a professional person at such times.

A report titled 'Young Men on the Margins'<sup>71</sup> identified a number of factors that brought young men to suicidal action, including:

- Relationship breakdown.
- The accumulation of stress - particularly brought on by feeling one's life was out of control or of being trapped in a particular situation.
- Unhappiness, panic and anger that remained unresolved over a long period of time.
- Alcohol use leading to impulsive behaviour.
- Awareness of a suicide script - many of the young men had knowledge of instances of suicide around them and in the media.
- Bullying and problems with identity (including sexual identity).
- Being tied to the maintenance of a traditional masculine identity.

An analysis of suicide data in Derry / Londonderry<sup>42</sup> identified a clear pattern of increase in young male suicide, and led the authors to conclude that there was 'a crisis' in young male suicide in Northern Ireland that demanded additional professional support services for those contemplating suicide. The authors make the important point that while the problems that sometimes burden young males might be regarded as trivial, they may, in fact, be perceived and experienced as major problems for the young men themselves.

Families need to be aware of the existence of problems such as alcohol and drug abuse, unemployment, and rising divorce rates, which play an important role in increasing the risk of suicide. Young men's state of mind is also an extremely important factor - as suicide can be triggered by depressive episodes or severe mental illness<sup>42</sup>.

A mapping exercise of young men's health and personal development projects in the Northern area of Northern Ireland identified a number of gaps in relation to supporting young men who may be at risk of suicide and self harm<sup>43</sup>. These included:

- A general absence of work that specifically targeted young men, or that was specialised according to young men's particular needs.
- Although there was a wide range of relevant services that targeted young people generally, there were some areas with relatively high rates of suicide that appeared to have no locally based work specifically aimed at young men.
- Support is required in terms of raising awareness of the particular considerations for work with young men, and for designing effective interventions with young men.
- The need for an increased focus on personal development and mental health promotion when working with young men.
- The need to encourage an increased focus on evaluation.

In summary, there can be no quick-fix solutions to tackling the extensive and complex causes and risk factors that underpin the statistics on suicide in young men. These factors are diverse and intersecting, and the challenge of reducing suicide rates in young men demands a very comprehensive and multi-layered response. This must seek to intervene at a number of different levels, and involve a range of key stakeholders.

There can no room for inertia or ambivalence. There is both a public health and a moral requirement to act. It is not enough to be seen to act. There needs to be more concerted efforts to engage more effectively - and in a more sustained way - with young men, and to act in accordance with the best evidence that is available.

This report provides a blueprint and a roadmap for action which, it is hoped, will act as a catalyst for more focused efforts in tackling suicide in young men in the years ahead.

## 5. Policy Responses to Suicide in Ireland

National suicide prevention strategies have been advocated for many years by both the European Union and the World Health Organisation. *Reach Out: A National Strategy for Suicide Prevention*<sup>1</sup> was published in 2005, and aims to tackle suicide in the Republic of Ireland. In Northern Ireland, the publication of *Protect Life: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011*<sup>2</sup> aimed to reduce suicide by 10% by 2008, and a further 5% by 2011. Both strategies are designed around an all-Ireland action plan. These strategies are based upon best available evidence on the effectiveness of prevention strategies, and are set out under the General Population Approach and the Targeted Approach. Each of these approaches aims to assist the delivery of prevention activities under the following headings:

Table 3: Suicide prevention activities under the General Population and Targeted Approaches

General Population Approach	Targeted Approach
Family	Prisoners
Children and Youth	Unemployed
Third Level Education	Older People
Workplace	High Risk Occupations
Community and Voluntary	Bereaved by Suicide
Church and Religious	Deliberate Self-Harm
Sports Clubs	Mental Health Services
Police and Emergency Services	Alcohol and Drug Misuse
Primary Care, General Practice, Health and Social Services	Marginalised and Disadvantaged Groups
	Young Males
	Sexual Abuse Survivors

While some differences exist between the strategies in terms of key action areas, the overall aims are similar. Both strategies are based on a public health approach - first employed as a method of surveillance and prevention in the United States of America (USA)<sup>3</sup>. This approach has been adopted by the World Health Organisation (WHO)<sup>4</sup> and the European Union<sup>5</sup>. The public health approach includes:

- The identification of patterns of suicide in groups or populations through surveillance.
- Risk factor identification.
- Prevention or intervention.
- Evaluation<sup>4</sup>.

As highlighted previously, suicide in Ireland is the principal cause of death in young men aged 15 to 34 years. This is mirrored in Europe, and internationally, where suicide is a major contributor to mortality in young men. Although overall suicide rates in Ireland are relatively low in comparison to the rest of Europe, the rate of youth suicide is very high - with only Ukraine, Finland and Lithuania having higher youth suicide rates (see Figure 2).

In 2001, NOSP highlighted the need to focus on high rates of suicide in young men, and to encourage young men to access health services and other supports<sup>38</sup>. While suicide prevention strategies, both North and South, target young men specifically, there is little evidence that demonstrates effectiveness of initiatives aimed at preventing suicide in young men<sup>37</sup>.

Reach Out, the Republic of Ireland's Suicide Prevention Policy, identifies young men as a specific risk group to be targeted, and one of its objectives is to:

*"... develop services and initiatives that will help young men to cope with changing roles in society and involve them in the development of policy and services that affect them"* (Health Service Executive and Department of Health and Children, 2005, p421).



#### **Actions under this objective include:**

- Review all of the recent research and various service initiatives for men's health in Ireland (such as the appointment of a number of Men's Health Officers in the HSE) and internationally (such as the CALM project in England).
- Based on the review in Action Point 20.1, prepare a detailed service plan - setting out the evaluation criteria for the development of pilot mental health promotion and support initiatives for young men.
- Meet with voluntary organisations to discuss ways of developing partnership approaches to providing support for young men through the voluntary sector and in community settings.

Protect Life<sup>2</sup>, also singles out young men as a risk group warranting particular attention and, included among its actions, are:

- *"To ensure that targeted outreach programmes for young males, who may be at risk of suicide and self-harm, are available in local communities and in all Health and Social Service Trusts."*

- *“To implement a targeted information and awareness campaign for young males, aimed at breaking down the current male culture of not discussing their problems openly.”*
- *“To enhance the role of the community / voluntary sector concerning the provision of mentoring support for young people at risk of suicide and self-harm.”*  
(Department of Health, Social Services and Public Safety, 2006, p33<sup>2</sup>)

The National Men’s Health Policy<sup>64</sup> also calls for a more explicit focus on the gendered nature of mental health in men; with Action 8.3(16) calling for priority to be given to the implementation of Actions 20.1 - 20.3 of Reach Out in addressing the issue of suicide in young men.

There is, therefore, a clear and unequivocal policy mandate for specifically targeting mental health promotion and suicide prevention initiatives at boys and young men.

## 6. Suicide Prevention: Evidence, Principles and Models of Effective Practice

### 6.1 Evidence of Effective Practice

The two key factors that are known to be effective in reducing suicide rates are physician education in depression recognition and treatment, and restricting access to lethal means of suicide<sup>6</sup>.

The difficulty with evaluating the effectiveness of prevention strategies and interventions is that suicide base rates in populations (even high risk populations such as those with mental illness) are low. Subsequently, it is difficult to extrapolate differences in rates before and after interventions. Randomised Clinical Trials (RCTs) are the most valuable means to establish the effectiveness of interventions. However, RCTs cannot establish the impact of interchanging causes and effects in relation to factors such as health care reforms, changes in culture / religion, media coverage, unemployment, immigration policy, restriction in means for suicide, changed legislation, or changing patterns of drug and alcohol use - all of which are known to impact on suicide rates and deliberate self-harm<sup>7</sup>.

In a systematic review of suicide prevention strategies, Mann et al<sup>6</sup> state that:

*“The relative impact of different strategies on national suicide rates is important for planning but difficult to estimate”* (Mann et al, 2005, p2070).

The authors conclude that physician education increases the number of diagnosed and treated depressed patients; with accompanying reductions in suicide. In addition, they found that restricting access to lethal methods of suicide (firearms, pesticides, domestic gas, sale of barbiturates, analgesic painkillers, mandatory use of catalytic converters, construction of barriers at jump sites, and lower toxicity anti-depressants) have been effective in reducing suicide rates. The authors suggest that other interventions require further testing and evaluation to understand their short and long-term outcomes in relation to reducing suicide rates. These include strategies for influencing how the media reports suicide, pharmacotherapy (selective serotonin reuptake inhibitors), screening for at risk individuals, chain of care after a suicide attempt, and psychotherapy. While the ‘gold standard’ of Randomised Clinical Trials is desirable, it is often not possible. Therefore, use of the best available evidence is warranted as a pragmatic approach to evaluation and the development of prevention strategies<sup>10</sup>. This inevitably means that prevention and intervention programmes in many areas will have to rely on ‘weaker evidence’<sup>7</sup>.



## Other less intensive interventions tested through RCTs point to a number of positive outcomes<sup>7</sup>:

- Regularly sending letters (four times a year over a five year period) to patients who had attempted suicide - but refused aftercare - significantly reduced the suicide rate in a contact group compared to a no contact group<sup>74</sup>.
- Regularly sending postcards (eight times in the first twelve months after a suicide attempt) resulted in a significant reduction in the number of repeated suicidal acts during the first two years in the contact group compared to the no contact group<sup>75</sup>.
- An uncontrolled study of telephone services for the elderly in Italy revealed lower suicide rates than expected in the population who had this service<sup>76</sup>.
- Telephone contact one month after a suicide attempt reduced the number of re-attempts over one year<sup>77</sup>.

Initiating or transplanting prevention programmes that have worked elsewhere is also problematic. Bertolote<sup>8</sup> has stated that because suicide is so intrinsically linked to socio-cultural factors it is not, necessarily, the case that what has worked in one place will be effective elsewhere. In Ireland, Walsh<sup>9</sup> has posited that the diversity of causes that lead a person to suicide is so great that any search for a generic solution is futile.

While the WHO state that there is no definitive evidence that national policies are effective in reducing suicide rates, it is widely acknowledged that policies offer coordinated strategies and measures to concerned communities. However, only a few suicide prevention programmes have been rigorously evaluated for their effectiveness in reducing suicide and related risk factors<sup>4</sup>. Studies highlighted in the WHO report, which have been shown to have statistical significance in decreasing suicide rates, include both enclosed studies<sup>11, 12, 13</sup> and national and regional studies<sup>14, 15, 52, 53</sup>. These include the following programmes:

- ***US Air Force Suicide Prevention Programme ...***

The programme comprised 11 elements including:

- Leadership involvement
- Professional military education to deal with suicide
- Guidelines for commanders
- Community preventative services
- Community education and training
- Investigating interview policy (hands-off policy for personnel under investigation)
- Critical incident stress management
- Integrated delivery system for human services prevention
- Limited patient privilege
- Behavioural health survey
- Suicide event surveillance system

The programme resulted in a reduction in relative risk of 33% after the implementation of the programme.

- ***Group activity for the elderly in Japan and depression awareness training for General Practitioners ...***

The programme included a seven year implementation of depression screening - with follow-up by a general practitioner - and ten years of public education. The programme resulted in a 64% reduction in risk for women. However, no change in risk was found for men.

- 
- ***Training programme for General Practitioners on the diagnosis and treatment of depression in Gotland, Sweden ...***  
A significant decrease in the suicide rate in the region was attributed to the implementation of the programme in the areas in which GPs were trained.
  - ***Five year depression management education programme for GPs in a region of Hungary with a very high suicide rate ...***  
Suicidal ideation was found to be resolved more quickly in patients involved in the depression management education programme than in those assigned to the control group who received their usual care.
  - ***Reducing access to suicidal means ...***  
These reviews include the reduction of rates through the detoxification of domestic gas supplies, modification of car exhaust design, and limiting the quantity and packaging of paracetamol and aspirin.

A systematic review of literature regarding the effectiveness of suicide prevention programmes through community education concluded that although such programmes are widespread, the reporting of their efficacy is limited<sup>26</sup>. An important issue is that these programmes often fail to reach the target groups who are most at risk of depression and suicidal ideation. While changing the attitudes and improving the public's knowledge concerning suicide is often successful, this does not always translate into meaningful action among those who are most at risk. However, longer-term programmes that utilise a commitment of the society at multiple levels, and that succeed in establishing a community support network, have been shown to effectively reduce suicide rates<sup>26</sup>.

The Canadian Centre for Suicide Prevention has pointed to the benefits and risks associated with sports participation in relation to the well-being of young people<sup>47</sup>. Overall, studies suggest that the benefits of participation in sport include enhancement of social support, emotional and mental health, enhancement of positive lifestyle behaviours, and protection against depression and suicidal behaviour<sup>47</sup>. Research in Ireland (that explored the effectiveness of an integrated exercise / Cognitive Behavioural Therapy intervention for young men's mental health) reported potential for improving young men's mental health<sup>48</sup>. The interventions examined in the study were designed to address help seeking barriers which men face, while providing an opportunity to avail of support without feeling embarrassed. Criteria for participation included low prior physical activity levels, and not being in receipt of any psychiatric treatment prior to the programme<sup>48</sup>.

Some programmes that focus on individuals who had previously attempted suicide have been shown to be efficacious; particularly those that offer a multi-site intervention<sup>27</sup>. Hoven et al<sup>28</sup> advocate early intervention in childhood which, they argue, can result in a return on investment in 'human capital' (proposed by Heckman<sup>29</sup>) i.e. intervention and investment in the child as early as possible results in fairness, social justice and productivity for society at large. It is predicted that there will be a progressive trend towards suicidal behaviour occurring at younger ages<sup>28</sup>. Because of this, the earlier the investment, at a societal level, in interventions targeted at children, the higher the return. Developing mental health awareness among children, their parents and teachers has potential to decrease the burden of suicidal behaviour<sup>28</sup>.

## 6.2 Preventing and Limiting Access to Means of Harm

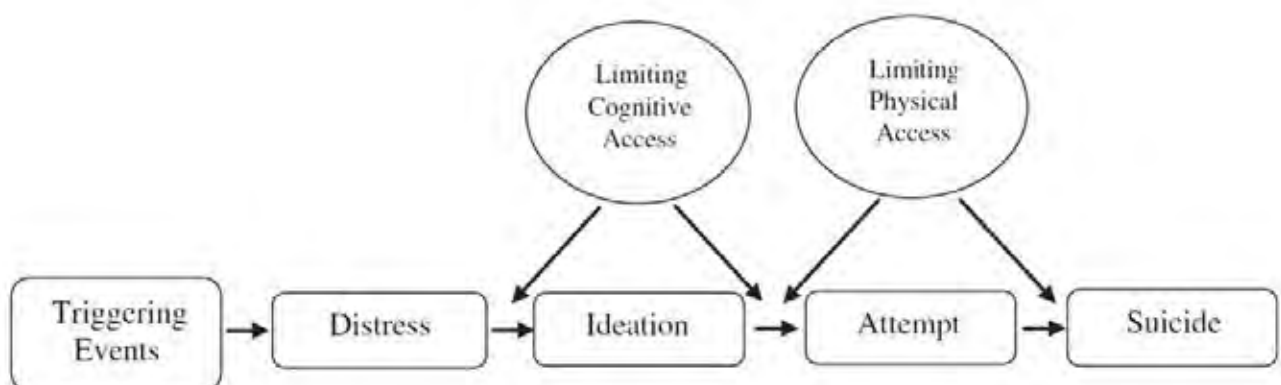
One of the most successful suicide prevention strategies is the reduction of lethal methods or restriction of access to the means of harm<sup>4,30</sup>. Such strategies include the construction of barriers at jump sites, restriction of access to firearms, detoxification of gas in homes, limiting access to pesticides used for lethal ingestion, limiting access to charcoal used for carbon monoxide poisoning, and restriction of access to the sale of barbiturates and analgesic painkillers<sup>4, 6</sup>. As discussed by Bertolote<sup>8</sup>, strategies that work in one region may not work in others. For example, ingestion of pesticides (a method used in Sri Lanka) or charcoal burning (a method in use in Asian cities) are not used in Western countries. Similarly, the use of firearms in the USA is not a frequently used suicide method in European countries because firearms are already restricted. However, restriction among particular groups within the wider population (such as farmers) - who may have access to particular means of harm - could be considered<sup>8</sup>.

Limiting or restricting access to hanging is one of the most difficult suicide prevention strategies - as it is impossible to remove ligature points or potential ligatures in the natural environment or within people's homes<sup>30</sup>. In this regard, strategies to reduce hanging have focused on institutional environments, such as prisons and hospitals (through the removal of potential ligature points both indoors and outdoors) - even though this population only accounts for 10% of hangings<sup>34</sup>. For those contemplating suicide, a particular suicide method must fulfil socio-cultural acceptability and availability in order for it to be selected as a method. However, changing attitudes towards specific methods of suicide is a challenging task<sup>30</sup>.

The fundamental assumption when reducing means is that high suicide risk periods are relatively short, and limitation may delay an attempt until this high risk period passes. In addition, it is believed that problem solving ability is reduced in suicidal individuals, and limitation of access to means makes it difficult for that individual to circumvent the method limitation. Restriction of methods is most useful where the methods used are highly lethal and commonly used.

Efforts to reduce suicide through limitation of access to methods can be categorised into two approaches: (i) efforts that limit physical access to suicide methods, and (ii) efforts that attempt to reduce the cognitive availability of suicide<sup>30</sup>. While limiting physical access to methods has been discussed, reducing cognitive availability of suicide pertains, in particular, to the responsible reporting of suicide within the media. In Figure 10, the authors indicate the available opportunities at which suicide intervention can occur. Limiting cognitive availability can potentially reduce the chances of suicidal ideation developing, while limiting physical access to suicide can reduce the risk of a suicide attempt.

Figure 10: Points of intervention between stages in the suicidal process<sup>30</sup>



[Florentine and Crane, 2010, p1627]

Florentine and Crane<sup>30</sup> report on several aspects of cognitive availability:

- How available a potential method of suicide is in one's mind plays a role in the method a person chooses to use to take his / her own life.
- Cognitive availability of suicide can be influenced by a range of factors at an individual, interpersonal and population level.
- For individuals who have been suicidal in the past, mental images of suicidal behaviour may come vividly to mind at times of distress, which means that suicidal ideation can be rapidly reactivated.
- Individuals may become habituated to the fear-inducing properties of suicidal behaviour over time. This may, in part, be due to repeated re-experiencing of suicide related imagery.
- Individuals who are vulnerable are more likely to be affected by exposure to suicide reporting in the media.
- The media often gloss over the more troubling aspects of suicide. For example, research has shown that many suicide attempters hold the misconception that a paracetamol overdose is a painless way to die, and that hanging is instantaneous - when, in reality, very few suicide methods are reliably painless.

*“Theoretically, challenging the false beliefs may be helpful in reducing the popularity of some methods. However, it is not clear what form such re-education interventions might take, particularly because whilst increased knowledge of the unpleasant aspects of suicide methods may act as a deterrent for some individuals, for others they may increase the method’s appeal”*

(Florentine and Crane, 2010, p1630<sup>30</sup>).

### 6.3 Youth Suicide Prevention

Risk factors for suicidal behaviour have been categorised into six broad domains: demographic and social factors; family characteristics and childhood experiences; personality factors and cognitive style (including sexual orientation); genetic and biological factors; psychiatric morbidity; and environmental factors<sup>44</sup>. In light of the complex interplay of risk factors, suicide prevention efforts among young people must attempt to diminish the influence of these factors separately or together<sup>44, 20, 45</sup>. However, in a review of the evidence on prevention strategies in the area of youth suicide and suicidal behaviour, Crowley et al<sup>44</sup> found such evidence to be weak. They recommend that existing promising approaches need to be evaluated systematically, so that factors that may lead to a reduction in youth suicide rates can be reliably established<sup>44</sup>. An outline of programmes which showed, at best, limited evidence of effectiveness is set out in Table 4.





Table 4: Interventions to reduce youth suicide with limited evidence of effectiveness<sup>44</sup>

Interventions	Limited Evidence of Effectiveness
School-based interventions	Programmes stressing behaviour change and coping strategies lowered suicidal tendencies and, in some cases, improved coping skills.
Clinical interventions	Depot Flupenthixol and Dialectical Behaviour Therapy showed some evidence of effectiveness.
Family interventions	Some evidence that universal interventions to diminish conflict and enhance cohesion between parents and children have persisting benefits in terms of behaviour and mental health of offspring.
Restriction of suicide means	Restricting access to paracetamol.
Interventions for at risk individuals	<p>Education and general coping skills training did have beneficial effects on suicidal potential and depression.</p> <p>'Moderate' studies (studies using moderately robust methodology) gave encouraging evidence for indicated suicide prevention programmes targeting at-risk youths.</p> <p>Problem-solving therapy and provision of emergency contact card showed some effectiveness in preventing deliberate self-harm. Weak evidence on recognition and assessment of risk.</p>
Media interventions	Promoting responsible media reporting.

Waldvogel et al<sup>20</sup> advocate a multi-faceted approach to prevention for adolescents at risk, with both the individual and community becoming aware of the risks of vulnerable youth. Such strategies should focus on reducing hopelessness and depression among youth, while encouraging communities to remain involved with young people<sup>20</sup>.

Suicide Prevention Australia<sup>46</sup> (SPA) reports that universal youth suicide prevention programmes offer the best value-for-money, and are the most prevalent youth suicide prevention programmes in Australia. These programmes are often integrated into an existing system, such as education or sporting programmes. It is believed that, in this way, the intervention can be targeted at everyone from low risk individuals (80% of the population of young people) to high risk individuals (5% of the population of young people - i.e. those engaging in deliberate self harm, those with a psychiatric diagnosis who require individualised treatment etc.). However, a comprehensive approach - which combines universal, selective, and indicated initiatives - will have the most effect in preventing youth suicide<sup>46</sup>.



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## Approaches to youth suicide prevention in Australia include:

### (a) *Universal Prevention Programmes ...*

- Anti-bullying programmes.
- Physical health promotion.
- Online and new media.
- Information and education programmes.
- Tertiary education, apprentice, and early career-based programmes.
- Socio-economic programmes (not established, but named as a potential in position paper).
- Media education (guidelines - further potential in raising awareness).
- Restricting access to means.

### (b) *Selective Prevention Programmes ...*

- Gatekeeper training - teachers, parents, GPs (recommending all frontline services).
- Suicide screening - gatekeepers administering suicide screening measures (questioning young people about risk factors and current social and emotional well-being).
- Mentoring / Peer support - training older students and youth focus programmes (not gatekeepers).
- Family programmes - raising awareness of signs and how to help, combat youth distress, education on youth issues and pressures, diminishing conflict in dysfunctional families.
- Programmes for at risk groups - those with an underlying mental illness, GLBTIQ, indigenous people, rural and remote communities, those involved in the juvenile justice system and those bereaved by suicide. Because the issues facing these groups are often social and environmental, rather than personal, these interventions must be culturally and socially appropriate.

### (c) *Indicated programmes ...*

- Crisis support services.
- Early intervention programmes.
- Mental health services.

Ireland is participating in a multi-level community based intervention, launched in 2010, which is part of a wider initiative that is being implemented in Germany, Hungary and Portugal<sup>19</sup>. This study, will implement a four level intervention:

- Level 1 - Training and practice support for primary care physicians in detecting and treating depression.
- Level 2 - Public relations activities to inform the general public about depression, including anti-stigma campaigns.
- Level 3 - Training sessions on depression and suicidality for community facilitators (gatekeepers).
- Level 4 - Overtures to high risk groups (non fatal suicide attempters), establishment of help-lines, and support for self-help activities with patients and relatives.

The study will be carried out in each country (Limerick in Ireland), and will use a control in each country (Galway in Ireland) to establish if the interventions are significant. The control will allow the study to adjust for other socio-cultural variables, thereby indicating if the interventions have been significant in reducing suicide and suicide attempts. In order to do this, the study will: (i) increase the size of the population under observation by aggregating data from four regions that have implemented a similar programme, and (ii) increase the numerator by constructing a composite primary outcome - consisting of completed suicides and, also, non-fatal suicidal acts<sup>19</sup>.

In the USA, Coroner and Goldston<sup>36</sup> outline a developmental framework in relation to suicide in young men and boys. This includes the role of substance abuse disorders, and depression and serious aggression. The same authors highlight a correlation between patterns of suicide among 11-21 year old males and developmental patterns of substance abuse disorders - indicating that these disorders may play a role in suicide in this age group.

Generalised Anxiety Disorder (the most prevalent disorder in youth) has a later age of onset - in middle to late adolescence - and this has also been shown to have a similar pattern to suicide in younger males. Available data on aggression in the USA shows a correlation between increasing severity of aggression in young men (severe violence and lethal acts of violence) and the age-related suicide pattern in young men. It is likely that there are *“shared underlying causes for the age-related patterns in suicide and serious violence including developmental changes”* (Conner and Goldman, 2007, p196)<sup>36</sup>.

The authors suggest that the developmental sequelae of substance abuse are often overlooked. Thus, symptoms of alcohol dependence are linked with suicidal ideation among aggressive adolescent males. Chronic alcohol related problems may lower the threshold for impulsive suicide after an acute life stressor - such as problems with the law or a relationship breakdown. In terms of suicide and depression, setbacks experienced by boys and young men (whether social, educational, legal or occupational) may contribute to substance abuse and / or depression that can compound these problems further and, potentially, lower the threshold to complete or attempt suicide.

**The authors set out three recommendations to reduce suicide in adolescent and young men:**

**(i) Interrupt the cycle of substance abuse and developmental failure ...**

- Conceptualise stressful life events (relationship break-up, job loss, criminal and legal difficulties, school expulsion).
- Conceptualise life circumstances (unemployment, lack of educational achievement).
- Promote achievements of age-salient developmental tasks which are associated with a decrease in alcohol related problems.
- Developmental achievements may actively contribute to ‘maturing out’ from alcohol abuse.

**(ii) Interrupt the cycle of depression and developmental failure ...**

- Identify depressed youth.
- Focus on enhancing social skills, social problem-solving ability, and social integration for depressed youths.

**(iii) Reduce the potential for suicide fatalities ...**

- Tackle the acute disinhibitory effects of some substances (particularly alcohol) - as young males may be especially vulnerable to disinhibition following stressful life events, thus increasing the likelihood of impulsive suicide attempts.

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## 6.4 Masculinity and the Lack of Help Seeking

Research has shown that more traditional aspects of masculine practice can raise particular barriers to men's effective and appropriate use of health services, and that the traditional male gender role can undermine men's mental health; inhibiting protective factors of help seeking and social support<sup>57, 58, 59, 60, 62</sup>.

An Irish study (carried out with 52 young men who had recently attempted suicide), reported that high levels of emotional distress were prevalent among study participants in addition to the existence, among many, of more long-term problems<sup>54</sup>. These young men had difficulty in identifying symptoms of emotional distress, and had problems managing that distress. The author theorised that these men's inability to seek help for their distress was influenced and mediated by their low socio-economic backgrounds and low level of educational attainment. However, it was also found that the impact of more dominant or hegemonic masculinity constructs encouraged these men to deny their emotions, and to feel shame if they could not live up to such ideals. In addition, it was found that this form of masculine identification maintained a local importance, and was upheld by other men in the area. With many of the men being unable to leave the area - due to inadequate resources - and being unable to disclose their distress, alcohol provided a culturally acceptable form of hiding this distress. In conclusion, the author states:

*“The key finding here is that the expression of emotions is not equally fluid and flexible throughout society, and that there may be environments where the containment of emotions can have lethal effects for some men. In this way, suicide may represent the externalised cost to society of the repression of normal emotions, the non-acknowledgement of a human need”* (Cleary, 2012, p504<sup>54</sup>).

Houle et al<sup>58</sup> also assert that there is a relationship between psychological health and adherence to traditional masculine gender roles. They argue that men who adhere more strongly to traditional masculine roles may experience greater feelings of shame upon encountering failure, have less perceived social support, and may feel unable to confide in family or friends - thus, diminishing their self-esteem and, potentially, leading to the undermining of their mental health.

Whilst Oliffe et al<sup>56</sup> also describe the limiting effect of masculinity on help seeking and depression in men, they argue that various masculinities emerge as potential solutions or pathways to counter suicidal ideation, such as establishing connections to family and peers, as well as the adoption of religious and moral beliefs:

*“Doing gender can privilege men's autonomy, and foster excessive and impulsive behaviours which restrict their help-seeking and social connections to heighten the risk for suicide. That said, it is also clear that masculine practices (some of which are idealised) can actually mitigate suicide risk. This was evidenced by participants' ability to counter suicide actions by pragmatically repackaging masculinity to meaningfully connect and confide in others as the conduit to effective self management. By endorsing diversity in masculinities within a broad range of settings, alternate scripts for depression and suicide can be made available to men”* (Oliffe et al, 2012, p512<sup>56</sup>).



In a review of the interplay between masculinities and depression, Oliffe et al posited that men's experiences, expressions, and triggers for depression are strongly influenced by dominant ideals of masculinity<sup>55</sup>. The authors pose the very legitimate question that:

*“If young men’s health risk taking (binge drinking and drug use) occurs as a result of wanting to prove their masculinity to other men and women, then what strategies might be legitimately available to men who experience depression but do not recognise it, or recognise it but cannot access professional help?”* (Oliffe and Phillips, 2008, p198<sup>55</sup>).

Conceptualising how young men weigh the impact of the stigmatisation of mental health in relation to their masculinity (and the associated pros and cons, friendships, intimate relationships and job opportunities etc.) provides a useful means for how we might begin to help men who experience depression and who, otherwise, may not come forward to seek help. The authors cite several examples which seek to reach out to men, rather than waiting for men to present - as is the traditional route. Among these, are virtual web-based services and supports which allow men to assess information and treatment while maintaining anonymity, and aligning help seeking as a masculine norm of being strong, gallant and rational.

In terms of the therapeutic process in treating men who decide to present with depression, Kilmartin<sup>61</sup> makes several suggestions for communicating with these men:

- At an early stage of the consultation, teach them about the potentially constraining effects of gender to help the client resist the cultural pressure to adhere to traditional masculine roles when life events conflict with life goals.
- Strongly recommend against premature ending of treatment when symptoms begin to improve slightly.
- Frame emotional expression as a skill that improves with practice (use sporting analogies).
- Build an emotional vocabulary which refers to body sensations and to introspection.
- Access the vulnerable feelings that are likely to underpin expressions of anger; as less socially sanctioned emotions often convert to anger.
- Health professionals should deal with their own views of masculine mental health, and resist the urge to adhere to the unhealthy aspects of gender conformity; particularly the traditional masculine norms.
- Expand men's understanding of masculinity by addressing their fear that therapy might be associated with 'feminising' them.

Indeed, it has been suggested that men who are recovering from depression need to reconstruct a valued sense of themselves and their masculinity as part of their recovery process<sup>63</sup> (conceptualising their recovery as a heroic struggle from which they emerge a stronger person). It is suggested that those who are in contact with men who are experiencing or recovering from depression be cognisant of this fact.

*“The power of hegemonic masculinity means that many men are likely to re-interpret potentially feminising experiences as ‘masculine’ and health professionals need to be aware of the problems, as well of the benefits, of narratives which emphasise control, strength and responsibility to others”* (Emslie et al, 2006, p2256<sup>63</sup>).

## 6.5 Principles of Effective Practice in Suicide Prevention Work with Young Men

The following is a list of ten key principles for effectively engaging with young men in suicide prevention work. These reflect a summary of some of the key findings from the literature review undertaken in this study, and build upon the National Men's Health Policy's<sup>64</sup> principles of best practice in working with men. These also reflect feedback from the stakeholder consultation phase of this research:

### **Focus on 'mind health' or 'mental fitness' not mental health ...**

- The term 'mental health' tends to have connotations with mental ill-health for many young men, and can be associated with wide-ranging stigmas and taboos - particularly within the context of more stereotypical masculine norms. Consequently, young men may be reluctant to engage with mental health programmes or initiatives out of fear of being ridiculed, feeling embarrassed or being undermined in some way.
- A focus on 'mind health' or 'mental fitness' should revolve around the type of skills and competencies that can support young men to: recognise and understand the source of feelings of sadness or despair; know how to deal with challenges and crises in their lives; have the knowledge and confidence to seek support and to access appropriate services when necessary.
- Such work should avoid seeing young men as 'the problem'. It should strive to adopt solution focused activities that develop a non-deficit approach to supporting young men to grow and develop in terms of emotional well-being, problem-solving, and emotional resilience.

### **Plan services and programmes with young men in mind, and work on developing trust and safety through the creation of non-threatening and male-friendly environments ...**

- At present, one of the biggest challenges in addressing the needs of young men is the absence of services and programmes that are specifically targeted at them. Auditing and gender-proofing existing programmes and services would help to draw increased attention to gaps in service provision for young men.
- The creation of an open, friendly environment on initial contact helps young men to overcome any mistrust or suspicions that they may have about prospective services or programmes. This creates safety, and enables young men to feel more confident and at ease. Young men quickly assess the 'comfort level' of services or prospective programmes, and whether they are likely to meet their particular needs.
- The use of positive images of young men in posters and other materials can help to build trust and rapport with them.
- Ensure there is clarity of purpose to the work, and that young men know what they are doing and why they are doing it. At the outset, be explicit about what is expected, regularly review what has been achieved, and get feedback from programme participants.
- Actively seek to engage with young men on their level - avoiding, where possible, hierarchical (and potentially confrontational) relationships between professional service providers and young male service users. Rather than controlling, directing or prescribing matters for young men, the focus should be on enabling, empowering and facilitating them to take control of their own mind health / mental fitness.
- There is a need for increased training and supervision of health care professionals in relation to identifying risk factors and warning signs associated with suicidal behaviour in young men, and in working effectively with young men.

## **Consult with, and involve young men in, programme development and programme delivery ...**

- Service providers can sometimes be fearful about engaging with young men - possibly seeing them as disruptive, troublesome or difficult to work with. However, when young men are consulted with and involved in shaping and determining programme outcomes, and where programmes are designed to meet young men's needs, the experience can be very different. Local reference groups should be established that are representative of the young men to be targeted, and they should provide ongoing feedback and guidance about programme direction.
- The success of any initiative hinges on understanding young men's motivation and reasons for being involved. This should be at the heart of programme design and delivery.
- The expansion of existing programmes into new areas can be fostered by current programme participants sharing their experiences with young men in other places. This can be further enhanced through the development of more formal networks of support; particularly through the use of social media.

## **Find a 'hook', and look for avenues that appeal to young men ...**

- Think carefully about the most appropriate 'hook' to engage young men, and be aware that this hook is likely to differ from region to region. Build mind health, mental fitness, and suicide prevention programmes around activities and areas of interest that appeal to young men. Examples of previous initiatives that have effectively capitalised on this approach include sports programmes (e.g. Alive and Kicking Goals, Back of the Net, It's a Goal), tertiary education programmes (e.g. Incolink, Ozhelp), and specific task-oriented or problem solving approaches (e.g. Mind Yourself).
- Programmes that have a high level of service user participation tend to be more effective in engaging young men.
- Making contact with young men is important, but sustaining contact is even more important. Monitor what works in keeping young men interested and involved, and learn from endeavours that are less successful in sustaining young's men involvement. Where possible, try to ensure that adequate resources are in place to follow through and provide more sustainable initiatives for young men.

## **Target programmes early ...**

- The targeting of programmes in childhood has been shown to result in a better return of investment in suicide prevention work. Schools, sports clubs and other youth settings have the potential to play an important role in supporting suicide prevention work with young men.
- The targeting of programmes in childhood also has a key role to play in interrupting the cycle of developmental failure, substance abuse and depression that can lead to suicide ideation in young men, and that disproportionately affects more marginalised groups of young men.
- It is vitally important that school-based and tertiary education programmes place a high priority on the development of emotional resilience and problem-solving among boys. Boys also need to be supported to develop a language for expressing emotional distress and, when faced with challenges or crises, they need a clear roadmap to know what to do, who to turn to, and where to access help.
- The connection between alcohol consumption and being emotionally expressive also needs to be challenged - and this needs to start early with boys. The corollary of this is that boys / young men do not have 'permission' to express concerns or anxieties except when under the influence of alcohol. This is highly damaging to their emotional well-being.
- The school setting is particularly important in tackling bullying and homophobia. In particular, the links between expressing emotional problems and being labelled as 'gay' places a significant barrier to boys and young men expressing emotional problems - as well as entrenching stereotypical views of what it is to be gay.

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## Target programmes at those young men who are most in need ...

- There should be an increased focus on targeting more vulnerable and at risk boys / young men (early school leavers, participants in early career based programmes, those involved in alcohol and substance misuse, unemployed men, gay / bisexual / transgender men, men involved in the criminal justice system, Traveller men).
- A multi-dimensional whole of government approach should be the basis from which at risk groups of young men should be targeted. *“The premise that the causes of suicide among young people are complex in their origins and need to be addressed on multiple levels remains the basic starting point”* (Australian Institute of Family Studies, 2000, p102<sup>65</sup>). Therefore, the development of strategic alliances and partnerships between different sectors should underpin effective suicide prevention work with young men.
- Regular contact (telephone, letter, use of social media), and follow-up support directed at high-risk groups, has been found to be an important contributory factor to reducing suicide rates and reducing the number of repeat suicide attempts.
- Young men are particularly vulnerable during times of crisis (relationship break-up, bereavement, being made redundant), and may be more amenable to interventions at such times. Ensure that this ‘window of opportunity’ is not lost. Look out for signs of distress or changes in behaviour, return phone calls promptly, and use a solution focused approach to counselling.

## Use language that is positive and solution-focused ...

- Ensure that language used to engage with young men is positive and respectful - not deficit based - and seeks to develop rapport with service users.
- For some young men, being emotionally expressive can be perceived as being ‘unmasculine’ and, as a result, may be associated with the repression of emotions - particularly those related to fear or sadness. Boys and young men should be supported in every way possible to know that: (i) having such emotions is part of everyday life (for both women and men), and (ii) having the language to express such emotions is an important aspect of overcoming problems and dealing with crises, and this improves with practice.
- It is important that service providers develop strong and comfortable body language to make young men feel at ease.

## Consider the use of role models and marketing in suicide prevention work with young men ...

- There needs to be an increased focus on the use of positive role models / champions (e.g. from the sporting, entertainment or music arenas) to support suicide prevention measures directed at young men. Care should be taken in the choice of role models - so as not to inadvertently promote the wrong type of messages or to reinforce gender stereotypes.
- High profile role models, who hold credibility and respect among boys and young men, need to be actively associated with: reducing stigma around mental health and suicidal behaviour; promoting help seeking behaviour; improving emotional resilience and problem-solving.
- Local role models and peers also play an important function in actively promoting projects, and have the capacity to allay fears or embarrassment that some young men might have about getting involved.
- Use word-of-mouth recruitment to overcome what, for many young men, can be an inherent suspicion of engaging with programmes. The use of ‘cold calling’ advertising or ‘parachuting-in’ experts from outside the community is often not as successful as simple word-of-mouth endorsement.
- Use ‘gatekeepers’ in education, workplace, sporting or community settings to encourage other young men to participate in programmes. One of the strongest forms of marketing is when someone, whom a young man trusts: (a) recommends a particular service or programme, and (b) provides a telephone number and a specific name of a contact person.



- Use social media, magazines or fliers to advertise and create an interest in programmes. There should be a clear focus upon what will be gained by attending these initiatives.

### Consider the potential of peer support and mentoring ...

- It is well known that young men learn a lot, informally, about the world from their peers, and this type of learning and support can be invaluable. We also know that young men tend to be reluctant to access conventional health services, and are more likely to approach a friend during times of crisis. Yet, many young men are unsure of how to support a friend or acquaintance at such a time. There is, therefore, a need for an increased focus on peer support and mentoring programmes which are directed at enhancing young men's sense of competence and confidence in supporting other young men in times of difficulty or crisis.

### Evaluate what type of suicide prevention interventions work with young men ...

- Notwithstanding the methodological limitations associated with developing evidence-based interventions, there is a need for an increased focus on supporting those tasked with delivering suicide intervention projects to evaluate the effectiveness of their work. *"The understandable wish 'to do something' about the problem of suicide has led to a flurry of activity, little of it evidence sustainable but most of it politically acceptable"* (Walsh, 2007<sup>9</sup>).
- The provision of funding for suicide prevention work with young men should be contingent on the capacity to demonstrate built-in evaluation measures. In particular, the focus of such endeavours should be on assessing the impact of programmes in terms of improving participants' perceived level of competence and confidence in preventing suicide, and in responding to suicidal behaviour (i.e. among young men themselves, their peers and families, community gatekeepers and health professionals).
- Programmes which target young men could adopt scales to measure levels of distress / competence both before and after a programme e.g. the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) or General Health Questionnaire 12 (GHQ-12).
- Whilst there is an understandable desire to transfer good practice from one setting to another, it is not, necessarily, the case that what has worked in one place will be effective elsewhere. Therefore, it is important to be aware that initiating or transplanting prevention programmes that have worked elsewhere can be potentially problematic.
- Support networks allow opportunities for sharing information in relation to suicide prevention work with young men. This can be further developed through the writing of journal articles and the provision of supervision / support groups - where small groups of workers meet, on a regular basis, to reflect on their work and to learn from each other.

## 6.6 Models of Effective Practice

During Phase 1 of YMSP, the authors conducted a search of both academic literature and 'grey literature' to identify evidence of models of effective mental health promotion and suicide prevention practice with boys and young men.

This section of our report provides a brief overview of some examples of effective practice that have been implemented nationally and internationally. These models reflect practice with young people generally and, where relevant, models which have shown evidence of specific effectiveness with young men.

## Mind Yourself (Ireland)

### Overview

The Mind Yourself<sup>66</sup> programme is a school-based problem solving brief intervention aimed at adolescents. Essential elements of the programme include:

- A holistic life-skills approach encompassing coping and problem-solving skills.
- A strengths-based approach, which focuses on hope, optimism and is solution-focused.
- A whole population approach to working with young people. This way, those who are most 'at risk' - but may never come into contact with services - are more likely to be reached.
- A community-based approach that is founded upon consulting with young people on their needs.
- A firm grounding in strategies to enhance problem-solving skills, emphasise optimism, and promote resilience among adolescents.
- The provision of information on resources and services available to young people.
- An empirical evaluation of the programme - so as to measure its effects on helplessness and hopelessness. Levels of depression, self-esteem, problem-solving strategies, and coping methods are also assessed.

### Methodology

Two sessions, approximately 90 minutes each, are delivered to adolescents in groups of 15 or less (ages 15-17) in school settings.

### Evaluated - Yes

Randomised pre and post group study, with experimental and control groups. Results show that the programme was effective in creating significant positive changes in terms of problem solving and emotional resilience. Other results indicate positive but non-significant changes in depressive symptoms (greatest reduction in boys) and self-harm thoughts.

## Back of the Net (Ireland)

### Overview

Back of the Net<sup>48</sup> (BTN) is an integrated exercise and Cognitive Behavioural Therapy intervention for young men's mental health. Trials show that the BTN programme was effective in reducing depressive symptoms in young men. The BTN programme is of further interest, as it is designed to address help seeking barriers specific to men - thereby, giving men a safe means to seek support without embarrassment.

### Methodology

10 week programme with 2 exercise sessions per week. Each session is integrated with themes which are delivered through a Cognitive Behavioural Therapy (CBT) approach. Further work has employed the use of online CBT techniques.

### Evaluated - Yes

The programme has been evaluated using a control trial methodology, and has shown effectiveness in reducing depressive symptoms in young men.

## Frameworks (USA)

### Overview

Using a public health model, the Frameworks / Connect programme<sup>67</sup> trains community members to play a critical role in suicide prevention. The programme strives to strengthen the development of a community coalition of service providers, parents and youth. The coalition is developed, trained, and supported to recognise youth at risk, and to connect those youth with help in an integrated, systematic and comprehensive way. Frameworks / Connect builds upon existing community resources and expertise, and addresses system gaps that may exist between schools, hospitals, police, mental health and/or other services. This is accomplished by training professionals and others about their roles within their own settings, as well as about their roles in interacting with other service providers. Emphasis is on coordination, communication, and connections between local resources, providers, citizens and youth, as well as reducing the stigma associated with suicide and help-seeking behaviour.

### Methodology

Training for key gatekeepers (1 day) in addition to Train the Trainer (3 days). This training aims to increase:

- Knowledge of the protocols and prevention skills, including recognition of risk and protective factors, and warning signs of a person at risk of suicide.
- Confidence in the use of the protocols.
- Comfort level with suicide prevention and postvention strategies.
- Competence in dealing with suicide events.
- Community capacity to provide an integrated response to suicide events.

### Evaluated - Yes

The programme has been evaluated using pre and post testing questionnaires designed to evaluate changes in knowledge, attitudes and beliefs as a result of the training.

## Alive and Kicking Goals (Australia)

### Overview

This project aims to reduce suicide among indigenous youth through the use of football and peer education. The project encompasses community development, leadership development, youth health, sport, music and education. The project participants visited Ireland in 2010.

### Methodology

Using peer mentors, the teams meet after practice each week to discuss suicide, self harm, and their plans and dreams for the programme.

### Evaluated - No

While there has been no evaluation of the programme, Suicide Prevention Australia's Youth Suicide Prevention Position Statement<sup>46</sup> highlights the programme as being of worth.

## Optimising Suicide Prevention programmes and their Implementation in Europe (OSPI Europe)

### Overview

OSPI is a multi-level, community-based intervention which is being implemented in Ireland (Limerick), Germany, Hungary and Portugal<sup>19</sup>. This project will have four discrete levels of intervention.

### Methodology

- Level 1: Training sessions and practice support for primary care physicians.
- Level 2: Public relations activities for informing the general public about depression, including anti-stigma campaigns.
- Level 3: Training sessions on depression and suicidality for community facilitators (gatekeepers).
- Level 4: Overtures to high risk groups (non fatal suicide attempters), establishment of helplines, and support for self-help activities with patients and relatives.

### Evaluated - Yes

The study will be carried out in each region (Limerick in Ireland), and will use a control in each country (Galway in Ireland) to establish if the interventions are significant. The control will allow the study to adjust for other socio-cultural variables, thereby indicating if the interventions have been significant in reducing suicide and suicide attempts. In order to do this, the study will increase:

- The size of the population under observation by aggregating data from four regions that have implemented a similar programme.
- The numerator by constructing a composite primary outcome, consisting of completed suicides but also non-fatal suicidal acts.

## MoodGYM (Australia)

### Overview

MoodGYM is an online Cognitive Behavioural Therapy (CBT) self-administered intervention, designed to teach CBT skills to people who are vulnerable to depression.

### Methodology

MoodGYM comprises five interactive modules, including cognitive restructuring, pleasant activities, assertiveness training, problem-solving, and downloadable relaxation sessions. The modules are made available sequentially on a weekly basis. All interactive exercises are stored in a personalised workbook and, at the conclusion of each module, an individualised feedback form is available for printing-off.

### Evaluated - Yes

Randomised control trials with 6 and 12 month follow ups<sup>78, 79</sup>. The programme has shown effectiveness in reducing symptoms of depression and dysfunctional thoughts. However, online programmes which are delivered with therapist guidance may be more effective in terms of retaining the participant through the whole CBT programme<sup>80</sup>.



## Coach the Coach (Australia)

### Overview

Coach the Coach<sup>68</sup> is a prevention programme that utilises a football team structure to reach young men in rural towns. The aim of the programme is to increase an individual's ability to recognise mental health conditions, and to encourage self help seeking and professional help seeking behaviours; thereby impacting on suicide rates. The programme is aimed at young men aged 15-30, and is delivered through a medium that these young men already recognise, respect and listen to. The programme is partnered with the School of Rural Health Research in the University of Melbourne.

### Methodology

A 12 hour mental health 'First Aid' course with the following content:

- Assessing the risk of suicide or harm.
- Listening non-judgementally.
- Giving reassurance and information.
- Encouraging participants to get appropriate professional help.
- Encouraging self-help strategies.

### Evaluated - Yes

Pre and post measures of club leaders' ability to: (i) recognise depression and mental health problems; (ii) be aware of supported treatment options; and (iii) respond with confidence to mental health problems. The evaluation concluded that rural football clubs appear to be appropriate sites for the promotion of mental health awareness. However, the benefit to players was less obvious - indicating that further research is required. The programme is highlighted within the Suicide Prevention Australia's Youth Suicide Prevention Position Statement<sup>46</sup>.

## Incolink - Life Care Skills Project (Australia)

### Overview

The Life Care Skills project<sup>69, 70</sup> aims to prevent suicide amongst young people in the building and construction industry. The programme raises awareness of suicide and its risk factors, and promotes positive life skills to support apprentices with the daily challenges of work and life. Incolink offers its training to all first year construction apprentices. The programme aims to reduce risk factors associated with suicide - such as relationship break-up, financial problems, gambling, and drug and alcohol abuse - while building resilience and other protective factors.

### Methodology

The programme focuses on providing information to apprentices through technical and further education providers, trade unions and employer associations, and to employers and employees on building sites. The programme is tailored to the specific needs of young men - including their learning styles - and in terms of delivery of the programme to maximise effectiveness and attendance.

### Evaluated - Yes

The programme has shown effectiveness in increasing awareness and knowledge of risk factors, increasing skills and knowledge of protective factors, and in promoting help seeking behaviour.

## 7. Learning from the Literature Review Phase

Suicide, in Ireland, is the principal cause of death in men aged 15-34 years of age. This is mirrored in other European and developed Western economies.

While national strategies highlight the need to focus prevention efforts on young men, there is little evidence to indicate that this has happened or, indeed, to substantiate the effectiveness of the prevention and intervention initiatives that have taken place. This is not due to evidence indicating ineffectiveness. Rather, there is a lack of evidence due to insufficient rigorous evaluation of these initiatives. It is often not possible to utilise the 'gold standard' of a Randomised Clinical Trial. Therefore, prevention efforts must rely on weaker evidence.

The reduction of means to harm, and the education of General Practitioners in depression recognition and treatment, is known to be effective in suicide prevention. In relation to reduction of means to harm, it must be pointed out that the target group - those aged 15-24 years - are the ones most likely to take their own life using violent methods; particularly hanging. Hanging is the most difficult method to restrict - as it is impossible to remove all ligature points in the environment.

Whilst interventions that revolve around sport and physician education offer much potential, it is also known that young men are those least likely to seek help in the event of mental health difficulties. Therefore, reaching young men who are experiencing suicidal thoughts can be difficult.

The targeting of suicide prevention initiatives through community education programmes - although widespread - has reported limited efficacy in terms of reaching their target groups. However, longer-term programmes that utilise a commitment by the wider society, working at multiple levels, and with a strong emphasis on the creation of community networks, can be successful.

The factors associated with increased suicide risk in young people include:

- Gender
- Genetics
- Mental health
- Alcohol and substance abuse
- Sexuality
- Socio-economic disadvantage
- Prior history of attempted suicide or deliberate self harm
- Relationship break-up
- Personality traits
- Restricted help seeking behaviour

In the Republic of Ireland, the impact of both increasing unemployment, and high levels of alcohol consumption, has been specifically implicated in rising suicide rates. The recent economic situation has seen a substantial increase in unemployment - especially among young males - and, in tandem with this, suicide rates have increased. While evidence suggests that alcohol consumption has a significant influence on suicide rates, it would seem that unemployment, alcohol and suicide are intertwined - again, particularly among young men. The recent rise in suicide rates has been attributed to the recession and increasing unemployment. However, the suicide rate in this period has also been moderated somewhat by decreasing levels of alcohol consumption.

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Youth suicide interventions include school-based interventions, clinical interventions, family interventions, restriction of access to means, interventions for at risk individuals, and media interventions - although most have shown limited evidence of effectiveness. An American developmental framework (designed to reduce the incidence of suicide in boys and young men) draws particular attention to the importance of interrupting the cycle of substance abuse, depression, and developmental failure.

Attempting to transplant a suicide prevention programme that has shown success in other countries can be problematic, as socio-cultural factors may render it ineffective. Increased risk in relation to suicide is influenced by:

- Demographic and social factors
- Family characteristics and childhood experiences
- Personality factors and cognitive style
- Genetic and biological factors
- Psychiatric morbidity
- Environmental factors

In order to reduce suicide, there needs to be a recognition that prevention efforts must tackle the complex interplay of these risk factors; either together or separately.

There can be multiple reasons why young men are reluctant to seek help when faced with a problem or crisis. These include:

- Embarrassment
- Shame
- Stigma
- Concerns in relation to confidentiality or that others might find out that they have a problem

In addition, misuse of alcohol, unemployment, and reluctance to approach a professional in times of difficulty, have also been cited as barriers to young men's mental well-being. Young men's state of mind is, however, also important - as suicide can be triggered by depressive episodes or severe mental illness.



Early intervention in childhood has been shown to be particularly effective.

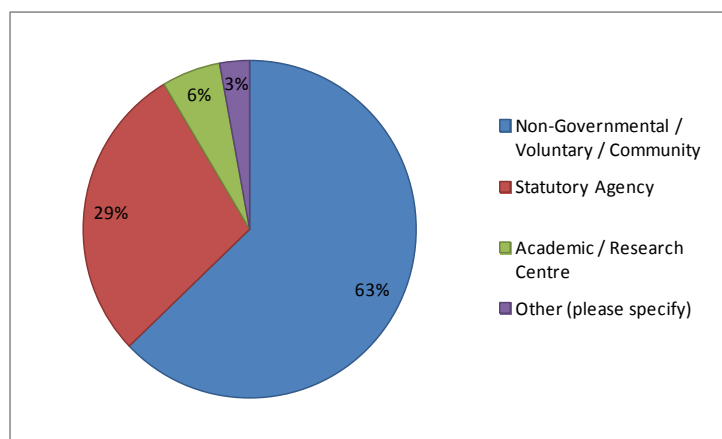
### 8. Stakeholder Surveys

#### 8.1 Profile of Respondents

The stakeholder survey<sup>iii</sup> elicited responses from a total of 72 organisations: 36 from Northern Ireland and 36 from the Republic of Ireland. The community based survey elicited responses from 175 organisations. Not every question was answered by every participant and, therefore, total responses to each question vary - depending on the number of participants completing each one. In some cases, respondents could select more than one option for particular questions. Therefore, where graphs do not total 100%, categories are not mutually exclusive - as respondents could select more than one option.

The majority of respondents (63%) indicated that they were from non-governmental, voluntary or community based organisations (Figure 11).

Figure 11: Respondent stakeholder organisation type (n=70)

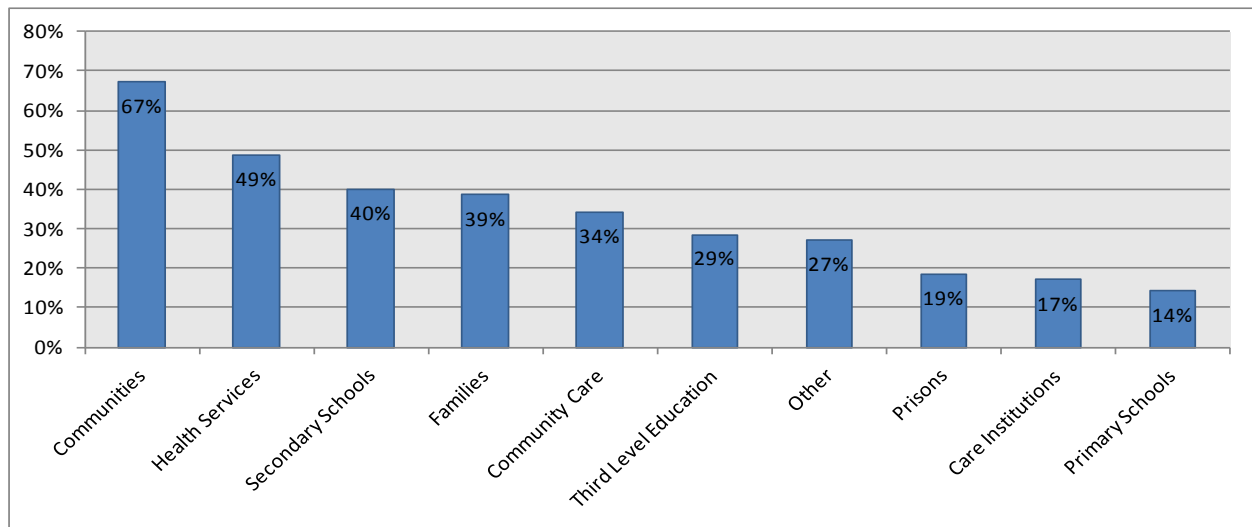


<sup>iii</sup> Except where stated otherwise, the term 'stakeholder survey' refers to responses from Survey 1 (i.e. stakeholders with a specific remit for mental health promotion / suicide prevention).



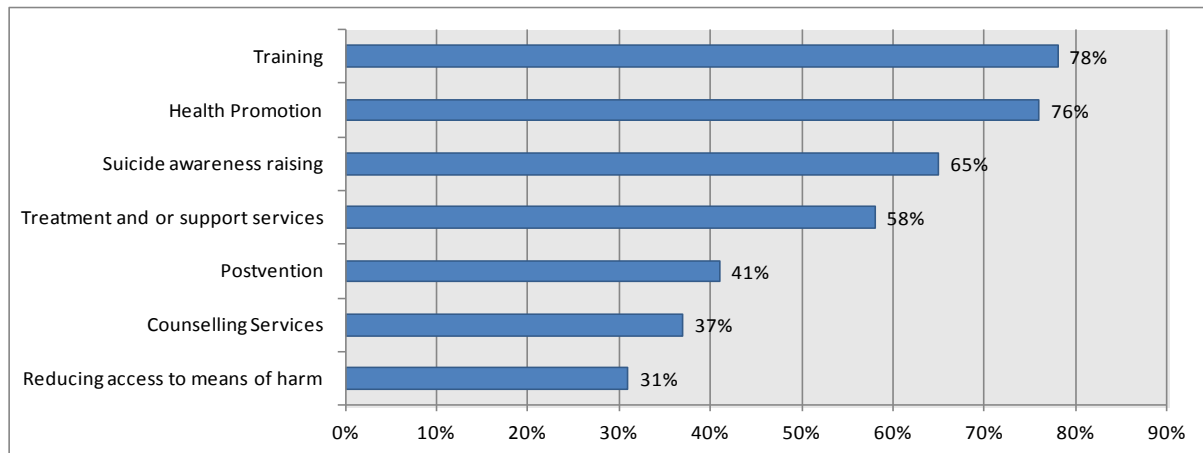
Figure 12 shows that respondent organisations worked across a broad range of settings; with many operating in multiple settings.

Figure 12: Percentage of respondents working within particular settings (n=70)



## 8.2 Types of Prevention and Intervention Work Carried Out by Respondent Organisations

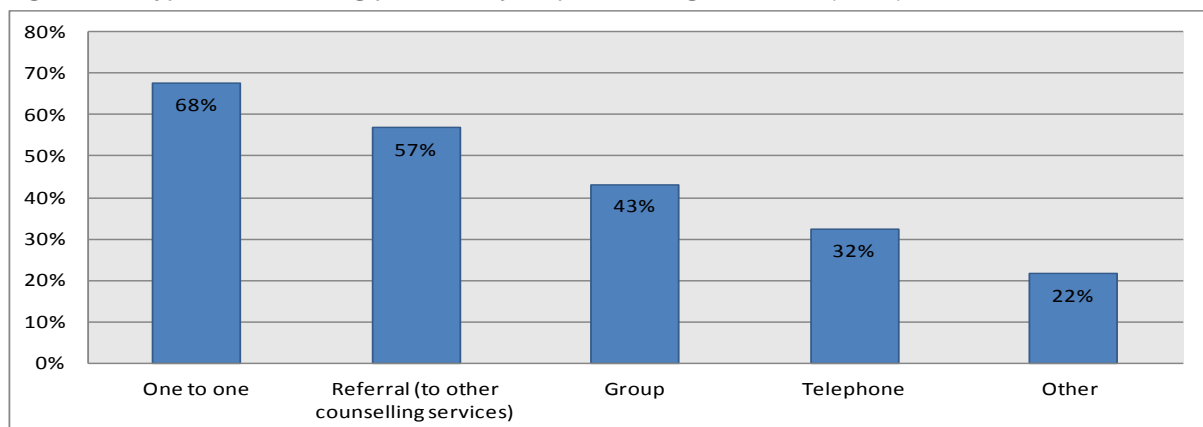
Figure 13: Percentage of respondents working within particular fields of prevention and intervention work



### 8.2.1 Counselling Services

Just over half (51%) of respondents (n=37) reported providing counselling services as part of their work. Most of these provided one-to-one counselling (68%), while 57% also referred to other counselling services, and 43% provided group counselling (Figure 14).

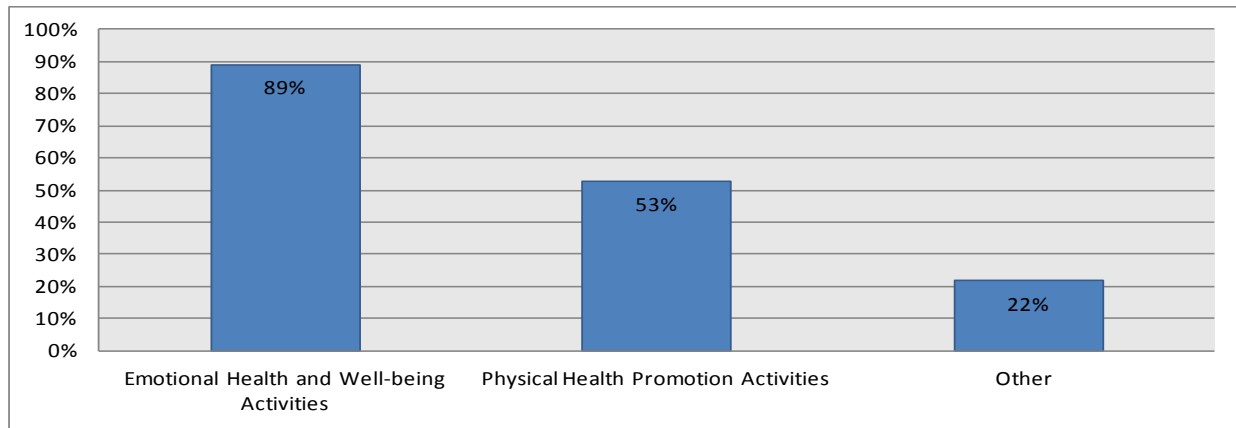
Figure 14: Type of counselling provided by respondent organisations (n=37)



## 8.2.2 Health Promotion

Some 76% of respondents (n=55) reported providing health promotion activities, of which 89% carried out emotional health and well-being activities, and 53% physical health promotion activities (Figure 15).

Figure 15: Type of health promotion activities provided by respondent organisations (n=55)

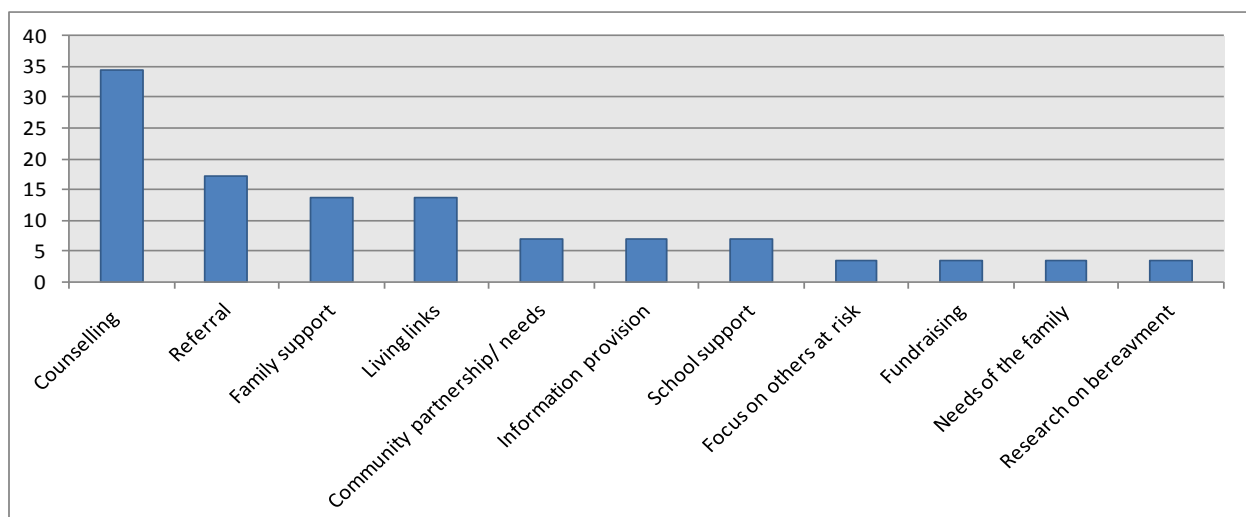


## 8.2.3 Postvention

Some 41% of respondents (n=30) indicated that they provided postvention support. This postvention work most frequently involved counselling at a one-to-one level or at a group level. Some organisations stated that they referred people to other services during their postvention work, while others provided the families of the bereaved with direct support - in some cases providing home visits, assistance with funeral arrangements, and organising follow-up care and support.

Several organisations provided, and assisted access to, the 'Living Links' programme (provision of assertive outreach support to the suicide bereaved). In addition, some organisations provided information to those bereaved, while others provided support to schools that had, in the past, been affected by suicide.

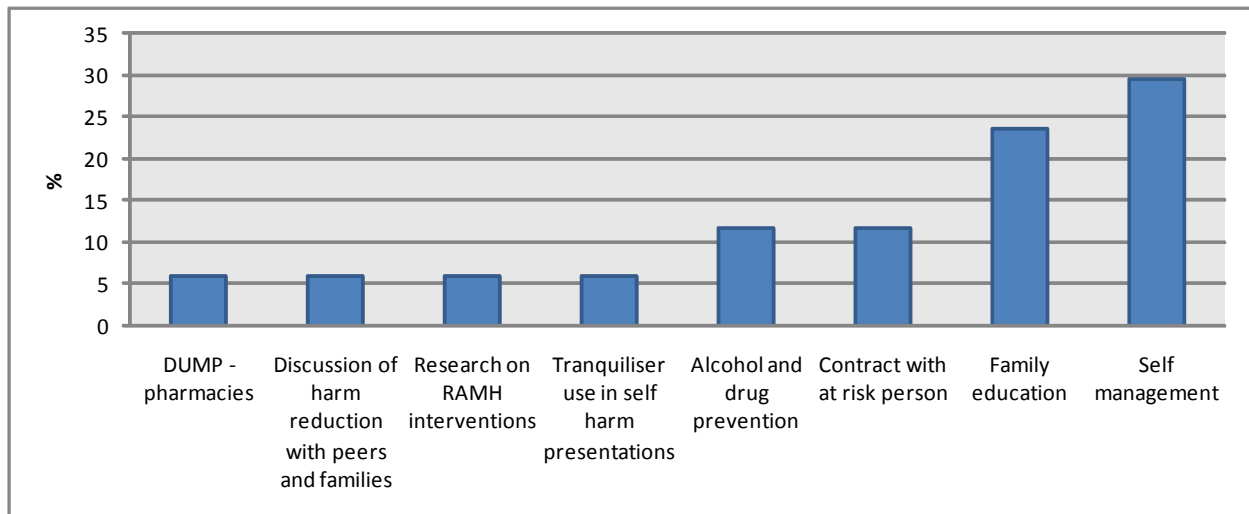
Figure 16: Types of postvention work engaged in by respondents (n=30)



## 8.2.4 Reducing Access to Means of Harm

Some 31% of respondents (n=23) stated that their work focused on reducing access to means of harm. This work included: self harm management; alcohol and drug prevention activities; family education (removing and securing medication and other possible means to harm); disposal of possible harmful medications no longer in use; use of minor tranquiliser in self harm presentations; research on reduction of access to means of harm interventions.

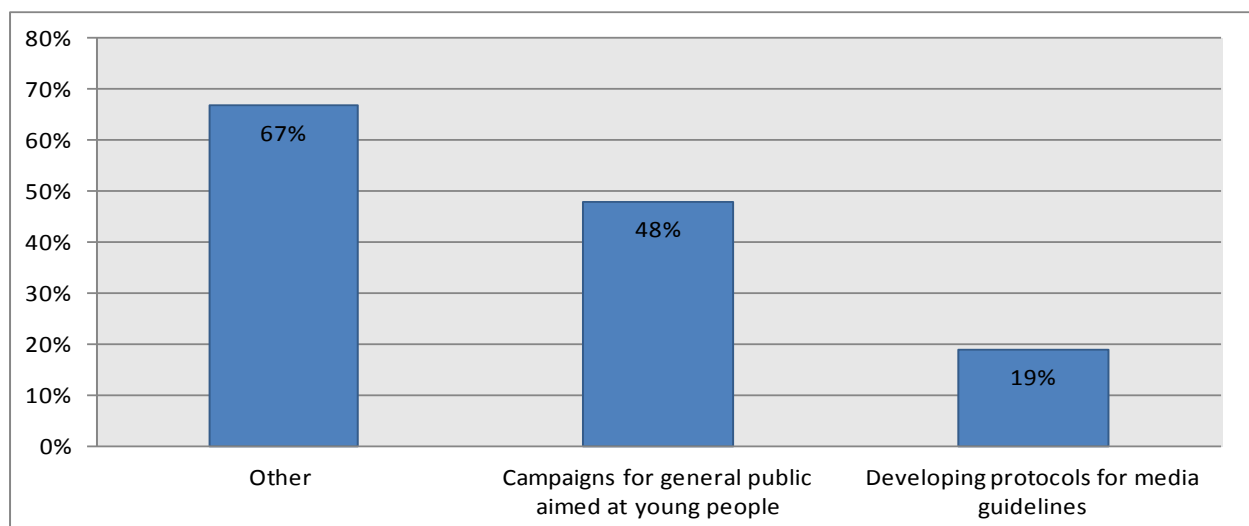
Figure 17: Types of work carried out by respondents to reduce access to means of harm (n=23)



## 8.2.5 Suicide Awareness Raising

Some 65% of respondents (n=48) stated that they provided suicide awareness raising activities (Figure 18). Of those, 48% reported using campaigns for the general public, 19% reported the development of protocols for media guidelines, whilst 67% reported being engaged in other suicide awareness raising activities that targeted: communities and community support groups; youth and youth services; the lesbian, gay, bisexual and transgender community; media; teachers and schools; those bereaved by suicide; GPs; high risk individuals (DSH); families; Traveller community; and political lobbying.

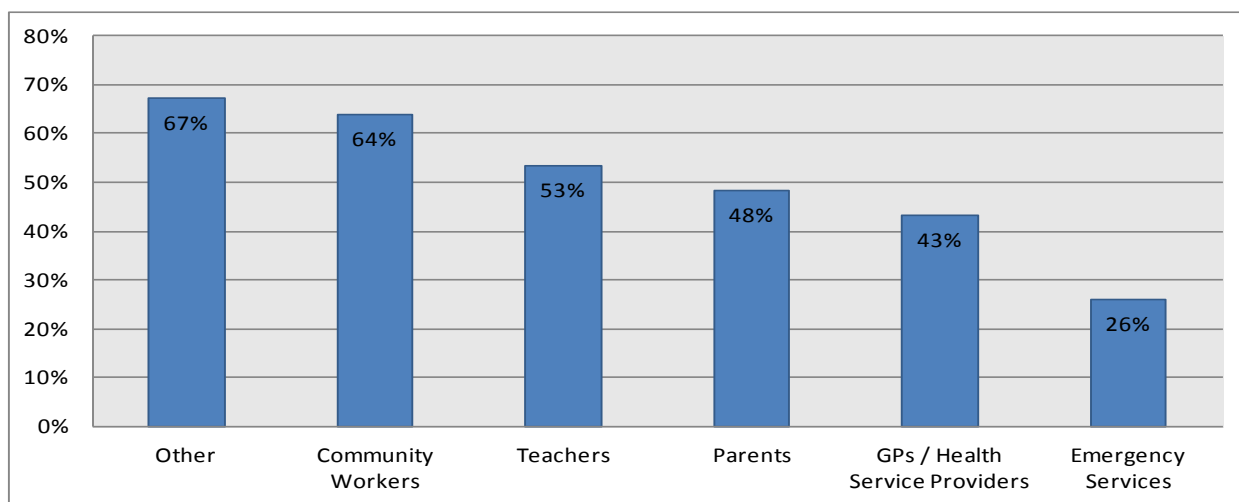
Figure 18: Percentage of respondent organisations providing suicide awareness raising activities (n=48)



## 8.2.6 Training

Some 78% of respondents (n=58) reported the provision of training as part of their service (Figure 19). The groups targeted most frequently included community workers (64%), teachers (53%) and parents (48%). The 'other' category (67%) included occupations such as: youth workers (including Traveller youth workers); community groups; leisure industry (including barmen, bouncers, coaches and sporting organisations); volunteers; carers; civil servants; drug agencies; LGBT; media and media students; mental health services; self help groups.

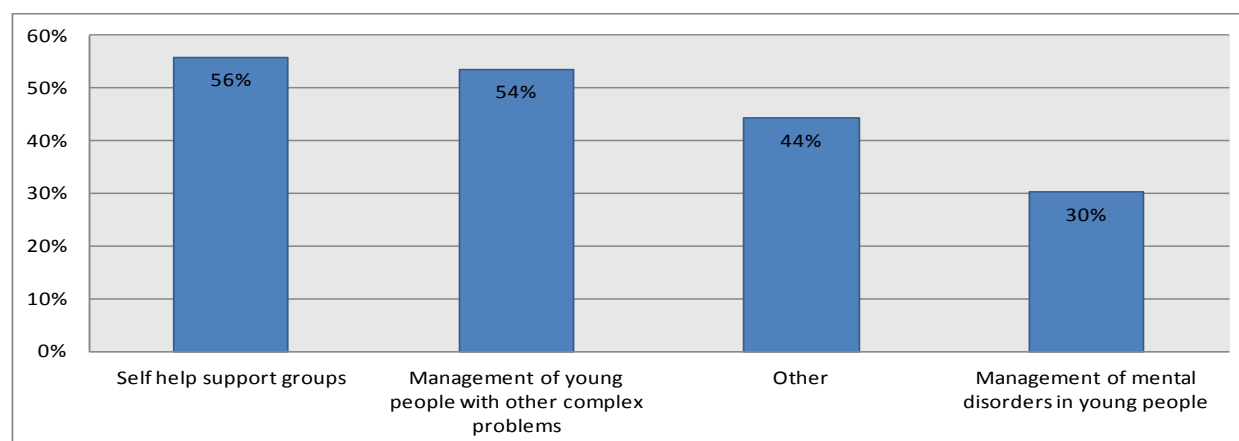
Figure 19: Percentage of respondent organisations providing training for specific occupations and parents (n=58)



## 8.2.7 Treatment and/or Support Services

Some 58% of respondents (n=43) indicated that they provided treatment and/or support services. These included: self-help groups (56%); services for young people with other complex problems (54%); services for the management of mental disorders in young people (30%); the provision of 'other' treatment or support services (44%). The 'other' category included: befriending; counselling; mentoring; creative therapy for young children; drug and alcohol management; men's development groups; psycho-educational programmes; telephone helplines.

Figure 20: Percentage of respondent organisations providing treatment and/or support services (n=42)

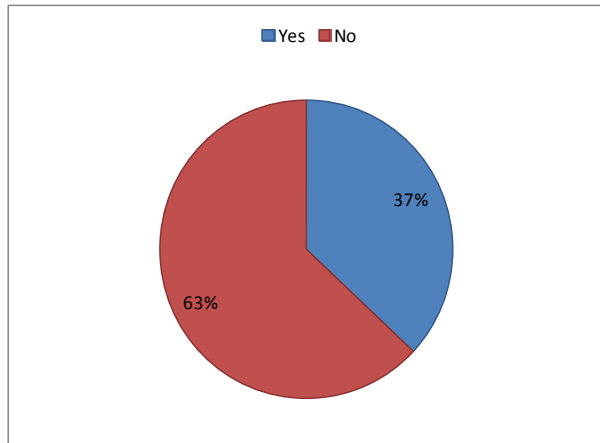




### 8.3 Perceived Capacity to Engage with Young Men

Just over one third (37%, n=22) of respondents who answered this question (n=60, 12 organisations skipped this question), reported that they specifically targeted young men as part of their work (Figure 21).

Figure 21: Percentage of respondents specifically targeting young men

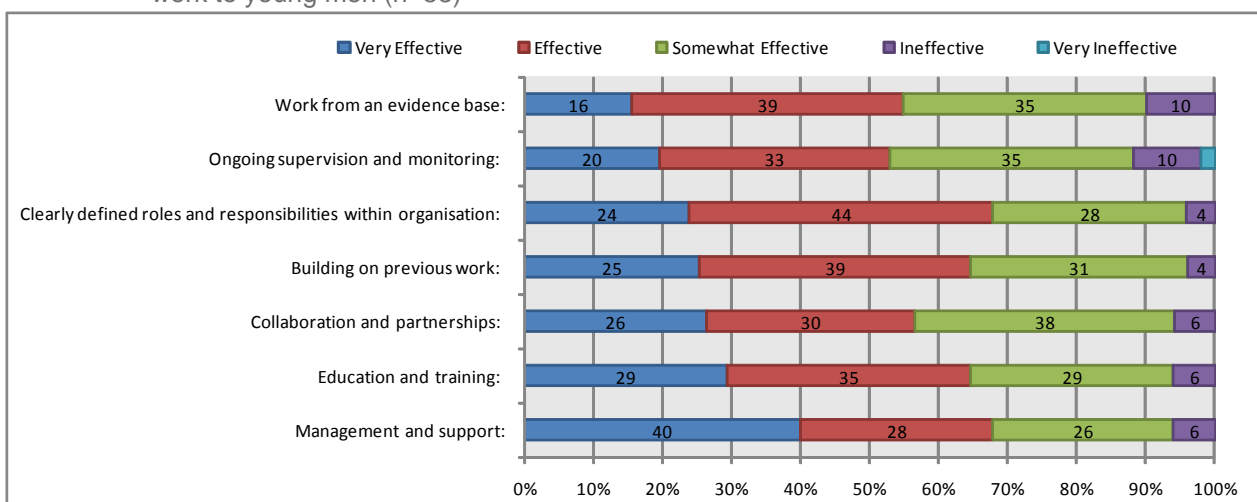


A broad spectrum of work was identified by organisations that reported specifically targeting young men. This included:

- Work with a personal development focus, such as physical and emotional health training in schools, mental and emotional well-being, resilience building, and mentoring programmes.
- Counselling and group work, including the provision of outreach and crisis support, youth work, and work with young gay men.
- A range of education, advocacy, and suicide prevention awareness programmes.
- Promoting improved access to services through signposting and referral mechanisms, and encouraging help-seeking.
- Tackling violence, criminal behaviour, and working with criminal justice referrals.

Over half of respondents (n=53) reported being ‘effective / very effective’ across a range of capacity defining measures in delivering suicide prevention and mental health awareness work to young men (Figure 22). Nevertheless, the corollary of this is that there is significant scope for enhancing and supporting the capacity of service providers to effectively engage with young men.

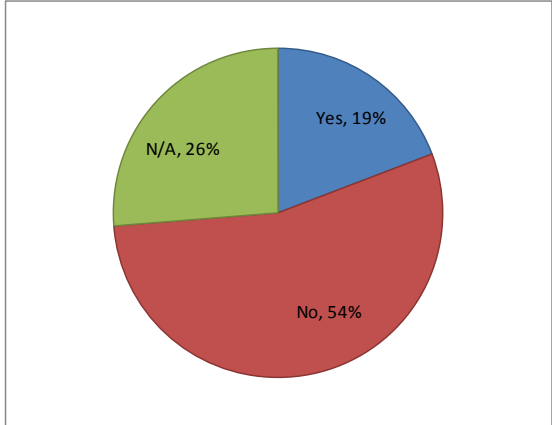
Figure 22: Perception of own organisation’s capacity to deliver suicide prevention and mental health awareness work to young men (n=53)



Among those respondents (n=57) who deemed external evaluation to be applicable to their work (Figure 23), only 11 organisations (19% of total respondents) stated that their work had been externally evaluated; with an additional 3.5% (n=2) indicating external evaluations were currently underway.

In the absence of an external evaluation being undertaken, an additional question was asked in relation to possible measures that were in place to gauge the effectiveness of this work. Such measures included client feedback and assessment, internal evaluations, management review, and clinical supervision.

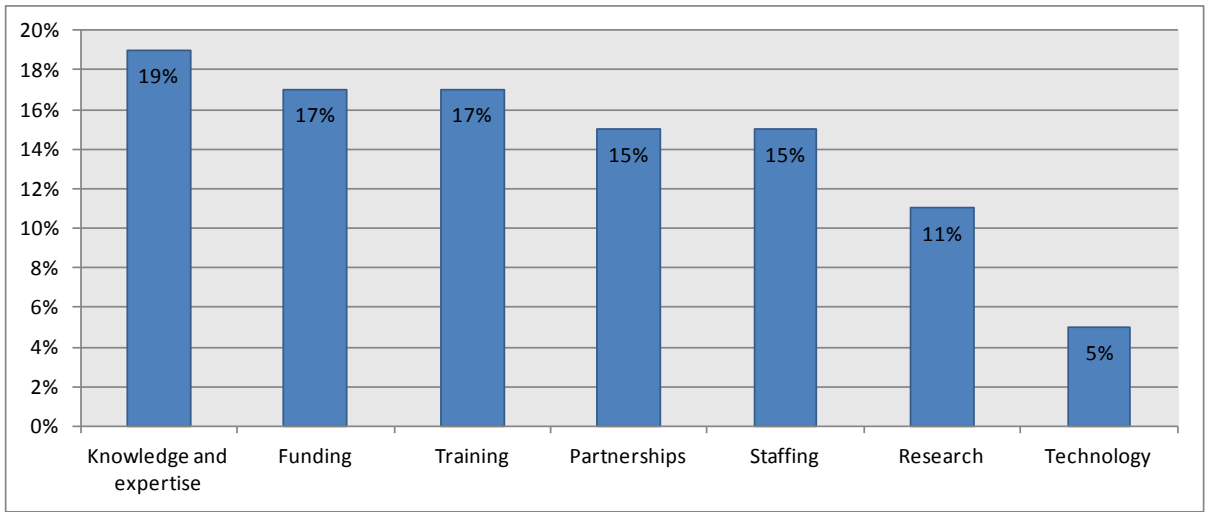
Figure 23: Percentage of respondent organisations whose work has been externally evaluated (n=57)



## 8.4 Barriers to Suicide Prevention and Mental Health Promotion Work with Young Men

Respondents were asked to rate the most significant barriers to suicide prevention and mental health promotion work with young men. The factors rated as being most important were lack of knowledge and expertise (19%), insufficient funding (17%), lack of training (17%) and partnerships (15%).

Figure 24: Barriers to suicide prevention and mental health promotion work with young men (n=53)<sup>iv</sup>



In an open-ended question that sought respondents' views on organisational and structural barriers associated with successfully targeting young men, a number of additional issues were highlighted:

iv. Aggregated scoring for each barrier

**Young men’s inability to communicate effectively about mental health and emotional well-being ...**

- Lack of emotional openness which was associated, in particular, with more traditional forms of masculinity and machismo.
- Lack of help seeking.
- Young men’s lack of support networks.

**Inadequacies within existing services ...**

- Lack of follow-up services.
- Lack of appropriate programmes for young men.
- Lack of psychiatric assessment outside of private health insurance.
- Lack of strong partnerships between service providers.
- The inappropriate placement of youth in adult mental health services.
- Inadequate provision of funding to provide effective services.

**Shortfalls in communicating effectively with boys / young men ...**

- Lack of effective communication of messages and campaigns that target young men.
- Inability to talk directly to young men.
- Lack of consultation with young men in the design and provision of services.
- Lack of understanding of young men’s lives.
- Inability to reach young men and sustain their engagement.

**The need for early intervention ...**

- The need for a much greater focus on interventions in school settings that have a specific focus on boys’ mental health and emotional well-being.
- Placing increased responsibility on schools to promote boys’ emotional and mental health.

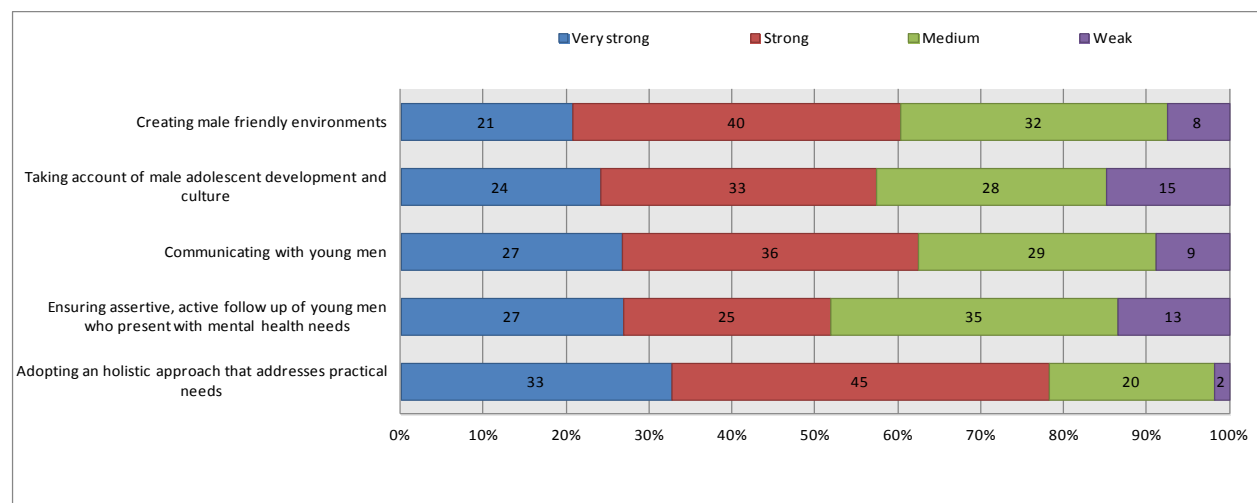
Other issues included the lack of research on creating effective partnerships, and lack of follow-up on research recommendations.

**8.5 Organisational Capacity to Reach Out to Young Men**

Between a half and two-thirds of respondents (n=59) reported being effective (‘strong’ or ‘very strong’) across a range of measures in reaching out to young men (Figure 25).

Nevertheless, there remains significant scope for improving service providers’ capacity in this regard. For example, almost one in two acknowledged that they needed better follow-up with young men who presented with mental health issues. Approximately four out of ten felt that they needed to: take greater account of male adolescent development and culture; create more male-friendly environments; communicate more effectively with men.

Figure 25: Respondent organisations’ perception of their capacity to reach out to young men (n=59)



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## 8.6 Challenges, Barriers and What Works Well

### 8.6.1 Challenges and Barriers to Working with Young Men

In an open-ended question, that asked about the principal challenges in working with young men, stakeholders identified a broad range of issues that were frequently intertwined - thereby adding to the complexity of identifying appropriate responses. In order of importance, these were ...

#### A. Issues with communication, disclosure and seeking help

Stakeholders repeatedly referred to the challenges experienced by many young men in acknowledging and communicating feelings, and being aware of their emotional and mental health needs. This was highlighted as a particular concern for young men during times of distress or during crisis periods:

*“Our workers say shyness or awkwardness about communicating feelings and emotions... an inability to understand their emotions and manage them.”*

*“... encouraging them to voice their feelings and deal with the pain of having lost friends; allowing them to access their anger in safe ways.”*

It was felt that young men’s reluctance to express their feelings was linked to restricted masculine norms of behaviour:

*“Breaking down traditional modes of masculinity and encouraging men to access support.”*

*“Getting them to open up and break that taboo that men don't cry; getting past their aggression to what lies underneath.”*

*“Stigma, bravado, fear of being seen as weak or letting others down (especially parents), difficulties in communicating. It takes a long time to build-up trust and get to the core issues.”*

Indeed, young men’s inability to deal with anger - and to recognise the source of their anger - was raised by a large number of stakeholders.

The difficulties experienced by young men in recognising and acknowledging feelings were attributed, in large part, to more traditional masculine ideology and machismo; with some stakeholders suggesting that this was a particular issue among rural men:

*“In farming families, young men are expected to be self-sufficient, and to inherit a farm and the associated pressures without seeking help from outside. Farming also tends to be very physically and emotionally isolating, and there is a culture of bottling-up problems rather than seeking help... there is a stigma that surrounds seeking help and support.”*

It was felt that this reluctance to be more open about feelings of anguish or distress carried over to a reluctance to seek help from health professionals or friends; with online media being the only resource for some:

*“Through our work we find young men are less likely to open up and talk about their feelings or go to visit a doctor or talk to someone else if they are experiencing some kind of trouble. However, they may be more likely to open up online through forums and other online media.”*

It was also highlighted that young men’s ‘failure’ to access services was attributed to their lack of awareness of what exists, as well as to previous negative experiences of some services - resulting in suspicion or lack of trust. It was felt that there was a particular need to signpost young men in the direction of appropriate services during times of crisis.



## B. Accessing, engaging and sustaining commitment

Stakeholders referred to the triple challenge of (in the first instance) accessing young men in places where young men feel comfortable, engaging them in programmes that are appropriate and attractive to them and, finally, sustaining them through the work:

*“Accessing them, engaging them and sustaining them in the work.”*

*“Getting the correct settings to work with young men. Engaging with them and getting them to engage with the service.”*

It was felt that these challenges were particularly pronounced among those sub-groups of men who were most likely to be in need of intervention and help. For such groups, compliance with treatment or support programmes, maintaining positive change, and overcoming the sometimes negative or hostile attitudes of service providers to young disadvantaged men’s lives, were highlighted as particular challenges:

*“Getting them to commit to the programme, especially if they are dealing with other issues such as drug use, alcohol misuse, being a young father, or that they don’t feel that life will ever get better for them in terms of job prospects.”*

It was also felt that the challenge of engaging and sustaining contact with young men is compounded by:

- Cutbacks in services, resources and staff.
- A lack of appropriate male specific programmes and services.
- Lack of trust - on the part of young men - in the services that are provided.
- Generational differences between service providers and young male service users.
- The provision of episodic services that fall short on follow-up.

*“Judgemental attitudes of others... families and statutory services that have exhausted support strategies, characterising this phenomenon as ‘client failure to engage’ or ‘non-compliance with treatment’ etc. We also find a very low understanding among health and social care professionals of the pervasive traumatic impact on some young men of contextual poverty, disadvantage, violence and chronic neglect, complicated by young men’s traditional coping strategies, including substance misuse and high risk behaviours. The episodic, sporadic nature of much statutory intervention - especially managing the service interface between adolescent and adult services.”*

It was felt that the disconnect between services and young men was compounded by the ‘siloeing’ or breakdown in communication between different services (e.g. mental health services, addiction services and criminal justice system):

*“Young people feeling unsupported and not listened to, having to repeat their worries to numerous professionals.”*

Some stakeholders felt that young men were now more receptive to seeking support and accessing services, and that the challenge was for services to be more innovative in their approach:

*“Young men are seeking out support more now than in the past, and this is really positive. It is now vital that service providers are innovative in their approach to service provision to maintain this involvement.”*



**Expand interventions that tackle alcohol and substance misuse in young men.**



### C. Alcohol and substance misuse

Alcohol and substance misuse were repeatedly cited by stakeholders as a hugely significant problem among young men (in terms of particular patterns of binge drinking; the links between drinking and increased suicide risk; drinking as a means of coping with distress; the confounding links between drinking and social disadvantage; drinking as a means of railing against authority) which results in a diminished sense of responsibility and anti-social behaviour:

*“The high level of acceptance there is around heavy alcohol / drug use as normative behaviour.”*

*“As with many services directed to young men at risk, the means and frequency of high risk, impulsive, alcohol-fuelled behaviours - including self harm and suicidal coping strategies - are the main challenge; exacerbated by disadvantage and youth culture characterised by over-exposure to violence, low trust in adults, and acute sensitivity to shaming patronage and traditional agents of social control.”*

### D. Unemployment, lack of opportunities and disadvantage

As borne out by the literature review, stakeholders were particularly concerned about the impact of recession on young men’s lives - particularly those experiencing social disadvantage - and by the inadequacy of existing services to reach out to such groups:

*“Unemployment and lack of opportunity that many young men experience is a major challenge, and these men are often hard to reach.”*

## E. Other challenges when working with young men

Amongst the other key findings to emerge were:

- Issues with confidence, self-esteem, identity, and lack of resilience among young men.
- Overcoming the stigma that was felt to be still attached to mental health issues - particularly in the Traveller community. Allied to this, was the need to challenge popular misconceptions and beliefs about suicide.

*“More and more young men are contacting us requesting a service, but there is still a barrier with regards to stigma - as so many of them feel that it is a indication to their peers and the general community that there is something wrong with them which needs to be fixed. They are embarrassed and frightened.”*

- Isolation - including those in rural communities, such as farmers and gay youth who are ‘not out’.
- Bullying and homophobia.
- Peer pressure among boys and young men to conform to particular masculine scripts.
- Educational attainment - both low attainment and pressure to succeed.

*“Poor standards of educational achievement, confidence and low self-esteem lead to an inability to engage with agencies that may be in a position to offer help.”*

- Confusion about sexuality.
- Family dysfunction.
- Segregation between communities e.g. Protestants and Catholics, Travellers and the settled community.

These barriers were very similar to those highlighted in Survey 2 (social inclusion / community based stakeholders) which included:

- Young men’s lack of emotional capacity to deal with mental health issues.
- Stigma associated with mental health - both within society and among young men.
- Alcohol and substance abuse.
- Young men’s reticence to engage, and an inability to access this target group.
- Lack of resources - funding, facilities, staff.
- Lack of ‘hooks’ to attract young men to services and programmes.
- Masculine ideology and the traditional male role.
- Unemployment, socio-economic and educational disadvantage.
- Lack of appropriate support services.
- Lack of help-seeking behaviour among young men.
- Mental health issues.

## 8.6.2 What Works Well with Young Men?

### A. Activities or programmes with a personal development focus and a strong emphasis on developing safety and promoting help seeking behaviour

Stakeholders repeatedly cited the importance for boys and young men of having a safe place to explore and articulate their feelings:

*“Carrying out activities that they can explore their thoughts and emotions in a non-threatening environment. An example of this is group counselling for only the young guys.”*

*“Personal development programmes for young men, integrated into their schools’ programme - through areas such as SPHE - can highlight these issues and provide an appropriate space for discussion.”*

Stakeholders favoured a range of programmes and activities focused on building self-esteem and confidence, promoting healthy living and emotional well-being, and improving energy levels. It was felt that these could be provided through individual and/or group work, as well as via interactive experiential workshops. One stakeholder summarised this point as follows:

*“(1) Initially a good connecting relationship. (2) Holding their fears and anxieties without a panic reaction. (3) Encouraging them to recognise the positive, meaningful aspects of their life. (4) Improving their energy levels by looking at their needs, physically, socially, and ways of managing their emotional distress.”*

It was also felt that the media had a key role in *“promoting help seeking behaviour and reducing the stigma of mental ill health.”*

### B. The importance of good staff and role modelling

The competence, commitment and ability of staff to engage with young men at their level - with an awareness of the issues within their lives and an ability to establish empathy with them - was named as an approach that worked well in suicide prevention and mental health promotion work:

*“One-to-one intervention with male-on-male intervention.”*

*“Commitment of staff and our ability to meaningfully engage, support and retain those most in need.”*

*“Having young male volunteers to provide counselling services.”*

It was acknowledged that the development of such skills requires on-going staff training and support. In addition, the aspect of role modelling - both by staff and male youth (‘youth ambassadors’) who have had previous mental health difficulties - was named as a means of engaging with young men around this issue:

*“If we can get a male staff member who takes on a role model approach, then this works really well. Following this up after discharge is difficult as we are a contained service, but we look for similar resources in the community.”*

*“Strong male role models in the teaching of SPHE, commitment from school leadership to SPHE.”*

*“Role-modelling by those who have been in crisis or distress and have moved to a better place.”*



### C. Open communication and trusting relationships

Stakeholders felt very strongly about the need to create open lines of communication which are underpinned by strong and trusting relationships. The importance, for staff, of having good listening skills and the ability to establish a non-judgemental, respectful rapport with young men - while communicating information in a relaxed and non-threatening manner - was also highlighted. It was suggested that having lines of communication with young men's partners and mothers would also be useful in suicide prevention and mental health promotion work:

*“Building trust so that the client can be open and honest about how they feel. We also have open discussions in our assessment process when the client ends with our project about suicidal thoughts and feelings.”*

*“Communication and providing the ‘space’ for them to talk.”*

*“Being honest and making it safe to talk openly and express vulnerability.”*

### D. Building relationships between services, and creating good networks and liaisons with effective referral

Just as the ‘siloining’ or ‘disconnect’ between different services was cited as a huge challenge to engaging effectively with young men, not surprisingly, the creation of strong working relationships, with good networks and lines of communication, was highlighted as a key barometer of what works well. It was also felt that there needs to be much better signposting to, and promotion of, relevant support services:

*“Building links to community and youth organisations.”*

*“Having access to details of support agencies and having good working relationships with support services.”*

*“Having all the counsellors here complete the ASIST programme and network with other prevention and health promotion services.”*

*“Staff training and establishing links in universities / colleges with the student support services is a key to prevention.”*

It was highlighted that effective partnership working is central to this:

*“Partnership working. Linking-in with specialist teams and negotiating / advocating on the young person’s behalf.”*

It was also felt that there is great scope for developing more effective outreach work with young men in their own communities.



## E. Client developed and led services

Stakeholders felt strongly about the need to consult with and listen to the needs of young men, in both developing and delivering programmes and services:

*“Allowing young men to develop what type of service they [have] want[ed] in order to be truly participatory in its function.”*

*“Engaging men in the process of programme development. Listening to the needs and developing programmes which are culturally appropriate.”*

## F. Examples of effective programmes and activities

Drawing upon their experience of working with young men, stakeholders named particular programmes and activities as being successful. These included:

- ASIST training
- Mind Yourself
- The Princes Trust
- Men’s Sheds
- Exploring Masculinities
- Practical activity which is task oriented, and incorporates outdoor activity and physical activity
- Alternative therapies
- Telephone helplines
- SMS texting

## 8.7 Top Priorities

Respondents were asked to rate their top priorities in relation to suicide prevention and mental health promotion work with young men. Whilst responses varied - reflecting, in part, the different priorities and agendas within different organisations - the top seven priorities (ranked in order of importance<sup>v</sup>) were as follows:

- 1) Awareness raising and signposting - recognising signs and symptoms, and knowing where and how to access support.
- 2) Resources - funding and staff to carry out such work.
- 3) Age and gender specific community-based services.
- 4) Mental health promotion and personal development for young men - with a focus on building resilience, reducing stigma, teaching positive life skills, and encouraging emotional communication.
- 5) Training - for frontline staff on all aspects of suicide prevention, and the most up-to-date examples of effective practice. Training should be extended to anyone who wishes to participate. ASIST should be compulsory for all key gatekeepers.
- 6) Challenge masculine ideology, and improve young men’s help seeking behaviour.
- 7) Early intervention, and the provision of appropriate services for those most at risk.

<sup>v</sup>. Ranked responses were themed, coded and weighted to generate the most important priorities as discussed by respondents

## 9. Key Learning: What is Needed?

The online surveys generated a huge amount of data from both organisations that work explicitly in the field of mental health and/or suicide prevention, as well as from others who have considerable experience of working with young men. All of these people were asked to offer suggestions as to what organisations need to do in order to improve the mental health of young men. This section outlines their responses.

### 9.1 Organisational Needs: To Engage Young Men

#### Resources

The provision of increased resources was the most important need expressed by organisations in relation to their ability to engage with young men. Stakeholders cited the need for additional funding, more staff, and training. This included: core programme funding; one-off programme funding; funding for staff; funding to build capacity within the organisation to engage with young men; funding to re-train staff in how to work effectively with young men. It was also reported that funding is required to expand services, and to roll out successfully piloted programmes nationally.

#### Training

Second, in order of importance, was training. Generally, stakeholders requested specific specialised training for staff in order to engage effectively with young men in the areas of men's health, young men's mental health, youth focused training, and on the guidelines and skills necessary to engage effectively with young men.

#### Partnerships

Third, in order of importance, was the call by respondents for the development of effective partnerships with other organisations - both statutory and voluntary - in addition to establishing networks for those involved in work with young men. Stakeholders also called for increased support at several levels (namely management, agency and governmental), and for improved pathways to support services and referral mechanisms between services for young men.

#### Provision of relevant, effective and targeted programmes

Fourth, in order of importance, was the need for relevant, effective and targeted programmes for young men. Stakeholders requested the provision of tailor-made and proven programmes likely to appeal to young men, and for an increased focus on mentoring services. In the absence of such programmes, some stakeholders stated that funding would be required to develop programmes of their own, and to provide increased support for evaluation of pilot programmes. Awareness raising - to increase knowledge of young men's mental health needs and the need for such work - was named by some stakeholders as a requirement. In addition, some stakeholders expressed a need to be able to market and generate brand awareness of services. A small number of stakeholders stated a need for more research, and for research data to target the areas of greatest need in relation to young men.

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## 9.2 Organisational Needs: Specific to Suicide Prevention Programmes for Young Men


Once again, the most important need expressed by stakeholder organisations was the need for resources. This was, primarily, a need for funding to develop and sustain programmes and work, but also to employ staff to run such programmes - with some placing an emphasis on the need for skilled male workers, who can act as role models with the target group.

In addition, the need for an increased focus on training was stressed - both to up-skill staff in order to be effective in engaging young men in this work, and to feel confident about using evidence based programmes which are suitable for youth workers to deliver directly to young men.

A number of stakeholders stated a need for effective partnerships in order to ensure collaboration with other organisations, agencies, families, and those bereaved by suicide. There was also a call for more evaluation of current work in order to understand what has, or has not, been successful.

Other needs expressed included:

- The development of a directory of services.
- An increased focus on the integration of suicide prevention work into mainstream youth work.
- Better profiling of models of effective practice, with ongoing review of established protocols.
- An increased research focus on the specific needs of young men.



Encourage the use of safe and responsible online resources in mental health promotion.

### 10. Stakeholder Focus Groups

The consultation stage of YMSP involved two elements: online surveys (detailed in Section 8) and meetings with key stakeholders (both service / programme providers and young men). These face-to-face consultations (Phase 3 of the overall initiative) took the form of focus groups:

- With key stakeholders - both Northern Ireland (n=12, held in Belfast) and Republic of Ireland (n=6, held in Dublin).
- With one group of young men (n=10, held in Cork).

The discussions primarily focused on seeking deeper reflection on the issues which were highlighted in the survey findings. However, they also encouraged broader consideration of any topics which participants felt were relevant - either from their own experience of working with young men or, indeed, from the perspective of being a young man.

The following discussion outlines the themes which arose during the focus groups. The first part of this chapter, details the outcomes of the two focus groups with key service providers, while the latter part documents the reflections of the young men's focus group.

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## Focus Groups with Practitioners and Service Providers

### 10.1 Introduction

The stakeholders in Northern Ireland and the Republic of Ireland discussed broadly similar issues in relation to suicide prevention and mental well-being. The most pertinent issues were:

- The perceived challenges associated with communicating with young men.
- Encouraging help seeking behaviour among young men.
- Overcoming what is regarded as a persistent stigma attached to mental illness and mental health.
- Addressing young men's awareness of mental health / well-being, and their lack of 'life skills'.
- What is regarded as the paucity of services that specifically address young men's needs.

Stakeholders also discussed what they felt had worked with young men from their perspective, and what was needed in relation to the development of suicide prevention and mental health promotion work with young men.

### 10.2 'Resistance to Connection'

There was repeated reference to the issue of young men's inability to disclose problems associated with their mental well-being. For many stakeholders, this was inextricably tied to young men's 'resistance to connection'; with the majority of participants feeling that young men are brought up and conditioned to be tough and not to express emotion. It was argued that, over many years, boys adapt to societal expectations to be tough and to 'handle their own problems'. They do this by building layers around themselves as protection, and this pressure to present a hard exterior to the world is particularly pronounced among young men from more disadvantaged communities:

*"It's very difficult to break down the resistance to connection... the power of holding on to themselves, and not revealing anything about themselves, is so strong... connection is required."*

Service providers felt that when they initiate personal development work with these young men - in the hope of getting to the kernel of the problems and concerns - they typically experience this type of resistance; as it goes contrary to what young men have always been told. In order to overcome this, some stakeholders stated that work must be done on an individual basis:

*"Young men have learned throughout their lives to build a hard exterior shell to protect themselves. When confronted with this type of work, they are being asked to contradict everything they have learned throughout their lives. It is the task of the people on the outside to peel back those skins. It must be done one-on-one."*

### 10.3 Lack of Help Seeking

Following on from the previous point, both focus groups felt that the majority of young men were resistant to seeking help during times of distress. It was felt that this reluctance to seek help was related to masculinity, and an expectation that young men should manage their own problems.

One stakeholder noted that there tends not to be any help seeking ethos in young men's lives. In particular times of stress, such as a relationship breakdown, it was felt that help seeking



behaviour is particularly poor. However, it was also stated that if young men decide to seek help after a relationship breakdown, it is likely to be from their GP. One stakeholder argued that this is problematic, as *“the GP cannot do anything about a man’s partner not wanting to be with them”*, and that, therefore, their first point of contact was not the correct point of contact. In other cases, Traveller men’s lack of help seeking in relation to mental health problems is affected by the stigma attached to mental illness within their own community.

## 10.4 The Stigma Attached to Mental Illness and Mental Health

The oft quoted saying ‘big boys don’t cry’ was cited as a key concept in relation to how mental health stigma works for young men. It was argued that taboos and stigma still surround mental health and emotional well-being - *“or simply being emotional”* - for young men. The idea of being seen as (or considered as) *“a nutter”*, is also a barrier which affects young men:

*“Young men may identify others in the area as having mental health issues. They are stigmatised, and they don’t want to be identified in the same way. They reflect on others, and themselves, and the stigma and fear attached to being identified as ‘being mental’. Mental illness can be seen as a terminal illness.”*

## 10.5 Young Men’s Awareness of Mental Health and Well-Being and their Lack of Life Skills

Against a backdrop of young men’s reluctance to seek help - particularly in relation to mental health issues - it was felt that emotional / mental health issues tend to fester, and that young men will:

*“... allow their problems to get worse and worse until they get out of control.”*

In other words, the threshold at which a young man is likely to seek help for an emotional / mental health issue is extremely high, and this is confounded by the stigma attached to mental illness:

*“Young men don’t even know what critical is, and they won’t tell because they think they may be seen as a nutter.”*

There was discussion regarding what young men are taught from an early age about being tough and self sufficient, and about a threshold of ‘emotional toughness’ developing from a young age. Several stakeholders stated that although much of what young men are taught throughout their lives affords them protection, it also has the potential to take them to a precipice - where their state of emotional / mental health becomes fragile, and their awareness and willingness to deal with problems is limited.

Another stakeholder stated that there is a lack of awareness of mental health concepts (such as self efficacy and resilience) among young men. They also lack life skills and effective coping mechanisms when, for example, dealing with grief (due to bereavement or relationship loss) and do not know where to grieve.

It was stated that attainment of life skills needs to start in the home. However, where life skills are not being learned in the family, there needs to be an increased onus on the school environment - as, otherwise, this lack of skills will be transferred to the next generation.

## 10.6 Improving Access to Services for Young Men

Much of the focus group discussion centred on the issue of services, including:

- Young people's negative experiences of services.
- The critical role of the GP as the first point of contact for young men in crisis.
- The potential for expanding the role of schools in promoting the emotional / mental health of boys.
- The key role that allied health professionals and community workers play in 'picking up on' and supporting young men in distress.
- The need for more services.
- The need to make existing services more accessible.

### The 'silo system' - young people's negative experiences of services

It was felt that the treatment of alcohol and drug misuse within current public health systems, both North and South, is largely failing young people, and is a cause of stress for those who present with such problems. There was strong consensus that existing systems treat alcohol or drug abuse as issues which are separate from mental health, when in reality, they are interconnected and part of the same problem.

Some providers spoke of young people telling and re-telling their story to numerous health professionals because of the *"silo system"* within the health service. This tends to be compounded by the *"cold and clinical reception"* which is sometimes afforded to young people who present with multi-faceted problems, and may serve to further alienate young people:

*"Alcohol or drug issues are treated separately to a mental health issue, when both are one in the same. This gives rise to young people seeing many different professionals and having to re-tell their story again and again; resulting in bad experiences and refusal to engage."*

*"If a person has a drug problem, they can get the message - 'get the drug problem sorted' - as if they were saying 'go and get your knee fixed'. The person comes away angry and despondent... the system is structurally flawed... young people come looking for warmth, care and compassion... they just want you to be there [for them]. The approach is as important as what's available."*

Other focus group participants spoke of their frustrations in working with young people who have been through the system and experienced the 'silo effect' - wherein they engage with one service and are, therefore, unable to engage with other complementary services. In this regard, it was felt that the system available to young people does not work effectively.

Another issue of concern was where a young person misses an appointment or session within the public health system and then they lose their place - the consequence being that they are unable to re-engage. One provider stated that this had been overcome within their community service by asserting that *"life takes over"*. This philosophy acknowledges the day-to-day reality of life events (e.g. relationship difficulties, episodes of depression which debilitate the person, or general 'ups' and 'downs'), and the need to be flexible in service provision rather than excluding the person from the service altogether. Such an approach enables a person to maintain engagement and continue a positive relationship with the service. It was felt that public services

must be cognisant of this fact, and work in a way which maintains engagement with the young person. One stakeholder stated that:

*“... bad experiences can be internalised, and can drive young people away from using services.”*

### **The critical role of GP services as the first point of contact for young men in crisis**

It was generally believed that GPs are a critical point of contact in situations where young people present with mental health difficulties. However, some felt that there were *“good and bad GPs”* and, as such, there was a lack of consistency in how GP services treat and deal with young people.

Some felt that when a young person presents with a mental health issue, the length of the GP consultation is too short to deal with the issue adequately. For some, in the Republic of Ireland, it was felt that going to the GP is not always the right answer. It was felt that due of the structure of public health provision in the South, if a person does not have access to private means (private health insurance), the only option is to go into the psychiatric system - an option which, for many, presents an immediate barrier:

*“In the public system, the only recourse is to go into psychiatric support systems... but once psychiatry is mentioned, it immediately presents a barrier: ‘I’m not going into that system’... it leaves the GP in an awkward situation about what to do.”*

A number of stakeholders highlighted the dilemma for GPs in terms of how to look after a person with suicidal or self harm thoughts after the consultation is finished. This presents an issue about where the GP’s responsibility ends:

*“One of the real issues for the GP is what happens to the person after they leave the surgery. Should they call them back... that’s time consuming. The GP is there to diagnose and prescribe... not to carry out the treatment.”*

Other issues arose in relation to the services available to a GP, including the aforementioned point about patients’ attitudes towards public psychiatric services. In addition, stakeholders both North and South, discussed the lack of referral to other services in the community. Issues raised in this regard included the lack of accreditation of other counselling and mental health support services within communities. However, for one stakeholder, it was felt that this is not acceptable, and that a step care approach is required:

*“We need a step care approach... primary care knowing and having value in community and voluntary services; asking questions like are they accredited; GPs not knowing what services are out there for people in distress - which is a barrier to suicide prevention. Primary care needs to be much more proactive and focused in building-up relationships with community services that can help young men to deal with mental health problems.”*

The issue of insurance and indemnity for GPs was raised in the Republic of Ireland in relation to GPs referring to services which are not part of the public health system. Ongoing work by the Irish College of General Practitioners (ICGP) and the Irish Association of Suicidology (IAS) towards the setting-up of an accreditation model for the HSE is to be welcomed. This would allow non-public health services to be accredited, and provide GPs with a wider means of referral.

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## **The potential for expanding the role of schools in promoting the emotional / mental health of boys**

Many stakeholders felt that schools need to play a more significant role in promoting the mental health and well-being of boys. Early intervention was felt by all to be essential in tackling mental health among young people. Programmes like PDMU in the North and SPHE in the South should play a greater role in developing young men's understanding of mental health and well-being. However, it was also acknowledged that this raises questions as to the scope of teachers' roles and responsibilities. In addition, it was highlighted that many young men, who are most at risk, do not attend school and are, therefore, outside of this safety net.

## **The key role that allied health professionals and community workers play in 'picking up on' and supporting young men in distress**

There was consensus in both focus groups on the critical role that allied health professionals and community workers play in 'picking up on' young men in distress, and being alert to opportunities to do so. If a practitioner feels unable to approach a person in distress, then it was felt that the opportunity to provide assistance is gone. This *"window of opportunity"* - as discussed by stakeholders - is vitally important for all who work with young people.

Some stakeholders (with experience as counsellors, community workers, and development workers), discussed what they felt were overly rigid protocols in dealing with people who are experiencing emotional or mental health difficulties. In some circumstances, codes of practice - such as directives not to touch clients - were seen as another level of the brutalisation of young men. No touching or hugging was seen, by some, as further marginalising these young men. For some, touch - and an ability to comfort - was critically important in working with people with mental health difficulties.

One of the challenges, for practitioners working with young people, is to work towards understanding *"why young men think the way they do"*. It was felt that there is a need for workers to see life from the perspective of a young man, and to understand why young men may not see, or may avoid, dealing with mental health issues. It was also stated that practitioners who come across as cold or clinical may be 'burnt out' and, in this regard, support for practitioners experiencing difficulty is as important as the help they provide to their clients.

## **The need for more services and to make existing services more accessible**

Whilst acknowledging the finite nature of resources, stakeholders felt that services must be made available, and that these services need to be truly accessible. In this regard, it was felt that agencies sometimes struggle with prioritising mental health issues and dealing with them effectively.

Once again, this raised the issue of *'siloing of services'*, such as for substance abuse issues. This was seen as preventing clients from accessing holistic care, while missing sessions often resulted in clients being further excluded from the service:

*"Having a substance abuse issue means you're siloed off to a particular service and cannot get holistic care. If a client misses a session, then they lose their place... siloing means clients get lost in the system, and can't get holistic care that looks at their problems as a whole, rather than as single elements in themselves which need to be fixed."*

Stakeholders also spoke of critical “*windows of opportunity*” - particularly in the context of statutory services’ inability to deal with young peoples’ mental health issues in a timely and effective manner. When an individual presents with a mental health difficulty, help must be immediate. For many respondents, both North and South, it was felt that the 9am - 5pm service is simply not adequate and does not work:

*“Help must be immediate... who’s to say that person will be here next week?... There’s the statutory agency wait of six weeks, and seeing twelve different professionals, and your story being told again and again... then they say, ‘don’t send me to another melter’. Services are alien, cold and clinical. Small things... it’s about the professional services and their inability to deal effectively... nine to five doesn’t work.”*

## 10.7 What Works?

Stakeholders spoke about what they felt had worked for them, in the past, when engaging with young men around mental health and emotional well-being issues:

- Some stated that taking a **reverse psychology** approach is useful. For example, young men typically come to services at a point of crisis in their life; often feeling weak and vulnerable. It was argued that, in such instances, young men should be complemented and reassured that their **ability to look for help is really a sign of strength**. Some stakeholders stated that this has the effect of delivering a positive message to other young men through word-of-mouth, and that it also challenges assumptions about what counselling is really about; namely, building life skills.
- Others spoke about **personal development courses** which men had fully engaged in. Some men had come with suicidal ideation. However, not all men needed counselling. Rather, for some, there is a need to learn about managing their own mental health.
- As highlighted earlier, the concept of **‘life takes over’** is often important for those whose lives are chaotic or in crisis. It was suggested that this would be a useful approach for public health services to acknowledge when dealing with young men, and would help to maintain the person’s engagement with the service.
- The **‘window of opportunity’**, highlighted previously, was seen as a vitally important aspect when dealing with young men with mental health difficulties. Services must look at how they can make their provision more accessible to young people when they are in need, and not just continue to operate within their normal working hours.
- **Role modelling** - by young men who have experienced mental health difficulties - was also discussed. These young men have experienced the process of becoming well, and have a unique perspective that can be particularly useful when working with other young men.
- It was felt that **stereotypes of masculinity needed to be challenged and demystified** by taking young men away from what they usually do, sitting together, and working through these issues. It was proposed that the provision of **safe spaces and environments** is essential - in order for them to share their experiences, and to have an outlet to discuss issues in their lives. **Encouraging ownership** over the process they are involved in was felt to be important. This gives the young man a sense of responsibility for what they are engaged in. Stakeholders also stated that **meeting young men at their level** - with a clear understanding about how life is



for them - contributes to more positive engagement and relationships between workers and young men. It was felt that it is very important to **accept young men as they are**; without being judgemental about what or how their life is.

- Both focus groups discussed the importance of those who work with young men having an **explicit understanding of the care they provide**. In particular, the point was made by those with experience as counsellors, community workers and development workers, that: *“Kids don’t want programmes. They want to know that somebody cares”*. Whilst it was felt that this does not, necessarily, mean a ‘touchy-feely’ approach (although this may sometimes be useful), a number of points were highlighted as being important when building trust, confidence and relationships with service users. These included: eye contact; smiling; giving a sense of warmth; being aware of your tone of voice; adopting positive and safe body language; making connections; using effective listening skills; ensuring clear communication; modelling and encouraging positivity; using humour.
- One of the challenges identified by the focus groups for those who work with young people, was how to care for yourself and to practice what you preach. **Self care for those who carry out the work** is essential if services are to be delivered effectively. It was also stated that there is not enough support for counsellors and others doing this work.
- It was felt that **persistence and perseverance** is an essential characteristic of working with young men. As stated by one stakeholder:

*“Persistence and perseverance... keep going... many young people who have been traumatised need repeated signs of compassion over and over again so it is hotwired into their brains, especially young men who haven’t had it for 100 years... so you have to persist and persist in the caring.”*

- **Providing food** was highlighted as a useful way of bringing young men in, and offers a natural and comfortable way of creating a relationship. It was felt that food has the effect of naturalising and normalising an otherwise abnormal situation.
- **Bringing services to your target group**, and making the programme culturally appropriate, was seen to be important. It was felt that stigma can be a barrier to entering a particular service - especially if it is known in a community that a service is targeted at people with mental health difficulties. This is particularly relevant within the Travelling community. Service providers also need to be trained to be aware of cultural issues within particular sections of society.



## 10.8 What is Needed?

- A 'one stop shop' approach to dealing with emotional, educational and physical needs. A holistic approach wrapped into one centre of well-being.
- Think about the individual. While services can provide the resources, self-efficacy and life skills can only be learnt by young people themselves.
- Early intervention and psycho-education in school with children as young as four years of age. This is the only way to begin to build mental health and well-being in children who may develop problems in later years.
- The notion of 9am - 5pm services must go. Services need to be responsive to 'windows of opportunity'.
- Workers and practitioners need to have core therapeutic principles. The most important thing is the relationship and what happens within that relationship. Workers must be aware of the baggage they carry into the work, while being open to being challenged. Therefore, good supervision is essential. They must also be able to build rapport with young men.
- Challenge how we view suicide - in particular, stress that suicide is not an okay thing to do and that it is a final act. Appropriate messages and information about suicide need to be promoted, as well as adopting extreme care in relation to how suicide is reported e.g. using terminology such as heroic, survival and glorification at funerals. In addition, the focus of suicide prevention initiatives should be on lives that have been saved, rather than on those who have died. This may be a discussion or debate which centres upon what cultural barriers can be put in place to prevent suicide becoming an option in people's minds, or a campaign focused on the capacity to survive (such as the 'I'm Alive' campaigns). However, as with all campaigns, an element of marketing comes into play, and tough questions must be asked in relation to the target audience. Such work needs to decide: (i) who is the primary target, (ii) who is the secondary target, and (iii) who will be left on the sideline. There is a need to get across the message that suicide is the final act, and that there is no coming back: ***"It's the end product"***.
- Target support networks for young people. Create rotas of care among friends to monitor at risk individuals.
- Primary care services need to become aware of, and refer to, services within their community who are best placed to provide support to patients who present with mental health difficulties.
- There is a need to educate people on the difference between 'mental health' and 'mental illness'. This may include psychiatric professionals, who often use the terms interchangeably. Education must also focus on allowing people to get past their fear of suicide and fear of discussing suicide. This includes asking a person in distress if they are suicidal.
- There is a need to understand how women can be supported (be they partners, mothers, daughters or friends) to respond appropriately to young men who they feel may be at risk of suicide - as they are often the ones who pick up that something is wrong in a young man's life.
- There is a need for greater efforts to tackle the issue of homophobia. This is a particularly sensitive issue within the Traveller community.

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## Focus Group with Young Men

The focus group with young men explored many topics, including: young men's fears and struggles; the perceptions of young men at a societal level; the 'pros' and 'cons' of online technologies; the negative connotations associated with mental health; problems with bullying - particularly in schools; the challenge of disclosure within a macho culture.

### 10.9 Fears and Struggles

Many of the young men talked about their fears and struggles - particularly in relation to the economy, unemployment, recession, and the negativity that prevails in the media in relation to current affairs. Some felt angry and resentful about what they saw as a betrayal on the part of government in relation to key decisions about the country's future, and about not having any input into decision-making at any level:

*"Young people, in general, get really angry about the decisions that were made, and it will have to be me - and people my age - that will have to pick up the pieces, and I don't feel let down, but I feel angry at the situation. You basically hedged my future on a big bet, and flipped a coin, and it came down on the wrong side, and the national debt is something like €27,000 per person. It just really annoys me and that I get angry at."*

*"I feel a bit more alienated about the whole political thing really. There is no young person's voice in any kind of political decision at all in any aspect. I'm just outta college and my plans are all one year plans, and they're all outside of Ireland: Australia, UK, New Zealand... Not that you feel forced out, but you feel you've nowhere else to go if you wanna survive. If you wanna make a decent go of it, or a decent living, you need to go. Options here are limited, if not non-existent."*

Concern was also expressed about: negative reports of youth always appearing to be a bigger story than positive reports; the persistent focus on alcohol and substance abuse among young men; negative perceptions of young men at a societal level (e.g. the sense of intimidation posed by gangs of young men).

### 10.10 Dealing with 'Difficult' Emotions

The young men also spoke about how they managed what they regarded as *"difficult emotions"* (particularly in relation to anger and distress) which broadly fell into either positive or negative approaches. Some, for example, described the cathartic effect of simply working off their anger (e.g. through exercise); of talking to someone about a problem; or of venting it through a public forum such as Facebook. Facebook was seen as a place where you could share with others, express anger at specific issues, or see other people's perspectives on particular subjects. For others, it was acknowledged that drinking is *"a solution"* to dealing with anger, and is frequently a prerequisite to sharing problems or difficulties between friends - a situation which quickly reverses once both parties are outside the safety of the drinking environment:

*"The best time to talk to a friend is after a beer... but he has to be drinking as well."*

*"Even when you talk when drunk and are serious, the next day you'll deny what you spoke about and say you were just talking shite last night."*

*"Yeah, if you did talk about something when you're drinking... I think it kinda stops and you don't talk about it the next day. It's like... that was when we were drinking, and this is when we're sober."*

It was also acknowledged that there is fear surrounding the disclosure of a problem or mental health issue by a peer and not knowing how to respond. For young men, it was felt that disclosure is seen as a sign of weakness, and that this is, primarily, the reason why young men do not come forward with mental health issues when affected. What is required, it was felt, is the clear message that talking about such issues is a sign of strength and not weakness:

*“It would be very unusual if somebody did actually say ‘I have a problem’. It’s seen as a sign of weakness. Lads are afraid to be seen to be as weak. You know all the hard guys that don’t care what anyone thinks, but really they do - that’s why they’re a hard guy. If you’re open enough to say this is how I feel, and I feel really bad, and I need help, then that shows that you don’t care what anybody else thinks, and that needs to be shown as a sign of strength. You kinda have to get that message across, and that it takes strength to talk.”*

## 10.11 Use of Online Technologies

Perspectives on using technology to communicate - at a superficial level as well as at a deeper level - varied among members of the group. Some felt that the Internet and blogs are a good way for young people to express issues in their lives which they feel strongly about. They also believed that there is rarely any bullying or making fun of someone who might write about difficulties that they are having. However, others felt that there are downsides to social media, such as cyber bullying (particularly at secondary school level), that some young people are not as comfortable using social media as is generally portrayed, and that it is not a good substitute for real contact during times of distress:

*“If I went online and said I’d a terrible day I think I’d get a load of abuse, and it’s likely I’d be told to just get on with it or something.”*

*“It’s different things for different people, and some would enjoy the venting and all that kind of stuff. And it comes back to when they’re doing that they feel they’re being listened to as well, and they get advice. But, for me, I’d be on Facebook, but I’d never put any of that kinda stuff down. I’d never have any of those kinda rants. It just wouldn’t be for me. I think there’s a lot of stuff written about young people... that they’re most comfortable with social media and all that kinda stuff, but there’s a lot that aren’t at all. They might be on Facebook, but it wouldn’t be something they’d turn to straight away. It definitely wouldn’t be something I’d turn to. It’d be the last place I’d go. If I’m stressed, or whatever, I’d go for a run, and I suppose everyone has different things, and I suppose my issue is that the media portray it as the young people are growing up with this and everyone loves it, and I think it’s far less of a general thing than how the media portray it.”*

*“It doesn’t substitute for real contact. For real problems, you really need personal face-to-face contact.”*

Some described the social media as a double-edged sword. It can be interesting and fun. However, there are also too many updates, and vague statements, and instances where some subscribers are crying out for attention. In such a situation, there is a lot of confusion and ambiguity about how to respond:

*“There is something very uncomfortable about seeing notices or blogs up on your ‘wall’, and you wonder whether you should do something, and you may not have seen them in two years, and they put something up and it’s very public, and you feel kinda guilty and think should I do something, I have other friends who are closer, and you need to determine should I try to do something and talk to this person or should I step away?”*



## 10.12 Negative Connotations of 'Mental Health'

The majority of the group had a negative concept of 'mental health'. Some believed it defined a state of *"sadness in general"*, while others stated it was contradictory - in that the word 'mental' was associated with insanity, while the word 'health' had positive physical connotations. However, others felt that the idea of mental health was not even part of a young man's outlook on life, and that *"they just don't know how to identify it"*. Participants felt that this was due, in large part, to mental health being a stigmatised topic:

*"First thing that comes to my mind is depression. That's what it would mean to men."*

*"They don't think 'I'm in good mental health'... they just see it as the norm. It's only when they're feeling down. I don't think they feel 'I'm in bad mental health'. I think they'd think 'I need to buck up' or... I don't think they'd think about mental health all that much really."*

*"There's not much knowledge about it really. It's a stigmatised topic. No one would talk about it. There's no discussion in public forums; not like physical health."*

It was noted that young men would not discuss mental health issues in the same way that they would discuss physical health issues. It was felt that if a young man was going to a doctor, he would have no difficulty telling his peers about his problem. However, if he was attending a psychologist or counsellor, it was felt that such a problem would not be discussed. This was mainly to do with the stigma surrounding mental illness:

*"It's seen as a sign of weakness, and it's not talked about. And people don't seem to talk about it, like 'your man over there is a nut bag'... but he's not, he's just struggling. They don't seem to understand that it's just like a physical problem, like a heart problem, he has a brain problem or a mental health problem."*

## 10.13 Bullying

The young men felt that bullying in schools is a highly significant source of mental health problems for males. Indeed, it was felt that bullying is often at its worst in secondary school, and can be spurred on by an individual's own problems. Not being part of a group, feeling like an outsider, or not wishing to become an outsider or to lose group membership, were all cited as sources of bullying:

*"I'd say it's at its very worst in secondary school. If you said to someone that you're feeling down, I'd say bullying would step in."*

## 10.14 Disclosure and Surviving within a Macho Culture

The group felt that a 'macho culture' is part of the problem, and that this culture is probably stronger in areas with higher levels of disadvantage compared to more affluent areas. In this regard, young men from disadvantaged areas would probably have more difficulty expressing issues of a mental health nature. However, it was also recognised that mental health issues affect every sector of society.



The group discussed the need for courage in discussing mental health among young men. Girls, they believed, had a vocabulary to discuss feelings and emotions, and this was engrained throughout their lives. As a consequence, women have the ability to talk about their emotions across a range of life experiences:

*“Girls can actually talk about their emotions. They talk about their emotions to do with anything. Guys may just talk about it when they’re depressed or something, but girls - they can talk about their emotions about a shoe or something. Because they talk about their emotions with anything, they find it easier to talk about mental health.”*

The topic of disclosure of a mental health issue by a peer was discussed. Most group members felt that the majority of young men would not feel comfortable about giving advice - as they would feel ill equipped. Some believed the best course of action in such a situation would be to *“say nothing and just listen”*. However, others were more conscious of possible negative outcomes:

*“I think people are afraid to give advice, cause if you give the wrong advice - and it makes things worse - then you’re gonna feel bad then as well.”*

*“You have to push that it’s okay to talk, and a lot of young men would be uncomfortable if someone came to them with a problem, and you have to push this is how you do it - just be there for them.”*

## 10.15 Suggestions for Promoting Mental Health in Young Men

- Early intervention with young boys in primary school, and throughout secondary and third level education.
- Talking rather than telling.
- Open, respectful, two-way communication.
- Reason with one another.
- Instil that talking is not a weakness but a strength.
- Marketing and campaigning with role models that young men look up to.
- Develop guidelines on how to deal with disclosure.
- Encourage disclosure and help seeking.
- Develop confidence in dealing with disclosure.
- Focus on friends and how to support peers.
- Encourage training and support in ‘how to spot signs’ (ASIST).
- Focus on putting more young men through ASIST - peer to peer.
- De-stigmatise the topic of young men’s mental health.
- Normalise marketing and advertising on mental health campaigns aimed at young men.
- Tie mental health in with the concept of physical health.



**Young men need to see emotional expression as a skill that improves with practice.**

### 11. Practical Pilot Interventions

The final stage of the Young Men and Suicide Project (Phase 4) sought to draw together learning from the literature review and stakeholder engagement stages of YMSP, in order to design, develop and implement two practical pilot interventions - one in Northern Ireland and the other in the Republic of Ireland.

The Advisory Group agreed that the two pilot initiatives should focus upon:

- A whole community approach in Northern Ireland (similar to the 'Frameworks / Connect' model developed in the USA).
- The use of online communications / social media with young men in the Republic of Ireland.

The purpose of these initiatives was to test - in a practical way - potential models of work, and to identify lessons which could inform future work.

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## Northern Ireland Pilot Intervention

### 11.1 Name of Initiative

To give a clear and distinct identity to the pilot intervention in Northern Ireland, it was called 'First Instinct'. This name reflected the underlying goal, i.e. to encourage and foster a first instinct in young men which is to seek help and support at times of difficulty, rather than taking their own lives or engaging in other self-destructive behaviours.

### 11.2 Target Area

The area targeted for the intervention was the geographic catchment of 'Colin' - situated between Lisburn and West Belfast. Colin is comprised of the housing developments of Poleglass, Twinbrook, Lagmore and Kilwee, and has a population of approximately 30,000 people. This locality had been identified by both the DHSSPS and the PHA as the preferred target area due to the high levels of male suicide within it, the level of health inequalities, and its disadvantaged status.

### 11.3 Partners

As this intervention focused upon a 'whole community approach', one of the first tasks was to seek 'buy-in' from local organisations. The key local partners were the Colin Suicide Prevention Task Group (which included staff from the South Eastern Health and Social Care Trust - SEHSCT) and Colin Neighbourhood Partnership.

### 11.4 Main Elements of Intervention

There were four main elements to this intervention ...

- Training for practitioners - to equip them to deliver the 'Mind Yourself' (MY) programme in local schools.
- Development of a Young Men's Advisory / Reference Group.
- Availability of training / workshops / seminars which can increase understanding of how to work with men and what constitutes a 'man's world'.
- Establishment of a mini 'Working with Men' resource library.

The introduction of the Mind Yourself programme was the main focus of work in the Colin area - with the other elements adding value to / supporting this core component.

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## 11.5 Mind Yourself Programme

### 11.5.1 Rationale for Choosing 'Mind Yourself'

The YMSP Advisory Group looked at a range of possible programme options (see Section 6), and 'Mind Yourself' (MY) was chosen because it was considered to be:

- A proven model of effective practice.
- Cost efficient.
- Relevant to the Irish setting (and easily transferable from the Republic of Ireland context - where it had been developed - to Northern Ireland).
- A viable and realistic option in terms of timescale and budget.

Previous evaluation findings had demonstrated that the programme was effective in creating significant positive changes in terms of problem solving and emotional resilience; with positive - but non-significant - changes in depressive symptoms and self-harm thoughts.

It was also felt that both the content and methodology of the programme were consistent with the principles of effective practice identified in this report, namely:

- A holistic life-skills approach encompassing coping and problem-solving skills.
- A strengths-based approach, which focuses on hope, optimism and is solution-focused.
- A whole population approach to working with young people (therefore, those who are more 'at risk' - but who may never come into contact with services - can be reached).
- A community based approach that consults young people on their needs.
- Built upon strategies to enhance problem-solving skills, emphasise optimism, and promote resilience among adolescents.
- Provision of information on local resources and services available to young people.
- Based upon an empirical evaluation of the programme which measured its effects on helplessness and hopelessness, levels of depression, self-esteem, problem-solving strategies and coping methods.

### 11.5.2 Aim of Mind Yourself Programme

The MY programme (which was developed in the Republic of Ireland) had already established itself as a critically evaluated model of effective practice. Therefore, the purpose of introducing it to Northern Ireland was not to test its effectiveness. Rather, YMSP sought to roll it out as a pilot in order to learn how it could be adapted to local circumstances / culture, and to make recommendations for its future use.

### 11.5.3 Overview of the Mind Yourself Programme

Mind Yourself is an evaluated, brief intervention that is aimed at adolescents. It was developed in the Republic of Ireland, as an evidence-based mental health promoting programme which seeks to enhance problem solving skills, emphasise optimism, and develop resilience and coping skills among adolescents. However, the programme had never been utilised before in a Northern Irish context.

A team of trainee facilitators was recruited from the greater-Colin area. Applicants had to apply for a place on the training course, and the essential criteria for selection included:

- Currently working / volunteering in a youth work setting.
- Good group facilitation skills.
- High level of communication skills.
- Ability to work with / deal with challenging issues.
- Experience of working with young people.
- Empathy with young adults and their life situation.
- Some understanding of / interest in mental health issues.
- Time to commit to completing the two full days preparation training.
- Commitment to deliver five Mind Yourself programmes within the next year to young people in the Colin area.
- Commitment to deliver MY - as part of a training team - to young people from St. Colm's High School in Twinbrook.

Desirable criteria included having already taken part in ASIST, Mental Health First Aid, Mental Health Awareness, Understanding Self-Harm etc.

In order to equip these local practitioners to deliver the MY programme in schools, a 'Training for Trainers' course was delivered by Dr Ella Arensman and Jacklyn McCarthy - from the National Suicide Research Foundation (NSRF) in Cork. This training took place over two full days (22nd and 23rd of March 2012) in Cloona House, Poleglass, and involved 13 trainees - all of whom worked in the greater-Colin locality.



The facilitation team - coordinated by Kevin Bailey, Suicide Prevention Coordinator, SEHSCT - also organised additional skill enhancement / practice days after the main training, in order to prepare the team for the delivery phase.

MY was delivered to all Year 12 pupils in St. Colm's High School, Twinbrook, on two consecutive Friday afternoons - 18th and 25th of May 2012. This entailed a 90 minute session on each day. Most of the facilitators worked in pairs with an average group size of 18 pupils.

Although not part of the original remit or budget for YMSP, MHFI felt that it would be important to engage a researcher to help to identify any learning from this intervention and to undertake an evaluation with the pupils. To meet this need, a baseline questionnaire (11th May 2012) and post-programme questionnaire (1st June 2012) were administered to all the students. This element of the programme was undertaken by Paula Kinsella (an MSc student from the Institute of Technology Carlow, working under the supervision of Dr Noel Richardson, Director, Centre for Men's Health, IT Carlow) with the support of the MY facilitators.



### A. FEEDBACK FROM A FOCUS GROUP WITH PROGRAMME FACILITATORS ...

#### **Mind Yourself was seen as a highly effective programme**

All participants spoke very highly of the programme, and felt that it had potential for a wider roll-out in Northern Ireland - both in schools and, potentially, in community settings. Whilst it was felt that much of the programme content was not entirely new, the programme succeeded in bringing together a number of key concepts in a way that was very accessible to the target group, and in *“very simple clear cut language for the young people to understand”*. In particular, participants welcomed the focus within MY on the development of practical skills and competencies among young people in relation to their mental health.

#### **The Train the Trainers programme equipped facilitators with the requisite skills**

It was felt that the ‘Train the Trainers’ programme prepared the trainee facilitators very well to deliver the programme. The aspect of training that was found to be most useful was the practical role-play exercises that enabled facilitators to explore how to deal with different scenarios as they might emerge in practical dealings with young people. It was felt that more time should have been devoted to this aspect of the training; with less needed on background content about the programme and statistics etc. (which, it was felt, could have been given to the facilitators as a handout prior to the training). It was felt that a third day of training would have been very beneficial, and would have replaced the need for facilitators to have follow-up meetings and practice sessions prior to the formal delivery of the programme.

#### **The duration of the Mind Yourself programme is too short**

All participants felt that the duration of the Mind Yourself programme was insufficient to ensure that each concept was grasped and understood by every participating child:

*“... we felt very rushed in trying to explain what are complex things - like what is the difference between a feeling and an emotion... we were trying to explain it to them in the space of ten minutes, and hoping they got it so we could move on.”*

It was suggested by one facilitator that being able to extend the programme to three sessions (instead of two) would allow for a more in-depth discussion around thoughts, feelings and emotions, and alleviate some of the pressure the facilitators felt to deliver the programme within the shorter time frame:

*“... people felt under pressure to deliver, and they felt that the hour and half session was not enough... you were literally just touching on emotions or thoughts... if you extended to three sessions instead of two, it would give more time to focus on it, but it would also give you more time to ‘beef out’ some of those concepts around thoughts, emotions and feelings.”*

It was proposed that the inclusion of an ‘Introduction Session’ at the outset could be used to: (i) cover background material and information (including key findings from the Lifestyle and Coping Survey), thus allowing more time in Sessions 2 and 3 to cover practical skills, and (ii) build trust and rapport between facilitators and participants, thereby encouraging and optimising participants’ level of involvement in Sessions 2 and 3:

*“I think that by the second day the trust levels had built with the kids to the point where they were really starting to open-up; whereas the first day they were a wee bit more reluctant... I think that if we had a third day, we definitely would have been getting more out of them.”*

## **Preferred elements of the Mind Yourself programme**

When asked what exercise(s) worked best in a school setting, the facilitators were divided. The three elements of the programme that were found to be most beneficial were the:

- Topic discussions.
- COPE exercise.
- Thoughts and feelings exercise.

*“For my group, it was talking about the two issues at the end - they really loved that. That’s when they really started to open up...”*

*“I reckon the COPE thing. It really got them looking at a problem in a whole different way, and I really believe that some will bring that and use that in their everyday lives.”*

*“They really liked the thoughts and feelings part... how I think of something makes me feel a particular way and then I act a certain way... they really got that, which was brilliant.”*

## **Building trust and rapport - the role of impartial, external facilitators**

Participants felt that, notwithstanding the need to build trust and rapport, students were more likely to engage with the programme if they felt that it was separate from their school programme. For example, one participant felt that even though, as external facilitators, they were not part of the school system, they were still looked upon by some young people in that way. As a result, this may have curtailed the full involvement of these young people.

It was felt by everyone that the programme could, and should, be adapted for use in community or informal settings. However, careful attention would need to be given to: (i) engaging young people in the programme, and (ii) ensuring that those young people who need the programme most are specifically targeted:

*“... young people who come to community groups are there because they want to be there - so they’re fully engaged in anything you throw at them. My concern about that is that you’re missing some of the vulnerable kids who don’t, for that very reason, go to community groups.”*

## **Key recommendations for the future delivery of the Mind Yourself programme**

In terms of other recommendations for future delivery of the programme, participants made a number of key suggestions:

- Building rapport and trust with participants from the outset to create a sense of safety for young people to fully engage with the programme:

*“... it’s really important to get onto their level, and for us to engage with them instead of them doing all the work to engage with us.”*

- It was felt that the timing of the programme - both in relation to the school year (end of last term) and the time during the week (Friday afternoon) - was not ideal to ensure 100% concentration or participation from all the students. It was suggested that if the programme was to run again, having it around the middle of the term would probably be most beneficial - not near holidays or exams.
- Low literacy levels emerged as a barrier to some young people's full engagement with the programme (e.g. in relation to writing tasks and completing the evaluation questionnaires). It was proposed that the delivery of future courses should account for this.
- It was felt that more time was needed to go through the information booklet that was given to the young people at the end of Session 1 - so as to maximise the potential of this important resource. It was felt that the booklet had a wealth of important information on who to contact in different situations, and what organisations can offer, but there was no time allocated for this in the programme:

*"... I kinda thought that the booklet they got was fantastic. The amount of information in it is amazing, but I was kinda surprised that we were just chucking it to them as they were going out the door... in the hope that they would open it sometime."*

- One participant suggested that the Mind Yourself programme should be adapted for use with First Year students, and delivered over successive years in an incremental and progressive way. It was felt that an adapted version of the programme could be very supportive in enabling children to adjust to the transition from primary to secondary school:

*"I'm thinking of a pre-emptive strike. Why wait until your problems have developed in Fourth Year to target young people? Why not get in there early on - particularly around that transition period when young people are particularly vulnerable moving from primary to secondary education."*

*"A potential option could be that you put in levels of the programme applicable to their age. You would tier that up each year as they go, so that they are getting similar - but different - elements or layers of learning... they are getting the progression."*

- It was felt that the mixing of genders in groups worked well, and that both sexes engaged with and enjoyed the programme equally:

*"... some of the lads would come out with something that they thought was good, and one of the girls would tut or visa versa, and it was really interesting, and I think that it made them engage more in what was happening, and it was good that we mixed-up the groups as well in relation to doing small group work. I think that was really important, because the first day we didn't, and it was boys on one side and girls on the other side."*

- A number of challenges were cited in relation to completing the programme evaluation, including:
  - Issues with literacy in terms of filling out the questionnaire.
  - The length of the questionnaire and the number of questions asked.
  - The timing of dissemination of Questionnaire 2 (after exams on a Friday afternoon).
  - Having a number of groups complete the questionnaire in a large hall.

These issues would need to be considered further for any future delivery of the programme.

## B. EVALUATION WITH PROGRAMME PARTICIPANTS

Preliminary findings from the evaluation of the Mind Yourself programme suggest that there were no significant changes to the main scale items that were measured pre and post programme delivery, namely; self-esteem, depression and resilience. As highlighted earlier, issues to do with the timing of the programme evaluation, the logistics of the evaluation, literacy issues among the target group, and the appropriateness of the evaluation tools for the target group, may all have influenced these results.

### 11.5.5 Recommendations for Mind Yourself in the Future

In light of the overall positive and enthusiastic response to the programme - both from the facilitators and from the students - and the valuable lessons learned from this pilot phase in relation to programme delivery and programme evaluation, consideration should be given to further delivery of the programme in Northern Ireland.

However, the following issues should be considered:

- Extending the duration of the programme.
- Delivering the programme during the early to mid term period (not close to exam time).
- Using simpler and more concise evaluation tools.
- Taking account, in advance, of literacy issues when delivering the programme and conducting the evaluation.
- Adapting the programme for use in community or other settings.

### 11.6 Young Men's Advisory / Reference Group

In order to give a platform to the experiences of local young men in the Colin area, it was decided to run a project which, it was hoped, would generate enthusiasm for the establishment of a Young Men's Advisory / Reference Group.

#### 11.6.1 Aim of Young Men's Advisory / Reference Group

Three main aims were identified for this initiative:

- Create a Young Men's Advisory Forum / Reference Group which can act as the voice of young men in the Colin area, and input to the planning of services and activities in the Colin Neighbourhood Partnership catchment area.
- Support participants to feel more confident about talking openly about issues that affect them.
- Help young men (and others in the community) to have a better understanding of the powerful impact of masculinity.



**Young men need safe spaces to meet and engage with their peers.**



Staff from the Work with Young Men Team in YouthAction Northern Ireland were contracted to design and deliver a group work programme, wherein the participants would be encouraged and supported to feel more comfortable and confident about sharing their life experiences and expectations.

To meet this objective, weekly sessions were held in Cloona House, Poleglass, between February and the start of May 2012. This programme lasted for eight weeks, and a total of fourteen young men participated in all or some of the sessions.

Local youth leaders in the Colin area were invited to participate as co-workers. It was hoped that this would help them to expand their own skills and experience in this specialist and evolving field of work, and would ensure that a level of competence was retained within the Colin community after the YouthAction team left. Umberto Scappaticci from Colin Neighbourhood Partnership was involved in all of the sessions, and two workers from 'Youth Initiatives' contributed to five of them.

The group work experience focused upon exploring masculinity, and the impact that this has on young men, their family, their friends and their community. At the end of the programme, the young men and workers who 'graduated' were asked to organise a practical project for other young men in their locality. Subsequently, they planned and ran a day of activities in St. Colm's High School which focused upon mental health. This was held on Thursday 25th October 2012, targeted all Year 11 pupils in the school, and was carried out in collaboration with the school's staff team.

There are, currently, plans to extend this Advisory / Reference Group, and for this body to become part of the wider Colin Youth Strategy Group.



### 11.6.3 Key Learning from the Young Men's Advisory Group Experience

Throughout the roll-out of the programme, a comprehensive range of feedback and evaluation mechanisms were employed to document the experience of the young male participants, the co-facilitators and the YouthAction NI worker. These recordings indicate that:

- The programme enabled a diverse group of young men to work together and to gain new skills alongside their peers.
- The approach that was adopted encouraged group members to have their voices listened to and respected, and to experience real participation.
- The ability of the workers to build meaningful relationships with the young men was seen as a key to the success of the project.
- This project would have benefitted from having a longer time-scale.
- The value base (which acknowledged the young men as active and equal stakeholders) was viewed as being important.
- Young men want and need capacity building programmes to provide opportunities for them to talk about being male, and to challenge issues around male stereotypes.
- Programme elements such as using movement, burning-off energy, and focusing upon issues that are relevant to the lives of young men were very successful.
- There is enthusiasm for further support and training to enable these young men to maximise their potential as community leaders, and to assist in the delivery of other projects in their own communities.
- To ensure maximum participation, young men need be engaged within their own spaces / places.
- There is a need to use different ways of communicating with young men - especially those who do not, currently, avail of youth sector provision.
- Voluntary, statutory and community organisations need to develop a coordinated approach to this field of work - to ensure that they are more effective in recruiting and retaining young men in programmes.
- A range of training initiatives for youth and community workers on engaging with young men should be developed and delivered. These should focus upon the key principles of how to engage with the needs / concerns of young men.
- In order to feel safe, transport arrangements need to be in place to ensure the maximum participation of young men when activities take place outside of their own local area.
- Young men need safe spaces to meet and engage with their peers.

## 11.7 Training / Workshops / Seminars

At the outset of this pilot intervention, it was felt that it would be useful to recruit a core group of local service providers, and to offer them an intensive package of training, support, mentoring, reflection and practical action in the field of working with young men. In this way, they would gain a more in-depth understanding of what constitutes a 'man's world'.

It was suggested that this programme would involve the recruitment of an inter-agency group, comprised of 10-14 practitioners, who would reflect the range of interest groups in the area e.g. education, youth work, community work, health, church, sports, probation, family work etc.

This body would then be offered a training package with a number of key components:

- A briefing meeting with line managers in each organisation to ensure they fully understand what their organisation is committing to and to confirm their assent.
- An internal organisational audit / review of their current level of 'male friendliness'.
- Three full day training sessions - focusing upon why we need to target young men / how to improve the mental health and health-seeking behaviours of young men / what practical actions could be undertaken locally to improve the 'First Instinct' of young men.
- An opportunity to plan and deliver a realistic and appropriate 'in-house' practical initiative to meet the needs of young men.
- An interim support session, plus ongoing telephone / email support from MHFI.

However, given the very high level of commitment needed for the 'Mind Yourself' programme - as well as the Young Men's Advisory Group aspect of this initiative - Colin Neighbourhood Partnership felt that it would be unrealistic to ask for an additional level of longer-term engagement from local people.

Instead, it was agreed that workers from the Colin area would be offered priority places at external standalone training / workshops / seminars being organised by MHFI. These events focused on a range topics including: 'Putting Men's Health onto the Agenda', 'Developing a Framework for Men's Health', 'The Men's Health Engagement Jigsaw', 'Setting-up a Men's Shed', 'Jest for the Health of it: The use of Humour in Promoting Men's Health Messages' ... It was also agreed that, if required, the Colin area could request specific one-off sessions on topics of particular local relevance.

## 11.8 Working with Young Men Resource Library

While many service providers now recognise that there is a need to engage with young men - and to offer innovative programmes to them - most have little idea of where to start, how to go about it, or what to offer.

To meet this need, it was decided that MHFI would research, identify and purchase a select range of off-the-shelf resources / games / photo packs / DVDs / reference materials which can help practitioners to better understand the world in which young men live, and offer practical suggestions for group work activities.

These materials were presented to Colin Neighbourhood Partnership at the end of the intervention, and are now based in Cloona House - where they form the cornerstone of an evolving working with young men resource library.

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## Republic of Ireland Pilot Intervention

### 11.9 Name of Intervention

The pilot intervention in the Republic of Ireland focused upon the development of an online mental fitness programme for young men called 'Work Out'.

### 11.10 Target Area

Although, primarily, targeting young men in the Republic of Ireland in the initial stages, this programme is now available to young men in Northern Ireland and further afield as well. However, the sources of additional help suggested on the site have, for the most part, an island of Ireland focus.

### 11.11 Partner Organisation

This initiative was undertaken in collaboration with the Inspire Ireland Foundation (Inspire). Inspire already has considerable experience and expertise in providing online mental health support to young people in the Republic of Ireland, primarily through ReachOut.com.

### 11.12 Overview of Intervention

The Work Out programme was modelled on an application which was originally developed by the Inspire Foundation in Australia; working collaboratively with the Australian Brain and Mind Research Institute. The materials within it were chosen because of the strong evidence base which indicates that they can have a positive impact upon the mental health of young men.

The core objectives of Work Out are to:

- Use the internet to promote help seeking amongst young men by ...
  - Challenging stereotypical attitudes of mental health.
  - Providing them with the language and tools to take positive action.
- Promote social connectedness.
- Promote mental health literacy.
- Challenge thoughts that impede help-seeking behaviour.

Work Out ([www.workoutapp.ie](http://www.workoutapp.ie)) is free and easy to access. It is based upon a series of brief online interventions (called 'Missions') which utilise the principles of Cognitive Behavioural Therapy. During Work Out, young men are invited to:

- Register for an account.
- Take a comprehensive test to assess their strengths and weaknesses.
- Undertake a series of practical Missions to improve their mental fitness.
- Use online reports to check (at any time) how they are improving.

The Work Out programme addresses four main areas:

- Being Practical
- Building Confidence
- Taking Control
- Being a Team Player

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The programme offers young men a standalone programme that they can access in their own time and engage with on their own terms. They can choose as many, or as few, Missions as they wish to within each of the main areas focused upon.

It is anticipated that the website and its content will be added to / amended over time as new needs or issues arise.

### 11.13 Development of Work Out

The website in Ireland looks and feels substantively different to the Australian one upon which it is based. These changes were made in response to feedback received from local young men during the testing phase.

At the outset, Inspire Australia shared topline results from research which guided the development of Work Out Australia (ARC Linkage Report, *'Understanding and Preventing Mental Health Difficulties in Young Australian Men Using the Internet'*, 2010). Subsequently, initial quantitative and qualitative data related to the testing of the 'Beta Version' of Work Out Australia were also shared. This helped to shape the technical specification for the development of Work Out Ireland.

In order to test the concept of Work Out with young men in Ireland - and guided by the Australian data - three focus groups were held in March 2012 in Carlow, Armagh and Belfast. Some of the key findings from these focus groups included:

- Young men liked the idea that something had been designed especially for them.
- The Internet was seen as a good way to engage with a lot of young men.
- It was felt that the concept of 'mental fitness' is engaging and relevant. Respondents felt that it is less off-putting than something which talks about 'mental health' or 'mental illness'.
- It was stated that the site needs to be *"less wordy"* and *"more practical"*.
- Missions need to be easy to complete. For example, the idea of having to print off worksheets (as in the Australian programme) was seen as a negative aspect.
- The 'Traffic Light' results indicating your mental fitness status (red: urgent / amber: warning / green: OK) were seen as a good idea.
- Everyone liked the fact that the assessment results are given in a very positive 'let's do it' and 'start to make a change' kind of way, and that the user can see how they are progressing over time.
- The rationale underpinning the site, and information on the organisations behind the initiative, are important for potential users, and need to be made more explicit.
- Signposting, and linking users into other services (e.g. ReachOut.com), is crucial ...

Originally, it was felt that the Irish Work Out site could be integrated into, and piggy-back on, the main Australian package. However, feedback from Irish users had indicated that the site needs to look (e.g. imagery used) and feel (e.g. language used) like it is designed for young men from Ireland. Additionally, it would be difficult to ensure that the site could remain locally relevant and up-to-date in the longer-term unless there is full control over it in Ireland.

To meet this need, permission was sought from Inspire Australia to replicate the overall site concept, and to use some of their content in a new Irish website.

## 11.14 Building the Irish Website

In late March 2012, an Invitation to Tender document was circulated - seeking a web designer to build an Irish version of the Work Out Australia site. This tender was awarded to Peter Duggan.

Building on the Australian and Irish data - and guided by good practice principles in online design and the user-journey experience - Inspire Ireland worked closely with the YMSP Advisory Group and the contracted design team, to build a suite of relevant Missions with a range of features and functionality. Central to this process, was the need to give site visitors a smooth 'user journey', and to encourage their continued engagement via a system of 'rewards / credits' - familiar to those who play games regularly online.

Another important feature of the website is that it was built with the concept of self-maintenance in mind i.e. the site is structured in such a way as to allow Inspire Ireland and MHFI to update and add to its content in the future - without recourse to expensive technology consultants.

The version of Work Out Ireland which was launched in October 2012 can, therefore, be extended and developed further if required; utilising the functionality already developed. This, however, will depend upon the outcomes of the initial trial period.

## 11.15 The Missions

The Missions are based upon the principles of Cognitive Behavioural Therapy, and require the user to make relatively minor changes to behaviour and/or thinking to improve the way they feel, and the way they respond to challenges or solve problems.

The version of Work Out which launched in Ireland has two Missions in each area:

Area	Mission Name
Being Practical	Body Clocking Take a Breather
Building Confidence	Enjoy Yourself My Strengths
Taking Control	Hurdles Face the Situation
Being a Team Player	Just Ask Networks

All of the Missions in Work Out Ireland have been developed with the user-journey in mind - making every effort to keep users on the site / online and minimising offline activity. For example, a sleep plan is generated for each user in 'Body Clocking' by selecting proposed sleep and wake times from a drop-down menu. Similarly, users can report their actual sleep and wake times on a daily basis online before taking the post-Mission test to determine any improvement.

Users receive email reminders to re-take the test one week after accepting a Mission. However, some Missions do still require offline activity e.g. 'Take a Breather' asks users to practice breathing exercises.



The missions in Work Out Ireland have been adapted from those in Work Out Australia (which contained a total of 32 Missions). In some cases, Missions were amalgamated (e.g. Body Clocking 1 and 2) while, in other cases, Mission titles were changed to make them more locally relevant (e.g. ‘Have my Back’ in Australia became ‘Just Ask’ in Ireland). Instructional text was also edited for cultural appropriateness as necessary.

## 11.16 The Tests

Validated psychometric tests are used in Work Out for two primary purposes:

- To determine the efficacy of the Missions.
- As part of the overall marketing proposition to ‘test your mental fitness’.

There is a comprehensive test that users take at the outset of the programme which determines their overall rating across each of the Mission areas. Users will be directed to re-take the test (or part of it) upon completion of both Missions in each of the four areas.

As an example, ‘Being Practical’ (formerly ‘Handling Pressure’) is measured using a 12-item scale; the first six items being from the GHQ-12 (General Health Questionnaire - although there is some repetition of K-6 items), and the next six items are the SOFA 6 (Symptoms of Fatigue and Anergia). Shorter pre and post tests are undertaken in the context of each Mission to determine any changes specifically related to each Mission.

Following completion of the overall test and each ‘post-Mission’ test, a range of possible responses are generated for the user, depending on their score. For example, the responses following the overall test for the Being Practical category includes the following:

Score	Response
0-8:	Looks like your mental health is in good shape. Well done, and keep it up by looking after yourself.
9-16:	You’re doing OK, but keep an eye on your stress levels, and take time out to relax and look after yourself better.
17-24:	You seem to be under pressure. As well as taking the Missions, you could do with talking to someone about how you’re feeling. This page on ReachOut.com will help you to take the next step, and figure out who to talk to about how you’re feeling (further details of support and crisis services are also provided).

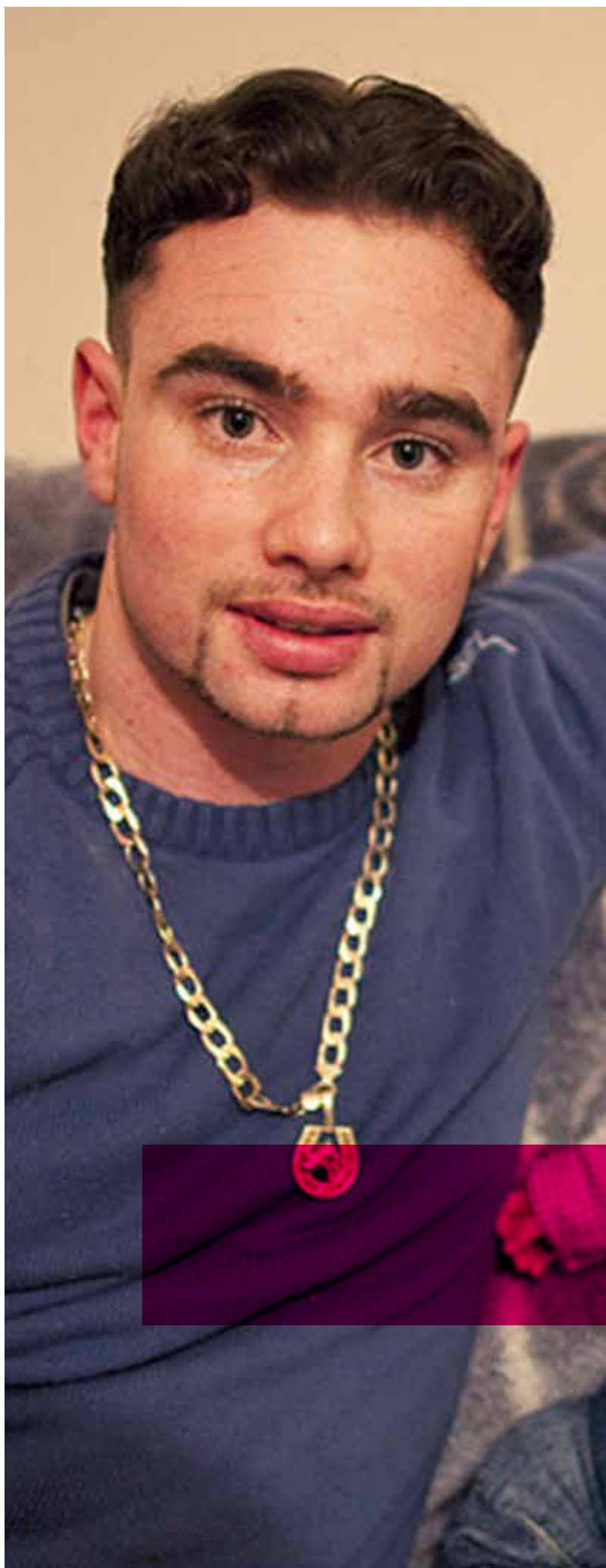
## 11.17 Marketing and Promotion

Work Out Ireland was promoted online through a targeted Facebook advertising campaign; utilising an additional budget allocation from the Health Service Executive's National Office for Suicide Prevention.

In addition, there was a traditional Press Release that was accompanied by photographs from a promotional shoot with the Ireland Football Team Manager, Giovanni Trapattoni, posing with ReachOut.com youth ambassadors. This release was issued in advance of World Mental Health Day 2012, and was featured in the 'Irish Times Health Supplement'; leading to radio interviews on RTE's 'Drive Time' programme and 'The Last Word' on Today FM.

Each of the partner agencies involved in the development of Work Out also promoted the intervention through their respective communication channels.

The launch was very successful in attracting visitors to the website, and over 500 people registered for the programme in the first two days after the launch.



## I2. Conclusion and Recommendations

“  
Identify and  
nominate  
a body to  
coordinate  
and oversee  
future  
developments.”



### 12. Conclusion and Recommendations

The aim of YMSP was to identify a range of possible means to promote positive mental health among young men on the island of Ireland, and to assess the efficacy of these approaches.

The case for having a specific focus on suicide prevention in young men is a strong one. As highlighted in this report, suicide is a major cause of death among young males on the island of Ireland. Although rates of attempted suicide and deliberate self harm (DSH) have, overall, been traditionally higher among females, rates of DSH are now higher among younger males than younger females.

While national strategies highlight the need to focus prevention efforts on young men, there is little evidence to indicate that this has happened, or to substantiate the effectiveness of such prevention and intervention initiatives that have taken place. This is not due to evidence indicating ineffectiveness; rather there is a lack of evidence due to insufficient rigorous evaluation of these initiatives. The ‘gold standard’ of the Randomised Clinical Trial is often not possible and, therefore, prevention efforts must rely on weaker evidence.

What is known to be effective in suicide prevention is the reduction of means to harm, and education of General Practitioners in depression recognition and treatment. Whilst interventions that revolve around sport and physician education offer much potential, it is also known that young men are those least likely to seek help in the event of mental health difficulties. Therefore, reaching young men who are experiencing suicidal thoughts can be difficult.

The targeting of suicide prevention initiatives through community education programmes - although widespread - has reported limited efficacy in terms of reaching the intended groups. However, long term programmes that utilise a commitment by the wider society - working at multiple levels and with a strong emphasis on the creation of community networks - can be successful.

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Factors associated with increased suicide risk in youth include: gender; genetics; mental health; alcohol and substance abuse; sexuality; socio-economic disadvantage; prior history of attempted suicide or deliberate self harm; relationship break-up; particular personality traits; restricted help seeking behaviour.

In the Republic of Ireland, the impact of both rising unemployment and high levels of alcohol consumption, have been specifically implicated in rising suicide rates; especially in young men. The recent economic situation has seen a substantial increase in unemployment - particularly in young men - and, in tandem with this, suicide rates have increased. While evidence suggests that alcohol consumption has a significant influence on suicide rates, it would seem that the impact of unemployment, alcohol and suicide is intertwined; particularly among young men.

Youth suicide interventions include school-based interventions, clinical interventions, family interventions, restriction of access to means, interventions for at risk individuals and media interventions - although most have shown limited evidence of effectiveness. An American developmental framework designed to reduce the incidence of suicide in boys and young men draws particular attention to the importance of interrupting the cycle of substance abuse, depression and developmental failure.

Attempting to transplant a suicide prevention programme that has shown success in other countries can be problematic - as socio-cultural factors may render it ineffective. Increased risk in relation to suicide is influenced by: demographic and social factors; family characteristics and childhood experiences; personality factors and cognitive style (such as sexual orientation); genetic and biological factors; psychiatric morbidity; environmental factors. In order to reduce suicide, it must be recognised that prevention efforts must tackle the complex interplay of these risk factors, either together or separately.

There can be multiple reasons why young men are reluctant to seek help when faced with a problem or crisis. These include embarrassment, shame, stigma, or concerns in relation to confidentiality / that others might find out that the young man has a problem. In addition, misuse of alcohol, unemployment, and reluctance to approach a professional in times of difficulty, have also been cited as barriers to young men's mental well-being. Young men's state of mind, however, is also important - with suicide being triggered by depressive episodes or severe mental illness.

The findings from both phases of the stakeholder engagement process - conducted as part of this study - raise a number of important findings. Particular attention needs to be focused on the key barriers cited to effectively engaging with young men. These included: lack of knowledge and expertise; insufficient funding; the paucity of services that specifically address young men's needs; lack of training; the absence of partnerships to support more holistic and sustainable approaches.

There is also much work to be done to overcome the organisational and structural barriers that stakeholders highlighted, including: the persistent stigma attached to mental illness and mental health; young men's inability to communicate effectively about mental health and emotional well-being; inadequacies within existing services - particularly with regard to engaging and sustaining commitment; shortfalls within service provision in communicating effectively with boys / young men; the need for early intervention; the need for an increased focus on dealing with alcohol and substance abuse; lack of research on creating effective partnerships; and lack of follow-up on research recommendations.



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Of particular note - from the focus groups with service providers - was the significance of the “*life takes over*” approach; taking advantages of windows of opportunity for engaging with young men; the importance of persistence and perseverance.

The concerns raised by young men, themselves, are also noteworthy, in particular: the negative perceptions of young men at a societal level; problems associated with bullying - particularly in schools; the challenge of disclosure within a macho culture.

In conclusion, there can be no quick-fix solutions to tackling the extensive and complex causes and risk factors that underpin the very grave statistics on suicide in young men. These causes and risk factors are diverse and intersecting, and the challenge of reducing suicide rates in young men demands a very comprehensive and multi-layered response, that seeks to intervene at a number of different levels, and that involves a range of key stakeholders.

There can no room for inertia or ambivalence - there is both a public health and a moral requirement to act. It is not enough to be seen to act - there needs to be a concerted effort to engage more effectively, and in a more sustained way, with young men, and to act in accordance with the best evidence that is available. The principles of effective practice identified in this report for engaging with young men in suicide prevention work, should inform and guide this engagement process.

Overall, this report provides a blueprint and a roadmap for action that, it is hoped, will act as a catalyst for more concerted efforts in tackling suicide in young men in the years ahead. We hope that the following recommendations will be adopted and used - by both those who commissioned this project and others with an interest in this field - as a means to improve the mental health and well-being of young men throughout Ireland.

**The key recommendations from the report are:**

**R.1** Develop and promote positive models of mental health that are **specifically targeted at boys and young men**

This report has proposed using the concept of ‘mind health’ or ‘mental fitness’. This would focus upon the type of skills and competencies necessary to support young men to: recognise and understand the source of feelings of sadness or despair; know how to deal with challenges and crises in their lives; build and develop positive life skills; have the knowledge and confidence to seek support; access appropriate services when necessary. Such an approach would avoid seeing young men as ‘the problem’, would seek to ensure that language used to engage with young men is positive and respectful, and would strive to adopt solution focused activities that develop a non-deficit approach to supporting young men to grow and develop in terms of emotional well-being, problem-solving and emotional resilience.

**R.2** Adopt a whole of government, joined-up approach, to young men’s mental health

Given the importance of promoting the mental health of younger (and, indeed, older) men, mental health promotion which targets this audience needs to be embedded across a range of health and social policies. A multi-dimensional, whole of government approach, should be the basis from which ‘at risk’ groups of young men are targeted. The development of strategic alliances and partnerships between different sectors needs to underpin suicide prevention work with young men. Effective strategies require engagement with, and cooperation between, a broad range of service and community sectors such as primary care, mental health, public health, community groups, prisons, sporting organisations, family and social welfare agencies ... Collaboration across government departments and different sectors is key to successfully influencing the determinants of mental health amongst young men.



### R.3 Plan services and programmes for and with young men, and work on developing trust and safety through the creation of non-threatening and male-friendly environments

At present, one of the biggest challenges in addressing the needs of young men is the absence of services and programmes that are specifically targeted at them. There needs to be increased funding and staff to carry out such work. Auditing and gender-proofing existing programmes and services could help to draw increased attention to gaps in service provision for young men - particularly age and gender specific community-based services. The creation of an open, friendly environment on initial contact helps young men to overcome any mistrust or suspicions they may have about prospective services or programmes. It creates safety, and enables young men to feel more confident and at ease. Actively seek to engage with young men on their level - the focus should be on enabling, empowering and facilitating young men to take control of their own mind health / mental fitness. There should also be a clear focus on consulting with, and involving, young men in programme development and programme delivery. Think carefully about the most appropriate 'hook' to engage young men, and be aware that this hook is likely to differ from region to region. The importance of persistence and perseverance in working with young men also needs to be stressed, and should be a core element of the 'life takes over' approach. Service providers should also be cognisant of taking advantage of 'windows of opportunity' for engaging with young men.

### R.4 Target early intervention and the provision of appropriate services at those most at risk

There should be an increased focus on targeting more vulnerable and at risk boys and young men (i.e. early school leavers, participants in early career based programmes, those involved in alcohol and substance misuse, unemployed men, gay / bisexual / transgender men, men involved in the criminal justice system, Traveller men). Regular contact (telephone, letter, use of social media), and follow-up support directed at high-risk groups, has been found to be an important contributory factor to reducing suicide rates and reducing the number of repeat suicide attempts. Young men are particularly vulnerable during times of crisis (relationship break-up, bereavement, being made redundant), and may be more amenable to interventions at such times. Ensure that this 'window of opportunity' is not lost by, for example, looking out for signs of distress or changes in behaviour, returning phone calls promptly, and using a solution focused approach to counselling.

### R.5 Expand interventions that tackle alcohol and substance misuse in young men

The reduction of alcohol consumption is one of the few unequivocal, evidence-based, measures that has been shown to reduce suicide and repeat DSH; with links between alcohol consumption and impulsive behaviour being a particular cause of concern. It is imperative that alcohol policy addresses this issue. It is also critically important to put in place measures that interrupt the cycle of alcohol / substance abuse, depression, and developmental failure that is associated with an exponential rise in suicide among more vulnerable groups of young men.

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## R.6 Challenge traditional masculine ideology that is associated with impaired help seeking behaviour in young men

For some young men, being emotionally expressive can be perceived as being 'unmasculine'. As a result, it may be associated with the repression of emotions - particularly those related to fear or sadness. Boys and young men should be supported in every way possible to know that: (i) having such emotions is part and parcel of everyday life (for women and for men); and (ii) having the language to express such emotions is an important aspect of overcoming problems and dealing with crises. Young men need to see emotional expression as a skill that improves with practice, and need to build an emotional vocabulary to be able to access the vulnerable feelings that are likely to underpin expressions of anger. There is a need to encourage acceptance among men that talking about difficulties and feelings is a sign of strength rather than weakness.

## R.7 Incorporate role models and marketing into suicide prevention work with young men

There needs to be an increased focus on the use of positive role models / champions (e.g. from the sporting, entertainment or music arenas) to support suicide prevention measures directed at young men. Care should be taken in the choice of role models - so as not to inadvertently promote the wrong type of messages or reinforce gender stereotypes. High profile role models, who hold credibility and respect among boys and young men, need to be actively associated with: (i) reducing stigma around mental health and suicidal behaviour; (ii) promoting help seeking behaviour; (iii) challenging bullying - particularly in secondary schools; and (iv) improving emotional resilience and problem-solving. Local role models and peers can also play an important role in actively promoting projects, and have the capacity to allay fears or embarrassment that some young men might feel about getting involved. Draw on 'gatekeepers' in education, workplace, sporting or community settings to encourage young men to participate in programmes. Use social media, magazines or fliers to advertise and create an interest in programmes, but have a clear focus upon what will be gained by attending such programmes.

## R.8 Have a more explicit focus on peer support and mentoring in suicide prevention work with young men

It is well known that young men learn a lot informally about the world from their peers, and that this type of learning and support can be invaluable. We also know that young men tend to be reluctant to access conventional health services, and are more likely to approach a friend during times of crisis. Yet, many young men are unsure of how to support a friend or acquaintance at such a time. There is, therefore, a need for an increased focus on peer support and mentoring programmes directed at increasing young men's sense of competence and confidence to support other young men in times of difficulty.

## R.9 Promote and encourage the use of safe and responsible online resources in mental health promotion and suicide prevention work with young men

There is a growing body of evidence which indicates that the Internet is the single most likely source of mental health information and support for young people. The relevance and potential of online resources was apparent in the days following the launch of the Work Out application which was developed for this project. The Internet and online resources have become a key part of the help-seeking process, whereby individual, personal problems, can be moved towards inter-personal solutions - since people can easily learn more about mental health issues and the types of support available to them for free and in confidence. However, it is important that

safe and responsible services are supported and promoted - as the range of online resources is vast. Inspire is working with the HSE's National Office for Suicide Prevention to develop good practice guidelines for the safe delivery of online support. These guidelines should be made widely available to those working with young men.

**R.10** Develop a one day training programme for all frontline staff on how to effectively engage with young men

Such a programme could be adapted from the existing Men's Health Training Programme (in the Republic of Ireland), needs to include a comprehensive resource pack, and should adopt a Train the Trainers model. There should be an explicit focus on: (i) identifying risk factors and warning signs associated with suicidal behaviour in young men; (ii) assisting service providers to become competent and confident about how to support young men who may be at risk, and to know where and how to access support; (iii) providing participants with practical tools to engage effectively with young men; (iv) having a strong focus on the development of partnerships and sustainable programmes; and (v) providing follow-up support.

**R.11** Ensure that research underpins all on-going and future work in the area of suicide prevention with young men

Notwithstanding the methodological limitations associated with developing 'evidence-based' interventions, there is a need for increased support for those tasked with delivering suicide intervention projects to evaluate the effectiveness of their work. The provision of funding for suicide prevention work with young men should be contingent upon the capacity of applicants to demonstrate built-in evaluation measures. This, therefore, will necessitate the inclusion of a research budget within the overall funding of projects. In particular, the focus of such endeavours should be on assessing the impact of programmes on improving participants' perceived level of competence and confidence in preventing suicide and in responding to suicidal behaviour (i.e. among young men themselves, their peers and families, community gatekeepers and health professionals). Service providers should be cautious about the potential pitfalls of transplanting prevention programmes that have worked elsewhere. Consideration should also be given to: (i) the development of support networks that allow opportunities for sharing information in relation to suicide prevention in young men; (ii) supporting practitioners with the writing of journal articles; and (iii) the provision of supervision / support groups - where small groups of workers meet on a regular basis to reflect on their work and to learn from each other.

**R.12** Identify and nominate a body to coordinate and oversee future developments in mental health promotion work with young men

This report outlines a broad and far-reaching range of recommendations. However, there needs to be a group / body identified who can, and will, take responsibility to progress the suggestions outlined in a practical way. It is unlikely that there will be a ground swell of support to set-up a new all-island forum or advisory group at the present time. However, it is critical that actioning these recommendations is part of someone's remit. Therefore, it is proposed that the national implementation groups, for the respective suicide prevention strategies, should consider taking on this role within their own jurisdictions.

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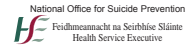
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The Young Men and Suicide Project Advisory Group was comprised of:



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