

# Providing meaningful care: using the experiences of young suicidal men to inform mental health care services

## Short Report



**Authors: Dr Joanne Jordan, Professor Hugh McKenna,  
Dr Sinead Keeney, Professor John Cutcliffe**

**Prepared for Health & Social Care Research and Development  
Division, Public Health Agency, Northern Ireland.**

**Address for correspondence:**

**Professor Hugh McKenna, Pro Vice Chancellor, Research and  
Innovation, University of Ulster, Cromore Road, Coleraine, BT52  
1SA.**

**e-mail: [hp.mckenna@ulster.ac.uk](mailto:hp.mckenna@ulster.ac.uk)**

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## Background

Suicide is the act of deliberately ending one's own life and is among the top 20 leading causes of death globally for all ages. Every year almost one million people die by suicide, a 'global' mortality rate of 16 per 100, 000 or one death every 40 seconds. Before 1950, suicides were more common in people over 45 years of age. In the latter half of the 20<sup>th</sup> century this pattern changed significantly, so that the majority of suicides were within the 15-45 age range. One of the most important factors underpinning this shift in age-related trends was the epidemic rise in suicide among young men in most industrialised nations. Significantly, rates of suicide in young men have shown evidence of decline since the late 1990s across most of the industrialised West.

In comparison to the trends identified above, the rise in suicide in Northern Ireland in general, as well as in relation to young men, is a more recent phenomenon. After remaining relatively static throughout the latter half of the 20<sup>th</sup> century, between 1999 and 2008, there was a 64% increase in suicide in Northern Ireland. In large part, the dramatic increase has been fuelled by a rise in male suicide, particularly marked in the 15-34 year age group. In 2002, almost 76% of all suicides were male, with 60% of these occurring in the 15-34 year age group; by 2008, 77% of all suicides were male and the percentage occurring in the 15-34 age group had increased to 72%.

The alarming rise in suicide, particularly among young men, prompted the DHSSPS to produce the first ever local-level Northern Ireland Suicide Prevention Strategy, 'Protect Life-A Shared Vision' (DHSSPS, 2006). Included in this strategy is an acknowledgement of the need for research to inform the development of policy as well as local-level service provision. The study reported here was one such research initiative funded by the then Research and Development Office, now the Health and

Social Care Research and Development Division of the Public Health Agency. It was a collaborative investigation between the Queens University, Belfast and the University of Ulster focused on those areas of Northern Ireland evidencing some of highest rates of suicide among the male population in the 16 to 34 age group.

## **Aims**

The overarching aim of the study was to obtain a comprehensive understanding of suicidal behaviour amongst men aged 16-34 to underpin the provision of accessible, acceptable and appropriate mental health services. In line with this aim, study objectives were to:

- elicit the experiences of men (aged 16-34) of being suicidal and their understandings of what would constitute meaningful caring
- explicate the specific caring processes that might make 'a difference' to caring for the suicidal person, that is, to inform what health care professionals can do.

The above aims and objectives were developed in order to answer two guiding research questions:

- How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?
- What is the required response of mental health care services for suicidal men, aged 16-34?

## Methods

An underpinning conceptualization of suicide as a multidimensional, complex phenomenon was reflected in the choice of a qualitative research design for this study. The fact that relatively little is known about young men's experiences of suicide further validated this approach. Consequently, in-depth interviews were chosen as the means of data collection. A purposive sample of young men was obtained according to: (i) age range and (ii) contact/lack of contact with statutory and non-statutory mental health services. The final sampling frame targeted four 'categories' of young suicidal men, defined primarily in relation to their (non) engagement with services. These were:

- *Men aged 16-34 currently engaged with statutory mental health services:* access was obtained through both the Belfast HSC Trust and Southern HSC Trust
- *Men aged 16-34 previously engaged with statutory mental health services:* access was to be obtained through both the Belfast HSC Trust and Southern HSC Trust.
- *Men aged 16-34 currently using a range of non-statutory counselling organisations:* access was obtained through a wide range of local-level community sector counselling organisations that dealt with suicidal young men in both the Belfast HSC Trust and Southern HSC Trust areas.
- *Men aged 16-34 who had not had any contact with statutory or non-statutory mental health services:* access was obtained through a comprehensive advertising campaign across a range of media.

A total of 36 young men were subsequently recruited. Data were collected by means of semi-structured interviews. All interviews were audio-recorded, with permission. Although questions were determined primarily by the unfolding discussion between the interviewer and participant, a limited number of pre-specified issues were

introduced. These included: a question addressing the support, including both formal and/or informal (mental) health care services, which a participant had sought, and; a question addressing the factors that had helped and continued to help maintain his wish to stay alive.

The overarching aim of the data analysis was to achieve *explanatory* value in terms of understanding suicidal and related help-seeking behaviour amongst young men. That is, analysis needed to move beyond the mere description of recurrent or common 'themes' to one that explored the context of and relationships between these themes. Data analysis was as follows. After initial verbatim transcription, Glaser and Strauss' (1967) process of open (substantive) coding was applied to each interview transcript. That is, the text was examined line by line in order to identify and subsequently 'code' processes in the data. Thereafter, individual labels (that is, codes) were compared with each other in order to develop clusters or categories of codes according to obvious fit. This allowed a tentative conceptual framework to be developed, comprising a number of categories (with associated labels). This framework was subsequently confirmed by further, conceptually-led reduction of the data. Here, the tentative categories were gradually grouped together under 'umbrella terms' by close examination to identify how they clustered or connected. This extended process gradually enabled the development of a number of core categories, which encompassed the entire dataset and captured the essential processes evident in the data.

The following procedures and processes were followed in order to enhance the validity and reliability of data analysis (Silverman, 2006). In terms of reliability: (i) all interviewers were trained with a view to establishing consistency in the conduct of interviews; (ii) all digital recordings were transcribed verbatim, and; (iii) transcripts were distributed amongst the research team for individual analyses, which were then shared in order to promote the full possibilities for analytical insight. In terms of validity: (i) comprehensive data treatment meant that all data were analysed and accounted for, and; (ii) constant comparison ensured that the final analytical framework was incrementally built up through comparison both within and across interview datasets.





## Findings

Three 'core categories' were developed: *Widening Access and Bolstering Pro-active Outreach*, *On becoming a man...*, and *Equipping young men for the challenges of 21<sup>st</sup> century living*. Collectively, these categories answered the two research questions.

### ***Widening Access and Bolstering Pro-Active Outreach***

Essentially, this category is concerned with current formal mental health services. Findings indicated that the type, nature, and geographical location of these services offered only limited help to address young men's suicidal thoughts and behaviours. Importantly, there was a clear need for more 'pro-active', 'outreach', suicide prevention services in addition to/distinct from responsive or reactive suicide services. In keeping with such a development was the parallel need for increasing awareness in the community, including young men, of the existence of such services. Further, the data highlighted how any media-based outreach attempts could profitably make use of technology more appropriate to the younger age group (for example, the internet, 'text messaging', email). In addition, findings confirmed the value in creating (more) community-based and relatively informal 'drop-in' suicide centres in line with young men's preferred contexts of (social) interaction.

The category also addresses the particular qualities and skills that young suicidal men found helpful in people with whom they worked. Especially in relation to the initial stage of the process of recovery, young suicidal men placed immense emphasis on such qualities and skills which emerged as the principal 'interventions' that the Mental Health Practitioners (MHPs) made use of. A firm interpersonal connection not only served as the platform upon which all future interventions were built but was made possible because of the practitioner possessing and, importantly, communicating certain attitudes. Finally, this category is concerned with initial attempts to combat the pervasive sense of disconnection referred to by the young

men in the study. Their accounts indicated that having a sense that they mattered, that someone else was concerned about and interested in them, was immensely important and had a specific countering effect on their suicidal ideation and perspectives.

### ***On Becoming a Man ...***

Participants described a range of issues, problems and perceptions that were significantly contributing to their initial and ongoing increased risk for suicide. Accordingly, this category is concerned with the interventions and services that could be provided to young men as a means of alleviating this risk. Participants made reference to possessing certain perceptions of what it was to be a 'successful' man in 21<sup>st</sup> century Northern Ireland. These perceptions were, by and large, unhelpful and unrealistic and served to contribute to their low self-esteem, level of personal stress and ultimately, to their increased risk of suicide. Accordingly, one role of MHPs was to gently challenge these constructs and perceptions and replace them with more realistic, helpful and attainable views of being a successful man.

Further, study data suggested the relevance of being able to access a 'peer group' within which young men can find support and hope from mixing with survivors of suicide. Being amongst others who were 'the same' created an opportunity for the young men to vocalize their feelings and behaviours in what was perceived as a 'safe' forum. Further, hearing the testimonies of other (formerly suicidal) young men highlighted the possibility of recovery and provided some form of conceptual understanding of the likely processes involved. Additionally, being exposed to these testimonies served as a protective factor, in that learning of the 'pain' of suicide from (multiple) others directly ushered the suicidal young men towards an understanding of suicide as unacceptable.

Finally, this category addresses suicidal young men's requirement for counselling (therapy) to address specific, unresolved issues. Participants referred to a wide

variety of problems and issues each of which, to a greater or lesser extent, was contributing to their risk for suicide. Accordingly, a wide variety of forms or types of counselling services were required (for example, for abusive childhood, relationship/marriage problems, addictions and dependency, loss and bereavement and family dysfunctionality). Evidently, where suicidal young men had received such specific forms of counselling help, they found it useful.

### ***Equipping Young Men for the Challenges of 21<sup>st</sup> Century Living***

This category is concerned with the processes and activities with which the young men engaged on their path to recovery from suicidality. It captures how this 'journey' was seldom completed quickly or easily and that recovery involved a process of establishing meaning in the young men's lives. Individual ways through which this (new) meaning was generated varied, but there were distinct commonalities across participants. In the context of their increasing sense of dissatisfaction with a 'meaningless life', MHPs could play an important role in helping the young men (re)discover personally meaningful phenomenon and experiences. As a result of finding this (new) meaning and purpose, the elevated risk of suicide appeared to diminish. Furthermore and importantly, participants found meaning in 'doing for other people', particularly other people who were experiencing similar challenges. Accordingly, there appears to be particular utility and value (as a suicide deterrent) to be involved in helping other people overcome their own challenges with suicidal thinking and actions.

The category is also concerned with providing suicidal young men with a range of opportunities to engage in pragmatic life skills, social skills, educational programmes and other meaningful activities. All of these, to a greater or lesser extent, provide them with a wide range of skills required to navigate their way successfully through the contemporary challenges of life in Northern Ireland. Further, such opportunities play an important role in keeping the young men occupied, thereby avoiding exposure to excessive isolation and rumination. Additionally, the category reflects suicidal young men's (growing) awareness of the powerful protective factor that having close, loving, concerned 'significant others' (most especially, family) can provide. Moreover, participants needed to be aware that their suicidal behaviour had

been accepted by these others; such acceptance affected their outlook, making them feel more hopeful about the future.

Finally, the category highlights the suicidal young men's acknowledgement of 'recovery' from their suicidality as an ongoing and long-term process and that within this extended time frame, 'hard work' on their part would be required. There is also a strong sense that while they were willing to engage in this long-term work, they would require ongoing support from mental health services and others who have endured a similar situation. To a lesser extent, this category is also concerned with the participants, in essence, 'learning to live' again. This included the important process of 'making sense' of their suicidality; interestingly, none of the young men referred to this process of 'sense making' in the past tense or as something they had completed. Additionally, it was evident that a number of inter and intra-personal processes were involved, not least the continued support from and involvement of (in this instance) the MHPs and fellow 'travellers' on the 'recovery' path.

## Recommendations

In the following, the two original research questions are used to structure study findings in terms of what they suggest as relevant to the provision of care for young suicidal men.

*(1) How can mental health care services be most appropriately configured to encourage their use by suicidal men aged 16-34?*

- Suicide related services need to reach out to young men *pro-actively*. These services should be community based and open-access.
- Part of this pro-active, community level service provision should be embedded in manifestly non 'mental health' contexts. These include sports clubs, schools, the workplace and community interest/self-help groups.
- Services, particularly those based in the community, need to be advertised more widely and in ways which reach out to young men. A range of media should be used to promote access and provide culturally relevant care, including media which have become a regular means of communication amongst young people.
- Services should be premised on an acknowledgement of the need for support to be provided to young men over the long-term so that they are to be enabled to move forward with their lives in a positive manner once the initial risk of suicide has been removed.
- Novel forms of suicide prevention outreach work should include those media that have become a regular means of communication among young people.

This includes social networking systems, the Internet, 'text messaging' and/or email.

- Services must continue to address the concerns of young men about issues of stigma and confidentiality regarding the care and treatment of suicidality. Some issues around signposting and labeling of suicide prevention services should be addressed immediately.
- Care should be based on a broad Recovery approach. The need to skill and support young men operates at both an individual and societal level and a fundamental part of this must involve creating an appropriate environment to promote participation and social inclusion of young suicidal men generally.
- Irrespective of the particular form of care/service provision, help and support needs to be delivered by those appropriately skilled and resourced.

*(2) What is the required response of mental health care services for suicidal men, aged 16-34?*

- It is essential that health care professionals care for young suicidal men in ways which respond to their basic emotional and interpersonal needs. It should be ensured that health professionals possess and convey therapeutic and supportive (non-judgemental) attitudes and realise the important bonding role they have in enabling young men to *reconnect with humanity*.
- Health care professionals should appreciate that their demeanour and attitude is crucial to a young man's sense of meaningful therapeutic engagement. Effective care is as much about how a young man perceives the relationship between himself and professional carer as it is about the 'technical' components of care.

- Care should be premised on an explicit acknowledgement of a young man as a human being with a unique personal biography.
- It should be ensured that treatment and care is relevant to recovery and onward trajectory through life if it is to be perceived as effective by young men. As part of this sense of 'moving forward', care should include help and support to develop a realistic appreciation of the (personal) possibilities that life offers as well as the skills to pursue these possibilities once envisaged.
- People with experience of suicide should be involved in care delivery and support. Hearing *first-hand* about these experiences serves as a powerful disincentive to suicide and learning about lives built successfully thereafter can act as an incentive for/basis of personal growth and development.
- Psychological therapies need to be made available as part of routine care, particularly those that equip young men with fundamental cognitive resources, including coping strategies (e.g. for dealing with stress, anxiety and disappointment) as well as other dimensions of mental/emotional well-being such as, for example, self-esteem.
- Maximising access must include taking steps to address the major challenges posed by stigma and discrimination, including comprehensive, population-level advertising and awareness raising campaigns as well as more targeted educational and workplace initiatives.
- Care should be premised on a Recovery rather than a 'risk reduction' approach.
- Additional education/training needs to be provided to health care professionals in order to support the provision of relevant care to young suicidal men.





## Conclusion

The findings of this study corroborate some of the core principles enshrined in national suicide prevention strategies of many western countries. These include: the United States (USDHHS, 2001), England (DoH, 2002), Scotland (The Scottish Executive, 2002), Ireland (HSE, 2005), New Zealand (Associate Minister of Health, 2006) and Australia (ADGHA, 2000). All have been developed in direct response to a significant global increase in the rate of suicide. Examination of these documents shows much conceptual and strategic overlap and corresponding similarities in emphases in relation to priorities set for the prevention of suicide. One such emphasis is that of interventions to help combat the stigma associated with suicide. Our research shows this to be particularly pertinent to the uptake and utilisation of mental health services among young men in Northern Ireland.

Encouragingly, there is evidence that national suicide prevention strategies can be effective in reducing the rate of young male suicide. For example, Morrell *et al.* (2007) traced a reduction in suicide in young men in Australia to the National Youth Suicide Prevention Strategy (NYSPPS). This strategy ensured that health and social care providers were resourced to implement a wide range of national and local-level interventions across primary prevention programmes, capacity building services and treatment support. Further, Stark *et al.* (2008) suggested that the recent priority given to promoting mental health and well being in Scotland, as part of the national suicide prevention strategy work, may have had an impact on reducing young male suicide. Specific interventions which mirror the policy and practice recommendations outlined in respect of this study include the 'See Me' anti-stigma programme, the 'Breathing Space' confidential telephone helpline targeted at young men, the development of a recovery-oriented mental health programme (the Scottish Recovery Network), as well as a large investment in media publicity about the nature and prevalence of suicidal behaviour.

Underpinning the development of the *range* of programs and related measures included in national suicide strategies has been the ongoing debate concerning the most appropriate approach to suicide prevention. Whilst a public health approach within suicide prevention is necessary in that it permits a broad range of social, economic, health, mental health, cultural and other risk factors to be integrated and targeted (Jenkins & Singh, 2000; Jenkins, 2002), the need remains for more targeted interventions (Beautrais *et al.*, 2005), including and particularly in relation to identified high-risk populations such as young men.

The evidence from our study highlights the importance of implementing a ‘package’ of measures. These include Northern-Ireland wide, population-level public health measures directed at reducing the stigma and discrimination associated with suicidal behaviour and related help-seeking. In addition, measures should be targeted specifically at the ‘at risk’ population of young men themselves (for example, care which is specifically configured around the help-seeking preferences of young men). These measures are inextricably linked; put basically, young men have to ‘turn up’ for care in order for that care to have a chance of being effective. They will continue not to attend services they perceive as both stigmatised and stigmatising irrespective of the quality of care these services may provide. However, as outlined above, there is growing evidence that, once implemented, such measures can be effective in reducing young male suicide.

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