



MIDDLE-AGED MEN AND SUICIDE IN IRELAND

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EXPLORING HOW TO SUPPORT THE MENTAL HEALTH OF MIDDLE-AGED MEN IN IRELAND

TABLE OF CONTENTS

List of Figures

Figure 1: Suicide Rates per 100,000 by Sex in the Republic of Ireland, 2006-2016	25
Figure 2: Age-Standardised Male Suicide Rates per 100,000 in the European Region, 2014	26
Figure 3: Male Suicide Rates per 100,000 by Age in the Republic of Ireland, 2006-2016	27
Figure 4: Age-Standardised Male Suicide Rates per 100,000 for 40-59 year olds in the European Region, 2014	28
Figure 5: Self-Harm Rates per 100,000 by Sex in the Republic of Ireland, 2006-2016	31
Figure 6: Self-Harm Rates per 100,000 by Sex for 40-59 years old in the Republic of Ireland, 2006-2016	31
Figure 7: Example A - Awareness Raising Campaign	62
Figure 8: Example B - Activity Based Programme and Support Groups	63
Figure 9: Example C - Education and Training Intervention	68
Figure 10: Example D - Psychological Support Intervention	69
Figure 11: Example E - Use of Technology	72
Figure 12: Marginalised Masculinities	95
Figure 13: Support Seeking and Coping Strategies	125
Figure 14: Negotiating the Dynamics of Engaging Middle-Aged Men	143
Figure 15: Engaging Middle-Aged Men in Suicide Prevention Model	166

Foreword	4
Thanks and Acknowledgements	6
List of Abbreviations	8
Executive Summary	9
1. Introduction	19
1.0 Middle-Aged Men and Suicide	19
1.1 Policy and Research Context	19
1.2 Scope and Purpose of Study	21
1.3 Governance	22
1.4 Aim	22
1.5 Research Questions	23
2. Review of Literature	24
2.0 Introduction	24
2.1 Suicide and Self-Harm Statistics	24
2.1.0 Suicide Statistics in Ireland	24
2.1.1 Self-Harm Statistics in Ireland	29
2.1.2 Suicide and Self-Harm In 'Priority Groups'	32
2.2 Risk and Protective Factors for Suicidal Behaviour	35
2.2.0 Introduction	35
2.2.1 Gender and Masculinities	36
2.2.2 Suicide Risk Factors	38
2.2.3 Protective Factors	52
2.3 Key Principles of Engaging Men and Evidence of Effective Practice	55
2.3.0 Introduction	55
2.3.1 Key Principles and Approaches to Effectively Engaging Men	56
2.3.2 Evidence of Effective Practice	60
2.3.3 Community Capacity Building and a Socio-Ecological Model of Health	73
2.4 Conclusion	79
3. Methodology	82
3.0 Study Design	82
3.1 Sampling	83
3.2 Data Collection	85
3.3 Data Analysis	87

3.4 Ethical Approval and Considerations	88
4. Results	90
4.0 Introduction	90
4.1 Marginalised Masculinities	94
4.1.0 Introduction	94
4.1.1 Mid-Life Transitions	96
4.1.2 Societal Challenges to Middle-Aged Masculinity	106
4.1.3 Subordinated Identities	113
4.2 Support Seeking and 'Coping' Mechanisms	124
4.2.0 Introduction	124
4.2.1 Moving Beyond Stigma: Negotiating Pathways to Seeking Support	128
4.2.2 Supports to Mental Health and 'Coping' Mechanisms	136
4.3 Negotiating the Dynamics of Engaging Middle-Aged Men	143
4.3.0 Introduction	143
4.3.1 Interpersonal Dynamics	144
4.3.2 Service Provider Dynamics	147
4.3.3 Systemic Dynamics	155
4.4 Conclusion	161
5. Discussion	164
5.0 Introduction	164
5.1 Individual Level Factors and Suicide Prevention in Middle-Aged Men	167
5.2 Relationship Level Factors and Suicide Prevention in Middle-Aged Men	172
5.3 Community and Institutional Level Factors and Suicide Prevention in Middle-Aged Men	175
5.4 Health Systems and Society Level Factors and Suicide Prevention in Middle-Aged Men	178
6. Conclusion and Recommendations	182
6.0 Conclusion	182
6.1 Recommendations	184
References	190

List of Tables

Table 1: Socio-Ecological Model of Suicide Risk Factors	38
Table 2: Protective Factors for Suicidal Behaviour	52
Table 3: Focus Groups with Middle-Aged Men at Risk of Marginalisation	84
Table 4: Service Provider Focus Groups	85
Table 5: Themes and Sub-Themes	91

Biographies

Tim, a Middle-Aged Man	92
Séan, a Divorced Father	93
Niall, a Farmer	110
Conor, a Gay Man	111
Kwame, a Non-Irish National Man	120

Johnny, a Rural Isolated Man	121
Kevin, a Transgender Man	126
Cathal, a Traveller Man	127
Jack, an Unemployed Man	140
Ian, a Victim of Domestic Abuse	141

FOREWORD

Over the past ten years, the suicide rate among middle-aged men (40-59 years old) in the Republic of Ireland has been the highest of all age bands. The self-harm rate among this age group has also increased in recent years. This worrying situation is compounded by the fact that, within this cohort of men, there are a number of specific 'at risk' groups for whom suicide and suicidal behaviour is more prevalent. These statistics are of particular concern to both the HSE National Office for Suicide Prevention (NOSP) and the Men's Health Forum in Ireland (MHFI).

'Connecting for Life: Ireland's National Strategy to Reduce Suicide, 2015-2020' identifies at risk demographic cohorts, and explicitly lists middle-aged men as being among the "groups for whom there is evidence of vulnerability to and increased risk of suicidal behaviour". Thus, it is timely that the Middle-Aged Men and Mental Health Project (a three year initiative, led by MHFI and funded by NOSP) should seek to explore the factors underpinning the high suicide rate among middle-aged men in Ireland, with a view to providing more effective and gender specific programmes, services and resources to support their mental health and wellbeing in the future.

This project particularly focuses upon those sub-populations of men who are most vulnerable and at risk of marginalisation, and this report documents the findings from the research conducted in Year 1 which sought to:

- collate existing evidence on the mental health of middle-aged men in Ireland;
- offer an opportunity for men in this age band to have their say about the issues and challenges that impact on their lives;
- record the experience of service providers who work to support these men;
- explore mental health risk and protective factors for this age group;
- define the principles and dynamics of effective practice;
- highlight existing intervention models;
- make recommendations on how to improve the mental health of middle-aged men in Ireland.

We are delighted to introduce this report which establishes the context of, and lays the foundation stone for, further developments in this field. We would like to thank all of the men who were prepared to honestly share their personal stories, as well as the support and service providers who engaged in a process of critical self-reflection. We believe that the input of both these groups will help to ensure that we have a solid evidence base to inform, and a roadmap to steer, Years 2 and 3 of the Middle-Aged Men and Mental Health Project. Future developments will, therefore, respond to identified needs and the real life experience of this age group and those who work with them.

We hope that this report will both challenge and inspire you to work towards change which can improve the mental health and wellbeing of middle-aged men in Ireland. The HSE National Office for Suicide Prevention and the Men's Health Forum in Ireland are firmly committed to this goal.

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The image features a landscape of rolling mountains under a sunset sky. The sky transitions from a pale blue at the top to a warm orange and red glow near the horizon. The mountains are rendered in various shades of blue, from deep navy in the foreground to lighter, hazy blues in the distance. A large, dark blue geometric shape, resembling a triangle or a trapezoid, is positioned in the upper right quadrant, partially overlapping the sky and the top of the mountains. Inside this dark blue area, the text "WE COULDN'T DO IT WITHOUT YOU" is written in a clean, white, sans-serif font, arranged in five lines.

**WE
COULDN'T
DO IT
WITHOUT
YOU**

LIST OF ABBREVIATIONS

●	ACCESS	Advocacy, Connection, Communication, Education and Training, Stigma Reduction and Awareness, Support
●	CHO	Community Health Organisation
●	EMAM-SP	Engaging Middle-Aged Men in Suicide Prevention
●	EU28	European Union 28 Member States
●	GP	General Practitioner
●	IMSA	Irish Men's Sheds Association
●	IRC	Irish Research Council
●	LCDC	Local Community Development Committee
●	LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex
●	MABS	Money Advice and Budgeting Services
●	MAMRM	Middle-Aged Men at Risk of Marginalisation
●	MDN	Men's Development Network
●	MHFI	Men's Health Forum in Ireland
●	NCMH	National Centre for Men's Health
●	NGO	Non-Governmental Organisations
●	NOSP	National Office for Suicide Prevention
●	UK	United Kingdom
●	USA	United States of America
●	WHO	World Health Organisation

EXECUTIVE SUMMARY

MIDDLE-AGED MEN AND SUICIDE

Over the past 10 years, the suicide rate among middle-aged men (40-59 years old) in the Republic of Ireland has been the highest of all age cohorts.

Self-Harm rates amongst middle-aged men have also increased in recent years, reaching a high of 207 per 100,000 in 2012. This is of particular concern, considering the higher lethality of suicide acts among males as well as the greater risk of suicide following self-harm amongst males.

Despite these trends, there has been little attention on middle-aged men in public, policy or research discourse. Numerous studies have reported that economic recession and increased rates of unemployment are associated with a decline in mental health and increased rates of suicide and self-harm within a global, European and Irish context. These statistics indicate a clear and urgent need for a specific suicide prevention focus targeting middle-aged men.

Suicide prevention is often understood in terms of risk and protective factors. This approach is necessary in order to determine and develop effective suicide prevention strategies and interventions. Gender encompasses socially constructed roles or normative behaviours for males and females. The key factors that are associated with gender and suicide among men are:

- Men's use of more lethal methods.
- A reticence to seek help.
- Higher rates of alcohol and substance misuse.
- Factors specific to 'high risk' groups.

Individual factors that increase the risk of suicide include a previous suicide attempt, family history of suicide, chronic pain, mental disorders, alcohol and substance misuse, hopelessness and job or financial loss. The disruption of relationships, social bonds and support networks can compound suicide risk by undermining one's sense of purpose and belonging. Community factors such as disaster, conflict, acculturation, discrimination and trauma or abuse also increase the risk of suicidal behaviour. Finally, community and health system, and societal factors relating to access to means of suicide, inappropriate media reporting, and stigma associated with help seeking can increase the risk of suicidal behaviour. Conversely, strong personal relationships, religious and spiritual beliefs, and lifestyle practices of positive coping strategies and wellbeing can protect against suicidal behaviour. However, limited evidence exists in the literature in relation to the specific factors underpinning the high suicide risk of middle-aged men at risk of marginalisation which is the key focus of this study.

Suicide and suicidal behaviour is more prevalent among certain 'priority groups' in Ireland that have been identified as being more vulnerable to suicide. Indeed, the primary focus of this study is on middle-aged men who are 'at risk' of suicide based on being middle-aged and on having at least one other identity characteristic. Thus, a spotlight was placed on middle-aged men who are gay, transgender, Travellers, victims of domestic abuse, non-Irish nationals, farmers, unemployed, rurally isolated, ex-prisoners, and separated/divorced fathers.

Being marginalised is associated with a greater risk of suicide. The evidence gathered in this report indicates that middle-aged men, more broadly, are increasingly at risk of marginalisation. Therefore, whilst the research focus is justifiably on 'at risk' groups, this study's findings are applicable to all middle-aged men, including and beyond the groups identified as being at risk of marginalisation.

There has been a breadth of evidence supporting and informing key principles and approaches to effectively engaging men with their mental health. Building trust and rapport is of paramount importance and transcends many of the guiding principles in engaging men. These include:

- Working in an informal environment and creating a safe space.
- Adopting a strengths-based approach.
- Using positive non-stigmatising language.
- Finding the 'hook'.
- Consulting with men.
- Adopting a partnership approach.

A review of existing evidence points to five broad categories as potential sites for future suicide prevention work with middle-aged men. These are:

- Awareness raising campaigns.
- Activity based programmes and support groups.
- Educational and training interventions.
- Psychological support.
- Use of technology.

POLICY AND RESEARCH CONTEXT

From a policy and research perspective, there is a strong case for a specific and more targeted approach to mental health promotion and suicide prevention work with middle-aged men.

Connecting for Life identifies 'at risk' demographic cohorts, and explicitly lists middle-aged men as being among the "groups for whom there is evidence of vulnerability to and increased risk of suicidal behaviour" (pages xii / 32). It also calls for "...targeted campaigns to improve awareness of appropriate support services to priority groups" (Action 1.2.2); providing "...community-based organisations with guidelines, protocols and training on effective suicide prevention" (Action 2.2.1); and the development and delivery of "...training and awareness programmes."

Theme 2 of the National Men's Health Action Plan (Health Service Executive, 2016, p12) states the need to "contribute to the implementation of the priority programmes for Healthy Ireland... with a particular emphasis on reducing health inequalities between different sub-populations of men". Central to this theme is to "support the implementation of the 'Connecting For Life' Implementation Plan by developing and implementing new initiatives (e.g. middle-aged men) that promote positive mental health and resilience among at risk groups of men" (Action 2.4).

GOVERNANCE

The Men's Health Forum in Ireland (MHFI) commissioned this study in response to the pattern of increasing suicide behaviour among middle-aged men in the Republic of Ireland, with a view to informing policy and practice in this area. This study explores the perspectives of both service providers and 'at-risk' groups of middle-aged men to establish the key issues that are impacting 'at risk' groups of middle-aged men's mental health, as well as barriers and opportunities for engagement.

This study was funded by the National Office for Suicide Prevention (NOSP) and was conducted by the National Centre for Men's Health (NCMH) at the Institute of Technology Carlow. The Irish Research Council (IRC) provided a scholarship for an MSc student as part of the Employment Based Postgraduate Scheme and the Men's Development Network (MDN) acted as the host organisation. This research was further supported by an inter-agency Advisory Group established and convened by MHFI. This group comprised representatives from statutory and non-governmental organisations (NGOs) with an interest in men's health and suicide prevention.

AIM

The aim of this study was to explore the factors underpinning the high suicide rates among middle-aged men at risk of marginalisation in the Republic of Ireland, with a view to providing more effective and gender specific programmes, services, and resources to support their mental health and wellbeing.



RESEARCH QUESTIONS

- What are the key issues that impact the mental health and wellbeing of middle-aged men at risk of marginalisation?
- What are the challenges, barriers and opportunities for engaging middle-aged men at risk of marginalisation in relation to mental health?
- How can existing services/programmes be adapted to engage more effectively with middle-aged men at risk of marginalisation in relation to mental health?
- How can middle-aged men at risk of marginalisation be supported to care for their mental health and to access support services promptly during times of difficulty or crisis?
- What are the key principles that will inform follow-up measures (e.g. bespoke training, programme/resource development) that address the aim of this study?

METHODOLOGY

This study adopted a qualitative research approach using the principles of grounded theory to inform data collection and data analysis. Focus groups and phone interviews were used with 'at risk' groups of men (n=9; representing diversity in terms of social class, ethnicity, race, sexual orientation) and with a broad range of service providers (n=7). Ethical approval was sought from, and granted by, the Institute of Technology Carlow's Ethics Committee.

This study gives a voice to, in particular, more marginalised or 'at risk' populations of middle-aged men. It gives them an opportunity to have their say about the issues that impact on their lives - their fears, anxieties and challenges in relation to mental health and what is needed to support their mental health. It does so by exploring how gender intersects with multiple layers of risk factors and with due regard to the wider socio-cultural context of men's lives. Crucially, the study also solicits insights from service providers about the issues underpinning the high suicide rates among middle-aged men and their own perceived challenges and barriers to engaging these men.

This is the first in-depth study in Ireland to explore the possible links between middle-aged men at risk of marginalisation and increased suicide risk; a focus which has also been absent in the international literature. Thus, this study fills a gap in the existing literature on mental health promotion and suicide prevention strategies targeted, in particular, at middle-aged men at risk of marginalisation in the Republic of Ireland. Furthermore, the literature to date has gravitated towards a now familiar binary argument - middle-aged men are largely 'the problem' (emotionally withdrawn, reluctant to seek help) and service providers do not know how to engage middle-aged men. This study seeks to embrace the complexity that lies in between and to improve our understanding of the issues involved.

RESULTS

The findings of this study emerged in three broad themes:

1. Marginalised Masculinities.
2. Support Seeking and Coping Mechanisms.
3. Negotiating the Dynamics of Engaging Middle-Aged Men.

Marginalised Masculinities captures a broad range of issues and challenges that were identified as sources of psychological distress and which, potentially, predisposed middle-aged men to increased suicide risk. This theme explores mid-life transitions which are associated with a recurring set of challenges, including: declining health status and acknowledging mortality; diminishing life or career opportunities; increasing pressures at middle-age associated with the provider role; facing-up to the 'failure' of unfulfilled aspirations and expectations at middle-age; and the cumulative and multiplicative effects of psychological distress.

These issues were compounded by what were seen as significant new societal challenges (zero hour contracts, multiple career paths, changing role of men) and an unravelling of the more traditional pillars of society (church, politics). This resulted in more vulnerable groups of middle-aged men, in particular, feeling that they had been cast adrift between two vastly different generations.

Against this backdrop of grappling with the unique transitions of middle-age, and at a time of significant wider societal challenges, many groups of middle-aged men also reflected upon feeling rejected, discriminated against and stigmatised on the basis of different aspects of their identity. Not surprisingly, some actively sought to withdraw and retreat 'into themselves'. For many groups of middle-aged men, isolation and loneliness had a crippling effect on their lives. Indeed, the harsh reality for many of these men was that rejection, withdrawal and isolation interfaced in multiplicative ways and were closely aligned to significant psychological distress in their lives - including, in some cases, suicidal behaviour.

Support Seeking and Coping Mechanisms explores how men navigate and access support (or not) during times of psychological distress. The continued stigma associated with mental health, and with men accessing support for mental health issues, was a significant undercurrent to middle-aged men's approach to seeking help and coping during times of psychological distress. It was a cause of considerable concern that the most commonly reported trigger to seeking support for many men was having reached a crisis point - a reality that was influenced by prevailing gender norms and men's past negative experience of services (which were generally seen as inadequate, over-stretched and over-medicalised).

It was also felt that this age cohort of men had been reared on more traditional masculine values such as being responsible, invulnerable, stoic and self-reliant. This conflicted with being seen as 'weak' or becoming a 'burden' by seeking support. Whilst being in a stable environment, connection to others and self-awareness were identified as key supports that helped to keep middle-aged men well, the opposite was also true for some men; with alcohol use being highlighted as a particularly problematic 'coping' strategy for many men in psychological distress.

An important backdrop to this theme is how men provide support to other men during times of psychological distress. Whilst all were open to this - and wanted to do 'the right thing' - there were several concerns about saying or doing 'the wrong thing' or 'driving someone over the edge'.

Negotiating the Dynamics of Engaging Middle-Aged Men relates to the dynamics between men, service providers, support services, societal structures, and society more generally, which influence men's engagement with services and social groups.

A range of factors had a bearing on the dynamics of engaging middle-aged men:

- At an interpersonal level, it was reported that the forging of strong relationships hinged upon establishing trust, being relatable, finding common ground, and gaining credibility. Conversely, factors that inhibited effective relationships included age and class differences, and the use of complex or stigmatised language.
- At a service level, a number of factors were identified, including the importance of having a 'male-friendly' environment, utilising self-guided strategies to facilitate recovery, finding a 'hook' or incentive to engage men, and the advantages of pragmatic, partnership and community-based approaches to engaging men.
- At a systemic or organisational level, stigma was also a recurring theme, as well as: pressures to deliver best practice approaches against a pre-determined set of outputs; the undervaluing of what were described as 'soft outcomes' (such as connection, self-worth, and self-efficacy); and inconsistent funding streams.

CONCLUSION

Despite the disturbing increases in suicidal behaviours among middle-aged men in the Republic of Ireland in recent years, and at a time of unprecedented socio-economic change, there has been an equally disturbing inertia and ambivalence at a policy and service delivery level in terms of addressing this issue. To compound the problem, middle-aged men's voices have largely not been heard in terms of advocating for their own mental health needs. Historically, this age cohort of men have simply 'got on with it' and 'sorted out their own problems'. Sadly, this is having increasingly tragic consequences in terms of rising rates of suicide and self-harm among middle-aged men.

This study's findings make the issue of suicide in middle-aged men visible, and give a voice to those more vulnerable and 'at risk' groups to have their say about the issues and challenges that impact on their lives. By drawing on the experience of service providers - who are at the coalface in working with middle-aged men - the findings also signpost both the challenges and opportunities in terms of engaging more effectively and reaching out to middle-aged men.

Much of the existing focus of health policy, in Ireland and elsewhere, is on behaviour modification and increasing personal capacity to effect change. However, it is imperative that policy also accounts for the wider social determinants of health that, in the context of this study, result in circumstances that push more vulnerable and marginalised groups of middle-aged men into isolation and increased risk of suicide.

There is a need for both bottom up and top down approaches to create sustainable change, both in terms of:

Culture change - to ensure society is more open to and accepting of middle-aged men at risk of marginalisation (MAMRM) expressing their concerns.

Structural change - to ensure that when men do seek help it is available and accessible.

The hope or expectation for finding a single magic formula that will be the panacea for addressing the high suicide rates among middle-aged men is not realistic - nor could it be in the context of the complexity and interplay of the causes and risk factors for suicide. Identifying recommendations and a roadmap to address the issues and challenges that have been raised is not the main challenge; mobilising the will and necessary commitment to translate these into tangible outcomes is.

RECOMMENDATIONS

The following overarching recommendations are presented in this report, and cover six key areas: **A**dvocacy, **C**onnection, **C**ommunication, **E**ducation and Training, **S**tigma Reduction and Awareness, and **S**upport (ACCESS) ...

R1: Advocacy

Identify and facilitate key advocates to drive the agenda on middle-aged men and suicide prevention.

R2: Connection

Support middle-aged men at risk of marginalisation to build and strengthen relationships with friends, family and service providers.

R3: Communication

Increase lines of communication between services to better support middle-aged men's mental health and wellbeing.

R4: Education and Training

Develop specific education and training programmes for both middle-aged men and service providers to support middle-aged men's mental health and wellbeing.

R5: Stigma Reduction and Awareness

Reduce stigma relating to mental health and to men seeking support for mental health issues, and raise awareness across society of the issue of middle-aged male suicide.

R6: Support

Extend the availability of statutory mental health services nationwide and increase the accessibility to services for marginalised groups of middle-aged men.

1. INTRODUCTION

1.0 Middle-Aged Men and Suicide

Over the past decade, the rate of suicide has been rising among middle-aged men (40-59 years old) in the Republic of Ireland. Indeed, this age cohort now has the highest suicide rate of all age categories. Similar rises in suicide rates among middle-aged men have been reported in the United Kingdom (UK) and the United States of America (USA) (Coope et al., 2014; Phillips et al., 2010). Self-harm rates amongst middle-aged men have also increased in recent years. This is of particular concern considering the higher lethality of suicide acts among males, as well as the greater risk of suicide following self-harm amongst males. Indeed, the rate of self-harm is likely to be even higher, as the recorded rates merely represent the cases which present to hospital emergency departments.

These trends need to be considered against a backdrop of unprecedented socio-cultural and economic change in Ireland. Numerous studies have reported that economic recession and increased rates of unemployment are associated with a decline in mental health and increased rates of suicide and self-harm within a global, European and Irish context (Reeves et al., 2012; Stuckler et al., 2009; Corcoran et al., 2015).

1.1 Policy and Research Context

From a policy and research perspective, there is a strong case for a specific and more targeted approach to mental health promotion and suicide prevention among middle-aged men.

Connecting for Life – Ireland’s National Strategy to Reduce Suicide - identifies ‘at risk’ demographic cohorts, and explicitly lists middle-aged men as being among the “groups for whom there is evidence of vulnerability to and increased risk of suicidal behaviour” (pages xii / 32). It also calls for “...targeted campaigns to improve awareness of appropriate support services to priority groups” (Action 1.2.2); providing “...community-based organisations with guidelines, protocols and training on effective suicide prevention” (Action 2.2.1); and the development and delivery of “...training and awareness programmes.”

Recommendation 8.3 of the National Men’s Health Policy (Department of Health and Children, 2009, p114) specifies the need for “a clear focus on the gendered nature of [men’s] mental health” and calls for “more gender competent community-based mental health services” and for an increased focus on “joint programmes between primary care services, addiction services and community-based mental health services”.

Theme 2 of the National Men’s Health Action Plan (Health Service Executive, 2016, p12) states the need to “contribute to the implementation of the priority programmes for Healthy Ireland... with a particular emphasis on reducing health inequalities between different sub-populations of men”. Central to this theme is the need to “support the implementation of the ‘Connecting For Life’ Implementation Plan by developing and implementing new initiatives (e.g. middle-aged men) that promote positive mental health and resilience among at risk groups of men” (Action 2.4).



1.2 Scope and Purpose of Study

Despite a significant increase in suicide and self-harm rates among middle-aged men in recent years, and against a backdrop of unprecedented socio-economic change, there has been a lack of focus on addressing the issues underpinning suicidal behaviour among middle-aged men in the Republic of Ireland. Whilst many existing interventions include middle-aged men among their target reach of population groups (e.g. Mojo, Samaritans and the Little Things Campaign), there has been a general absence of interventions that have specifically targeted middle-aged men.

This study gives a voice to more marginalised or 'at risk' populations of middle-aged men, in particular, to have their say about the issues that impact on their lives - their fears, anxieties and challenges in relation to mental health and what is needed to support their mental health. It does so by exploring how gender intersects with multiple layers of risk factors, and with due regard to the wider socio-cultural context of men's lives.

Being marginalised is associated with a greater risk of suicide and the evidence gathered in this report indicates that middle-aged men, more broadly, are increasingly at risk of marginalisation. Therefore, whilst the research focus is justifiably on 'at risk' groups, this study's findings are applicable to all middle-aged men; including and beyond the groups identified as being at risk of marginalisation.

Crucially, this study also solicits insights from service providers about the issues underpinning the high suicide rates among middle-aged men and their own perceived challenges and barriers to engaging this age group. This is the first in-depth study in Ireland to explore the possible links between middle-aged men at risk of marginalisation and increased suicide risk; a focus which has also been absent in the international literature.

This study fills a gap in the existing literature on mental health promotion and suicide prevention strategies targeted, in particular, at middle-aged men at risk of marginalisation in the Republic of Ireland. Furthermore, the literature, to date, has gravitated towards a now familiar binary argument - middle-aged men are largely 'the problem' (emotionally withdrawn, reluctant to seek help) and service providers do not know how to engage them. This study seeks to embrace the complexity that lies in between and to improve our understanding of the issues involved.

1.3 Governance

The Men's Health Forum in Ireland (MHFI) commissioned this study in response to the pattern of increasing suicide behaviour among middle-aged men in the Republic of Ireland, with a view to informing policy and practice in this area. This study explores the perspectives of both service providers and 'at-risk' groups of middle-aged men to establish the key issues that are impacting 'at risk' groups of middle-aged men's mental health, as well as barriers and opportunities for engagement.

This study was funded by the HSE National Office for Suicide Prevention (NOSP) and was conducted by the National Centre for Men's Health (NCMH) at the Institute of Technology Carlow. The Irish Research Council (IRC) provided a scholarship for an MSc student as part of the Employment Based Postgraduate Scheme and the Men's Development Network (MDN) acted as the host organisation. This research was further supported by an inter-agency Advisory Group established and convened by MHFI. This group comprised representatives from statutory and non-governmental organisations (NGOs) with an interest in men's health and suicide prevention.

1.4 Aim

The aim of this study was to explore the factors underpinning the high suicide rates among middle-aged men at risk of marginalisation in the Republic of Ireland, with a view to providing more effective and gender specific programmes, services, and resources to support their mental health and wellbeing.



1.5 Research Questions

The following research questions were explored in this study:

- What are the key issues that impact the mental health and wellbeing of middle-aged men at risk of marginalisation?
- What are the challenges, barriers and opportunities for engaging middle-aged men at risk of marginalisation in relation to mental health?
- How can existing services/programmes be adapted to engage more effectively with middle-aged men at risk of marginalisation in relation to mental health?
- How can middle-aged men at risk of marginalisation be supported to care for their mental health and to access support services promptly during times of difficulty or crisis?
- What are the key principles that will inform follow-up measures (e.g. bespoke training, programme/resource development) that address the aim of this study?



2. REVIEW OF LITERATURE

2.0 Introduction

The section provides a review of the literature in relation to men's health, suicide, effective practice in relation to engaging men around mental health and suicide prevention, community capacity building and the socio-ecological model of health. Section 2.1 primarily focuses on the statistics relating to men, suicide and self-harm in Ireland with a particular focus on middle-aged men (40-59 years old) and 'priority' groups. Section 2.2 gives a brief overview of the gender and masculinities literature and explores common suicide risk and protective factors. Section 2.3 explores the key principles for engaging men around mental health and critiques some of the more established models of effective practice. It also discusses community capacity building and the socio-ecological model of health which provides an important theoretical basis and a matrix from which to contextualise the intersection of suicide risk factors and levels of influence that can potentially be leveraged to address the issue of suicide among middle-aged men.

2.1. Suicide and Self-Harm Statistics

2.1.0 Suicide Statistics in Ireland

Suicide - the act of intentionally ending one's own life - is a major concern among communities around the world. An estimated 800,000 people die by suicide annually, with the rate of attempted suicide being 10-20 times greater (WHO, 1999; WHO, 2014). On average, this equates to a death by suicide every forty seconds and an attempt every three seconds. It is likely that this number may even be larger, as suicide is often under-reported - possibly due to the stigma surrounding the issue and the fact that suicide is still illegal in some countries - and due to unreliable registration of deaths in certain countries.

Against a backdrop of rising suicide rates internationally towards the latter half of the 20th century, this pattern has been quite pronounced in the Republic of Ireland, particularly between 1980 and 2000. This coincided with a period of considerable transition in Irish society (Department of Health and Children, 2005).

There are stark sex differences in suicide rates - on average, the male suicide rate is 3.5 times greater than the female rate in developed or high human development index countries (WHO, 2014). This disparity is even wider in the Irish context. Over the past eleven years, the male suicide rate was, on average, 4.4 times greater than the female rate (see Figure 1). There was a decrease in suicide rates between 2001 and 2007, but this trend was reversed in 2008. This coincided with the onset of an economic recession and rising unemployment rates. Initial studies reported a short-term increase of 13% in the rate of suicide in light of the recession (Stuckler et al., 2009). Research measuring medium term impacts of the economic recession on male suicide in Ireland reported an increase of 57% by the end of 2012, when compared to forecasted pre-recession suicide trends (Corcoran et al., 2015).

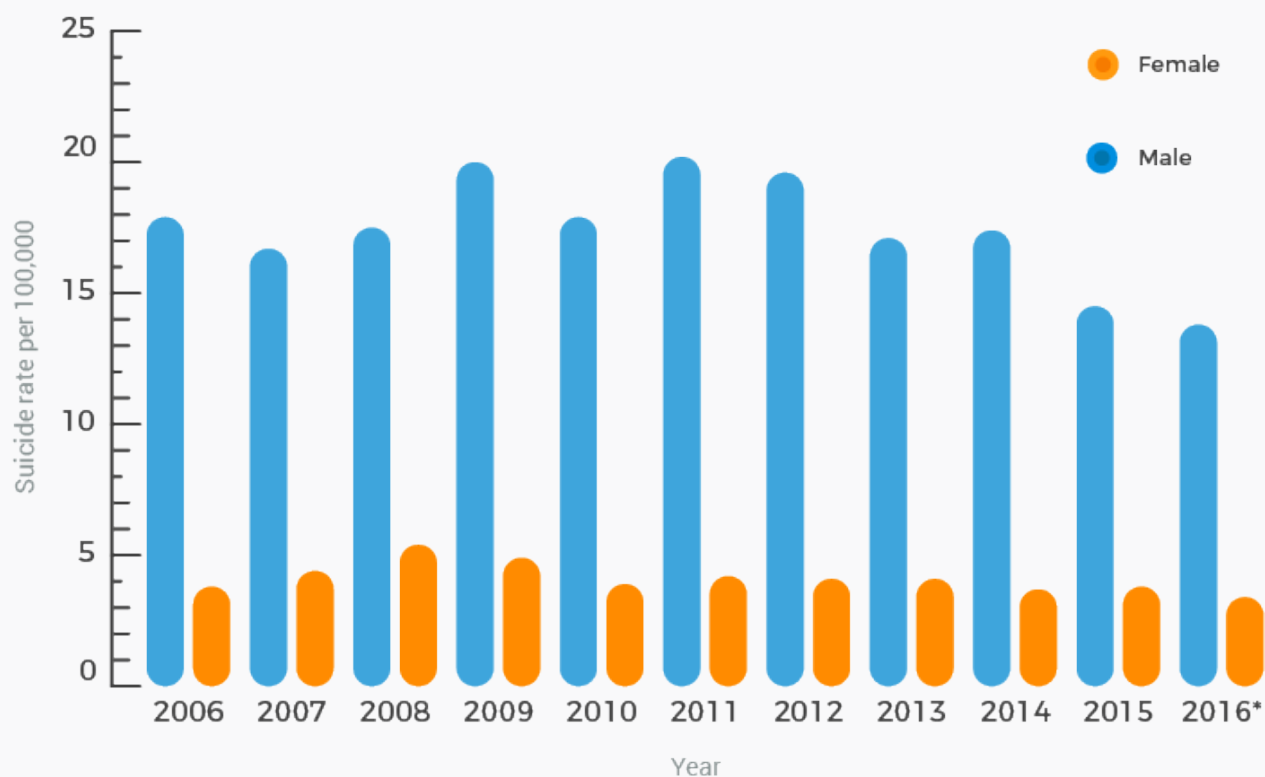


Figure 1: Suicide Rates per 100,000 by Sex in the Republic of Ireland, 2006-2016

*2016 figures are provisional and subject to change

Source: Central Statistics Office

Within the context of the European Union (EU28), the male suicide rate in Ireland of 18.4 per 100,000 is just below the EU28 average of 18.5 per 100,000 (see Figure 2). The highest male suicide rate in 2014 among the EU28 was in Lithuania at 59 per 100,000 whilst the lowest was in Cyprus at 6.8 per 100,000.

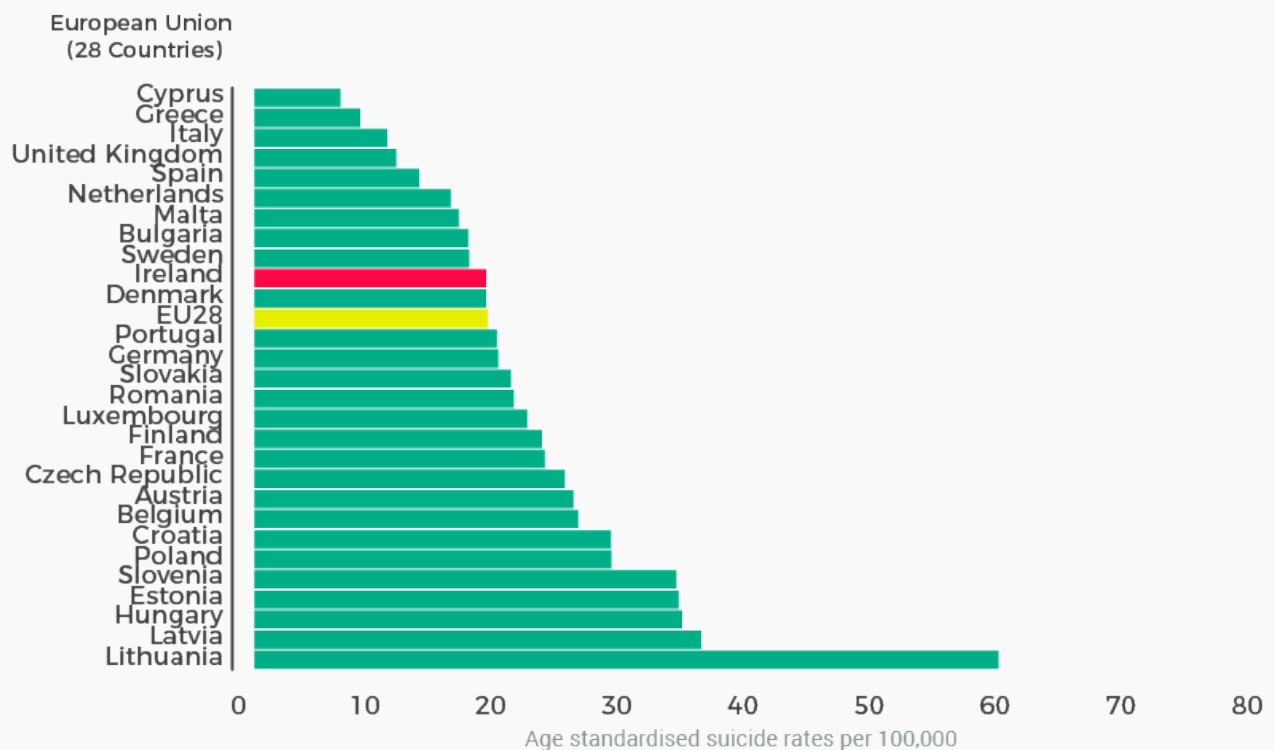


Figure 2: Age-Standardised Male Suicide Rates per 100,000 in the European Region, 2014
Source: EuroStat, accessed April 2017

Recently, media and scholarly attention with regard to male suicide has gravitated towards younger men (Shiner et al., 2009; Pitman et al., 2012; Richardson, 2013). Indeed, the plethora of suicide research with young men is warranted considering that suicide is the second leading cause of death of people aged 15-29 years old and youth suicide accounts for the majority of potential years of life lost (WHO, 2014). However, this should not divert attention away from the more recent pattern of rising suicide statistics amongst middle-aged men which, for the purpose of this report, has been defined as 40-59 years old. Indeed, since 2008, the highest suicide rate in Ireland has been among middle-aged men, representing a shift away from a previous pattern of higher suicide rates among younger men (see Figure 3).

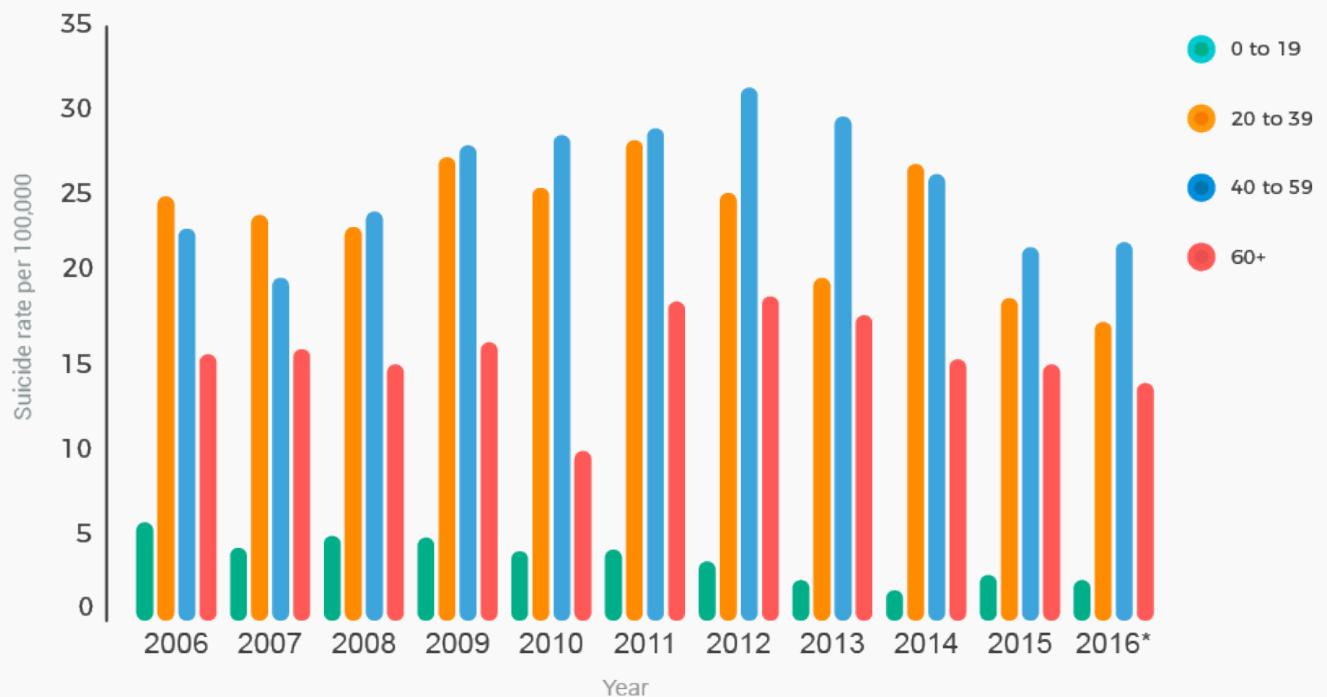


Figure 3: Male Suicide Rates per 100,000 by Age in the Republic of Ireland, 2006-2016
 *2016 figures are provisional and subject to change
 Source: Central Statistics Office

Despite this, there has been little attention on middle-aged men in public, policy or research discourse (Shiner et al., 2009; Wyllie et al., 2012). Similar rises in suicide rates among middle-aged men have been reported in the UK and the USA (Coope et al., 2014; Phillips et al., 2010). The highest middle-aged male suicide rate in the Republic of Ireland was recorded in 2012, with a rate of 31.4 per 100,000 (see Figure 3).

There was a reduction in middle-aged male suicide rates between 2012 and 2014, with a levelling off being apparent from the provisional data for 2016. Nevertheless, the middle-aged male suicide rate has remained stubbornly high over the past ten years. These statistics indicate a clear and urgent need for a specific research focus that explores the factors underpinning the high suicide risk among middle-aged men, with a view to informing a more targeted suicide prevention approach to this cohort.

Within a European context, the age standardised suicide rate for middle-aged men in the Republic of Ireland in 2014 was 26.4 per 100,000, which is just above the EU28 average of 24.8 per 100,00 (Figure 4).

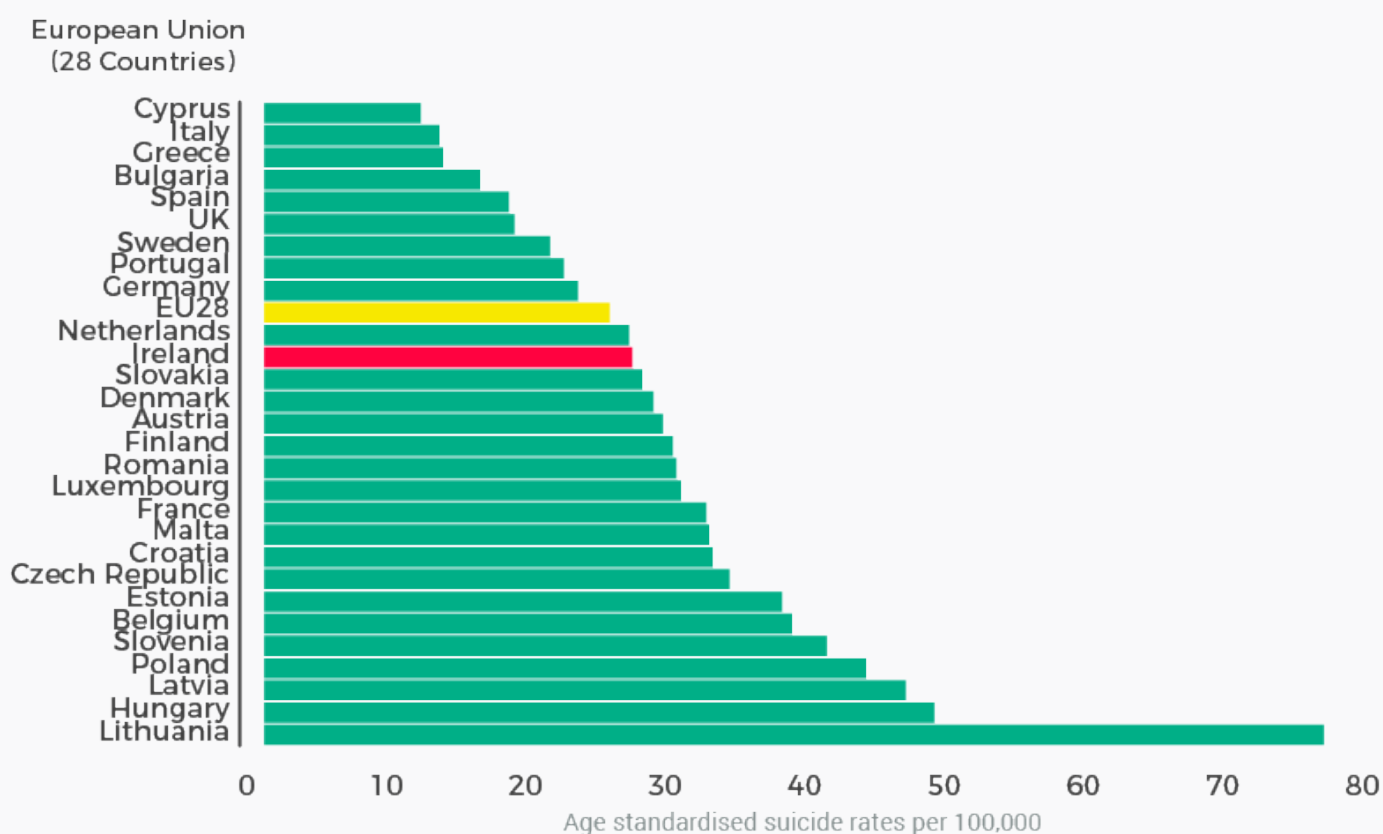


Figure 4: Age-Standardised Male Suicide Rates per 100,000 for 40-59 year olds in the European Region, 2014
 Source: EuroStat, accessed April 2017

2.1.1 Self-Harm Statistics in Ireland

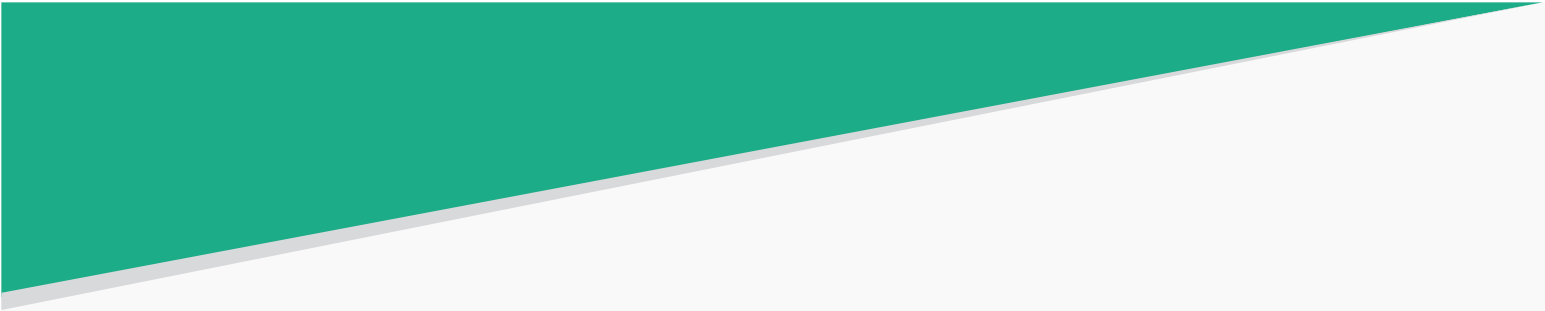
The National Self-Harm Registry of Ireland defined self-harm as:

“An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingest a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences” (National Self-Harm Registry Annual Report, 2016, p13).

This definition accounts for varying levels of suicidal intent. Although it has been reported that 85% of all self-harm acts are carried out with the goal of ‘releasing tension’, it is estimated that the risk of suicide increases by 40 to 100 times during the twelve months following a self-harm act (Yates, 2004; Owens et al., 2002; Hawton & Fagg, 1988). In both self-harm and suicide attempts, there can be different motivations for the behaviour - self-preserving ritualistic coping behaviour versus more violent suicidal behaviour. However, both indicate mental health struggles. Therefore, self-harm behaviour is a clear and important indication of the need to intervene to stabilise mental ill health, improve coping strategies and, therefore, prevent suicide.

While suicide rates tend to be higher among males, self-harm rates are more prevalent in females. The self-harm rate in Ireland rose significantly between 2007 and 2010, but there were successive decreases between 2011 and 2013 (Griffin et al., 2017). Since then the rates have stabilised. In 2016, the female self-harm rate was higher (209 per 100,000) than the male self-harm rate (172 per 100,000; Griffin et al, 2017). However, this gap has narrowed considerably in recent years (see Figure 5) - from 37% in 2007 to 24% in 2016 (Griffin et al., 2007).

Male self-harm rates rose disproportionately compared to female rates from 2007-2011 with male self-harm rates rising by 20% and female rates rising by just 2% over this period. It is suggested that the economic recession is likely to be a key contributor to this pattern of increase (Griffin et al., 2016). Although self-harm rates rose among all age groups of men between these years, the highest rate of increase was among 20-39 year old men.



Self-harm rates amongst middle-aged men increased between 2007 and 2012, with a high of 207 per 100,000 in 2012. The middle-aged male self-harm rate has fallen considerably since 2012 and, as of 2016, is lower than pre-recession figures. However, the gap between the middle-aged male self-harm rate and middle-aged female self-harm rate has narrowed from a 30% difference in 2007 to a 24% difference in 2016 (see Figure 6). These rising statistics are a particular cause for concern considering:

- The higher lethality of self-harm acts used by males generally compared to females.
- The higher lethality of self-harm used by males compared to females for an equivalent self-harm act.
- A greater risk of suicide following self-harm amongst males when compared to females,

(Mergl et al., 2015; Carroll et al., 2014).

Men's reluctance to seek help for mental health issues, and their lower perceived social supports, might reduce the likelihood of them seeking support in a timely fashion following an act of self-harm (White et al., 2011; Möller-Leimkühler, 2003). Indeed, this further reinforces the need for a specific suicide prevention focus among middle-aged men in the Republic of Ireland. It should be noted that these self-harm rates may be higher, as they are based solely on cases of persons who presented to hospital emergency departments and do not account for the many more cases which may not have presented. Indeed, recent reports in Ireland found that only 10.6%, 11.3% and 11.8% of LGBTQI individuals respectively who engaged in self-harm acts, presented to an emergency department (Higgins et al., 2016; Morey et al., 2008; Doyle et al., 2015). The official figures are, therefore, likely to represent just the tip of the iceberg in terms of the true scale and gravity of self-harm in Ireland.

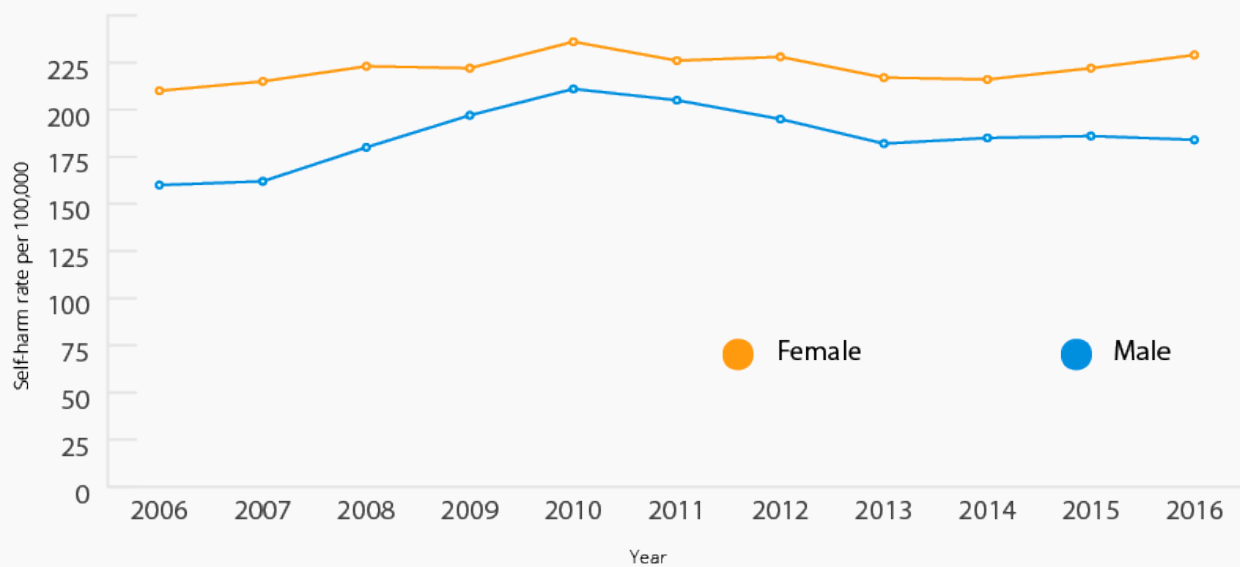


Figure 5: Self-Harm Rates per 100,000 by Sex in the Republic of Ireland, 2006-2016
 Source: National Suicide Research Foundation Annual Report 2016

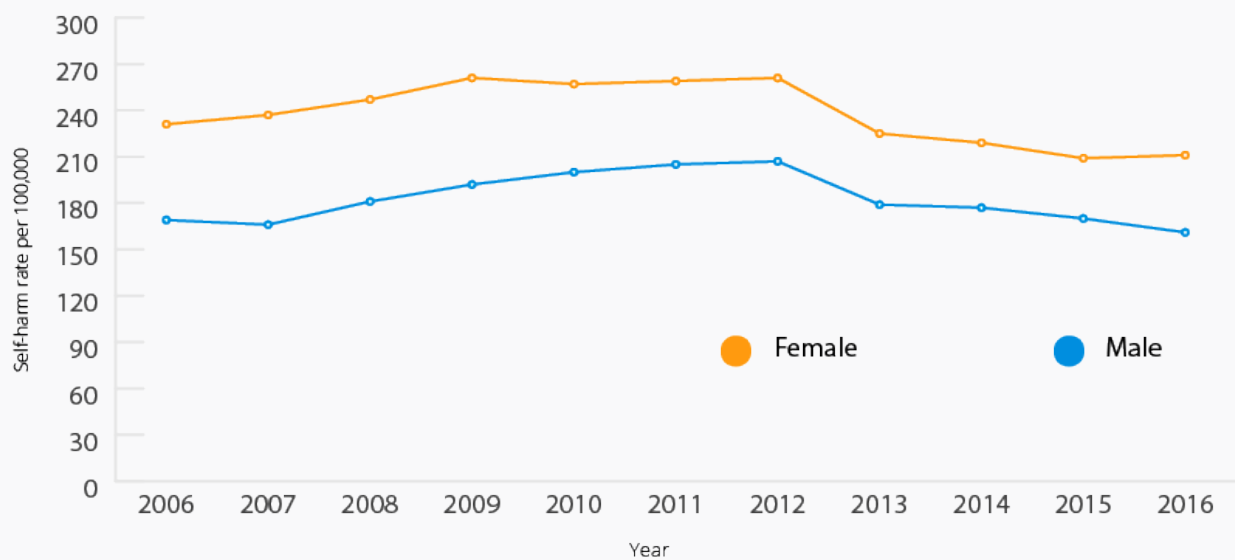


Figure 6: Self-Harm Rates per 100,000 by Sex for 40-59 years old in the Republic of Ireland, 2006-2016
 Source: National Suicide Research Foundation Annual Report 2016

2.1.2 Suicide and Self-Harm In 'Priority Groups'

The primary focus of this study is on middle-aged men who are 'at risk' of suicide based on being middle-aged (40-59 years old) and on having at least one other identity characteristic. A spotlight was placed on middle-aged men who are gay, transgender, Travellers, victims of domestic abuse, non-Irish nationals, farmers, unemployed, rurally isolated, ex-prisoners and separated/divorced fathers. For ease of reference, these groups will, hereafter, be referred to as middle-aged men at risk of marginalisation (MAMRM). The rationale for adopting a specific focus on these population groups of men is discussed below.

Suicide and suicidal behaviour is more prevalent among certain 'priority groups' in Ireland, defined as "a population group identified as vulnerable to suicide in Ireland" (Department of Health, 2015, p73). For the purpose of this study, suicidal behaviour refers to a range of behaviours, including planning for suicide, self-harm and suicide ideation. It is noteworthy that both middle-aged men and middle-aged women have been identified as priority groups within Ireland's National Strategy to Reduce Suicide. Other priority groups have been determined based on their 'minority status' (e.g. members of the LGBTQI community, Traveller community, victims of domestic abuse, migrants), certain occupational groups (e.g. farmers) and other demographic groups (e.g. economically disadvantaged) (Department of Health, 2015). This is not an exhaustive list of all priority groups outlined in the strategy but constitutes some of the groups that are the focus of this research study.

It is also important to acknowledge that certain priority groups can have multiple 'at risk' identity characteristics that may exponentially increase their level of risk (e.g. a middle-aged gay farmer). Additionally, particular suicide risk factors for suicide and suicidal behaviour may be more prevalent in some populations such as separated and/or divorced fathers, unemployed people and those living in rural communities, thus placing these groups at a higher risk of suicide (Fazel et al., 2011; Sadler and Bebbington, 2009; Cleary et al., 2012). Although these population groups are not outlined as priority groups within Ireland's National Strategy to Reduce Suicide they,

nevertheless, carry an increased risk of suicide behaviour and have been included as 'priority' groups for the purpose of this study.

Suicide strategies often identify priority groups based on one characteristic in association with the degree of risk of that characteristic relative to the general population (Wyllie et al., 2012). However, these strategies often do not take account of the social, economic and cultural context in which gender interacts with other risk factors (Robinson et al., 2013; Wyllie et al., 2012). There is, therefore, a need to explore and understand the relationship between gender (in this case masculinities) and these complex risk factors for suicide and suicidal behaviour during mid-life. According to Canetto and Cleary:

"...there is much to be gained in learning the ways in which a diversity of men experience, express, and cope with suicidal ideation and behaviours across a diversity of cultures"

(Canetto and Cleary, 2012, p462).

It is important to note that although individuals may belong to one or several of these priority groups, only a minority will engage in suicidal behaviour. Likewise, these priority groups do not account for the totality of suicides or suicidal behaviour. Although suicide rates and self-harm rates for MAMRM are an important backdrop for this study, these statistics are not so easily attained or useful. Due to low population numbers within some MAMRM groups (e.g. 40-59 year old transgender men in Ireland), suicide rates and self-harm rates can be skewed and unreliable. Furthermore, these statistics are often not released publicly due to confidentiality issues.



However, some reports have provided information on the increased suicide risk of particular 'priority' groups. A study exploring the health of Travellers reported that male Travellers have suicide rates which are 6.6 times greater than the general population on the island of Ireland (UCD, 2010). Another study, exploring the risk of suicide among men who experienced a relationship breakdown, found that suicidal thoughts and suicidal attempts were three times higher among divorced men and two times higher among separated men compared to married men (Sadler and Bebbington, 2009). A report in Ireland found that one in five LGBTQI individuals had attempted suicide, with 35% of these being transgender people and 18% being gay men (Higgins et al., 2016). Furthermore, it has been reported that gay men consider suicide with a stronger intention to die compared with heterosexual males who experience suicidality (Plöderl, Kralovec, & Fartacek, 2010). These findings indicate a clear need to target particular 'at risk' groups of middle-aged men who may carry a greater risk of suicide compared to the general population of middle-aged men. Thus, the groups of middle-aged men at risk of marginalisation outlined earlier are a key focus of this report.



2.2 Risk and Protective Factors for Suicidal Behaviour

2.2.0 Introduction

Suicide prevention work, and the complexity of factors underpinning such work, is often understood in terms of risk factors and protective factors (Robinson et al., 2013). The World Health Organisation (WHO) noted that the identification of key risk and protective factors is necessary in order to develop an effective suicide prevention strategy and to determine the type(s) of intervention required (WHO, 2012). Therefore, for the purpose of this study, it is important to explore suicide risk and protective factors in the wider literature in order to gain an understanding of how they might impact MAMRM and inform more effective strategies to reduce the suicide risk of this cohort.

There are many diverse and intersecting risk factors that are associated with suicidal behaviour which usually occur concurrently, and which can exponentially increase an individual's risk of suicidal behaviour. Protective factors, on the other hand, can reduce a person's vulnerability to suicidal behaviour and increase an individual's resilience (WHO, 2012; WHO, 2014). However, the contingent nature of protective factors was highlighted in a study on suicide and gender in mid-life (Shiner et al., 2009). This study found that the loss of certain protective factors, such as relationship break-up or the disruption of social bonds and support networks, can become a source of risk if they begin to unravel (i.e. isolation).

Before discussing suicide risk and protective factors evident in the international literature, it is important to give a brief overview of the gender and masculinities literature - in order to give a backdrop to how suicide risk and protective factors might impact men, specifically. This is the focus of section 2.2.1. Section 2.2.2 explores suicide risk factors through the lens of a socio-ecological model of health, as used by WHO in their report 'Suicide Prevention a Global Imperative' (WHO, 2014). Section 2.2.3 then explores protective factors in relation to suicide using the categories outlined in the same WHO document (WHO, 2014).

Suicide risk factors and protective factors can be categorised in many ways. Risk factor classifications include individual, familial, demographic, socio-environmental and life stressors (Waldvogel et al., 2008). Protective factor classifications include individual, psychosocial and societal level (McLean et al., 2008). However, the WHO approach was used for suicide risk and protective factors, as it was adopted for Ireland's National Strategy to Reduce Suicide - Connecting for Life (Department of Health, 2015) and due to its international recognition.

2.2.1 Gender and Masculinities

Despite the gender related pattern that exists in the epidemiology of suicide, gender is often viewed as a descriptor rather than a causal risk factor in suicidal behaviour (Payne, 2008). While sex refers to the anatomical and physiological differences assigned at birth between males and females (Giddens, 2009, p601), gender encompasses socially constructed roles or acceptable behaviour for males and females involving different social norms and expectations for both sexes (Möller-Leimkuhler, 2003). These norms, behaviours and expectations are influenced by early socialisation and social institutions to determine what is considered masculine or feminine. Therefore, gender is something we do rather than who we are.

Masculinity is fluid and not a consistent entity in any social group - it is performed differently across a range of activities, settings and cultures, and may even change within cultures over time. Thus, it is more appropriate to use masculinities and femininities to account for the differences between varying groups of men and women. These masculinities are often competing and conflicting with one another, locating themselves in relation to what is known as hegemonic masculinity.

Hegemonic masculinity is described as the “most honoured way of being a man”; requiring “all other men to position themselves in relation to it” and which “ideologically legitimates the global subordination of women to men” (Connell and Messerschmidt, 2005, p832 in Gough et al., 2016). Indeed, hegemonic masculinity’s exalted position creates marginalised and subordinated masculinities which are judged to fall short of ‘masculine’ standards (Gough et al., 2016).

Although, the dominant or hegemonic form of masculinity can vary between cultures and is subject to change over time, it is often represented by middle-class, middle-aged, heterosexual men. Therefore, gay men, transgender men, men from a lower socio-economic background and ethnic minority men may become subordinated and/or marginalised. This can lead to violence, stigmatisation and rejection, which has been shown to increase individuals’ vulnerability to suicidal behaviour (Haas et al., 2010; Fazel et al., 2011; UCD, 2010; Wyllie et al., 2012).

This is an important backdrop to consider when exploring how particular suicide risk factors such as discrimination may be intensified for some groups of men at risk of marginalisation.

The traditional masculine 'role' is often characterised by a desire for power and dominance, aggression, courage, independence, rationality and competitiveness, efficiency, success, and control whilst simultaneously concealing vulnerability and weakness (Möller-Leimkuhler, 2003; Payne et al., 2008). The key factors that have been reported to mediate the relationship between gender and suicide include: men's use of more violent methods; men's reluctance to seek help; higher rates of alcohol and substance misuse among men; as well as factors specific to particular high-risk groups (Richardson et al., 2013). It is against this backdrop of gender that the next section explores the risk and protective factors associated with suicidal behaviour, paying particular attention to middle-aged men and marginalised groups.



2.2.2 Suicide Risk Factors

The WHO has stratified common suicide risk factors into four primary levels of influence: individual, relationship, community, and society and health systems (WHO, 2014). This approach, which views health determinants through various levels of influence, is known as a socio-ecological model of health and is discussed in further detail in section 2.2.3.

The individual level relates to risk factors which are specific to an individual such as personality traits, mental disorders and previous suicide attempts. Relationship level risk factors include the extent to which an individual's connection to or relationship with family, friends and significant others can impact suicidal behaviour. Community level risk factors are shaped by historical, cultural and legal factors which may also contribute to suicidal behaviour. Finally, the society and health systems level risk factors relate to wider societal environmental and structural factors which may contribute to suicidal behaviours. Table 1 presents a summary of these risk factors.

Table 1: Socio-Ecological Model of Suicide Risk Factors

Individual Level	Relationship Level	Community Level	Society and Health Systems Level
<ul style="list-style-type: none"> • Previous suicide attempt • Family history of suicide • Chronic pain • Mental disorders • Alcohol and substance misuse • Hopelessness • Job or financial loss 	<ul style="list-style-type: none"> • Sense of isolation and lack of social supports • Relationship conflict, discord or loss 	<ul style="list-style-type: none"> • Disaster, war and conflict • Stresses of acculturation and dislocation • Discrimination • Trauma or abuse 	<ul style="list-style-type: none"> • Access to means • Inappropriate media reporting • Stigma associated with help-seeking behaviour

Source: World Health Organisation, 2014

Individual Level Risk Factors

A previous suicide attempt is one of the strongest predictive factors of future suicidal behaviour. A systematic review of evidence on suicide risk and protective factors reported that between 17% and 68% of those who died by suicide had made a previous suicide attempt (Beautrais et al., 2005). A longitudinal study which followed up individuals after a suicide attempt, reported an increased suicide risk of 0.5 - 2.0% within one year of an attempt, and over 5% after nine years (Owens et al., 2002). Similarly, a systematic review and meta-analysis of longitudinal follow-up studies on individuals following a self-harm act, found a pooled estimate incident rate of subsequent fatal self-harm of 1.6% at one year, 2.1% at two years, 3.9% at five years, and 4.2% at ten years (Carroll et al., 2014). The fatal repetition rate of self-harm was greater in males compared to females and greater among those with an average age above the median of 34 years, which indicates that middle-aged men may face a particularly high risk.

Family history of suicide also has the potential to lower the threshold for suicide for individuals who are grieving (Van Orden et al. 2010). The loss of a family member can also decrease support networks, whilst stigma associated with suicide can impede help-seeking and help-giving from others (WHO, 2014).

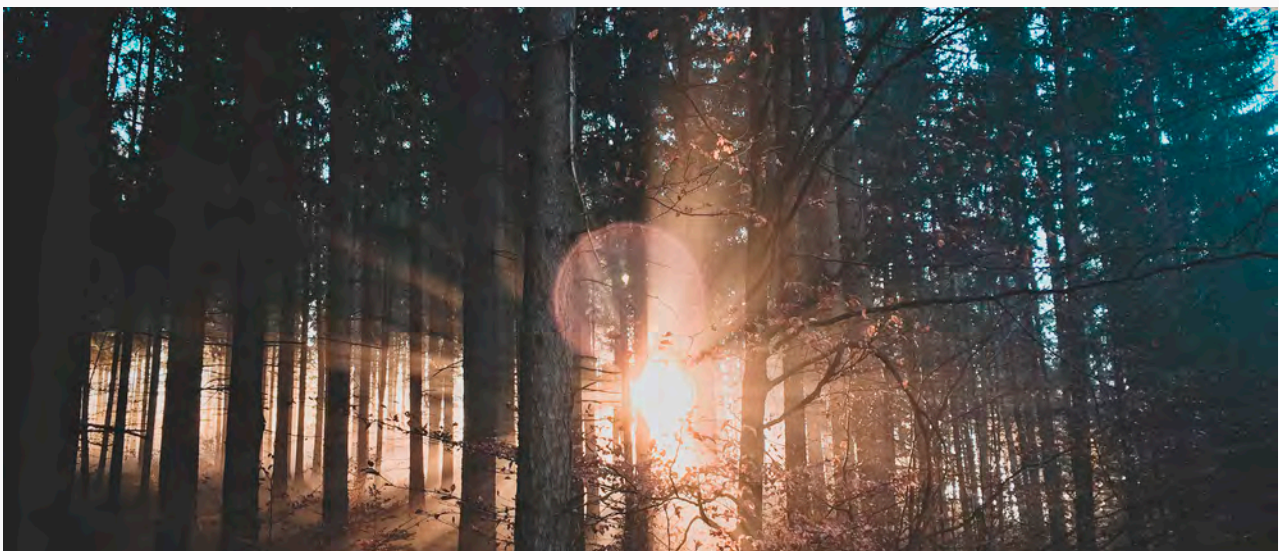
Mental disorders are believed to be a significant suicide risk factor, in particular mood disorders, anti-social behaviour and substance use disorders (Beautrais et al., 2005). A spectrum of mood disorders, known as affective disorders, was found to increase the lifetime risk of suicide by 4% (Bostwick and Pankratz, 2000). The most common mood disorders associated with suicide risk are major depressive episodes and bipolar disorder. A recent study, which explored suicide among individuals aged 34-64 years old in the USA between 2005 and 2010, found that 43.1% of males and 44.9% of females had experienced a depressed mood over that time period (Hempstead and Phillips, 2015). However, it has been suggested that clinicians often fail to identify depressive symptoms in men due to the use of generic diagnostic criteria that may not be sensitive enough to male depression (Olfiffe and Phillips, 2008).

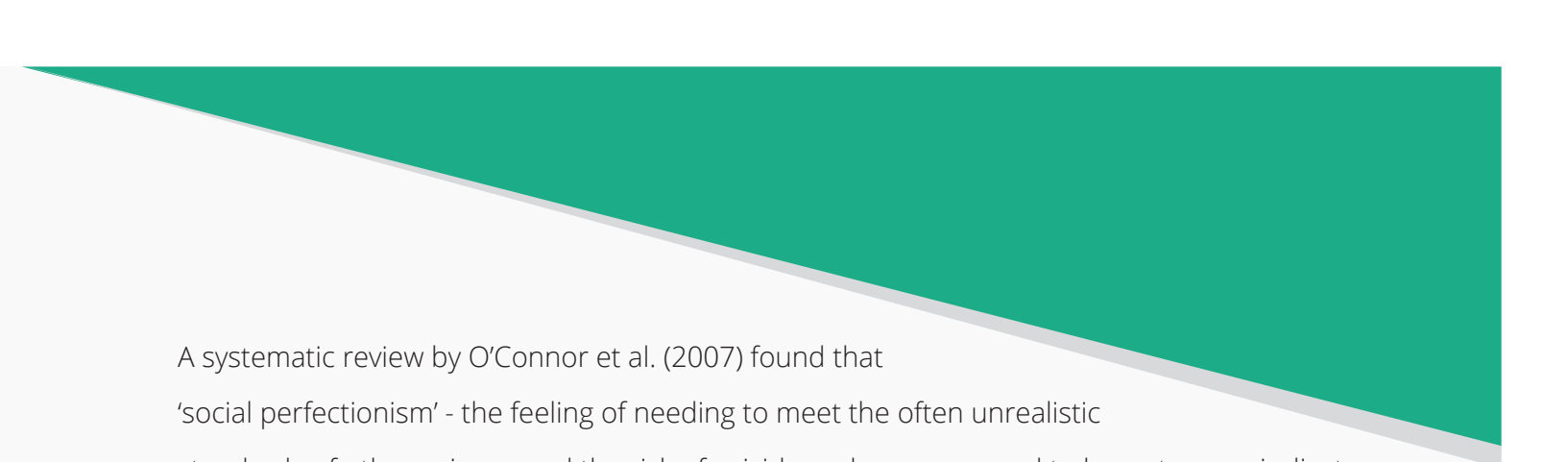
It should be acknowledged that these behaviours and disorders are relatively common, and most individuals suffering from them will not display suicidal behaviour. Nevertheless, the co-morbidity of these disorders and behaviours can result in suicidal behaviour (WHO, 2014). Indeed, Beautrais et al. (2005) reported that depression, substance misuse and anti-social behaviour were co-morbidities often found in males engaging in suicidal behaviour.

Alcohol and other substance misuse disorders were reported to be contributing factors in 25-50% of all suicides (Schneider, 2009). A study conducted in Ireland, found that alcohol consumption has a significant effect on suicide rates, particularly among young men, and pointed towards the reduction of alcohol consumption in young people as a necessary mechanism for suicide prevention work in Ireland (Walsh and Walsh, 2011). As well as being a depressant, it has been suggested that acute alcohol intoxication can lead to increased impulsivity and reduced inhibitions, leading to an increased likelihood of suicidal behaviour during a time of crisis (Wyllie et al., 2012; Rosenberg et al., 2005).

Acute alcohol intoxication at the time of death by suicide was also found to be more prevalent among men compared to women (Kaplan et al., 2013). It has been suggested that men are more likely to 'self-medicate' or to use alcohol to cope during times of crisis (Wyllie et al., 2012). This may be seen as a more acceptable and masculine way of coping rather than what may be construed as a more feminine practice of seeking help (Richardson et al., 2013).

Particular personality and psychological factors are also associated with an increased risk of suicidal behaviour. Hopelessness relates to a person's loss of motivation and expectations about the future and has been associated with suicidal behaviour (WHO, 2014). In a five year follow-up study of 302 participants who were deemed to have made medically serious suicide attempts, a high score on the Beck Hopelessness Scale was associated with future suicidal behaviour (Beautrais, 2004). However, it has been proposed that it is the inability to generate positive future thoughts, not the accumulation of negative thoughts, that is most strongly associated with suicidal behaviour (MacLeod et al., 1997).






A systematic review by O'Connor et al. (2007) found that 'social perfectionism' - the feeling of needing to meet the often unrealistic standards of others - increased the risk of suicide and was proposed to be a stronger indicator of attempted suicide compared to suicidal ideation. However, little evidence exists with regard to gender differences in social perfectionism among suicidal individuals (Wyllie et al., 2012).

Previous studies have shown that perfectionistic self-preservation - self-promotion and the concealment of errors to present a specific image - tend to be more prevalent in men compared to women (Besser et al., 2010). This may cause increased distress among men who experience loss of employment, for example, where there may be an increased tendency to present a perfectionistic image through the concealment of 'errors' in a bid to adhere to particular masculine ideologies. However, most of this research has been conducted with young adults (Wyllie et al., 2012) and more research is needed to establish if similar patterns are evident among middle-aged individuals.

Impulsive and/or impulsive aggressive behaviour has been cited as predisposing risk factors for suicidal behaviour, as individuals are more likely to act on their suicidal ideations (Brent and Mann, 2006). Simon et al. (2001) found that 24% of survivors from almost fatal suicide attempts, attempted to take their own lives within five minutes of the initial ideation. However, impulsivity alone does not mediate who dies by suicide, but is a mechanism which may prompt an individual to make a suicide attempt (Wyllie et al., 2012). A study by Geigline et al. (2009) found that gender was not a predisposing factor in the impulsivity of the suicide attempt.

Abnormalities in serotonin functioning have gained most attention in biological studies of suicidal behaviour, mainly due to the role of serotonin in mood regulation. In fatal and non-fatal suicide attempts, polymorphisms of the serotonin transporter gene and the serotonin A receptor gene were found in fatal and non-fatal suicide victims (Gould, 2003). However, serotonin mutation is not a direct cause of mental health problems, but moderates responses to environmental factors - increasing the likelihood of experiencing depression after stressful events (Caspi et al., 2003).



Chronic pain has also been associated with an increased risk of suicidal behaviour, with findings suggesting that those with chronic pain face a 2-3 times greater risk of suicidal behaviour compared to the general population (Tang and Crane, 2006).

Unemployment has been reported to increase the risk of suicide, particularly with the co-morbidity of other suicide risk factors such as depression or alcohol misuse (WHO, 2014). It is believed that unemployment has a direct effect on an individual's mental health through financial stress, decreased access to health care due to lack of affordability, and increased likelihood of depressive illnesses (Classen and Dunn, 2012). A retrospective study, focusing on unemployment and suicide carried out in 63 countries over the period 2000-2011, found that unemployment was related to an increased relative risk of suicidal behaviour of 20-30%, and the association between unemployment and suicide was greater in countries with a lower unemployment rate pre-crisis (Nordt et al., 2015). The latter point is of particular importance within an Irish context when we consider that the unemployment rate tripled from 4% to 15% between 2008 and 2012 (Corcoran et al., 2015).

A plethora of evidence points towards a greater impact of unemployment on suicide rates among men compared to women within a global, European and Irish context (Chang and Stuckler, 2013; Stuckler et al., 2009; Corcoran et al., 2015). Indeed, Corcoran et al. found that, by the end of 2012, the male suicide rate in Ireland was 57% higher than what was projected based on pre-recession trends, whereas the female rate was reported to remain almost unchanged (Corcoran et al., 2015). However, other studies have concluded that the impact of unemployment on suicide is greater among females (Miller et al., 2014) or that there are no observable differences between the sexes (Nordt et al., 2015).

Among the key explanations for the inconclusive evidence in relation to these sex differences are: (i) the use of a joint model to maintain statistical power versus separate analysis for men and women (Nordt et al., 2015), and (ii) the emergence of 'ecological fallacies' wherein an association that exists at an aggregate level (i.e. unemployment rate and suicide rate) may not represent the association at the individual level (Wyllie et al., 2012).



Despite this inconclusive evidence, many attempts have been made to explain why unemployment may have a greater impact on males. Men's propensity to place a higher value on their employment status and their perceived role as provider and breadwinner, may result in a loss of identity and purpose when unemployment occurs (Turner et al, 1994). A study which explored the links between suicide and unemployment in Ireland during the 'Celtic Tiger' era found that unemployment was a strong risk factor for men aged 35-54 years old (Corcoran and Arensman, 2011). Another study which found the impact of unemployment to be greater in men at mid-life, postulated that there has been a greater accumulation of investment in work at this age which becomes central to a man's sense of self; increasing his vulnerability when unemployment ensues (Shiner et al., 2009). Finally, the move away from industrial based employment to service based employment in recent decades has had implications for middle-aged men, particularly those from a lower socio-economic background (Wyllie et al., 2012). These findings highlight the need for an increased focus on unemployed middle-aged men within a suicide prevention context in Ireland. Furthermore, little research has been conducted on exploring the impact of unemployment on suicide risk among marginalised groups. For example, the All Ireland Traveller Health Study reported that only one in ten Travellers were in paid employment, whilst changes in the labour market have led to further restrictions in access to more traditional sources of employment for Travellers (UCD, 2010). This study sought to explore the nuances and complexities of intersecting suicide risk factors such as unemployment and marginalisation among middle-aged men.

Relationship Level Risk Factors

Relationship level risk factors relate to a person's immediate relationships (such as family, friends and colleagues) which can have an impact on suicidal behaviour. A sense of isolation and a lack of social supports are recognised in the literature as predisposing factors for increased suicide risk (WHO, 2014; Hall-Lande et al., 2007).

Isolation has been described as an individual feeling disconnected from social circles such as family, friends, peers and societal structure more generally, and is often coupled with feelings of loneliness and despair (WHO, 2014). Durkheim's theory of egotistic suicide and Joiner's Interpersonal Theory of Suicidal Behaviour both recognise social isolation and lack of integration as predisposing factors to increased suicide risk (Durkheim, 2001; Joiner et al., 2009).

Individuals who reside in geographically isolated areas may face an increased risk of suicidal behaviour due to a lack of social contact, which may result in increased levels of loneliness and reduced availability of informal support during times of crisis (Hirsh, 2006). Furthermore, the depopulation of rural communities has led to a loss of primary relationships, culture and sense of community, which has also been associated with suicidal behaviour (Hirsch, 2006). Finally, there may be a lack of professional support from health professionals and mental health organisations in rural areas, which can lead to poor identification and treatment of suicide in rural communities (Kessler et al., 1994). These findings underpin the urgent need to focus on middle-aged men who live in rural areas.

It has been reported that as men approach their 30s, their peer relationships begin to decline (Wyllie et al., 2012) resulting in the fragmentation of social bonds and smaller social circles at middle-age (40-59 years old) (Shiner et al., 2009). It has been reported that men tend to have less supportive social networks with fewer meaningful friendships, and that even in the presence of strong social networks, men still experience greater levels of perceived loneliness compared to women (Wyllie et al., 2012). This may have particular implications for middle-aged men in terms of getting adequate support from social networks during times of distress. Furthermore, it has been noted that it is not until men become distressed that they begin to comprehend the extent of their social isolation and their lack of meaningful social support (Joiner, 2011).

Wyllie et al. (2012) reported that emotional relationships between male friends often revolve around 'doing' or 'being alongside' rather than talking about emotional distress and, that when men do talk about emotional distress, it tends to be from a point of crisis or in a spontaneous way. However, Lefkowich and Richardson (2016) found that, in Men's Sheds, multidirectional support allowed men to act in ways that were caring, compassionate and nurturing, while feeling more comfortable expressing vulnerabilities.

The sources of isolation for middle-aged men are not evident in the literature outside of relationship breakdown (Joiner et al., 2009). Indeed, relationship breakdown has been reported to be a significant factor for increased suicide risk among men, and middle-aged men particularly (Shiner et al., 2009). By middle-age, men tend to have invested a considerable amount of time into relationships, as with work, which leaves them particularly vulnerable when these relationships unravel (Shiner et al., 2009).

Wyllie et al. (2012) reported that men tend to rely more on their partners for emotional support and suffer the loss of relationship breakdown more intensely. Furthermore, men are more likely to be separated from their children as a result of a relationship breakdown, which challenges men's role as a father and, in turn, impacts upon their sense of belonging and purpose, which may lead to suicidal behaviour (Owen, 2003). This highlights an urgent need to focus on divorced fathers and middle-aged men who experience high levels of isolation.



Community Level Risk Factors

Community level risk factors are those which are prevalent in the communities in which people live. Experiencing civil conflict, war or natural disasters have been associated with increased suicidal behaviour through increased unemployment, financial instability, and impact on overall health and social wellbeing (WHO, 2014). However, there is evidence to suggest that suicide rates go down initially following a disaster or conflict which may be explained by an acute need for social cohesion, although this varies between groups (WHO, 2014).

Discrimination is another factor which has been associated with an increased risk of suicide and has been defined as treating an individual or group differently, usually negatively, relative to the rest of a community or on the basis of race, ethnicity, sexual orientation, gender identity etc. (Taleb and Dahdouh, 2016). Discrimination has been reported to lead to a stressful social environment through rejection, violence, victimisation, stigmatisation and loss of freedom which may evoke suicidal behaviour (WHO, 2014).



Discrimination on the basis of sexual orientation and gender identity has been linked with suicidal behaviour in high income countries such as the USA (Almeida et al., 2009) and the Netherlands (de Graff et al., 2006). Similarly, a report on mental health and wellbeing among the LGBTQI community in Ireland found that 75.2% of participants had experienced verbal abuse in their lifetime and 20% reported being physically attacked due to their LGBTQI status (Higgins et al., 2016). The authors found that gay males, transgender and intersex participants were most vulnerable to discrimination and experienced the highest rates of verbal, physical and sexual harassment. However, transgender and intersex people had the highest incidences of suicide attempts, with gay males having the lowest rate of attempts. This validates the need to understand how different risk factors can compound each other and have different effects on different population groups, whilst also exploring possible protective factors that may be present in different groups. The same study found that the younger LGBTQI people (14-18 years old) had higher reported suicide attempts (31.9%) when compared to those in the 46+ age group (18%). However, there is evidence to suggest that in gay men, suicide attempts are more closely linked with when a person recognises and discloses their sexual orientation rather than their chronological age (Paul et al., 2002).

The All Ireland Traveller Health Study reported high levels of individual and institutional discrimination among the Travelling community in Ireland (UCD, 2010). The report found that Traveller men's suicide rates were 6.6 times higher than that of the general population on the island of Ireland, with Traveller men reporting discrimination as one of their main sources of stress. Other studies have also reported the association between discrimination and suicide among migrants, asylum seekers, and refugees (Kalt et al., 2013).

The acculturation of ethnic minorities - such as Traveller men and non-Irish national men - has also been reported to generate feelings of isolation, depression, discrimination, and a mistrust of state-affiliated social and health care services (WHO, 2014). Men who fail to match up to culturally normative or dominant hegemonic masculinity are also perceived to fall short of being 'masculine' and face further stigmatisation from other men (Gough et al., 2016). This indicates a clear need to focus on Traveller men, non-Irish national men, gay men and transgender men who may face an increased risk of suicidal behaviour due to discrimination and/or acculturation.

Exposure to particularly traumatic events such as disciplinary or legal incidents, bullying and work-related crises have been associated with increased suicidal behaviour (WHO, 2014). Childhood adversity and abuse has been highlighted as an important risk factor for young people, and is one which also transfers to adulthood (Dube et al., 2001). Findings from this adverse childhood experience study found that the risk of a suicide attempt increased by 2-5 fold across the life span as a result of childhood adversity, demonstrating how the exposure of such events can have a long-term impact on risk of suicide (Dube et al., 2001).

Society and Health Systems Level Risk Factors

Society and health systems level risk factors relate to the wider influence of societal norms and health systems which may result in suicidal behaviour. Access to the means of suicide is a prominent risk factor for suicide (WHO, 2014) and the restriction of means to such access is recognised as an important mechanism for suicide prevention (Sarchiapone et al., 2011). The European Alliance Against Depression (EAAD), which comprises sixteen European countries including Ireland, found that the most common method of suicide was by hanging (49.9%), followed by drug poisoning (12.7%), jumping (9.5%) and firearms (7.6%) (Varnik et al., 2008). Poisoning by other means, lying before a moving object, drowning and other methods made up the remaining percentages.

Men are reported to use more lethal and violent methods in a suicide act such as hanging or firearms versus drowning or overdosing, which is believed to be the cause of the higher rates of completed suicide amongst males compared to females (WHO, 2002). These patterns are mostly evident within an Irish context, with the most common method for male suicide between 2007-2012 being hanging (74%), drowning (9%) and firearms (6%); whereas the most common methods for females were hanging (60%) drowning (18%) and overdosing (14%) (Department of Health, 2015).

Although firearm related suicide remains relatively low in Ireland, possibly due to tight legislation around gun ownership, a study found that over the period 1980-2004: 94% of firearm related suicides in Ireland were male, 22% of which were aged 45-64 years old, and the prevalence was six times greater in rural areas compared to urban areas (Sarma, 2008). This indicates a pattern that middle-aged males living in rural Ireland may face an increased risk of suicide through increased access to firearms.

Inappropriate media reporting on suicide may increase the risk of 'copycat' suicide among vulnerable people who may identify with the person who has died or with the circumstances in which individuals have taken their lives (Pirkis et al., 2006). Such inappropriate media reporting includes gratuitously covering celebrity suicides, reporting and/or showing pictures of the method used, reporting on unusual methods used, reporting on suicide clusters, or normalising suicide as an acceptable response to adversity (WHO, 2014). However, it has been noted that this media induced contagion effect is more impactful among young people and older people, with a relatively low effect on middle-aged people (Sisask and Värnik, 2012).

Timely and effective access to healthcare systems is crucial to reduce the suicide risk of vulnerable individuals (Cho et al., 2013). However, access to such resources may be limited or complex in certain countries, particularly for individuals who have a low level of mental health literacy (WHO, 2014).

One of the most commonly cited reasons, particularly among men, for a delay in help-seeking is a lack of knowledge about mental health related issues or available treatment (Wilson, 2007). The stigma attached to mental health and suicide can also be a substantial barrier for individuals to seek help in times of need (WHO, 2014). This stigma can also be a barrier to those who may be in a position to give support, as they might not acknowledge the situation nor believe the individual in distress needs support (WHO, 2014).

It has also been suggested that stigma and suicidal behaviour has a reciprocal relationship; suicide may cause stigmatising attitudes, but stigma towards mental health disorders may be a risk factor for suicide (Carpiniello and Pinna, 2017). The same authors reported that negative perceptions are held of individuals who engage in suicidal behaviour which can result in: (i) being labelled as weak, unable to cope and selfish; (ii) social exclusion and isolation; and (iii) profound feelings of shame, embarrassment and guilt (Carpinello and Pinno, 2017).

These stigmas are intensified for men, as mental health difficulties and help-seeking represents a failure to meet particular masculine ideologies - eliciting further feelings of shame and embarrassment. This may result in men being less likely to seek help for mental health issues and to legitimise health service usage only when a perceived threshold of distress has been exceeded (O'Brien et al., 2005). Men's reluctance to seek help during times of distress has been noted as a 'double jeopardy' (Houle et al., 2008) or 'double burden' (Keohane and Richardson, 2017); wherein their sense of shame in help-seeking compounds their perceived 'failures' in not being able to cope with their own problems, which may increase their risk of suicidal behaviour. Furthermore, it has been reported that marginalised groups may have a mistrust of state affiliated services and health services more generally, which may act as an additional barrier for timely help-seeking (WHO, 2014; Robinson et al., 2013).

It should be noted that men are not a homogenous group, that is to say not all men are reticent about help-seeking. There is also evidence to suggest that reframing masculine ideologies (such as the provider and protector role) as a positive trait for help-seeking and help giving can interrupt the suicide process (Oliffe et al., 2012).

Little evidence exists in relation to the stigma of suicide and help-seeking behaviour among middle-aged men specifically. One study exploring middle-aged men and suicide reported that middle-aged men have experienced a changing emotional culture in recent times, becoming aware of the 'good to talk' narrative but uneasy to behave accordingly (Wyllie et al., 2012). However, the evidence in relation to this appears to be inconclusive. Therefore, there is a clear need to explore men's perceptions of the stigma of suicide and help-seeking at middle-age in order to better support MAMRM during times of psychological distress.



2.2.3 Protective Factors

Much of the suicidal behaviour literature gravitates towards suicide risk factors, but much less is known about protective factors (Silverman, 2011). Protective factors are described as factors which guard people from suicide (WHO, 2014).

Many suicide interventions focus on reducing the risk of suicide, but it is equally important to strengthen factors that have been found to improve an individual's resilience and connectedness (WHO, 2014). The WHO report (2014) identified three broad protective factors which either counter specific risk factors or protect against specific risk factors for suicide. These are outlined in Table 2 and include: (i) strong personal relationships; (ii) religious or spiritual beliefs; and (iii) lifestyle practice of positive coping strategies and wellbeing.

Table 2: Protective Factors for Suicidal Behaviour

Protective Factors
<ul style="list-style-type: none">• Strong personal relationships• Religious or spiritual beliefs• Lifestyle practice of positive coping strategies and wellbeing

Source: World Health Organisation, 2014

It should be noted that some of the literature describes protective factors as merely a 'positive' way of looking at risk factors i.e. effective coping as a protective factor and ineffective coping as a risk factor (Beautrais et al., 2005). Therefore, protective factors were excluded from further discussion if they were simply the opposite of risk factors that had already been discussed.

Strong Personal Relationships

Strong personal relationships may act as a protective factor against suicide by providing sources of emotional, social and financial support in times of crisis (WHO, 2014). Social support can counter the effect of suicide risk factors with high levels of social support being reported to:

- i. Mitigate suicide ideation in the context of high incidences of negative events in students (Kleiman et al., 2014).
- ii. Buffer the risk of suicide associated with depression (Chioqueta and Stiles, 2007).
- iii. Mitigate negative self-appraisals following negative events, thereby reducing the risk of suicidal ideation (Johnson et al., 2010).
- iv. Elicit high levels of self-esteem (Kleiman and Riskind, 2013).
- v. Elicit a sense of belonging which is negatively associated with suicide (Joiner et al., 2009).

Furthermore, community social support - defined as anything that leads an individual to believe they are cared for, loved, respected and a member of a network of mutual obligations (Cobb, 1976) - is also thought to be a potential protective factor against suicide through buffering the effects of risk factors and reinforcing help-seeking behaviours in times of distress (Christensen et al., 2012; Zadavec Šedivy et al., 2017). This can be related to existing theories of suicide, where social integration is believed to have an inverse relationship with suicide rates (Durkheim, 2001; Joiner et al., 2009). Indeed, Zadavec Šedivy et al. (2017) found an inverse relationship between the value a region places on social support and suicide rates across 23 European countries, including Ireland, with a stronger relationship observable among men. This may be due to a buffering effect on risk factors such as isolation and to the challenging of gender role expectations relating to help-seeking in men. Therefore, there is a clear need for suicide prevention programmes to encourage social support and to challenge or reframe gender role expectations among men. However, if particular groups are socially excluded from the community, access to such social support may be limited, which may act as a risk factor through thwarted belongingness. Therefore, it is crucial that programmes aiming to promote connectedness and social support are specifically tailored to meet the needs of the intended target group.

Religious or Spiritual Beliefs

Religious beliefs and spirituality have been documented as protective factors against suicide. A meta-analysis of studies in this area found that religious and spiritual beliefs had a protective effect by: (i) providing religious coping mechanisms during times of distress; (ii) offering social supports through religious communities; and (iii) promoting specific religious teachings which encourage altruism, charity and abstaining from alcohol consumption (Wu et al., 2015). However, it has been noted that, based on moral stances, religion may also add to the stigma of suicide, thereby deterring individuals from seeking help for suicidal thoughts (WHO, 2014).

Lifestyle Practice of Positive Coping Strategies and Wellbeing

Effective positive coping strategies and subjective personal wellbeing have been reported to act as protective factors against suicide (Sisask et al., 2008). Wellbeing is shaped by personality traits which can determine an individual's vulnerability or resilience towards distressing life events (WHO, 2014). Problem solving skills is one such trait that has been found to protect individuals against suicide (Elliot and Frude, 2001). However, Esposito et al. (2003) found that it was not problem solving skills that determined suicidal from non-suicidal behaviour, but a lack of confidence in one's ability to solve problems.

It has also been shown that an internal locus of control - the belief that one is responsible for one's own success as opposed to external forces or luck - is a protective factor against suicide when comparing a general youth population to youths who made medically serious suicide attempts (Donald et al., 2006). Other personality traits which are believed to protect against suicide are optimism, self-efficacy, and perceived self-control of behaviour, thoughts and emotions (McLean et al., 2008). Healthy lifestyle choices which encourage physical and mental wellbeing such as physical activity, suitable sleep and diet, social contact, and effective management of stress are also considered important protective factors for suicidal behaviour (WHO, 2014).

2.3 Key Principles of Engaging Men and Evidence of Effective Practice

2.3.0 Introduction

It is well documented in the literature that service providers experience difficulties in engaging men around mental health and wellbeing issues. A key focus of this study has been to explore service providers' challenges, barriers and opportunities to engaging MAMRM in relation to mental health. Therefore, it is crucial to explore the wider literature in relation to engaging men and to establish 'what works' in order to gain further insights into service providers' experiences.

This section presents the current research evidence in relation to what constitutes best practice in engaging men around mental health and wellbeing within the wider context of suicide prevention. This report adopts a broader view of suicide prevention work with men which includes elements that might, traditionally, be viewed as mental health promotion.

A recent scoping review exploring effective suicide prevention strategies with men noted the paucity of suicide prevention strategies specifically targeting middle-aged men (Struszczyk et al., 2017). This highlights the importance of this study in terms of informing the development of gender specific resources to support middle-aged men's mental health. Given the paucity of evidence regarding suicide prevention and middle-aged men, this section reviews effective suicide prevention strategies with men more generally and, where appropriate, places a particular emphasis on programmes or strategies that have included middle-aged men or population groups considered 'at risk' of suicide.

Whilst it is tempting and understandable to seek to transplant 'effective practice' from one setting to another, to do so may not, necessarily, result in the desired outcomes - since suicide is so intrinsically linked to socio-cultural context. Also, the rush to do something about the problem, whilst often well intentioned and politically expedient, may not always be backed up by good evidence (Richardson et al., 2013). Finally, the identification of effective practice - albeit limited in the specific context of middle-aged men - is not the main challenge; finding the resources to translate this into action is.

Section 2.3.1 synthesises some of the key principles that inform effective engagement with men around mental health and wellbeing. Section 2.3.2 focuses on five broad approaches which have been shown to be successful and which could guide future work with middle-aged men. Finally, section 2.3.3 looks at community capacity building and what can be learned to engage men and reduce suicide risk.

2.3.1 Key Principles and Approaches to Effectively Engaging Men

There has been a breadth of evidence supporting and informing key principles and approaches to effectively engaging men with regards to mental health. Building trust and rapport is of paramount importance and cuts across many of the guiding principles in engaging men. A number of policy documents, reports and research papers have outlined key principles in working with men around mental health, and these form the basis of this section (Department of Health & Children, 2009; Richardson et al., 2013; Grace et al., 2014; Lefkowich et al., 2015; Robertson et al., 2015; Struszczyk et al., 2017).

The key principles that are most commonly reported in these documents are:

- Working in an informal environment and creating a safe space.
- Adopting a strengths based approach.
- Using positive non-stigmatising language.
- Finding the 'hook'.
- Consulting with men.
- Adopting a partnership approach.

Finally, these key principles are most commonly integrated into a programme together. When combined, they appear to produce a synergistic effect which maximises ownership, trust and an overall feeling of enjoyment and safety within the programme (Robertson, et al., 2015).

Working in an Informal Environment and Creating a Safe Space

Creating safe 'male friendly' spaces, where men feel welcomed and at ease, is crucial to engaging men around mental health issues (Richardson et al., 2013). When engaging men around mental health, men often prefer spaces which are not exclusively associated with mental health (Grace et al., 2014). Such settings often include spaces which are familiar to men such as sports clubs, sheds, music venues etc. or spaces where men already gather (Robertson et al., 2015). However, these spaces are not homogenous and should be tailored to meet the needs of the specific group of men being targeted (Robertson, et al., 2015).

Adopting a Strengths Based Approach

A strengths based approach, which builds on the positives and focuses on hope, optimism and solutions (rather than a deficit orientated approach) is reported to be a crucial element in engaging men and retaining their involvement (Department of Health & Children, 2009; Richardson et al., 2013; Grace et al., 2014; Robertson et al., 2015). Programme facilitators should be empathetic with men, non-judgemental and understanding of their circumstances (Robertson et al, 2015).

Finding ways of reframing support seeking as masculine has been shown to be effective in interrupting the suicidal process in men (Oliffe et al., 2012; Jordan et al., 2012). Gender sensitive training has been shown to be beneficial in instilling this strengths based approach in service providers working with men, as well as increasing their confidence levels to do such work (Grace et al., 2016; Osborne et al., 2016). However, although such training has been adapted to specifically suit the needs of young men in response to the high suicide rate of young men in Ireland (Grace et al., 2016), no such training exists with regard to middle-aged men.



Using Positive Non-Stigmatised Language

A focus on language which is strengths based, non-stigmatised and non-feminine, facilitates effective engagement with men around mental health issues. For example, a focus on language such as 'mind health' or 'mental fitness' as opposed to mental health (Richardson et al., 2013), 'coaching' instead of therapy and 'activity' instead of 'health' (Robertson, et al., 2015), have been found to appeal to men. Using positive imagery of men during the recruitment, consultation and engagement processes has also been reported to be effective in working with men (Robertson et al., 2015; Richardson et al., 2013).

Finding the 'Hook'

The use of an incentive or a 'hook' has been identified as an effective way to facilitate men's engagement in mental health initiatives (Richardson et al., 2013; Grace et al., 2014; Lefkowich et al., 2015; Robertson et al., 2015; Struszczyk et al., 2017). It is important to note that the 'hook' may differ between groups of men so it is important to consider what might work best with the intended target group. Examples of 'hooks' include initiatives which encourage social interaction, sports participation and educational programmes.

Activity based interventions act as 'hooks' but also promote solidarity and provide opportunities for the sharing of knowledge and skills between men which has been found to increase self-esteem and self-efficacy (Robertson, et al., 2015). Indeed, men's sense of connectedness with family, friends and mental health professionals has been highlighted as an important factor in preventing male suicide (Struszczyk et al., 2017).

Consulting with Men

Those tasked with developing initiatives should consult with men in the development process, exploring their needs, strengths, concerns, and desired outputs (Richardson et al., 2013; Lefkowich et al., 2015; Robertson et al., 2015). This approach builds trust, promotes transparency, helps gain access to local knowledge, establishes 'street cred', and encourages community members to promote and validate the initiative within their social grouping (Lefkowich et al., 2015).

Initiatives that are 'grounded' in the community increase men's social networks and help to combat isolation (Robertson et al., 2015). It is also important to consider the various socio-cultural backgrounds of the men that are being targeted, and the inequalities that may be present which influence their perception of services whilst, at the same time, being mindful of assets of various cultures that may facilitate engagement (Robertson et al., 2015).

Adopting a Partnership Approach

Establishing partnerships between organisations - particularly those which are trusted by men in the community - increases the strength, sustainability and acceptability of the programme, extends its reach, and provides a greater pool of resources and expertise from which to draw (Lefkowich et al., 2015; Robertson et al., 2015). Ensuring common values, principles and expectations between partners, prioritising trust, delegating responsibility, and thinking outside of the box to include unconventional partners have also been noted as key strategies in facilitating a partnership approach to engage men (Lefkowich et al., 2015).

Other Approaches

Other effective principles that were noted, but less common, included: adopting pragmatic and solution orientated approaches (Department of Health & Children, 2009); the use of role models, targeting interventions early and directed at men most in need, peer support and mentoring, working from an evidence base (Richardson et al., 2013); virtual or arms-length approaches such as online, telephone, email etc. (Robertson et al., 2015); and emotional regulation techniques such as changing unhelpful thoughts (Struszczyk et al., 2017).

2.3.2 Evidence of Effective Practice

Building upon the key principles of engaging men around mental health outlined earlier, this section explores a range of interventions that have proven effective in supporting men's mental health and/or addressing the issue of male suicide. Whilst suicide has a devastating event - with rippling personal and societal consequences including complex bereavement and contagion effects - thankfully it remains relatively rare in population terms (average annual male suicide rate in Ireland over the past eleven years was 17.4 per 100,000). As a result, it can be difficult to extrapolate differences pre- and post- interventions (Richardson, et al., 2013). Thus, it has been suggested to use the best available or 'weaker evidence' (Hawton & van Heeringen, 2009) when randomised clinical trials are not feasible (Windfuhr, 2009). This section reports on interventions which have shown reductions in suicide or suicidal behaviour in men, as well as interventions which have been effective in enhancing mental health, help-seeking behaviours and stigma reduction.

Five broad categories were identified as potential sites for future suicide prevention work with middle-aged men. These include:

- i. Awareness raising campaigns.
- ii. Activity based programmes and support groups.
- iii. Education and training interventions.
- iv. Psychological support.
- v. Use of technology.

However, many effective suicide prevention interventions are multimodal and typically comprise several activities running concurrently, such as awareness campaigns, support groups and training of health professionals. This approach has been shown to reduce suicide, challenge stigma and change attitudes towards mental health in men (Hübner-Liebermann et al., 2010; Oyama et al., 2010; Szekly et al., 2013; Ono et al., 2013; Robinson, et al., 2013; Robinson et al., 2014). Therefore, many interventions described in this section could fit into numerous categories, but have been assigned to one category based on best fit.

Awareness Raising Campaigns

Campaigns which raise public awareness of suicide have been shown to be effective in reducing male suicide (Hübner-Liebermann et al., 2010; Oyama et al., 2010; Szekly et al., 2013; Ono et al., 2013; Matsubayashi et al., 2014). These awareness raising campaigns comprise a number of different components such as the distribution of posters and brochures, the delivery of public lectures, action days, advertisements which disseminate information on symptoms of depression, and signposting to appropriate support services.

Matsubayashi et al. (2014) focused on raising awareness of the symptoms of depression and promoting support seeking behaviour (see Figure 7). Paid members of staff and volunteers distributed materials to commuters and pedestrians at train stations and on the street across 41 locations. The primary target was middle-aged men but materials were given to any individual passing by. The materials comprised: information on the symptoms of depression; approaches to tackling depression; signposting to appropriate mental health services; services not overtly associated with mental health (personal debt and other economic concerns; websites; and messages that encouraged support seeking if in psychological distress).

Initially, the intervention was thought to have no immediate effect, but the total number of suicides reduced two months after distribution of the materials. The estimated effect was a reduction in one suicide per month when materials were distributed fifteen days per month. This effect lasted for four months, but no longer than five months, and was more pronounced amongst males compared to females. The authors concluded that awareness raising campaigns alone were effective in reducing suicide in men in the short-term, but showed weakened effects compared to campaigns incorporated into a multimodal strategy such as that adopted by Hübner-Liebermann et al. (2010).

Man Therapy, originally an American campaign, was adapted for Australia and utilised multi platforms (TV, radio, print, online) to target men aged 30-54 years old. It sought to raise awareness of the signs and symptoms of depression, and encouraged men experiencing these symptoms to seek support on an associated website (IPSOS SRI, 2014). A post-campaign survey found that the campaign reached the equivalent of 1,506,000 men who were 30-54 years old. Men who had engaged with the website reported that the campaign positively impacted their knowledge, attitudes and behaviours in relation to depression and anxiety.

Figure 7: Example A - Awareness Raising Campaign

Example A: Awareness Raising Campaign (Japan)

The Effect of a Public Awareness Campaign on Suicide: Evidence from Nagoya, Japan
[Matsubayashi et al., 2014]

Overview: The focus of the campaign was to raise awareness of the symptoms of depression and to promote support seeking behaviour amongst residents in the city of Nagoya, Japan. Paid members of staff and volunteers distributed materials to commuters and pedestrians at train stations and on the street across 41 locations. These materials were distributed every morning and evening Monday-Friday in the months of February, March, May and June in 2010, 2011 and 2012. The materials comprised information on the symptoms of depression, approaches to tackling depression, signposting to appropriate mental health services, services not overtly associated with mental health (personal debt and other economic concerns) and websites, as well as messages which encouraged support seeking if in psychological distress.

Target Group: The primary target was middle-aged men, but materials were given to any individual passing by.

Result: There was not an immediate effect, but the total number of suicides reduced two months after distribution. The estimated effect was a reduction in 1 suicide per month if materials were distributed 15 days per month. This effect lasted for 4 months, but no longer than 5 months, and was more pronounced amongst males compared to females. It was concluded that greater frequency of materials distributed was associated with fewer suicides in the following months.

Figure 8: Example B - Activity Based Programme and Support Groups

Example B: Activity Based Programme and Support Group (Ireland)

Mojo: Creating Male Space [www.mojo.ngo]

Overview: Mojo is a 12-week dynamic personal development programme targeted at unemployed men experiencing psychological distress with a view to supporting them to be in control of their lives. The programme adopts a partnership approach with local agencies. In the pilot phase it had four main components:

1. Link working to assist men to articulate and attain their goals.
2. Delivering wellness and resilience supports.
3. Information provision on local support services.
4. Physical fitness and wellbeing taster.

Target Group: Unemployed men in psychological distress.

Results: Gardener (2014) conducted focus groups/interviews/surveys with 22 men who had participated in the Mojo Project. Of the participants, 59% reported contemplating or attempting suicide and 27% reported self-harming prior to attending the programme.

Following the programme, 81% of men reported a perceived improvement in mental health and no men reported engaging in self-harm behaviour in the 6-month period following the programme. There was a reported improvement in men's engagement with employment or training services, and a reduction in social isolation and alcohol and drug misuse. There were also benefits for stakeholders which included increased awareness of their service in the community, greater community networks, increased skills and capabilities, and increased knowledge of community-led approaches.

Activity Based Programmes and Support Groups

Activity based interventions and support groups have been shown to promote and improve mental health among men, with social interaction believed to be the key mediating factor in facilitating positive change. Studies exploring the Men's Shed approach found that Shed membership had a positive impact on self-reported mental health and wellbeing, particularly among older men (Milligan et al., 2013; Flood & Blair, 2013; Wilson et al., 2013; Lefkowich and Richardson, 2016).

Milligan et al. (2013) reported that the benefits of Men's Sheds on self-reported mental health were mediated through reduced social exclusion and isolation as a result of increased sense of purpose, accomplishment and control, self-esteem and support networks. Similarly, another study noted that social connectedness was a key factor in improved mental health among participants in Men's Sheds, and suggested that Shed membership was likely to reduce perceived mental health stigma and increase men's willingness to seek support from a wider range of sources (Flood & Blair, 2013).

Within an Irish context, Lefkowich and Richardson (2016) found that key features of Shed participation - i.e. using and developing new skills, feeling a sense of belonging, supporting and being supported by peers, and contributing to the community - had a hugely positive effect on men's overall sense of wellbeing. With this in mind, it was decided to target a Men's Shed group in rural Ireland to solicit insights on both the suicide risk factors associated with rural isolated men, as well as the potential benefits to one's mental health of participation in Men's Sheds.



Mojo, a twelve week dynamic personal development programme targeted at unemployed men experiencing psychological distress in Ireland, has shown to be effective in enhancing men's mental health (Gardner, 2014; see Figure 8). The programme adopts a partnership approach with local agencies and, in the pilot phase, had four main components: (i) 'link working' which involved supporting the men to develop a personalised care plan and then to connect with the relevant services to attain their care plan goals; (ii) delivering wellness and resilience supports; (iii) information provision on local supports and services; and (iv) a physical fitness and wellbeing taster. Of the 22 participants who took part in the pilot evaluation, 59% reported contemplating or attempting suicide in the past, with 27% reporting self-harming prior to attending the programme. Following the programme, 81% of the men reported a perceived improvement in mental health, whilst none of the men reported engaging in self-harm behaviour in the six month period following the programme. There was also a reported improvement in men's engagement with employment and/or training services, and a reduction in social isolation, alcohol and drug misuse. In addition, there were benefits for stakeholders who reported increased awareness of services in their community, greater community networks, increased skills and capabilities, and increased knowledge of community-led approaches.

Exercise interventions such as 'Football United' have also proven to be effective in addressing early stage mental health issues. This Australian-based football intervention found decreases on the 'peer problem scale' and greater results on the 'prosocial scale' among teenage boys compared to a control group following participation in the initiative (Nathan et al., 2013). However, in a review on what works with engaging men and boys around mental health, it was reported that exercise interventions show 'promise' for addressing depression and anxiety in males, but not all studies showed improved mental health for males (Robertson et al, 2015).

Education and Training Interventions

Education and training interventions on mental health and/or suicide prevention to men, community 'gatekeepers' and health professionals has been utilised to address the issue of suicide in men. Delivery of educational workshops to men as part of a wider suicide prevention intervention in the military have proven to be effective in reducing male suicide. These covered suicide risk factors, intervention skills and signposting to appropriate referral services (Knox et al., 2003; Shelef et al., 2016).

Indeed, another workplace intervention in Australia, 'MATES in Construction' (see Figure 9) consisted of delivering general mental health awareness training, suicide first aid training, as well as providing other additional supports to construction workers such as suicide prevention hotlines, case management and field officers. The programme evaluation (Gullestrup et al., 2011) found: increased awareness and knowledge of suicide prevention; increased levels of confidence among suicide first aid trainers to intervene and signpost; increased uptake of available support services; and increased help-seeking behaviours.

Another intervention - 'It's a Goal!' - consisted of an education programme delivered in a sport setting, and was found to be effective in increasing confidence, self-esteem, and facilitating a return to work for men who participated (Pringle and Sayers, 2004). These interventions reinforce the effectiveness of the informal environment in engaging men around mental health issues.

General practitioner training has also been found to be one of the most effective ways of reducing suicide and suicidal behaviour, with a reported decline in annual suicides of between 22% and 73% (Mann et al., 2005). Studies which implemented educational videos, interactive workshops, lectures and educational events at conferences with general practitioners were found to reduce suicide in men through improved screening of depression and strengthening of relationship with outpatients (Hübner-Liebermann et al., 2010; Szekly et al., 2013). Another study found increased use of primary care services by adolescents, including increased access for mental health concerns, following a personalised letter sent by general practitioners (Aarseth et al., 2014).

Within the Irish context, a Train the Trainer programme ('ENGAGE Unit 6: Connecting with Young Men') was developed to support service providers to engage young men around mental health issues. This was found to increase service providers' confidence, knowledge and skill in engaging young men, as well as their capacity to advocate for increased engagement with young men within and beyond their respective organisations (Grace et al., 2016).

The training of key community members or 'gatekeepers' to increase awareness of suicide risk factors has also been shown to reduce suicide in men (Knox et al., 2003; Hübner-Liebermann et al., 2010; Gullestrup et al., 2011; Ono et al., 2013; Shelef et al., 2016). However, as this was part of a larger suicide prevention strategy, it is difficult to ascertain what the direct effects of the gatekeeper training were.

The 'Framework Programme' used an ecological model to address the issue of youth suicide and delivered 'gatekeeper' training to build the capacity of the community to identify 'at risk' youths and signpost them to appropriate services (Baber and Bean, 2009). Gatekeepers included a range of professionals (police, clergy, educators) as well as parents and youths themselves. There were reported increases in: (i) awareness of youth suicide; (ii) the belief that mental health services are useful; (iii) likelihood to seek support from adults arising from concern over 'at risk' friends; and (iv) adult preparedness to assist youths in distress.



Figure 9: Example C - Education and Training Intervention

Example C: Education and Training Intervention (Australia)

MATES in Construction [Gullestrup et al., 2011]

Overview: MATES in construction is a large-scale multimodal suicide prevention programme for construction workers in Australia. The intervention consists of:

- General Awareness Training: General awareness of mental health and suicide prevention.
- 'Connector' Training: Receive skills to identify the warning signs of suicidality and support for the 'at risk' individual until he is connected to the suicide first aid worker.
- Suicide First Aid Training: Receive Applied Suicide Intervention Skills Training (ASIST) and offer support to the 'at risk' person.
- Field Officer: Increase awareness of the programme, recruit new sites, and provide support to sites participating in MATES.
- Case Manager: Link 'at risk' workers with external support (mental health support as well as financial counselling, drug and alcohol intervention etc.).
- Suicide Prevention Hotline: 24-hour emergency hotline staffed by trained mental health professionals.
- Provision of postvention support.

Target Group: Gender was not recorded, but 85.6% of construction workers in Queensland were male at the time of the project.

Results:

- An increase in suicide awareness compared to a control group.
- Connector and suicide first aid trainers reported that they felt equipped to intervene with a suicidal person and knew where to signpost them to appropriate services.
- An increased number of workers accessed the helpline.
- 7.2% of the workers accessed external services.

Figure 10: Example D - Psychological Support Intervention

Example D: Psychological Support Intervention (Finland)

Time Out! Getting Life Back on Track Programme
[Appelqvist-Schmidlechner et al., 2010]

Overview: Men who were exempt from military or civil service due to mental and/or behavioural issues were asked to participate in the study. The intervention group were offered a personal counsellor who received specific training for the intervention, whilst the control group were encouraged to seek support on their own terms should they feel the need.

The support programme was based on an interactional model for prevention. Men had the opportunity explore their current life situation, mental health, alcohol and drug misuse, and received support and encouragement from the counsellors to resolve any issues. The mean frequency of attendance for men who participated was 3.6 times. Men in the intervention group who attended more than twice were classified as fully participating.

Target Group: Young men in psychological distress.

Results: After the one year follow-up, men who fully participated in the intervention reported a 63% decrease in psychological distress compared to 40% in the control group. Furthermore, 58% of men who fully participated in the programme reported that their life had improved as a result of the programme.

The interactional model for prevention recognises that problems may develop due to the interaction of various life stressors which has a cumulative effect; that is to say they are not precipitated linearly by single causes. It was postulated that this interactional model provided a more comprehensive model of support for young men rather than trying to address one specific behaviour or symptom (depression, substance misuse)

Psychological Support

The provision of psychological support programmes has been found to reduce the re-occurrence of suicide attempts. Chen et al. (2012) found that following-up with individuals who had attempted suicide - contact within one week after the attempt and the provision of psychological support for six months, primarily by phone, afterwards - was effective in reducing the risk of suicide re-attempt in an intervention group compared to a control group. Furthermore, sending letters to individuals (four times per year for five years) who had attempted suicide, but refused to engage with aftercare, reduced the suicide rate in the contact group compared to a non-contact group (Motto & Bostrom, 2001).

An evaluation of effective practice with men and boys around mental health found that the use of cognitive behavioural therapy and other forms of therapy were useful in reducing anxiety and symptoms of depression (Robertson et al., 2015).

'Time Out! Getting Life Back on Track' (see Figure 10) is a psycho-social support programme from Finland for young men exempted from the military (Appelqvist-Scmidlechner et al., 2010). The support programme was based on an interactional model for prevention where men had the opportunity to explore their current life situation, mental health, alcohol and drug use, and received support and encouragement from the counsellors to resolve any issues. After the one year follow up, men who fully participated in the intervention (defined as attending more than twice) reported a 63% reduction in psychological distress compared to a 40% reduction in the control group. Furthermore, 58% of men who fully participated in the programme reported that their life had improved as a result of the programme. The interactional model for prevention recognises that problems may develop due to the interaction and cumulative effect of various life stressors; that is to say they are not precipitated linearly by single causes. It was postulated that this interactional model provided a more comprehensive model of support for young men, rather than trying to address one specific behaviour (e.g. depression, substance misuse). The factors which were perceived to mediate the programme's success were high motivation of stakeholders, effective intersectoral collaborations, adequate organisational support, and training of counsellors (Appelqvist-Scmidlechner et al., 2012).

Use of Technology

The use of technology to engage men around mental health has also shown some promise. A telephone and online chat service in Belgium was found to have a greater reduction in suicide and first-attempt at suicide in males compared to females (Pil et al., 2013), which suggests that men may, at least initially, prefer arms-length services.

The use of 'MoodGYM', an online interactive cognitive behavioural therapy programme, was found to decrease symptoms of depression and anxiety in adolescents - post-intervention and for a six month follow-up period - compared to a control group, with a greater decrease in depressive symptoms observed in males compared to females (Calear et al., 2009). However, greater adherence was reported amongst females compared to males.

In Australia, 'BeyondBlue' reported on a number of its initiatives which utilised technology to support the mental health of men and marginalised groups (IPSOS SRI, 2014; see Figure 11). One such initiative, 'Man Therapy', has been described in detail in the awareness raising campaign section. 'Proppa Deadly' targeted Aboriginal and Torres Strait Islander people, and aimed to lessen stigma and increase knowledge of mental illnesses whilst encouraging action on depression and anxiety. In this programme, Aboriginal and Torres Strait Islander people tell their personal stories of depression and anxiety which are broadcast on radio. Although it has not been extensively evaluated, and the impact on depression and anxiety is yet unknown, the IPSOS SRI report found that community members' responses were extremely positive. The report concluded that campaigns which consulted with men from the intended target group were most successful. However, in the absence of a rigorous evaluation, the findings in this report must be treated with caution.

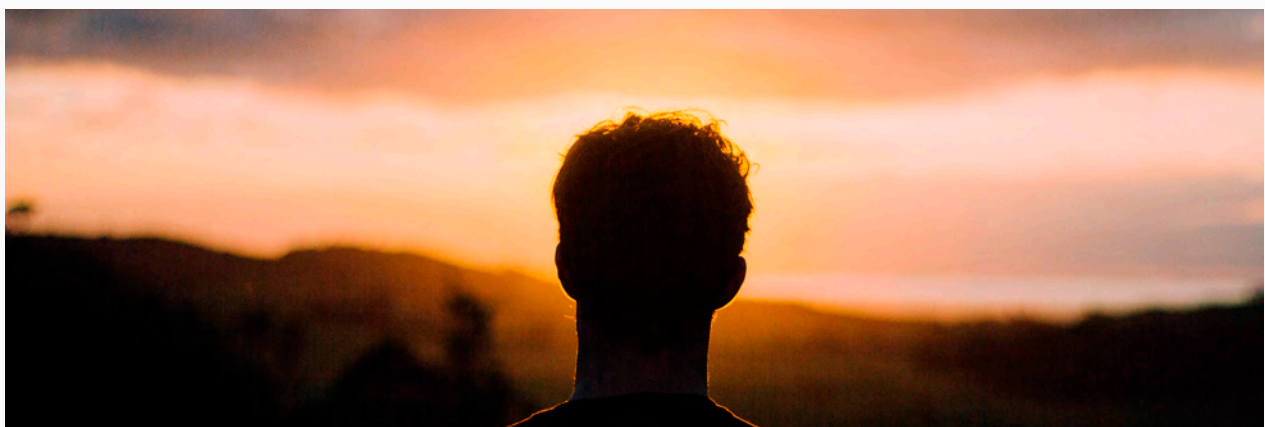


Figure 11: Example E - Use of Technology

Example E: Use of Technology (Australia)

Man Therapy and Proppa Deadly [IPSOS SRI, 2014]

Man Therapy

Overview: Man Therapy is a multi-platform campaign (encompassing TV, radio, print and online) aimed at raising men's awareness of the signs and symptoms of depression, and encouraging men experiencing signs and symptoms of depression to take action by visiting the Man Therapy website.

Target Group: Males aged 30-54 years old.

Results: The campaign reached the equivalent of 1,506,000 men aged 30-54 years old across Australia. Most of these men were reached through television advertisements, with radio being the next most prominent form of marketing. However, television advertisements were more expensive, whilst radio provided the best value for money. The campaign was well-received, and was praised for its 'fresh perspective' and relatable and humorous character who fronted the campaign. Men reported that the campaign resulted in a positive impact on their attitudes, knowledge and behaviours in relation to depression and anxiety.

Proppa Deadly

Overview: Proppa Deadly targets Aboriginal and Torres Strait Islander people, and aims to lessen stigma and increase knowledge of mental illnesses whilst encouraging action on depression and anxiety. Aboriginal and Torres Strait Islander people tell their personal stories of depression and anxiety which are broadcast on the radio. The first part of each story describes how the person experienced their symptoms, while the second part describes which supports they accessed and actions they took to recovery.

Target Group: Aboriginal and Torres Strait Islander people.

Results: An extensive evaluation has yet to be conducted (to the knowledge of the authors of this report), but an initial evaluation found that it was well received among Aboriginal and Torres Strait Islander people.

2.3.3 Community Capacity Building and a Socio-Ecological Model of Health

Much of the men's health narrative to date is that men are largely a problem to be 'fixed'. This is compounded by prevailing neo-liberalist approaches to health which equate adverse health outcomes with poor health 'choices' without due regard to the social determinants of health (Grace et al., 2016; Richardson, 2010).

For a group that faces many barriers in engaging with mental health services (and services more generally), community capacity building and focusing on empowerment and inclusivity, may be a good fit to encourage men to engage with mental health.

Community capacity emphasises empowerment or a 'bottom up' approach, wherein community problems and, subsequently, solutions are identified and implemented by community members and organisations rather than those in power imposing their agenda (Raeburn et al., 2007).

Nutbeam (1998) describes community capacity building as enabling people to take action.

Thus, it is not done to people, but with people as individuals and/or as a collective. There is also an aspiration for community capacity building to have a salutogenesis approach, focusing on strengths and assets that exist within the community, rather than a pathogenesis approach, that focuses on weaknesses (Chaskin, 2001; Simmons, 2011; Easterling, et al., 1998). Both of these approaches are also consistent with key principles of engaging men around mental health and reinforce the need to work with men in this way. Community capacity building is most commonly applied to 'disadvantaged' communities. For example, Hounslow (2001) notes the importance of community capacity building measures to stem the tide of widening inequalities between population groups arising from economic restructuring and social change that can cause entrenched pockets of disadvantage.

The term 'community capacity building' has emerged as an important element of effective health promotion practice, and has become ubiquitous in a range of other functional areas such as social welfare, family and community work, and social and urban planning (Hounslow, 2002).

References to the term in Irish policies and programmes are evident in government initiatives that attempt to finance or facilitate capacity building in the community setting (e.g. Healthy Ireland - Men, CEDRA Energising Ireland's Rural Economy, National Community Action on Alcohol Pilot Project). Indeed, it plays a central role in 'Connecting for Life' - Ireland's National Strategy to Reduce Suicide, with Goal 2 being:

"To support local communities' capacity to prevent and respond to suicidal behaviour"
(Department of Health, 2015; p40-41).

In the health promotion field, Hawe et al. (2000) identified community capacity building as having three main uses:

- i Building problem solving capabilities in communities and systems - a more generic capacity where community groups increase their ability to identify health issues and develop ways to address them.
- ii. Building partnerships and organisational environments - to help sustain programmes and 'gain' positive outcomes through the network of organisations and community groups once funding through the initiating agency ceases.
- iii. Building infrastructure or service development - the capacity to deliver particular responses to particular health problems.

Further to this, Labonte and Laverack added that there were at least three actors in any health promotion capacity building relationship, broadly corresponding to the three uses listed above:

- Community members/groups.
- Health promoters.
- Health agencies (government/NGOs).

Thus, they noted the capacity of each actor in the capacity building relationship:

- For community groups, in isolation or in partnership, to effectively tackle the primary determinants of health affecting the members of that community.
- For health promotion professionals to aid community groups in the process

- For health organisations to assist community groups in the process, and support health promotion professionals to do the same.

(Labonte and Laverack, 2001a)

These are important considerations when creating interventions or policies to engage men around mental health and to support men to take ownership of their own mental health.

There is no universally accepted definition for community capacity building. Even with its roots in the community development field, practitioners still find it problematic to define. Simmons (2011) reviewed a number of community capacity definitions, and deducted a common formula with three features:

- i. It is a process or an approach.
- ii. It is not a definitive thing, but a collection of domains, characteristics, capabilities, aspects and dimensions.
- iii. It is underpinned by a clear purpose or rationale.

From these features a working definition is offered for community capacity building:

“The identification and leveraging (or similar verb) of <insert identified characteristics> for the purpose of <insert rationale; context dependant>” (Simmons, 2011, p198).

Applying this to the context in which community capacity is used within Goal 2 of ‘Connecting for Life’, it can be seen that the aim is to provide/deliver mental health promotion programmes, guidelines, protocols, and training to priority groups and community-based organisations to prevent and respond to suicidal behaviour. Although the purpose here is to build the capacity of communities to ‘prevent and respond to suicidal behaviour’, others argue that increased community capacity is a desirable outcome in itself, as it contributes to active citizenship and social trust (Hounslow, 2002). Indeed, Labonte and Lavarack (2001a) describe community capacity building as being:

- A means to an end - where building capacity can increase the effectiveness and sustainability of programme delivery (for others to take on programmes).
- An end in itself - where the capacity of the community is increased (organisationally and individually) to work in unison to solve problems (enable others).
- A process - wherein capacity building strategies are routinely incorporated as an important element of effective practice - or a ‘parallel track’.



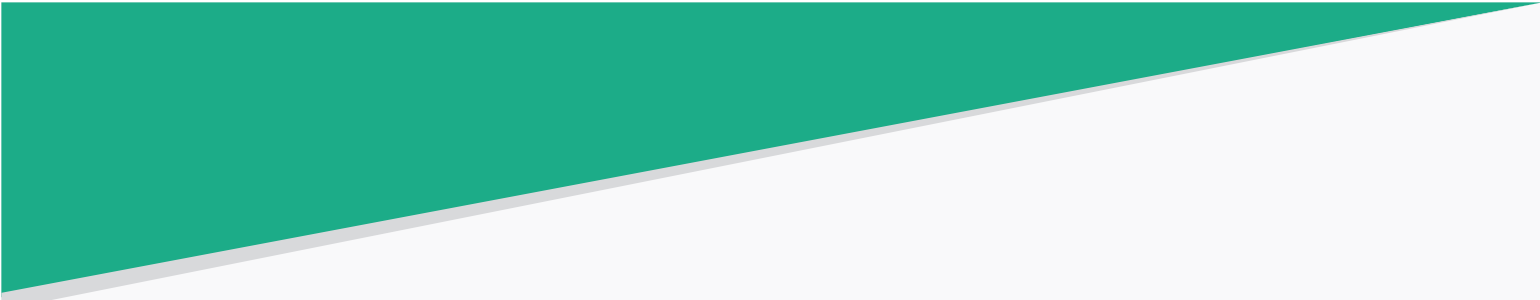
This would be most useful within a suicide prevention context for men where problem solving capabilities and partnership approaches are key elements. Arguably, the most comprehensive definition of community capacity building is offered by Goodman et al. and this will be used for the purpose of this study:

"It [community capacity building] is a process as well as an outcome; it includes supportive organisational structures and processes; it is multi-dimensional and ecological; in operating at individual, group, organisational, community and policy levels (our understanding of community is that it encompasses all these sectors); and it is context specific" (Goodman, 1998, p260).

Goodman's definition draws on many parallels with the key principles of engaging men such as: consulting with individuals in the development of programmes; using strengths based approaches (salutogenesis); and adopting partnership approaches. Furthermore, many of the risk factors described for middle-aged men are due to their socio-economic environment. Thus, if community capacity building measures were consciously incorporated into suicide prevention programmes, wherein community members develop skills to identify and address other problems in their community (also a protective factor for suicide), it would be a prudent way of addressing these broader social determinants of health which are impacting suicidal behaviour. This approach would also address what are often termed as 'soft outcomes' in community programmes. These can have a far-reaching impact on the health of the community, but often go ignored.

As is evident in the community capacity building literature, there is a focus on addressing various levels of influence to improve health gains. Similarly, a socio-ecological model of health stratifies the environment into various levels of influence to understand and address health related issues (Sallis et al., 2008).

A socio-ecological model of health recognises that a person's health outcomes can be determined by their interactions with their physical and socio-cultural environments. In an attempt to unravel the complicated relationships between individuals and their environment, researchers have segmented the environment into various levels of influence: intrapersonal factors, interpersonal factors, institutional factors, community factors and public policy (McLeroy et al., 1988).



The WHO report on suicide (WHO, 2014) also used a socio-ecological model to explore suicide risk factors which have been discussed in depth previously. McLeroy et al. (1988) suggested that interventions could be implemented at each level of influence:

- Intrapersonal factor interventions - to change attitudes, knowledge and beliefs of individuals.
- Interpersonal and institutional factor interventions - to create change in social relationships and organisational environments.
- Community factor interventions - to improve health services or empower groups.
- Societal factor interventions - implementing public policy or facilitating citizen advocacy.

This may be a useful approach to adopt when developing multimodal suicide prevention interventions to ensure a holistic approach to tackling the issue of suicide in middle-aged men. Indeed, the socio-ecological model also recognises that these multiple layers are interactive and reinforcing, whilst each layer may impact an individual differently depending on their beliefs and practices (Golden and Earp, 2012). Therefore, it has been concluded that the most effective approach to create sustainable health change is to target all of these factors simultaneously (Stockols, 1996). However this may not always be practical or realistic.

The socio-ecological model of health may be an important theoretical model to consider when exploring suicide risk amongst middle-aged men, and how various levels of influence might support men around mental health and suicidal behaviour.

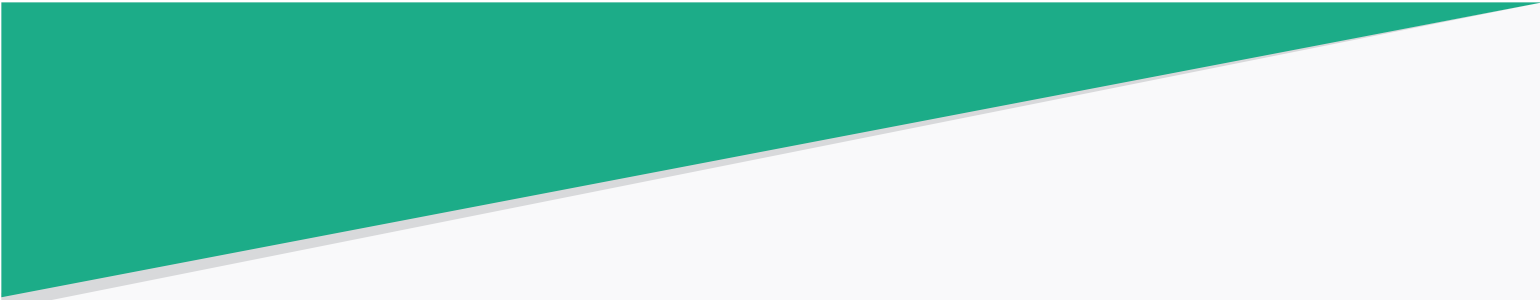
2.4 Conclusion

Although media and scholarly attention has, for good reason, gravitated towards young male suicide, there has been comparatively less focus on the rising suicide statistics among middle-aged men (40-59 years old). Over the past ten years, the suicide rate among middle-aged men in the Republic of Ireland has been the highest of all age cohorts. Although self-harm rates continue to be higher among females compared to males, this gap has been narrowing in recent years; a pattern which is consistent among the middle-aged population cohort. It is well documented that self-harm is associated with an increased risk of suicide. These worrying statistics indicate a clear need for a specific and more targeted suicide prevention focus on middle-aged men.

Middle-aged men have been identified as a 'priority group' within Ireland's National Strategy to Reduce Suicide (Department of Health, 2015). Other priority groups have been identified based on a range of factors such as minority status, occupation, socio-economic group or the prevalence of particular risk factors.

Suicide strategies often identify priority groups based on one characteristic in association with the degree of risk of that characteristic has relative to the general population. However, such strategies rarely account for the interaction of gender with other risk factors. Thus, the primary focus of this study has been on exploring the lived experiences of middle-aged men who are 'at risk' of suicide based on being middle-aged (40-59 years old) and having at least one other 'at risk' identity characteristic. Therefore, the spotlight in this study has been on middle-aged men who are gay, transgender, Travellers, victims of domestic abuse, non-Irish nationals, farmers, unemployed, rurally isolated or separated/divorced fathers.

Suicide prevention is often understood in terms of risk and protective factors. This approach is necessary in order to determine and develop effective suicide prevention strategies and interventions. Gender encompasses socially constructed roles or normative behaviours for males and females. The key factors that are associated with gender and suicide among men are: men's use of more lethal methods; a reticence to seek help; higher rates of alcohol and substance misuse; and factors specific to 'high risk' groups.



Individual factors that increase the risk of suicide include a previous suicide attempt, family history of suicide, chronic pain, mental disorders, alcohol and substance misuse, hopelessness, and job or financial loss. The disruption of relationships, social bonds and support networks can compound suicide risk by undermining one's sense of purpose and belonging. Community factors such as disaster, conflict, acculturation, discrimination and trauma or abuse also increase the risk of suicidal behaviour.

Community and health system and societal factors relating to access to means of suicide, inappropriate media reporting, and stigma associated with help-seeking can increase the risk of suicidal behaviour. Conversely, strong personal relationships, religious and spiritual beliefs, and lifestyle practices of positive coping strategies and wellbeing can protect against suicidal behaviour. However, limited evidence exists in the literature in relation to the specific factors underpinning the high suicide risk of middle-aged men at risk of marginalisation.

A number of key principles have been found to be effective in engaging men around mental health. These include: working in an informal environment and creating a safe space; adopting a strengths based approach; using positive non-stigmatising language; finding a 'hook'; consulting with men; and adopting a partnership approach. The adoption of these principles helps to maximise the sense of ownership, trust, safety and enjoyment that men experience through engaging with such approaches.

There is, however, a gap in the existing literature with regards to best practice for engaging MAMRM around mental health and suicide prevention. Particular models and interventions have proven to be effective in addressing suicidal behaviour in men and/or supporting their mental health. These include: awareness raising campaigns; activity based programmes and support groups; education and training interventions; psychological support; and use of technology.

Evidence suggests that the most effective suicide prevention interventions are multimodal and comprise several such activities running simultaneously. Community capacity building measures, which prioritise empowerment and inclusivity (often termed as 'soft outcomes') also have a critical role in encouraging men to engage with mental health. A socio-ecological model of health provides a useful framework in which to untangle suicide risk and protective factors, and to develop a holistic approach to multimodal interventions to tackle the issue of suicide in middle-aged men.



3. METHODOLOGY

3.0 Study Design

This study adopted a qualitative research approach using the principles of Grounded Theory to inform data collection and data analysis. Qualitative research adopts an interpretive, naturalistic approach and develops explanations of social phenomena from the perspective of participants' lived experiences (Denzin and Lincoln, 1994).

Focus groups and phone interviews were used with men 'at risk' of marginalisation (n=34) representing diversity in terms of social class, ethnicity, race, sexual orientation, and with a broad range of service providers (n=35). A focus group is a form of qualitative research wherein a group of people are asked about their opinions, perceptions, beliefs and attitudes towards a particular concept or service - in this case, middle-aged men and mental health. Focus groups capitalise on communication between research participants by using group interaction and group dynamics to collect data (Kitzinger, 1995). This method allows the researcher to analyse a range of interpersonal communications which can highlight cultural values or group norms which can prove useful for examining why different population groups access or do not access health services (Kitzinger, 1995).

Focus groups have been noted as a useful method of data collection when discussing sensitive topics, particularly when in the presence of friends and/colleagues or among homogenous groups - as participants can feel relatively empowered and supported within the group (Bloor et al., 2002 in Berg, 2010; Morgan, 1993). Furthermore, focus groups have been found to be an effective technique when exploring the attitudes and needs of staff (Denning & Verschelden, 1993). However, participants in focus groups are discussing issues within a specific context and within a specific culture and, therefore, may not be expressing their individual view (Gibbs, 1997). Furthermore, individuals might be discouraged from participating in focus groups and may not trust others in the group due to the sharing of such sensitive or personal information (Gibbs, 1997).

In a small number of cases, telephone interviews were used in lieu of a focus group. This was as a result of time constraints for some participants (e.g. GPs, psychiatrists) and highly sensitive social circumstances among other participants. Although telephone interviews lack key interpersonal and non-verbal communications which play a critical role in this study, they were the only viable option to collect data among certain cohorts. Conversely, some researchers argue that telephone interviews may provide an immediate sense of anonymity and are effective for obtaining 'hard-to-locate' individuals or when asking very sensitive questions (Champion, 2006 in Berg, 2010).

3.1 Sampling

Focus groups and phone interviews were carried out for this study using a mixture of purposive sampling and snowball sampling. Purposive sampling involves the researcher using specialist knowledge about a particular group to select subjects who represent the intended population group (Berg, 2010). This proved useful for gathering service providers and leading experts in the men's health field. Snowball sampling relies on identifying key contact persons or gatekeepers who then recommend or assist in recruiting more participants. In this study, gatekeepers often acted as a link for co-ordinating a date, time and a venue for certain focus groups.

Without looking for statistical representativeness, the sample chosen represents diversity on the grounds of a range of other identity characteristics, thus ensuring that a range of personal characteristics and experiences are highlighted in the study. The target groups were identified on the basis of: (i) specific sociodemographic characteristics identified in the wider literature as being associated with a higher risk of suicide (see Table 3), and (ii) service providers who engage with these cohorts (see Table 4). Although target groups were recruited on one identity, it does not discount the heterogeneity that may exist within these groups, nor does it dictate the questions that were asked or how the focus groups were facilitated. Participants were encouraged to reflect on their own experiences and perspectives, thus allowing free movement between the multitude of social locations in which they operate.

A total of thirty four middle-aged men at risk of marginalisation were interviewed for this study, which accounted for nine target groups. The mean age for this group was 50.3 years old, with an age range from 40-59 years old. It was intended to conduct a focus group with ex-prisoners, but it transpired that ex-prisoners were part of other groups recruited and, therefore, the decision was taken not to recruit a specific ex-prisoner group.

A total of thirty five service providers were interviewed from a range of occupational backgrounds which constituted seven target groups. These service providers worked at various levels of organisations (CEO to front line staff) and there was a mixture of academics and practitioners.

Table 3: Focus Groups with Middle-Aged Men at Risk of Marginalisation

Category	Number of Participants (N)	Method and Duration of Data Collection
Unemployed Men	5	Focus Group (1 hour 14 minutes)
Farmers	8	Focus Group (1 hour 5 minutes)
Traveller Men	4	Focus Group (1 hour 14 minutes)
Rurally Isolated Men	6	Focus Group (55 minutes)
Non-Irish National Men	4	Focus Group (1 hour 32 minutes)
Transgender Men	2	Phone Interviews (51 minutes and 52 minutes)
Male Victims of Domestic Violence	1	Phone Interview (49 minutes)
Divorced Fathers	2	Phone Interviews (1 hour 5 minutes and 39 minutes)
Gay Men	2	Focus Group (48 minutes)
Total	34	


Table 4: Service Provider Focus Groups

Category	Number of Participants (N)	Qualitative Method Used
Men's Health Expert Group	4	Focus Group (1 hour 54 minutes)
Community Based Workers with a Remit for Men's Health	6	Focus Group (1 hour 1 minute)
Statutory Mental Health Services	5	Focus Group and 1 Phone Interview (1 hour 5 minutes and 39 minutes)
Mental Health Organisations	6	Focus Group and 1 Phone Interview (50 minutes and 39 minutes)
Defence Forces	6	Focus Group (1 hour 23 minutes)
General Practitioners	2	Phone Interviews (58 minutes and 36 minutes)
Community and Voluntary Organisations	6	Focus Group (1 hour 2 minutes)
Total	35	

3.2 Data Collection

Each focus group or phone interview was conducted in a comfortable and convenient location for the participants, and at a time and date that was suitable to all. The purpose of the focus group was explained to participants prior to commencement, along with the expected length of the focus group. Upon arrival, informal conversations were had with participants, over light refreshments when possible, about sports, the weather or their journey to the location. This served as an important means to build rapport prior to commencing anything related to the research topics.

A participant information sheet and informed consent sheet were circulated via email in advance of the focus group and circulated a second time at the beginning of the focus group. Both of these documents were summarised and read aloud. The researcher then asked if the participants had any questions and, subject to some minor clarifications, all participants signed and returned the informed consent sheets to the researcher. The same approach was conducted with phone interviews and participants returned the informed consent via email or post prior to commencement of the interview. Permission for the focus group to be audiotaped was sought from participants in advance.



Informal introductions were used with both service provider groups and MAMRM groups at the beginning with the aim of creating a relaxed and comfortable environment. However, this was not needed with the MAMRM groups, as the majority of the men within the groups had previously known one another. Therefore, this round of introductions was dropped with MAMRM groups for the remainder of the study and the researcher got to know the men's names individually prior to commencing the focus group.

Interview guides for both service providers and MAMRM were used which contained a series of questions and prompts relating to the main research questions. These questions and prompts were informed by the literature review, members of the Advisory Group, and by academic and workplace supervisors. These questions were reviewed for appropriateness in terms of suitability of language and how they might 'land in the room' with men and service providers alike. Open-ended, clear and sensitive questions were used in a conversational approach to explore and unravel the lived experiences of the research participants.

When participants found it difficult to talk about sensitive topics, the researcher showed empathy and encouraged participants to take as much time as necessary. Reflection on and clarification of statements and viewpoints were useful to gain a deeper insight of an issue and to avoid misinterpretation.

Following completion of a focus group, participants were thanked for their contribution and were reminded about the mental health supports in place should they feel the need to access them. The interview guides were refined and modified in response to the ongoing analysis of the data. It was felt that the sequencing of questions was crucial. In order to put participants at ease, and to build rapport before broaching more sensitive questions, the earlier part of the focus group/ interview focused on more routine, non-threatening questions. More sensitive and personal questions were asked in the middle-portion of the interview, before concluding with more positive questions such as perceived helpful supports and networks.

Each MAMRM focus group/interview lasted on average one hour and two minutes, whilst each service provider focus group/interview lasted on average one hour and seven minutes. After consultation with the Advisory Group, it was decided that the total time allocated to conducting phone interviews with each cohort should equate approximately to the duration of one focus group (e.g. three telephone interviews of twenty minutes equated to one focus group of sixty minutes).

The majority of the audiotaped recordings were transcribed verbatim. As the researcher began analysing and coding the data, and when data saturation was approaching, summary transcriptions were conducted and key quotes noted. Pseudonyms were used for each participant to ensure anonymity and confidentiality.

3.3 Data Analysis

A Grounded Theory approach was used in this study (Glaser and Strauss, 1967) which is a qualitative research methodology wherein theories are generated from the data collected. A Grounded Theory approach comprises simultaneous data collection and analysis ('constant comparative analysis'), with each focus group informing and guiding the others as the research process unfolds (Strauss and Corbin, 1998). This allows all seemingly relevant topics to be discussed in subsequent focus groups.

Concepts emerge from focus groups and/or interviews as a result of the transcripts being coded iteratively using open and comparative coding techniques and themes are developed. The codes within this study were continuously refined using constant comparative analysis, which guarded the researcher against bias by challenging emerging concepts with new perspectives and data, and acted as an important process to accurately reflect what participants felt to be the most important concepts.

Multiple coding techniques were used (Barbour, 2001), wherein the second author coded a sub-sample of transcripts, cross-checking coding strategies and interpretation of the data. This approach sought to maximise validity and reliability of the findings. The ongoing refinement and analysis of the data led to the grouping of codes into sub-themes and, eventually, three primary themes emerged. Theme memos and conceptual maps were utilised to track evolving relationships between themes. Data saturation was reached when the gathering of new data no longer shed any additional light on the theory or themes (Charmaz, 2008).

Finally, in order to present a real-life context to the reader with regard to the lived experiences of the various groups of MAMRM, ten personal biographies were drafted which highlight the key findings of the study. These are presented in the Results Chapter.

3.4 Ethical Approval and Considerations

Ethical approval was sought and granted by the Institute of Technology Carlow's Ethics Committee. Mental health and suicide prevention are highly sensitive topics of research. Therefore, it was seen as critically important to be mindful of the complex challenges inherent in researching mental health and suicide prevention. Ethical consideration was given, in particular, to the following:

- Protecting the wellbeing and safety of research participants.
- Data protection.
- Voluntary participation.
- Informed consent.
- Equity.
- The mental health of the research team.

Appropriate measures were taken in response to these ethical considerations.



4. RESULTS

4.0 Introduction

The findings of this study emerged in three broad themes:

Theme 1: Marginalised Masculinities.

Theme 2: Support Seeking and Coping Mechanisms.

Theme 3: Negotiating the Dynamics of Engaging Middle-Aged Men.

These themes represent the opinions and perspectives of both the men and the service providers. However, theme 3 is predominantly drawn from the perspective of service providers with minor input from the men.

'Marginalised Masculinities' explores factors which caused psychological distress among middle-aged men. This report uses the term psychological distress to indicate a continuum of distress among men ranging from low to increased risk of suicide and suicide behaviour. Men's position on this continuum was influenced by multiple and intersecting factors including: exposure to single/multiple risk factors, duration of this exposure, their own levels of resilience and coping mechanisms, and support structures.

'Support Seeking and Coping Mechanisms' explores how men access support, or do not, during times of psychological distress, associated barriers with accessing support, and the ways men cope - which can be adaptive and maladaptive.

Finally, 'Negotiating the Dynamics of Engaging Middle-Aged Men' explores the facilitators of and barriers to effectively engaging men and supporting them during times of psychological distress. Table 5 gives an overview of the themes and sub-themes covered in this section.

Table 5: Themes and Sub-Themes

Main Theme	Sub-Theme	Where
Theme 1: Marginalised Masculinities	Mid-Life Transitions	Section 4.1.1 and Figure 12
	Societal Challenges	Section 4.1.2 and Figure 12
	Subordinated Identities	Section 4.1.3 and Figure 12
Theme 2: Support Seeking and Coping Mechanisms	Accessing Supports - Triggers and Barriers	Section 4.2.1 and Figure 13
	'Coping' Mechanisms and Supports to Mental Health	Section 4.2.2 and Figure 13
Theme 3: Negotiating the Dynamics of Engaging Middle-Aged Men	Interpersonal Dynamics	Section 4.3.1 and Figure 14
	Service Provider Dynamics	Section 4.3.2 and Figure 14
	Systemic Dynamics	Section 4.3.3 and Figure 14

As highlighted from the outset of this report, a specific objective of this study has been to give a voice to more 'at risk' or marginalised groups of middle-aged men. Interspersed throughout this Results Chapter are a series of biographies written from the perspective and lived experiences of these marginalised groups. These biographies are the amalgamation of experiences from different men within each group and provide a clear sense of the challenges facing each of the 'at risk' cohorts of men. However, the findings from this study also show that simply being middle-aged also presents challenges - including to those who are not seen as an 'at risk' population group. These 'mainstream' men may only be one critical incident away from significant psychological distress. Therefore, a composite biography on 'a middle-aged man' is presented initially followed by nine 'at risk' biographies.

BIOGRAPHY 1

Tim, a Middle-Aged Man: “The only constant in life is change and you have to keep adapting”

Mental health is everything that you do; it can be both positive and negative. But it is also something that many of us don't fully understand. If you don't know about something, then it's hard to know how or where to look for ways of addressing it when things go wrong. So, we slip into mental health difficulties without realising it and, by the time you realise it, you are on this rollercoaster and it is very hard to stop.

When I became unemployed at middle-age, I felt like I had no chance of getting another job. They wanted somebody younger, faster, stronger, cheaper. I felt like I was being eaten away. With some of the jobs on the *** (names Employment Agency), you end up with less money than if you weren't working. Even though the job they are offering might be good for you, to get you out and have a purpose, you still need money to keep your place going and pay the bills. So, you end up in a Catch 22.

Death comes more into the equation too at middle-age, and you miss loved ones that have passed. You are sitting there thinking of that conversation that you never had a chance to finish - that can be soul destroying. I feel like I should be wiser, I should cope, I should be better able to deal with my emotions, but the fact is change is hard.

We are the last generation before the huge big change out there. We did what our fathers did, but now our children live in a different world and everything has changed. Sometimes, I think to myself, am I part of that world or this one? We grew up thinking that we had to be the breadwinner, that all the responsibility was on us in the household. I think, because of that, I lost my way a little bit when I became unemployed and I started to feel that I am not needed as much anymore. But I think the only constant in life is change and you have to keep adapting.

Mental health is something I became proactive about. I realised that I had to identify how I really felt, rather than thinking about how I should be feeling. There are so many expectations of how you should feel and behave, and to do otherwise is a weakness. I battered myself black and blue for things I thought were weaknesses. I became more aware of triggers that made me feel unwell, and I began to normalise and accept my emotions. I realised I couldn't be angry at myself for feeling angry. I used to close off and say nothing to nobody. I think now I understand that it is very important to speak out. Just to say something to somebody instead of closing yourself off.

I don't think you can generalise it and say men don't talk about mental health. Given the right environment, men certainly do talk. Education is huge, and it is about making men aware. Just challenging those stereotypes and letting men know that it is alright and safe to talk about these things.

BIOGRAPHY 2

Séan, a Divorced Father: “You feel like a lone wolf pushed out of the pack”

I was no longer the breadwinner of the house when there was no bread to be won. In my case, my marriage broke up over it. I lost my job, my house and my family. There are massive pressures all the time when you are not working, sending the kids to school, college, bills, everything just keeps piling on. When you are down like that, you feel like every little thing is putting you down even further - another nail in the coffin. You just become so isolated when your relationship breaks down. You feel like a lone wolf pushed out of the pack.

All my children went to her side. I didn't get to see them. Even some of my own brothers and sisters chose one side or the other, and some of them didn't want to get caught up in it - so they didn't talk to me at all. Without that social interaction, I started to think “what is the point of being here?” I started to feel like nobody would notice if I was gone.

When you get to middle-age you think things should be settling down and levelling out. You should be thinking about retirement with your family, but then everything turns upside down. You are out on your own, back where you started. I remember crying, and looking up at a Sacred Heart, and saying “why me?” I tried to provide, I tried to work, I tried to do everything, and I still ended up on my own.

I found it very hard to seek out help the first time. It took me three years. I sort of knew I was getting worse and worse. My blood pressure was going crazy and I felt like I was having a meltdown. I just didn't want to admit that I had a problem and I was afraid of what people would think. I got so bad I signed myself into psychiatric care. I was just going to see the psychiatrist and she would give me the prescription and off I went. I was telling her what I thought she wanted to hear.

It wasn't until I found myself lying in bed for two or three days that I started to tell myself: “I'm not going to go like this. I have come a long way and I have to do something about this”. I went back to the psychiatrist and started to do what they were asking me to do. That is something men need to learn - don't go through the motions. When you start doing what they ask, you sort of realise that this stuff works. I started to take care of myself physically and mentally, whilst occupying myself during the day. I went back to education and I began volunteering with the rugby, which gave me a purpose and something to look forward to at the weekend.

Mindfulness was great for me. It worked because it was sort of like the start of a rugby game. There was always the focus before the match started - just imagining what you are going to do, slowing your thinking down to the pace of play.

Looking after your mental health is an ongoing thing, keeping on top of it like. It's never too late to get help.

4.1 Marginalised Masculinities

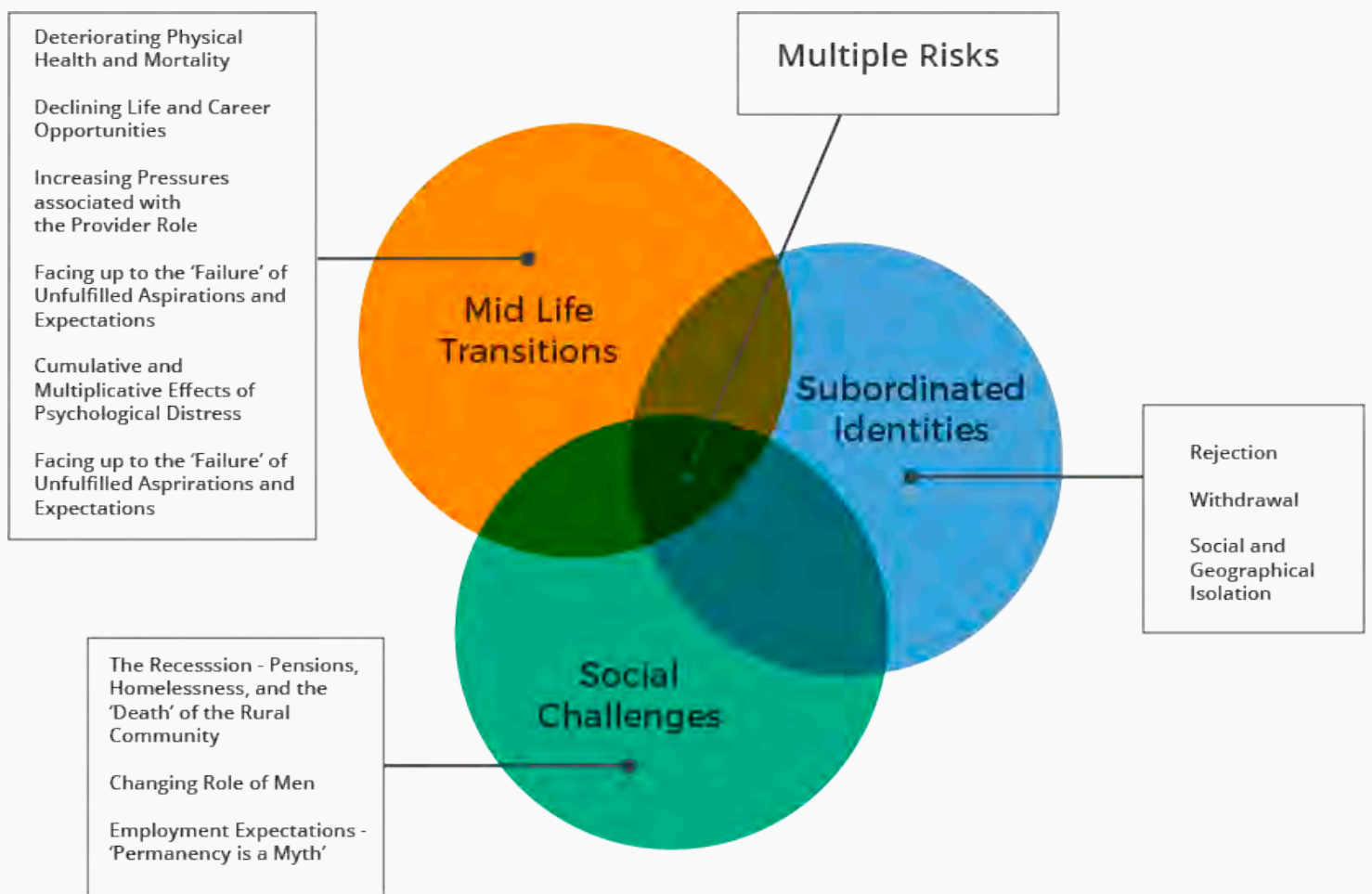
4.1.0 Introduction

The theme marginalised masculinities captures a broad range of issues and challenges that were identified as sources of psychological distress and which, potentially, predispose middle-aged men to increased suicide risk. This theme consists of the views and perspectives of both the men and service providers.

Section 4.1.1 explores mid-life transitions which are associated with a recurring set of challenges including: declining health status and facing up to mortality; diminishing life or career opportunities; increasing pressures associated with the provider role; facing-up to the 'failure' of unfulfilled aspirations and expectations; and the cumulative and multiplicative effects of psychological distress. These challenges are compounded by what was seen as significant new societal challenges (zero hour contracts, multiple career paths, changing role of men) and an unravelling of the more traditional pillars of society (church, politics). This results in more vulnerable groups of middle-aged men, in particular, feeling that they have been cast adrift between two vastly different generations. These issues are discussed in section 4.1.2. with a particular focus on the unique challenges posed to middle-aged men. Finally, section 4.1.3 explores other aspects of identity (race, ethnicity, sexual orientation, gender identity) which present different pathways through which middle-aged men experience rejection, isolation or withdrawal; thereby assuming a subordinated or marginalised masculine identity.

These three lenses through which we explore the factors that cause psychological distress among middle-aged men do not exist in isolation. Rather, they intersect and compound one another, creating knock-on and multiplicative effects. Indeed, the men in this study also highlighted the progressively damaging effects of feeling marginalised or being exposed to challenges over a long period. In other words, whilst the impact, for example, of an undiagnosed health issue (e.g. bipolar), gender identity issue (e.g. transgender) or difficult life transition (e.g. becoming unemployed) were seen as significant and impactful issues in their own right, it was the prolonged exposure to these [or multiples of these] issues that was seen as having a 'wear and tear' and exponential adverse effect on men's mental health over time. Figure 12 gives a brief overview of this theme in the form of an infographic and shows how the intersection of the sub-themes can potentially increase middle-aged men's exposure to multiple suicide risk factors.

Figure 12: Marginalised Masculinities



4.1.1 Mid-Life Transitions

Deteriorating Physical Health and Facing Up to Mortality

The consensus from both middle-aged men and service providers was that particular transitions at middle-age pose a unique set of challenges for middle-aged men. For many of the men, the deterioration of one's physical health brought about through ageing, illness or injury had significant knock-on implications in terms of psychological distress. Physical changes, a propensity to gain weight, a 'slowing down' effect, and reduced capabilities to carry out habitual tasks, were repeatedly cited as sources of torment and frustration for middle-aged men. The latter, was particularly troublesome for middle-aged men working in the construction industry or as farmers, as declining health resulted in declining work productivity and, thus, more financial strain. This reduced capacity to 'perform', embodied in an ailing physical body, is captured by James:

"...if your physical health deteriorates, and you are not able to do the things that you think you should be able to do, then that obviously affects you mentally... you are not able to make the farm perform as well as it could..." James, Farmer

The increased onset of physical ailments associated with ageing also impeded men from participating in physical activity to the level they once enjoyed. This was particularly troublesome for those men for whom physical activity served as a social outlet or means of stress release:

"I do high intensity running and my doctor gave out to me, he said... you are too big and too old to be doing that... I am like 'well it keeps me mentally well'. So we are being limited by our age". Dermot, Gay Man

Both service providers and the men stressed how coming to grips with their own mortality had potentially significant mental health implications for middle-aged men. As well as having an ageing physical body, there is also increased exposure to death among loved ones. Some lamented missed conversations they wished they could have had before their loved ones had passed. This compounded issues for middle-aged men who experienced relationship breakdown, such as Simon, who found himself feeling very isolated and lonely:

“Death comes in too because you miss someone... You didn’t get a chance to finish that conversation that you had twenty years earlier... That can be soul destroying too. All it takes is another trigger from something else and you are on your own, like a lone wolf pushed out of the pack”. Simon, Divorced Father

Ciaran, a men’s health expert, but also a middle-aged man, reflects on this reality check and the inevitability of losing loved ones in the transition to middle-age:

“...you are at the age where mortality becomes real... Your mother, your father, your best friends are starting to get terminally ill and die... It was four weddings and a funeral, now it’s four funerals and a wedding”. Ciaran, Men’s Health Expert

‘On the Scrapheap Before Your Time’ - Declining Life and Career Opportunities

For those men who were actively seeking employment, it was perceived that fewer employment opportunities existed at middle-age due to being ‘classified as an old man before your time’. This, in turn, undermined their perceived role as the provider of the household which, for most of this age cohort, was a key pillar of masculinity. As a middle-aged man seeking employment in the construction industry, Simon expresses his dismay and frustration with long-term unemployment. He described the insidious and carnivorous impact that repeated rejection from employment positions has had on his mental health:

“When you lose your job... and it goes on and on... and it becomes a couple of years and no chance of getting another job because you are too old, or you are no longer able to do it, or you are just not qualified enough to do it anymore, or they want somebody younger... You sort of feel you are being eaten away... The jobs don’t want you, they want somebody younger, faster, cheaper” Simon, Divorced Father

Service providers expressed similar views. Aaron, a statutory mental health service provider, noted that, from his experience, men who become unemployed at middle-age have fewer subsequent employment or career opportunities than younger men which, he felt, tends to 'grind the guy down'. The absence or loss of employment was seen as particularly significant for this age cohort of men, for whom employment was inextricably linked to identity - thereby rendering men more susceptible to mental health difficulties following the loss or absence of a job. Both the men and service providers felt that middle-aged men tend to put more 'stock' on their work, and that a man's identity, self-worth, ego and fulfilment are seamlessly intertwined with his occupation. Thus, it was felt that a loss of purpose, identity, and shame ensued when this age cohort of men became unemployed:

"I just don't feel a part of the whole scheme of things. I have been unemployed since the recession. I don't feel needed, or wanted, I feel a bit closed off from everything. This has been going on quite a few years... For me, I have nothing to say about what my career is or my line of work - identity. The sense of belonging, to belong to something - a purpose".

Martin, Unemployed Man

It was felt by service providers in the Defence Forces, that some middle-aged men within their organisation were particularly vulnerable when approaching retirement age. Those military personnel who were less successful in terms of availing of training or career opportunities were seen as particularly vulnerable, by virtue of having limited employment or career opportunities once they retired. Men who were single and lived in accommodation within the Defence Forces were also perceived to be particularly vulnerable in this regard.

All participants reported that a loss of routine and stimulation associated with unemployment was also a significant factor which contributed to psychological distress. Some of the men reported difficulty in finding a reason to 'get up in the morning' due to feeling apathetic or ambivalent. Simon reflects on the festering effect of long-term unemployment, and notes that

the more time he had on his hands, the greater the propensity for him to have suicidal thoughts:

“When middle-aged men get to that stage [long-term unemployment] they are no longer busy. Having a reason to get out of bed even. It is very hard to keep adapting, you are not busy, so it all keeps piling on top of you. That is when finding a reason to keep living becomes a problem”. Simon, Divorced Father

The onset of psychological distress due to a lack of stimulation and unemployment was particularly evident among Traveller men. This was compounded by what was seen as widespread discrimination towards Travellers - particularly in terms of employment opportunities (see section 4.1.1) - and often led to maladaptive coping mechanisms such as alcohol misuse (see section 4.2.2) or crime. Joe a Traveller man, rationalises that alcohol fills a void created by unemployment:

“I wouldn’t be able to go to work and go drinking every day. There would be something on my mind, I’d be occupied - I would know the work is there, so I would have to get up and do it. But when there is nothing else to do, the first thing you would do would be to go drinking”.

Joe, Traveller Man

Reflecting on his experience of prison, Anthony argues that if he could have continued to have had a focus or purpose to his life, such as he has experienced on his employment scheme, he would not have resorted to crime to provide for his family:

“It [crime] is something I did because as we were saying, you have to provide for your family. If I had a job, I wouldn’t have handled stolen property... I worked with [named organisation] on a CE scheme on the maintenance programme. It was working for my dole, but it had me occupied. In that three years I never committed one crime... I was looking forward to every morning to going in because I was out cutting the grass, I was fixing locks on the doors, I was setting up meeting rooms. Just maintenance, that’s all I was doing, but it kept me occupied and I wasn’t getting in trouble. But then it stopped. I don’t know why it only runs for two or three years and then stops”. Anthony, Traveller Man

Patrick draws an analogy between the lack of stimulation associated with unemployment, coupled with living in the confined space of Traveller accommodation, to an 'open prison' - which appeared to reinforce a sense of hopelessness and helplessness amongst the Traveller men in the community:

"Living in a confined area you are looking at the one thing every day... talking to the same people every day... the one conversation every day. A part of me feels like it is an open prison. You're lying in bed, you go out for a walk around you, go from him to him, and then after an hour you're back in your cell [house] again to watch the television, and then you go from the television to the bed and vice versa. You get back up in the morning and do the exact same thing again. It's an open jail". Patrick, Traveller Man

These accounts suggest that unemployment rendered many groups of middle-aged men (Traveller men in particular) powerless, trapped and imprisoned, with little hope of regaining control over their lives.

Increasing Pressures Associated with the Provider Role at Middle-Age

Middle-age is a time that all participants associated with increased responsibility and financial pressures, both of which were perceived to be potential sources of significant psychological distress. This was particularly evident among fathers, when faced with situations in which their perceived role of provider was undermined. Impending bills, loans, mortgages, and children going to college were reported as financial burdens that tended to be felt most acutely by this age cohort. When placed against the wider backdrop of a volatile labour market during the economic recession and the negative impact of unemployment on middle-aged men's mental health, such financial pressures added significantly to the precarious position in which many of the men found themselves. According to Frank, a transgender man, this constant financial struggle was comparable to a treadmill, running to stay still, whilst Jim describes the 'juggling act' of trying to reconcile his varying financial responsibilities:

“It puts a financial pressure on the farmer as well. If you have two or three in college at the one time, you are trying to make a living, you are trying to keep them in college, you are trying to save money for a bit of a pension. So it is a juggling act”. Jim, Farmer

The psychological distress associated with financial pressure was compounded for many groups of middle-aged men who felt additional pressure to provide for and be responsible for the household. Although it was felt that traditional gender roles between men and women had changed considerably in the past few decades, many of the men still reported feeling immense pressure to be the provider of the household whilst remaining stoic, strong and silent through adversity. This often resulted in men having the façade of external contentment, but internally struggling considerably, as Ciaran describes:

“On the surface, it was just the swan that looked graceful going about its business, but underneath it was paddling like mad and trying again to get some traction, and it didn’t really know how to go”. Ciaran, Men’s Health Expert

All participants noted that this failure to provide both financially and in terms of opportunities, elicited feelings of shame, embarrassment and emasculation for middle-aged men. This was particularly evident amongst the Travelling community, where traditional masculine roles were seen as being intensified:

“...it’s the shame it [failure to provide] brings on you. Once the young lad sees someone else with them (new runners) they want them, but you can’t get them because you don’t have the money and that would depress you. The Travelling man is the provider, he’s the one who is supposed to look after his family”. Liam, Traveller Man

Daniel, a men’s health community based service provider, noted that emasculation was a big issue for unemployed men, many of whom were experiencing a sense of failure by not being able to provide. Service providers also reported that men had a tendency to be heavily self-critical when they ‘failed’ in their role as provider, irrespective of whether the issue was within or beyond their control. James, a farmer, also reflected on how he perceived men to internalise ‘failures’ outside of their control, such as a family member not taking up the option of making their livelihood from the farm:

"Within men we are good at internalising it all - well I have failed. We would see it as a failure if we haven't been able to make it attractive enough for the next person to stay there". James, Farmer

Andrew, a men's health expert, reported that as a society we tend to compare ourselves to our peers, which can become a source of additional psychological distress. He described this as "the internal comparison calculator" which, he explained, triggered the onset of negative self-talk and the conclusion that one's achievements in life were always to be overshadowed by one's failures:

"As a man, you have been trained to feel responsible for all of this [perceived failures] and to provide for all of your family... even if your wife is working and earning as much or more than you... so you have major pressures on yourself. Also with the celebrity culture and the highlighting of monetary success for men. So your internal comparison calculator is going on saying 'well you are a heap of shite and you have amounted to very little' and you might think you have amounted to nothing". Andrew, Men's Health Expert

Facing Up to the 'Failure' of Unfulfilled Aspirations and Expectations

Men reported feeling pressurised and a weight of expectation to have achieved certain milestones and accomplishments by middle-age such as having a relationship, a family, a home and steady employment; in other words "having your track made" (Christopher). When these key benchmarks of masculine identity were not met or disrupted, such as through unemployment or relationship breakdown, there were potential implications - not only directly to men's mental health, but in terms of a more deep-rooted sense of failure and a feeling of going backwards in life which compounded psychological distress. This was particularly evident among divorced fathers and victims of domestic violence who recounted the loss of their marriage and family home through relationship breakdown:

"...when things should be settling down and levelling out and you are starting to retire - look at your children, grandchildren and your wife - everything turns upside down. You are turfed out and you are back where you started... It was heartbreaking. I remember crying and looking up at a Sacred Heart and saying why me?" Joey, Divorced Father

In the context of unemployment, Aine, a men's health community based worker, articulates how attitudes towards unemployment by certain government agencies can further reinforce these feelings of helplessness and hopelessness among unemployed middle-aged men:

"...that in itself [unemployment] can reinforce that sense of hopelessness and helplessness in an area... I think sometimes, for some agencies, such as [government agency], their attitude to [unemployed] people can be quite hostile and reinforce that sense of, you know that you are sponging off the state, that you are not contributing". Aine, Community Based Men's Health Service Provider

This weight of expectation to succeed and provide, often led to men working extensive hours in their earlier life. Thus, as men approached middle-age, some with new found free time, they began to lament missed opportunities for connection with their children who typically had grown up and begun to move out of home. This was a particular source of psychological distress among divorced fathers. Chris, a community based men's health worker, reflects on his experiences of engaging with middle-aged men for whom this loss of contact with their children was a pertinent issue:

"For a lot of the middle-aged men it was about disappointment in that group, that they didn't have the connection with their children that they wanted when they were growing up... they had seen their job... was to get out there and work and do things. Some of them were lamenting the fact that they had missed it". Chris, Community Based Men's Health Service Provider

This weight of expectation that many men felt coincided with a time of reflection and questioning of what they had achieved in life. Some men began to regret missed opportunities, failed aspirations, and felt like life was 'passing them by'. This was often referred to as 'the mid-life crisis' or 'philosophical crisis' where middle-aged men questioned their life choices (past), the scale and value of their achievements (present), and their ability or capacity to achieve outstanding aspirations (future). Nathaniel, a General Practitioner, articulates that this could be comparable to a man's biological clock:

"...feeling like life is passing you by, and you have got to provide, and this is your last chance to sort of have done something with your life, and that all happens quite quickly... so there is a pressure. It is not the biological clock that women have but there is a biological clock in a way". Nathaniel, General Practitioner

Men who discussed this 'mid-life crisis' predominantly reflected on the likelihood of them not achieving their long-term aspirations and how quickly time had passed them by. James reflects on missing the boat and the contraction of opportunities from youth to middle age. There seems to be inevitability about not achieving what he had set out to achieve in his earlier life:

"I suppose you have the optimism of youth, and your life is ahead of you, and there is so much time to build and do stuff, and then you are forty/fifty and you realise I haven't done this, and time is running out, and I don't have the energy... you are going 'shit my time is nearly over and I haven't done half of what I wanted to do". James, Farmer

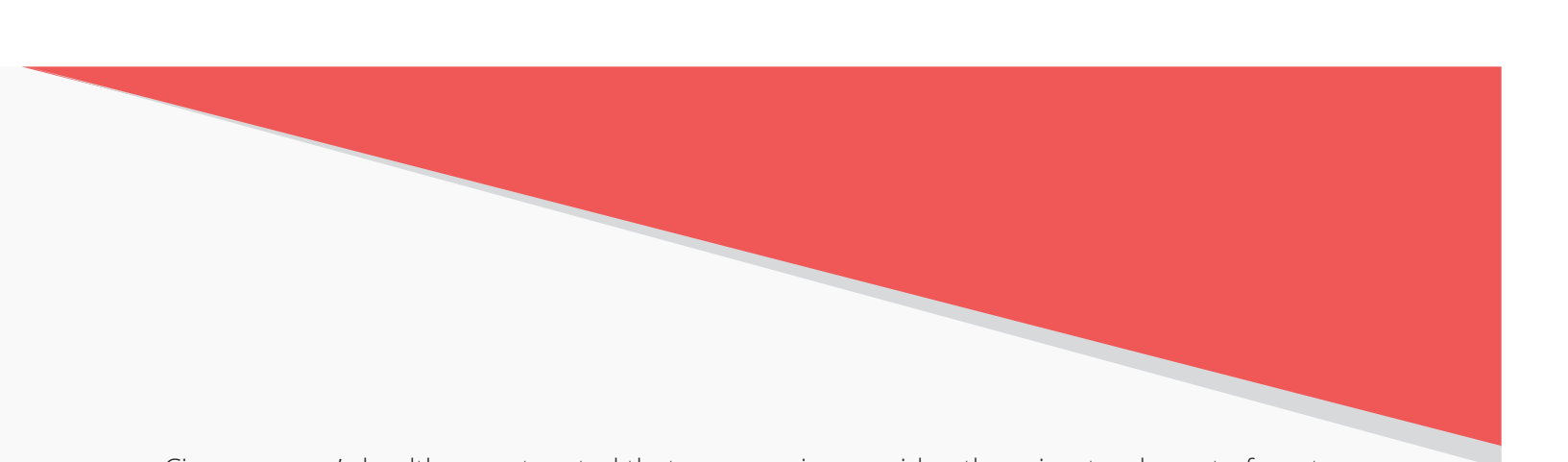
Dermot similarly postulates that middle-age forces men into confronting the harsh realities of unfulfilled hopes and aspirations; a recalibration of optimism versus realism:

"Plans you would have had in the future, you are in that future, and it hasn't happened the way you expected... in your twenties and thirties your possibilities are endless... because possibilities give hope... there is hope for change... But now I am more realistic that, more likely, I am not going to have the family, it has dampened the hope. Possibilities, opportunities you are aware that they are less accessible to you". Dermot, Gay Man

Cumulative and Multiplicative Effect of Psychological Distress

All participants stressed that whilst all of the individual issues that caused middle-aged men psychological distress were notable in their own right, it was the cumulative or multiplicative effect that frequently served as "the nail in the coffin" (Simon). This was also seen as eroding or impairing middle-age men's resistance to dealing with new problems. Simon articulates the devastating and cumulative impact that the death of a parent, unemployment and a relationship breakdown had on his mental health - which led to him having suicidal thoughts:

"When you are down you feel like somebody is putting you down even further. Another nail coming into the coffin... You have life changes going on, it is very hard to keep adapting. You are not busy, so it all keeps piling on top of you. That is when finding a reason to keep living becomes a problem. Nobody would really notice if you were gone anyway". Simon, Divorced Father



Ciaran, a men's health expert, noted that, as a service provider, there is a tendency to forget or overlook the fact that several of these issues can be happening in tandem for middle-aged men. When the men discussed this cascading effect of psychological distress, many used verbs such as 'slipping', 'sliding' or 'spiralling' into depression and alluded to a sense of losing control:

"...you could become very unwell [mentally] without knowing how to stop the slide". Paul, Unemployed Man

"...how easy it is to slip into depression again". Fintan, Transgender Man

This, in conjunction with men's reticence about seeking support, often led to a point of crisis, with some believing that they were too ill to seek help themselves or were contemplating suicide. It is important to consider how middle-aged men who experience high levels of social isolation, or who have a poor support network, might potentially find a way to navigate mental health support if they feel they are too low to access it on their own.

Pia, a psychotherapist, felt that men's lack of awareness or denial of what triggers their psychological distress, coupled with poor self-care practices, were major contributing factors to this 'sliding' effect. Many service providers commented on the speed at which middle-aged men could spiral into severe psychological distress. Adrian, a statutory mental health service provider, notes the difficulty for anyone to adequately cope with multiple sources of stress:

"Your threshold to deal with something like that, I imagine very few people would have that ability. It is only a matter of weeks until you start receiving letters on top of missed direct debits on car insurance, life insurance null and void, home insurance null and void... meanwhile you are still dealing with the shock of losing your job". Adrian, Statutory Mental Health Services

Andrew describes the pace at which middle-aged men can progress or 'slip' into psychological distress, and he suggests that government agencies reinforce feelings of worthlessness and hopelessness:

"We hear men coming out of the [government agency] saying well it was the tone they used with me. I know they are looking at me as if I am nothing... so now I am a man who was employed, was providing for my family... and now I feel like I am at the absolute bottom of the heap... so there is that experience of a service that is there to support them [middle-aged men] is actually feeding into the issue [psychological distress]". Andrew, Men's Health Expert

It is worth considering what intervention points are possible for support services and service providers to stem this cascading or 'sliding' effect of psychological distress for middle-aged men.

4.1.2 Societal Challenges to Middle-Aged Masculinity

Throughout the past number of decades, Ireland has undergone huge economic growth and subsequent economic recession. Whilst this, and the pace of societal change more generally, has thrown up challenges for all, the findings from this study suggest that these changes have posed particular challenges for middle-aged men. Other societal challenges, such as the changing role of men, temporary employment contracts, multiple career paths, the decline in the influence of the Church, and the demise of rural communities have resulted in middle-aged men, in particular, feeling somewhat left behind in society:

"Life has moved at a very fast rate and you feel left behind". Fred, Farmer

Some men found it increasingly difficult to adapt to change with age due to, as Alan describes, becoming more 'set in his ways':

"I think, myself, that the only constant in life is change and as you get older it's more difficult to change because you get set in your ways and it's more difficult to see a different way of doing something". Alan, Rural Isolated Man

This difficulty in adapting to change amplified the stress associated with societal challenges and compounded middle-aged men's psychological distress.

'The Recession' - Pensions, Homelessness and the Death of the Rural Community

The economic recession was commonly cited throughout the transcripts as a primary factor which contributed to the high suicide rate among middle-aged men. Indeed, Pia, a mental health organisation service provider, feels that the economic recession brought middle-aged men to their knees:

"...the recession was so bad that there were so many fatalities from suicide - the recession really pushed men to their knees". Pia, Mental Health Organisation

Turbulent financial markets, and the impact on pensions in particular, were cited as a major cause of psychological stress for middle-aged men. Service providers highlighted what they saw as the common practice by employers of 'robbing' employees of their pensions, leaving them and their families financially insecure:

"...pensions have been absolutely devastated. There has been robbery around pensions... [organisations] running away with pensions and so on. So there is a huge fear among middle-aged men that you are heading into a life of nothing, of poverty... you are thinking there is going to be nothing left for us or the inheritance of our children".

Andrew, Men's Health Expert

Economic recession also resulted in increasing numbers of middle-aged men being unable to meet mortgage payments, with homelessness, as Nathaniel describes, being an ever-looming threat in Ireland over the past few years:

"Now we see the problem of people losing their houses. People have been paying their mortgages for fifteen years and now they have nothing". Nathaniel, General Practitioner

The impact of recession was seen as being more pronounced in rural Ireland. Some farmers and rural isolated men felt that their communities had simply been 'left behind' and forgotten about, and had fallen further and further behind the economy of the country's capital. Vacant units and the closure of businesses in rural Ireland were highlighted as visible scars of recession and as embodying the dearth of opportunities in these areas:

"...it always seems that we (West of Ireland) get left behind. It just gets accelerated with this recession. Dublin has picked up and has moved on, but there is nothing happening down here... It always seems every time something happens the West seems to get left further behind".

Mike, Rural Isolated Man

Beyond the pub, rural men felt that sporting events and the church were the only remaining social fabrics within their communities. However, these men also identified what they felt was a fall-off in religious practices in recent decades, which was seen as another blow to the social connection within their community. This epitomised the decline of more routine, casual interactions in rural communities - such as with neighbours after Church gatherings - and were seen as starving community members of human contact and being at the core of a more insidious and toxic source of isolation.

Changing Role of Men

Many middle-aged men reflected upon feeling caught in a time-warp - clinging on to more traditional masculine and patriarchal values embodied in the breadwinner role whilst, simultaneously, feeling that their sense of place in society had been disrupted and displaced – and this, at a time, when the key pillars of church and state within Irish society were unravelling around them. Alan, a rural isolated man, articulates this point, noting that he felt caught between two vastly different generations:

"We're the last generation before the huge big change out there. What our fathers and grandfathers would have done, we would have done, but now our children are brought into a different world... Sometimes you look and think am I part of this world or that one?" Alan, Rural Isolated Man

The changing role of men - or the "erosion of the male model" as Aaron, a statutory mental health service provider, put it - along with the changing labour market (industrial to consumer based industries), were cited as key contributory factors to some middle-aged men feeling undermined, useless, and suffering a loss of role. Aaron laments the loss of this patriarchal dividend and attributes the associated loss of control, power and identity to many of this age cohort of men "feeling pretty worthless":

"There has been the erosion of the 'male model' over the years where previously the guys would go out and make the money and do the manual labour type jobs, but that is not the case anymore. Their [middle-aged men] role has been much affected in these past few years which can leave fellas feeling pretty worthless... being in charge, and those things that were prevalent in the past, that is not that case anymore". Aaron, Statutory Mental Health Service Provider

Indeed, some men reported similar difficulties with their changing role within the household. Leonard's reflections on men no longer being the sole breadwinner, seems to present similar challenges in terms of an erosion or loss of role or identity:

"...men were usually the breadwinners in our generation... now most women are working and sometimes I think a lot of men feel that they have lost their way or that they are not needed as much as they used to be". Leonard, Rural Isolated Man

The changing role of men was a significant source of psychological distress for non-Irish national men who felt that their role as a man was displaced in Irish society. They perceived that men have no relevance in Irish society and, in a sense, have been rendered useless:

"I am not saying that the women should be put down but, in our culture, the man is the authority of the household. It is the role of the man to give advice and guidance - to be the provider. But it seems like the narrative is skewed against the man here and that we are no longer relevant". Saud, Non-Irish National Man

BIOGRAPHY 3

Niall, a Farmer: “You have to make a conscious effort to stay connected”

As you approach middle-age you start to feel that you haven't succeeded or achieved enough - you are thinking, shit, my time is nearly over and I haven't done half of what I wanted. Your health starts to deteriorate and you are not able to do as much as you used to, which affects men because we wrap most of our identity and self-worth around our work. I spent years building up my farm; often not spending much time with my family. Only lately did I realise that my sons or daughters had no interest in taking on the farm which was hard to take. As men, we are good at internalising it all. We would see that as a failure - we haven't made it attractive enough for the next person - but that is not the way it is.

Isolation is a major problem for us farmers. You can become isolated quite quickly in our environment. There is a lot of work to be done on the farm, so there is always an excuse not to go anywhere. The phone stops ringing very quickly though, and people stop asking for you.

There is the whole death of the rural community as well. It's not just the pubs, it's shops, schools, sports clubs. It's less and less people which means if you are left, there are less social interactions. But you have to make a conscious effort to stay connected through family, friends, men's groups or even farmers' groups to have the bit of banter. The camaraderie of that, you feel a sense of belonging, that you are involved and wanted. You need to keep a good work-life balance as well, and realise that work is only so much of the week.

The mindfulness course our farmers' group did was huge for me. You don't necessarily have to practice it, but you are aware of it - the breathing and relaxing. It is there in the back of your mind during busy or stressful times, which sets your mind at ease. It gives me the confidence and contentment to run my business during stressful times.

I also did SafeTalk - a suicide prevention training - with my farmers' group, which has made me feel a lot more comfortable offering help to lads who might be a bit down. I am now a bit better at noticing the signs, having a chat with them, and moving them on in the right direction. I was talking to a man yesterday who went through a bad separation. About nine months ago, I sat down with him one day for about five minutes and, from that, he decided he was going to get help and he is in a lot better place now.

My perception of mental health changed completely since I did those couple of mental health training days. The more you learn about mental health, the more you realise you need to look after it - it's not something you can take for granted.

BIOGRAPHY 4

Conor, a Gay Man: “We have marriage equality, but we don’t have equality”

When you get to middle-age there is a sense you should be growing up. When I was younger, I thought my possibilities were endless - hope for the family, the car, the house, but now I’m realising that might not happen. You had plans for the future, but things didn’t unfold the way you expected.

I had very negative experiences growing up as a gay man. Being gay wasn’t legal until 1994 so, when I was thinking of who I was, it was illegal, wrong and bad, and you could be arrested for it. I remember feeling that I would die with this secret; never able to talk about it. Everything just becomes kind of split which, I think, doesn’t really leave you. There is always this side to you where you are going okay, don’t say that or mention this.

When you hit middle-age then it all becomes a bit jaded. You have spent many years dealing with people being uncomfortable around you - ‘oh you are gay, I have friends who are gay’ - those little shitty things.

We have marriage equality, but we don’t have equality. There is a sense of shame coming from society; a negative feedback around being gay. As you are growing up and starting to question your sexuality, you have already internalised all this negativity - this kind of internalised homophobia. So, by the time you are middle-aged, you could have been carrying around this negative perception of yourself for twenty-five years. We are named ‘the gay community’ and it is bullshit - because it assumes that gay men are a homogenous group and we are not.

I find that staying connected to friends and family is really supportive for my mental health. Joining a social group, having a job and hobbies you enjoy, all of these things give you a sense of belonging and a sense of being needed. You need to build these supports when you are well, because you won’t know how to access them when you are not. You can’t drag men to things either. Just having it there and knowing it can be used is important.

We need to let men know step-by-step that they are worth something more; that they have a right to set a goal, a right to love their life and themselves. Then men will start to look for more and ask for more.

We, as men in general, have this super odd notion that a hyper-masculine man is the ideal man in Ireland. Most men don’t fit into that, never mind gay men. So, it is about figuring out how all men can have the permission to be the man they are, without having to be the man that others expect them to be.

I think we need to encourage more talking and vulnerability in men and build on that. Most men wait until they are in crisis to get help. We have to start off really gently. It is okay to be vulnerable. It is okay to ask for help.

Expected Career Paths - 'Permanency is A Myth'

Both men and service providers reported that recent trends in employment contracts - away from the traditional model of 'a job for life' to temporary contracts - had particular implications for middle-aged men's mental health. Oscar reports that his generation of men grew up with the idea that gaining employment meant a job for life:

"I come from an era where people thought once you had a job, you had a job for life. Now it is generally beginning to be accepted that people are going to have to work longer and have two or three different career paths along the way". Oscar, Transgender Man

Many service providers believed that, in a society where multiple career paths and temporary contracts are now the norm, middle-aged men are finding it increasingly difficult to adapt. Adrian, a statutory mental health worker, feels "permanency is a myth" with regards to employment in today's society, and notes the vulnerability of middle-aged men undertaking temporary contracts during a period of their lives marked by increased responsibility and financial pressure:

"...he has just entered a twelve month renewable contract. If you are not used to that, it is a vulnerable place to be when you have mouths to feed, mortgages to pay, kids to put through college... permanency is a myth". Adrian, Statutory Mental Health Service Provider

The increased fluidity and transience of career paths was also cited as a particular cause of psychological stress in the context of middle-aged men's identity being tied up in their employment. The men's perceived difficulty in adapting to change was seen as having particularly significant implications for unemployed middle-aged men who faced the challenge of changing careers and retraining:

"It is daunting at my age to go back and start to learn a new process or go back to education".
Oscar, Transgender Man

Indeed, Adrian, postulated that this relationship between identity and employment resulted in men being more inflexible and less open to new career opportunities, and holding out for job opportunities within their field - even in the face of dwindling employment opportunities. For those men who worked in the industries most affected by recession (e.g. construction), this left them in a particularly vulnerable position. Shauna, a statutory mental health service provider, notes the difficulty in retraining for some men due to their increased responsibilities at middle-age:

"...they have things that are dependent on them, so to stop and change altogether would require a complete change of income and I don't think there is a possibility to do that after a certain age". Shauna, Statutory Mental Health Service Provider

4.1.3 Subordinated Identities

In addition to the unique challenges faced by men at middle-age, and set against a backdrop of wider societal challenges, other aspects of identity such as race, ethnicity, employment status, sexual orientation, gender, and geographical location, were also highlighted as having significant implications for men's mental health.

This section examines how various societal structures were seen as actively discriminating against and stigmatising middle-aged men on different aspects of their identity. It also explores the impact and repercussions of this, particularly in terms of middle-aged men's withdrawal from societal structures due to negative experiences, rejection, or mental health difficulties.

Finally, this section explores various pathways through which middle-aged men become isolated. The consequences of feeling on the margins of society - in terms of isolation, rejection and withdrawal - interlink and impact one another, and ultimately result in more vulnerable groups of middle-aged men, in particular, feeling abandoned and powerless.

Rejection - "We're Put Down as the Lowest of the Low"

Men's experiences of rejection from the social fabric of society, and societal structures more generally, manifested in terms of discrimination and stigma directed at different aspects of their identity such as sexual orientation, ethnicity, race, or gender. Indeed, rejection was a particularly pertinent issue for gay men, Traveller men, non-Irish national men, and transgender men. However, men who experienced mental health difficulties, unemployment and relationship breakdown, also reported a sense of rejection. This left many feeling unwanted by society, isolated and lonely, and had drastic implications for their sense of belonging and self-esteem. Patrick discusses how this discrimination resulted in him feeling depressed or, as he put it, in a "dark place":

"When I go home I'm in this dark place. I'm being discriminated against. I'm Irish. There are no one more Irish than the Travellers and still we're put down as the lowest of the low".

Patrick, Traveller Man

Traveller men were particularly vocal about their experiences of discrimination and rejection from society. These men discussed being regularly refused admission to local premises (particularly pubs) and institutions, which elicited feelings of frustration, shame and depression. This situation was compounded when old school friends from the non-Travelling community witnessed this. Traveller men also reported being refused the right to hire venues for social events, such as weddings, on the grounds of their ethnicity. This was a source of particular stress for Traveller men, for whom failure to provide was a significant source of perceived failure, and was compounded by the importance of the marriage celebration in Traveller culture. Joe describes his sense of hopelessness and despair that this insidious and constant experience of discrimination causes, and the detrimental impact it has on his confidence, self-esteem and overall self-efficacy:

"...walk into a pub, order a drink, you have six lads in the corner, settled lads from the community and you get refused. You feel that small, you feel like scum... I've no real confidence in life, there's nothing really out there for me. There's no one really turning around and saying 'he's human, he's Irish'... I want to work. I want to get on with everyone. I want to be able to get my daughter married and get my son married, go into the local, go down to the football field".

Joe, Traveller Man

These Traveller men also discussed being called derogatory names and the sense of hatred and shame they felt when called 'ye people'. Indeed, this kind of language epitomised the extent to which discrimination towards the Traveller community was perceived to be ingrained in Irish culture and passed from generation to generation. Gay men and transgender men reported similar experiences of rejection from their community. Frank, a transgender man, described being rejected from his own family, which forced him to move to a different area and resulted in him experiencing significant psychological distress:

"You are forced to leave the people that you have loved all your life as your siblings, and it is hurtful in a way that they cannot or don't want to continue offering the same thing that they have offered you all of your life up until now". Frank, Transgender Man

Dermot and Josh, gay men, also reflected on what they experienced as blatant rejection, and even physical violence, by not being 'the norm'. They also reflected on the more insidious comments that reinforce this feeling of 'other'. Dermot described the frequent patronising comments of others saying that 'they too have gay friends'. Other people's discomfort around them has a wear and tear effect on their psychological wellbeing:

"I am a single queer man in a heteronormative world with other men who identify as straight and the majority of them don't feel comfortable around you. It definitely has an impact".

Dermot, Gay Man

"There is an additional stress because you are not like everybody else... by the time you hit middle-age it is just a bit jaded. You have gone through this for twenty-five years and you are going - am I still having to deal with... this uncomfortableness". Josh, Gay Man

Rejection from employment opportunities was a particular issue for Traveller men and transgender men. Traveller men described their sense of hopelessness with ever attaining employment, and felt that potential employers dismissed them as candidates for jobs once they found out their ethnicity. Fintan, a transgender man, described his difficulty finding work despite being suitably qualified due to his erratic and broken work history that was associated with being a transgender man. He described the very practical difficulty of getting an employment reference, as his previous employers knew him as a different person. Upon taking up a voluntary position, he feels frustrated and undermined by not being allowed to work face-to-face with customers, which further stigmatises and alienates his identity and results in a loss of confidence and self-esteem:

“They think they are doing you a favour by giving you voluntary work, but they won’t let you work face-to-face with people”. Fintan, Transgender Man

Men who suffered from depression also discussed feeling that their future career path or employment potential could be undermined due to their mental health difficulties. These men felt that they could not tell future potential employers the truth about their mental health difficulties as they would be ‘found out’. Indeed, this was particularly true for men in the Defence Forces, where it was felt that ‘admitting’ mental health difficulties and/or suicidal thoughts inevitably had negative implications for that person’s career, as Ruan describes:

“Anyone suffering mental health difficulties in the Defence Forces has to enter a biomedical model... which policy states that a person has to be taken out of the barracks and put on sick leave until such time as they see a psychiatrist. They will automatically be medically downgraded, which has an impact on their career as they can’t apply for overseas or training until they are upgraded again, which may take a while”. Ruan, Defence Forces Service Provider

Men seeking employment who were rejected from employment opportunities reported overall feelings of worthlessness and hopelessness. It also appeared that some groups of middle-aged men internalised this rejection over time. This resulted in some of these men internalising feelings of shame or embarrassment about aspects of their own identity. Indeed, in the Traveller men focus group, the word ‘shame’ was mentioned sixteen times, whilst the word ‘embarrassment’ was mentioned nineteen times in relation to being a Traveller man:

“We were talking earlier about the embarrassment of Travellers. It’s the embarrassment of not wanting it known by people, seeing you doing what you’re doing”. Liam, Traveller Man

A community-based service provider who works with Traveller men also noted that this ‘identity crisis’ faced by Traveller men was a highly significant issue. Indeed, gay men also noted a similar sense of shame at an early age, by being constantly positioned as an ‘other’ category within a heteronormative society. In Dermot’s view, this may be a casual factor in the high suicide rates among gay men. Gay men described what they called ‘internalised homophobia’, wherein perceived negative messages from society in relation to homosexuality were internalised and

were the source of significant and chronic psychological distress:

"...you get negative feedback around being gay. So you grow up, and suddenly you start to question your sexuality, and think maybe I am gay, but you have already internalised all of that negativity... It is the most psychologically hard thing to get through". Josh, Gay Man

Dermot, also discussed exclusion within the gay community, noting that sometimes 'passing' for a straight man is preferable, and that more feminine gay men can be often rejected. Transgender men discussed an overwhelming sense of isolation and the 'hidden shame' associated with being transgender. Fintan, described the devastating impact the stigmatisation of transgender people had on his mental health, which drove him further into isolation and not wanting to 'deal' with his issue. Oscar also described this inner conflict he was experiencing as a transgender man, which was a huge source of guilt and depression for him. He described having his 'guard up' all of the time out of fear of being rejected. He also described his inner turmoil and conflicting emotions; feeling selfish for wanting to be open about his 'real' self, guilty for not telling others how he felt, and also ashamed for not being true to himself. This was a significant source of psychological distress for Oscar, as he notes that these emotions made him feel suicidal and further compounded the feeling that he was a burden on his family:

"At that stage I remember feeling like I can't go on like this and everybody would be better off without me being there... I knew I needed to allow the real me to be... I felt very selfish... I felt guilty all the time for thinking like that and that would make me depressed. Not having the courage to disclose exactly who I am made me even more depressed. I couldn't even be true to myself never mind being true to everybody else who saw me as a different person to who I really am inside". Oscar, Transgender Man

It is important to consider these internalised feelings of rejection within the context of the culture and generation in which these men grew up, particularly for gay men and transgender men. Gay men reflected on growing up in Ireland at a time in which homosexuality was illegal, while transgender men noted how, in a pre-internet era, they found it very difficult to access information or to understand how they were feeling. Thus, the context of the time in which these men grew up, had a significant bearing on the way they transitioned to adult gay or transgender men; not surprisingly with significant mental health implications for both groups. Overall, feeling on the margins, rejected and discriminated against resulted in these groups of middle-aged men experiencing significant and prolonged psychological distress.

Withdrawal - "It Makes You Feel Like You are Better Off on Your Own"

Withdrawal emerged in the data as a conscious or deliberate disengagement from societal structures - often as a result of negative experiences such as rejection or discrimination. Withdrawal appeared to be a coping mechanism for some men to avoid further negative experiences and stigmatisation. Joe, a Traveller man, notes that due to the embarrassment and shame he feels from constant rejection from societal structures such as pubs, shops, or employment, he has ceased trying to gain access, concluding that he feels like he is better off on his own:

"It makes you feel like you are better off on your own. It makes you want to be on your own".

Joe, Traveller Man

Similarly, men who experienced significant psychological distress and depression described their withdrawal from society. Liam, an unemployed man, describes his door 'growing horns' and his fear of going out in public due to his depression and anxiety:

"...I ended up becoming a recluse. The inside of the door used to grow horns - I didn't want to go out... I used to go out in a hoodie. I had the paranoia thing in case anyone would recognise me and think there was something wrong with me". Liam, Unemployed Man

This was also a significant factor for divorced fathers who explained how their relationship breakdown consumed their lives and how they began to lose interest in taking part in social activities. For Colin, however, he manages to find alternative coping mechanisms through education on mental health and becoming more self-aware in relation to the triggers for his psychological distress:

"I wouldn't hide it as much as I used to. I used to close off and say nothing to nobody. I think now I understand it is very important to speak out". Colin, Unemployed Man

Isolation - “It Feels Like the World is Going on Without You”

Isolation emerged from the transcripts of both the men and service providers as a primary cause of psychological distress among middle-aged men. Isolation was multi-faceted and was associated with a decline or lack of social outlets for middle-aged men, mental health difficulties, relationship breakdown, rejection from societal structures, and geographical isolation. Isolation for men was not just about a lack of contact with others but, more significantly, was frequently about feeling alone - even when surrounded by friends and family. This sense of loneliness was crippling for some men, particularly those who lived on their own. Paul described his isolation as feeling like “the world is going on without you”. Similarly, Liam refers to the dreadfulness of isolation, feeling abandoned by society and left to die:

“...that isolation is dreadful... Last December I didn't even have a Christmas tree up. I had nobody. My best friend became the booze... I didn't feel like I was on a pity party, I just didn't care. I felt like I was abandoned and left there to die”. Liam, Unemployed Man

Some service providers and middle-aged men felt that men have a propensity to become isolated at middle-age through a decrease in social opportunities and a lack of social outlets. Due to work commitments, responsibilities of fatherhood, and ageing more generally, men reported having lost connection with many friends and other social outlets. Whilst socialising through playing sports was seen as having diminished for most men by middle-age, volunteering in sport was noted as a valuable alternative. Dermot describes the narrowing of his circle of friends and how he finds it more difficult to connect with others as he grows older:

“...as you get older that circle [friends] narrows. It is harder to connect when you are older. I think you are more discerning of who you are connecting with”. Dermot, Gay Man

Indeed, some service providers felt that men, more than women, have a tendency to ‘disappear’ in middle-age. Men and service providers also reported a perceived lack of social outlets available for men and that men are fearful, shy and intimidated about joining a social group. The perception was, therefore, that men steer clear of organised groups and are less amenable or adaptable to forming or joining groups with other middle-aged men.

BIOGRAPHY 5

Kwame, a Non-Irish National Man: “It is one big culture shock”

In today's society, it's all pressure, pressure - we really don't have any time for fellowship, or to just sit and chat. With the middle-aged man, there are all these expectations associated with work, family and the social group you belong to. We set ourselves these expectations we think we need to fulfil or other people expect us to fulfil. If you do not reach these by a certain time, then you are nobody.

As **** [non-Irish National] men living in Ireland, it is one big culture shock. I am not saying that the women should be put down but, in our culture, the man is the authority of the household, to give advice, guidance and be the provider. But it seems like the narrative is skewed against the man here and we are no longer relevant. This affects the family and is a problem for many men in our community.

A lot of people from my community work in health care support. If a woman is the caregiver, she can attend to both sexes, but a man cannot attend the female sex. Even with child benefits, only the mother should fill out the form. Why? ...

Men of our community feel disenfranchised. When it comes to applying for a job, even though you are qualified, because of where you come from you are not going to get it. You are kind of rendered useless. The carpet has been pulled from under our feet. We want to contribute, but feel that we can't. Our community has also been forgotten about. They don't even know we are here. It is business as usual. When policies are being formulated, it is business as usual. It should not be business as usual. Ireland has changed. It happens at state level and local institutions. We are present, but not seen.

Faith is the resolute cushion for people of our community. Without it, the levels of suicide would be a lot higher in our community because that is our only release. Faith is the bedrock. What people of faith have is hope. Hope is that there is something bigger and greater than the self. That is so important in the culture that we live in now; a culture in which we are consumed by ourselves.

When you have faith, it is a lot easier for you to withstand suffering, because you know suffering does not have the last word. I am not talking whether scientifically this is right, but it helps with the way a man carries himself in life. When you pray it creates a space for you to reflect - what is happening to you, what is happening around you - and in the creation of that space you are being mindful of yourself. Some people call this mindfulness. Finally, faith gives you a community and all of you together form a supportive network which gives you strength for the week ahead.

BIOGRAPHY 6

Johnny, a Rural Isolated Man: “It feels like you are forgotten about sometimes”

I lost my job during the recession. I was in the building trade and I never found a way back into it. I kept trying to look for a job, asking around, sending out CVs, but all that constant rejection makes you feel a bit worthless.

At my age, I feel like I should have accomplished things in life - have my track made. But instead of getting comfortable in life, I feel like things are going the opposite way. It's hard to tell people this kind of stuff though. It's a male thing. Be strong, man up, don't let on that you might need help.

It feels like the west of Ireland keeps falling further and further behind. There are vacant units everywhere, and that affects the mind, you know. There needs to be something to instil a bit of life into the small villages, to bring a bit of hope and sustainability. It feels like you are forgotten about sometimes.

A lot of men around here live on their own. I think they know no other way of life. The pub was the only social outlet for loads of men but now, with the drink driving laws, that has stopped. I am not saying that you should drink and drive, but that was the only social outlet for a lot of men. Social isolation is a huge problem around here. It affects the mind, but I think it can be daunting for them to join a group.

I think a lot of the lads around here would never have been involved in any groups or even been in a room together as a group of men outside of sports or the pub. It can all make you depressed, and you don't want to meet people. You don't want to go out. You wouldn't even go for a walk down the road in case you would run into a neighbour. You go into your shell. I find it hard to know where to go when I am feeling like that and no matter what way I look at it, there is a bit of shame and it hurts my pride when I get into trouble like that.

But then [Men's Group] started up in our community, it made me a little bit more involved and brought me out of my shell. I think men can associate with a [Men's Group]. It's kind of a safe place. It's a new way to develop yourself - learn new skills. I am making new friends all the time without realising it. It's a place where I can do things and leave things. That is the general idea of it, to get men to socialise and talk to each other.

We do lots of activities; cooking classes, basket weaving, suicide prevention training. It is all suggested by us which gives us that bit of ownership over it. We have connected in with Tidy Towns, ETBs, the HSE and the County Council. That's what we are about; building ourselves up and building the community up as well.

Change is hard but you have to keep knocking on that door, keep trying and adapting. That's what groups like this are for, so men can come together and support each other to make that change. It might not work all the time, but at least you are trying.

Christopher recounts his experience of trying to get his neighbour to join a social group, but he was overcome by fear:

"I know one fella that was supposed to come to the Shed, and he actually came one night and drove away again and I've been trying to get him to come since, but I think it's just this fear and he knows himself, he said: 'I need to get out of the house' and he said one day... he said: 'there's a fella down the road and he's got social isolation disease so I'm afraid I might get it'. They were talking about it on the radio and he thought social isolation was some sort of flu or something like that". Christopher, Rural Isolated Man

Having recognised loneliness as a key issue for middle-aged men in his locality, Con, General Practitioner, noted the dearth of appropriate service options available to him to which he could potentially refer these men. Shauna, a statutory mental health service provider also expressed her worry for these men who often go unnoticed or 'fall between the cracks'.

This disconnection and lack of support networks associated with isolation were issues for middle-aged men navigating difficult transition points or stressful life events. This was particularly evident among men who experienced a relationship breakdown, as the primary source of their psychological distress was also their primary support network. In describing his break-up, Simon, a divorced father, referred to his sense of complete isolation - which also coincided with the loss of his job and noted that family and friends often avoided him so they would not appear to be taking sides. He describes the importance of social interaction at such times which, in its absence, led him to question the point of his existence:

"Complete isolation. Your marriage breaks down, your relationship breaks down, your kids no longer need you, you haven't got a job to go to - it's kind of what is there?... Even some of my own brothers and sisters go one way or the other and they don't want to get caught so they don't talk at all... You need social interaction with other people, and when you don't have that that makes you start to think what is the point of being here?" Simon, Divorced Father

Even among middle-aged men with support networks, many described feeling isolated when they experienced mental health difficulties or stressful events due to a perceived pressure to adhere to certain masculine norms like stoicism and self-reliance. Men also reported avoidance in sharing these worries or issues out of fear of burdening those around them and because of a perceived stigma that surrounds mental health. Indeed, suffering in silence from mental health difficulties, or 'bottling it up' as some men called it, further reinforced feelings of isolation and loneliness.

Geographical isolation was another contributing factor to psychological distress which impacted those middle-aged men living in rural communities. The paucity of social outlets, the lack of access to support groups and fewer employment opportunities were all pertinent issues for these men. It was reported by some men that there was a mass migration of rural community members to urban localities and further afield due to the economic recession. Although young people were seen as more likely to migrate, this, as Joe stated, also impacted the remaining community members by reducing social interactions. This transition to a more urbanised Irish society was seen as causing 'the death' of the whole rural community:

"There is the death of the whole rural community... That means if you are left there (rural Ireland) there are less social interactions. The community is gone real low. In this greater area, you have a false community of people who work in Dublin and live out here. They don't get involved in the community". James, Farmer

The closure of rural pubs, and the increased restrictions posed by drink driving laws, was also perceived to increase levels of isolation among middle-aged men in rural Ireland. Although these men agreed in principle with the new restrictions on drink driving, they highlighted how the pub was the only social outlet for many middle-aged men in their community and that there were no alternative means of socialising:

"I am not saying you should drink and drive, but there are a lot of farmers out there that that is their only social outlet. That is not happening now... The bit of slagging is not there anymore. So we are coming into a generation where the social outlet is going to have to change, but at the moment there is none - we are at a transition between no pubs and something else".

Fred, Farmer

Although the closure of pubs was perceived to impact men's mental health, some also felt that the consumption of alcohol at home in isolation equated to a maladaptive means of coping with psychological distress.

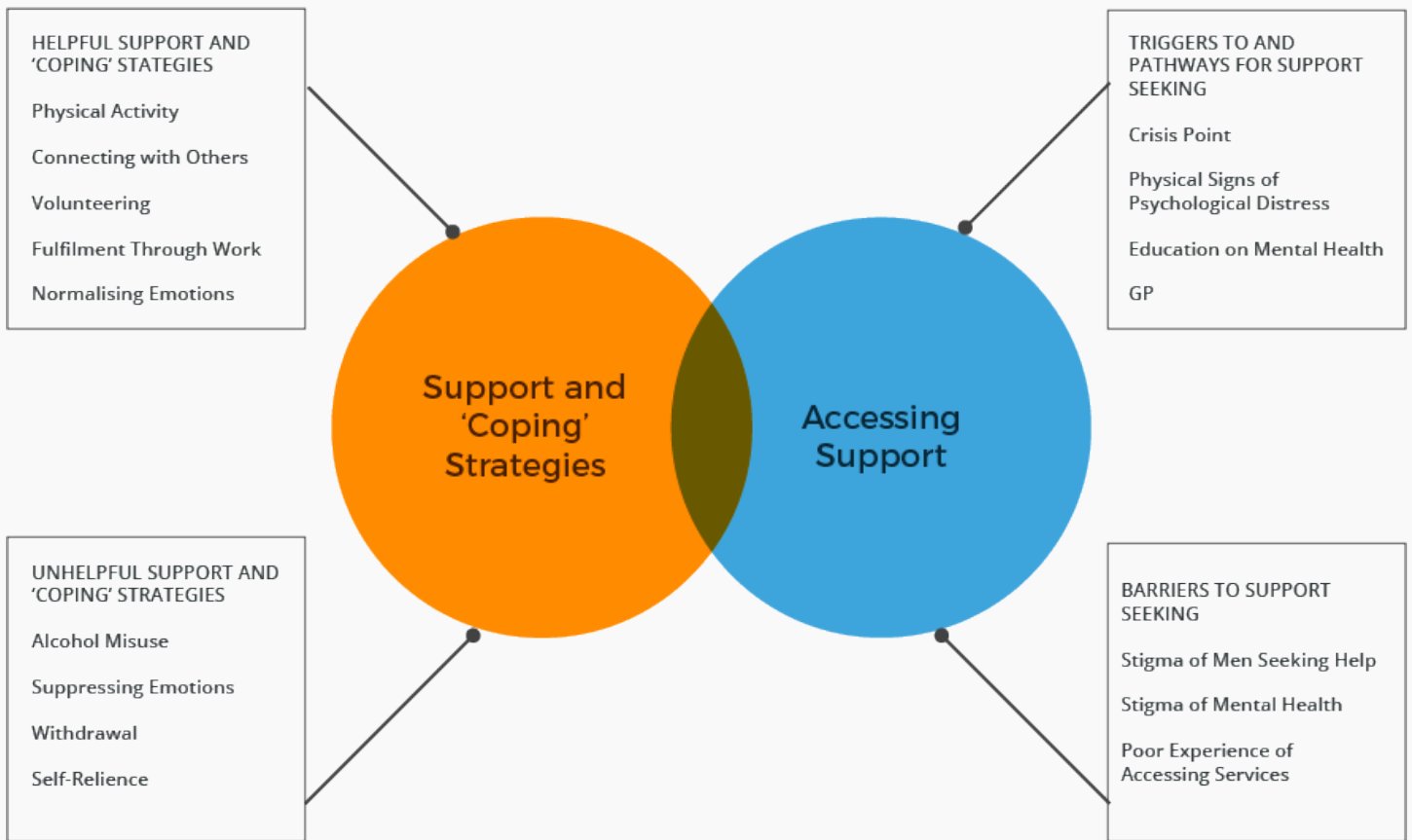
Rejection due to aspects of middle-aged men's identity and subsequent isolation was reported to be intensified among men living in a rural area. Dermot, a gay man, felt that the increased diversity that existed in urban areas increased the likelihood of finding people with mutual interests. Fintan, a transgender man living in a rural area, also reported that his primary source of support was a two hour drive from where he lived, which was particularly challenging during periods of psychological distress when he needed more immediate support.

4.2 Support Seeking and Coping Mechanisms

4.2.0 Introduction

The support seeking and coping mechanisms theme explores how men navigate and access support, or not, during times of psychological distress. Section 4.2.1 explores the barriers men face in accessing support which covers the stigma of mental health, the stigma of men seeking help, and poor experiences and accessibility of services. This section also looks at triggers to and pathways for support seeking as reported by the men. Section 4.2.2 examines supports to middle-aged men's mental health and men's use of adaptive/maladaptive 'coping' mechanisms during times of psychological distress. Figure 13 gives an overview of the theme support seeking and coping mechanisms.

Figure 13: Support Seeking and Coping Strategies



BIOGRAPHY 7

Kevin, a Transgender Man: “It felt like this inner conflict of who I really am”

When somebody goes into hospital with a broken leg they are never labelled an ex-orthopaedic patient, but when I went to a mental health hospital I was labelled for the rest of my life.

I still think I have that hangover effect of not feeling comfortable getting into a formal mental health process, but sometimes you reach a point where there is no other option. It's not like a stitch in time saves nine - you wait till the whole thing is ripped up to shreds before you ask for help. Why? Because you don't see too many men around you talking about these problems. Big boys don't cry. Man up. These are things you hear all of your life.

I have experienced real suicidal thoughts. I felt that as I was getting older I needed to allow the real me to be - which felt selfish - but not having the courage to disclose who I really am made it worse. It felt like this inner conflict of who am I really, and I was always on my guard in case I would let the mask slip.

I remember thinking: “I can't tell my GP, he sees my parents”. There were no leaflets or flyers in the surgery, and I didn't even know what the name of this was. How do you describe that you feel like a boy? I lived in a heightened state of fear - will my family accept the true me? Will they reject me? Will I lose my job if I change my identity? How would I be accepted and seen by other men? You hear people make remarks about it your whole life, and you get a sense of how people might react if you broach the subject. That drives you even further into not wanting to speak about it or deal with it, which had a devastating impact on my mental health.

I found the support of a great therapist, where I had time to build rapport and who understood what I was going through. I think sometimes there are some well-meaning professionals that don't really understand the identity issues and, at times, I felt like I was almost leading them.

I find great support attending [Transgender Support Group]. I know most of my friends will have experienced what I feel, and I can rely on them to be there for me. I think it would be easier for us transgender men to transition and become, not invisible in the sense that we disappear, but in terms of just being accepted as men.

I think mental health professionals have a tendency to say “oh, you are transgender and that explains everything”, but often it doesn't. We need to make sure that they realise we are whole people; we are not defined medically because we are transgender - we are middle-aged men. All transgender people want to be accepted for who we really are and to be involved in the community exactly the same as everyone else.

BIOGRAPHY 8

Cathal, a Traveller Man: “The daily discrimination I face puts me in this dark place”

Alcohol is my main problem; a substitute to make you feel good when you have nothing else to do. I'm forty-nine and I've never really had a full-time job, because there are no jobs for Travellers. I'm just so ashamed and embarrassed to go for jobs because I know I don't have a hope.

I don't feel like getting out of bed sometimes. What are you getting out for, to walk out to the gate and walk back in? A part of me feels like I am in an open prison. You're lying in bed, you go out and talk to the other lads, after an hour you're back in your cell again. I spent a bit of time in prison a few weeks ago. I handled stolen property - which I know was wrong - but it was something I did to provide for my family. What would you do? I have a wife that is sick and four kids. For the four years I was working on the CE scheme, I never committed one crime. I looked forward to it every morning. Out cutting the grass, fixing locks on the doors, it kept me occupied and I wasn't getting in trouble. I don't know why it only runs for two years and then it stops.

The daily discrimination I face puts me in this dark place. I get refused from my local pub and it makes me feel so small - like scum. Sometimes I feel like I am better off on my own. I've no real confidence in life. There's no one really turning around saying: "he's human, he's Irish".

I want to work. I want to get on with everyone. I want to be able to get my daughter married, go into the local, go down to the football field, look at Man United in the pub. You just never got the chance in life you feel that you deserve. Unemployment, poverty, discrimination - it all builds up inside. I feel embarrassed and ashamed. I just feel like I am no addition to life. This is what's putting middle-aged Travellers into depression - not being able to do what you want to do in life, go where you want, socialise, provide for your family. You can't do it.

I have depression, but I got the help I needed through [Traveller Support Agency] and they referred me on to a psychiatrist. I go to see him every six months and I am on medication for my depression. There is help out there for Travellers, but we need to get them into a room to talk about these issues.

There needs to be some sort of doctor that could talk to us, who would have dealt with Travellers before, and get us to open up that little bit more. It will take them a while and some of the men might break down and cry, but that is normal. Sure that is the first step to recovery isn't it? Because you're talking about it? There's no point in hiding it. Middle-aged men think that there's shame; there's a stigma around mental health, but there shouldn't be. Open up lads. It's time to talk.

4.2.1 Moving Beyond Stigma: Negotiating Pathways to Seeking Support

The Stigma Attached to Mental Health and to Men Seeking Support

Both service providers and men perceived that there is a stigma associated with mental health and psychological distress which, they believed, posed a major barrier to men seeking support. Although reference to stigma cropped up regularly throughout the data, there was little evidence of the cause of this. Adrian, a statutory men's health service provider, suggested that this was rooted in the historical association between mental health and psychiatry, which equated mental health with mental illness. Indeed, Colin, an unemployed man, noted that he did not access counselling following the death of his wife as he thought only 'mad' people accessed counselling services. Oscar, a past mental health service user, reports how this stigma has impeded him from accessing services in the future:

"...the tag mental health patient or mentally ill patient follows you for the rest of your life. There is always that doubt in your mind - 'do they think I am still mad?' I still think I have that hangover of I am not that comfortable with getting into a formal mental health process, and if I can sort it out myself first I would do that". Oscar, Transgender Man

This stigma surrounding mental health typically elicited feelings of shame and embarrassment for men who were experiencing psychological distress; frequently impeding them from sharing this with family or friends. Shauna, a statutory mental health service provider, reported the very real fear for many men of running into peers in the waiting room of mental health services, and how this acted as a deterrent for many from accessing mental health services. Furthermore, many men who experienced psychological distress reported not confiding in family and close relatives due to a perceived feeling of burdensomeness, as Paul articulates:

"A burden, there is a word I would use. You are just a burden on everyone. You really are, your family, your friends - everyone". Paul, Unemployed Man

Larry, a men's health expert, believed that the medicalisation of the word 'depression' has diverted attention away from the essence of depression which, he argues, is a perfectly normal response to human sadness. This, he feels, often stands in the way of men adequately processing their emotions, thus serving as an additional barrier to coping with mental health difficulties:

"Depression belongs to the world of medicine at this stage... it is mostly sadness, not depression or clinical badness... I think there are a lot of reasons for middle-aged men to be sad in Ireland, and I think it would be a great starting point if we were honest enough to honour that and say it is not psychotic, your human sadness is actually telling you something that is one of the most fundamental things in life - there are things to be sad about". Larry, Men's Health Expert

Many felt that men are conditioned from a young age to be responsible, invulnerable, stoic and self-reliant which, they argued, significantly impedes men in later life from seeking support during times of psychological distress. Phrases such as 'man up', 'get on with it', 'big boys don't cry' and 'stop being soft' were regularly cited as the type of language that exemplified and shaped these masculine ideologies – innocuous, but impactful none the less, as James describes:

"I suppose there is a conditioning growing up, shut up or put up, get on with it, stop being soft... We all perpetuate it in small little ways. You never tell your kids don't talk about your feelings, but how many times do we pick them up, dust them off, and tell them they are grand get on with it". James, Farmer

On the other hand, psychological distress was perceived by many as a weakness and as representing a loss of control, whilst support seeking equated to an acknowledgement of vulnerability. In contravening more traditional masculine ideologies, the state of feeling vulnerable and the act of seeking help during times of psychological distress, were associated with shame and embarrassment for some. A more palatable alternative was to suppress emotions and to avoid seeking support; a 'choice' which, for some, led to problems spiralling to a crisis point and where contemplation of suicide entered their consciousness (see section 'Triggers to and Pathways for Support').

Peter, a rural isolated man, describes how accessing support causes men to feel ashamed and is impactful on their sense of pride:

"It's men not wanting to go because no matter how you look at it, there is a bit of shame to it, and a bit of pride, and if you get into trouble [psychological distress] you think I must be odd or there is something wrong with me". Peter, Rural Isolated Man

However, it is important to note that men did not easily accept or reject these masculine ideologies, but constantly grappled with and managed them in relation to mental health. Patrick, a Traveller man, felt the phrase 'men don't cry' misrepresented how men really are and reported his own difficulties in living up to masculine stereotypes. Similarly, Colin feels that a lot of masculine stereotypes are not representative of all men, and that men do open up and discuss mental health when given permission to do so and are educated on the topic:

"I have been involved in a lot of men's groups and they say men don't talk - in my experience men have no problem talking, no problem whatsoever. I think a lot of these stereotypes are not true... yeah there are a lot of lads out there that say I am not going to counselling, but that could be the way you are brought up, your parents, father, friends... I don't think you can generalise it and say men don't talk... Education is huge obviously, making people aware". Colin, Unemployed Man

Poor Experiences of and Difficulties with Accessing Services

Other barriers for men seeking support during times of psychological distress related to previous negative experiences of services and a perception of difficulties with accessing services. Some past users of mental health services reported feeling misunderstood by the service or not supported adequately which, subsequently, led to a loss of trust in the service and a lack of confidence in using that service in the future. This was particularly true for transgender men. Although service providers were, in Frank's experience, 'well meaning', he felt they had a lack of awareness and understanding of gender issues to support transgender people, which further reinforced his sense of a marginalised identity. He described being 'jumped about' between health professionals and between services which made it difficult for him to build a rapport with

providers and acted as a barrier to him being understood with regard to gender issues.

A few men who attended A&E following a suicide attempt also described poor experiences of health services. Liam reflects on his mistreatment in A&E following a suicide attempt as wholly insensitive and shambolic - an experience that prompted him to leave the service without being treated, despite being in such a distressed state:

“I was brought into a hall and there was people lying both sides of me on trollies... This was in A&E and he [doctor] was saying this chap tried to commit suicide... People were looking at me... Your one [nurse] came out then and said I was fine and to go back out to the waiting room... I sat there for about an hour and I just kept saying to myself, ‘it’ll be okay, someone will come and get you’... I just got up then and pulled a legger [ran away]. No humanity in it at all, no sensitivity... basically stripping the pedigree out of you in front of people... There was a little office across from me. They could have brought me in there for a chat”. Liam, Unemployed Man

Indeed, similar concerns about A&E were raised by service providers. Mental health organisation service provider Pia’s experience of engaging with middle-aged men was that they were generally reluctant to access A&E, even when at a crisis point. She believes that in being constantly overstretched, frontline A&E staff have a negative and less compassionate attitude to self-harm which, she argued, may be a possible reason for some men’s negative experience of A&E:

“There is a reluctance to step forward because you don’t believe you will get the help. Look at A&E for god’s sake, people who present having attempted suicide are treated with so little respect... I know one particular case where he was in A&E to get stitched and, because it was a self-harm piece, he wasn’t given anaesthetic when he was being stitched. Particularly in hospitals where nurses and doctors haven’t got the patience or the time... perhaps because their workload is so full on they haven’t got the time... they usually wait in A&E because they are seen by a psychiatrist which might take ten hours and they deem them safe to leave or not safe... with a follow up appointment in six weeks’ time”. Pia, Mental Health Organisation Service Provider

Indeed, the reality of overstretched primary care and statutory mental health services was found to be a major barrier for middle-aged men accessing support during times of psychological distress. General Practitioners (GP) spoke about how some men don’t have the language or confidence to discuss their psychological distress and often present with exaggerated minor physical ailments. Indeed, men’s inexperience and infrequency of attending the GP,

more generally, was cited as a major barrier for men attending the GP when they experience psychological distress.

GPs described the importance of looking beyond these physical ailments with men and having time and patience to get to the root of the problem and discuss mental health. However, due to the high number of patients, low contact time and lack of GPs, they also acknowledged the difficulty of finding the time to get to the root of the issue or, perhaps, missing symptoms which may deter men from seeking help in the future. Con, a GP, reflects on the hit-and-miss nature of getting to grips with mental health issues within the context of a busy Practice:

"...unless you are lucky enough to get to the heart of the issues quickly, they might feel like they are not being heard, or that they feel embarrassed about what they said and go back in their box... I would always make a point of engaging people I don't see often... but 10% of the time the place is going mental... If he had an emerging mental health issue, and I am running around, unless I have a moment of clarity or I pick up on something, it will be missed... If you had more doctors and resources obviously you would get to spend more time with them and get to the root of the problem". Con, GP

Service providers also felt that there was inadequate support for individuals who needed access to statutory mental health services. Many service providers and men spoke of the long waiting times to attend a psychiatrist, and the lack of additional support following psychiatric treatment such as counselling. Con, a GP, felt that access to psychologists and counsellors in a timely fashion was a significant problem in his locality which could take upwards of three months. Similarly, Aaron, a statutory mental health service provider and a psychiatrist, reports that the long waiting times for psychiatric treatment are morally wrong and can have disastrous implications, something he strives to avoid:

“I don't really have a waiting list for people in my clinic, because I think if there is a waiting list people get pissed off. I know in some parts of Dublin the waiting list for the psychiatric clinic is twenty two months. Nobody is going to wait that long to be seen. So even after twenty two months, people are either going to be better, dead or pissed off. It is not right that they should be waiting that long... if you are distressed, you need to be seen within a few days”. Aaron, Statutory Mental Health Service Provider

Indeed, Dom a divorced father, reported his friend ‘giving up’ on mental health services following these long waiting times, and was frustrated by the fact that psychiatrists only consult with people in their catchment area. He also raised the wider question of standards of care from non-statutory service providers. Based on his own negative experience of a ‘therapist’, he describes his loss of trust in ever accessing this therapy in the future:

*“I went to ****therapy and I found it a complete waste of time. At the beginning, I thought it was doing me some good, but then I realised that ****therapy was a very dodgy abused subject in Ireland... I am less likely to go for any ****therapy.... I was let down by that therapist. I think they were not qualified”.* Dom, Divorced Father

This was also perceived to be a problem by Barry, a psychotherapist and mental health organisation service provider. He felt that his own profession (psychotherapy) was not properly accredited or regulated in Ireland, which he felt undermined the profession and caused a stigma around accessing the service. Finally, it was believed by many service providers that GPs were not sufficiently aware of community-based services in their localities that could support men, and believed that GPs were too quick to prescribe medication for psychological distress. On the other hand, GPs felt that there was a dearth of adequate social supports for men who may be suffering from loneliness or isolation. Con, a GP, described feeling hamstrung in terms of any viable options beyond medication or counselling.

There appears to be disconnection and misunderstanding between services in the community, primary care and statutory mental health services on appropriate routes of referral for men. This is particularly problematic when we consider that men predominantly reported the GP as their first port of call when experiencing psychological distress.

Triggers and Pathways to Support Seeking

It should be noted that although many men reported having, in the past, experienced psychological distress or mental health issues, many also reported not having sought help or support. However, men who sought support discussed certain triggers or pathways for doing so. Somewhat alarmingly, the most commonly reported trigger to seeking support was having reached a crisis point. This crisis point was often reflected in the language used (with phrases such as 'end of the line', 'end of your tether', 'ripped to shreds' and 'on your knees') and, more typically, reflected the accumulation of multiple causes of psychological distress. This also seemed to be compounded by a reticence to seek support (linked to stigma), a feeling of burdensomeness, and a propensity to wait until symptoms were 'bad enough' to seek support. This is articulated by Frank who notes that it wasn't until he reached a point of crisis that he sought help:

"You reach a point where there is no other option but to [access mental health service]. It is not like a stitch in time saves nine. You wait till the whole thing is nearly ripped up to shreds before you ask for help... Why? Just that belief that you should be able to handle this yourself. You don't see too many men around you talking about these problems". Frank, Transgender Man

Other men described the physical symptoms of psychological distress, such as a perceived increase in blood pressure, as a key trigger to seeking support. Many men also reported that the presence, encouragement and assistance of close family and friends were important pathways to seeking support. These informal supports were seen as a stepping stone or crutch for some men to move towards more professional supports during times of psychological crisis. Assistance with making or attending appointments and the sharing of similar experiences were simple examples cited by the men as things which helped them to overcome stigma and access support.

Finally, men who had undertaken an educational course on mental health reported that their newfound knowledge increased their likelihood of seeking support during psychological distress:

"I would certainly be more inclined to look for some help compared to years ago before we did some of this work [mental health education]... I think it is hard to recognise what stage you should go looking for help... should you be feeling like that, should you not, just recognising that". Fred, Farmer

These men also suggested that early intervention in schools was the key to instilling this mental health knowledge in men. However, to make an impact on middle-aged men, it was suggested that educational training on mental health should be incorporated into existing models of practice, such as social welfare or single farmer payments. Furthermore, the men reported that recent attention in the media about seeking support on mental health issues increased their awareness of the issues and their likelihood of seeking support should they feel the need to do so.

Many men who had not accessed support for psychological distress mentioned that their first port of call would be to attend the GP or to seek support from family and friends. However, this appeared to be problematic for some men, who reported stoicism and fear of being burdensome on their families as major barriers to help-seeking (see section 4.1.3). Overall, men felt that moving from individual support - such as family, friends, the GP or counsellor - to an organisation/group would be the best pathway for recovery during psychological distress.



4.2.2 Supports to Mental Health and Coping Mechanisms

Many men and service providers reported a range of different supports that keep men in a positive mental health state or help them 'cope' during times of psychological distress. However, they also reported that some such coping mechanisms can be contraindicated and can, in fact, compound their psychological distress. Some of the supports that were described were more structural and constant aspects of men's lives, such as fulfilment in employment, having a strong sense of connection to loved ones, and being aware of triggers for psychological distress. Others were more reactive to psychological distress, such as seeking support through friends and services, mindfulness activities, alcohol use or withdrawing or retreating into oneself.

Some men stressed the importance of maintaining connection and accessing social outlets. However, as discussed previously, a perceived lack of social outlets, and a decline in social opportunities at middle-age, posed significant challenges for some to maintain these connections. By staying socially connected, men reported a sense of belonging, a feeling of being wanted and a sense of validation. As Dermot describes:

"Connection gives you that sense of belonging. Being needed. You still need to feel valid as you get older". Dermot, Gay Man

Similarly, James, a farmer, noted that connection provided him with a support network to discuss issues during times of psychological distress and a feeling that somebody cared about him. However, Dermot makes a critically important point about the need to build and maintain these connections and supports whilst in a positive mental state - as it is much more difficult to do so during a time of psychological crisis:

"Using supports but building supports first of all when you are well... Unless you build them, you won't know how to use them when you are vulnerable". Dermot, Gay Man

Having a passion for and fulfilment from one's employment was also viewed as a key support for positive mental health among men. Having the ability to normalise emotions, and accept both

successes and failures for what they are, was seen as a critical skill for men to adequately cope during times of psychological distress. Oscar, a transgender man, described that by allowing himself to accept his emotions as normal responses to normal experiences, this helped him to cope during times of psychological distress. Similarly, Larry a men's health expert and a middle-aged man, describes his experience of normalising emotions and how it has supported him:


"I have been mentored into such a place myself where I felt that my life has been normalised, and even the things I thought were deficits or difficulties have been normalised, and I have been allowed to develop both a language and an opportunity to feel and express feelings appropriately in that context with other men... Just being able to normalise the sense of my own life has been really really helpful for me". Larry, Men's Health Expert

Larry reflected on the power of crying, and noted how this resulted in one feeling 'lighter' and 'ready to begin again' after working through the sources of sadness in one's life. However, he also adds that it is not simply enough to cry and feel sorry for oneself, but that there is also a need for men to be supported and mentored in a safe environment to work through and process these emotions:

"...that is the other thing for us as men, very often we need to be careful on addressing the challenges in our lives as we have never had a safe space to talk. So a group of guys can get stuck on the tale of woe unless you have a very good mentor, ancestor, leader to say okay, take out the stuff we need to process, move it, and get on and do a bit of something else, come again to it, and not be overwhelming ourselves all of the time". Larry, Men's Health Expert

Having opportunities to access organised groups was reported as a major source of support for middle-aged men during times of psychological distress. Some men reported that the solidarity they felt with others in these groups instilled in them a sense of connection and normalised how they felt about challenging issues that they might have been facing. Paul describes the normalising effect he feels from organised groups as opposed to more formal mental health services:

"You can sit all day and talk to a counsellor, it's brilliant, but when you are sitting down and you are chatting to people with similar issues it makes you feel normal. A lot of the time you don't feel normal". Paul, Unemployed Man



Traveller men reported having a sense of kinship in their community which supported their mental health, whilst transgender men described their membership of an organised gender identity group as a 'comfort blanket' where they felt supported and understood. These organised groups also acted as a medium for education around mental health and as support mechanisms for men during times of psychological distress. Men discussed the benefits of undertaking educational training on mindfulness, sleep, hygiene and suicide prevention, which made them feel more adequately able to cope with psychological distress:

"The mindfulness thing we did... the breathing in your daily life it is there in the back of your mind in busy or stressful times, you are aware of it". Ollie, Farmer

Finally, having faith and religious beliefs were perceived to be significant protective factors against suicide among non-Irish national men. Felix believed that faith gives people a sense of solidarity and support. He also likened religious beliefs to mindfulness:

"Faith is the resolute cushion for people of our community. Without it, the levels of suicide would be a lot higher in our community because that is our only release. Faith is the bedrock. What people of faith have is hope. When you have faith, it is a lot easier for you to withstand suffering. When you pray, it creates a space for you to reflect... some people call this mindfulness. Finally, faith gives you a community". Felix, Non-Irish National Man

Men from the men's mental health support group talked about the benefits of developing a plan to keep themselves in good mental health, particularly in terms of being able to identify and counteract triggers for psychological distress. Men and service providers also described the benefits of peer support for mental health for both help-giver and help-receiver. Other supports and coping mechanisms for men included physical activity for stress release and the benefits to one's sense of self-worth that was derived from volunteering. However, some men admitted that they rarely think about addressing their mental health unless they felt themselves entering a negative psychological state. This reactive approach to mental health is articulated by Paul:

"I don't think you have a plan to keep yourself in good mental health until you become unwell... I don't think you are going around every day of the week thinking too much about your mental health. You don't really realise much about mental health until you become sick".

Paul, Unemployed Man

In contrast to supports which facilitate positive mental health, many men reported engaging in 'coping' mechanisms which, in reality, compounded their psychological distress. This emerged in the data as 'unhelpful coping mechanisms' - the most common of which was alcohol misuse. This was particularly evident amongst Traveller men for whom, as Patrick explained, drinking alcohol was '95%' of his mental health difficulties. Anthony also notes that he often drank alcohol as a release from a 'dark place', but realises it is only a short term fix:

"Drink is a substitute to make you feel good. It's a drug that takes you out of the dark place for four or five hours. You wake up in the morning and [click fingers], you are back to square one".

Anthony, Traveller Man



BIOGRAPHY 9

Jack, an Unemployed Man: “On the scrapheap before my time”

My whole life revolved around horse racing - I was a jockey. I used to go a million miles an hour and that all came to a sudden stop with my last fall.

When I stopped working, I started drinking. I used to sit up in the pub looking out at the rain thinking of the lads. First it was a few pints, then I was bringing a bottle of whiskey home. Things started to happen in my head that I couldn't understand. I became a recluse, and it felt like the inside of the door grew horns. I didn't want to go out. I tried to go back to work, but they told me that I was too old. It made me feel like I was on the scrapheap before my time. I ended up sleeping on a concrete floor and I burned everything - racing videos and photographs, everything - just to keep myself warm. I just didn't care about myself. I felt like I was abandoned by the world and left to die.

I was sitting staring down the barrel of a gun - I was seriously ready to pull the trigger - my phone rang. It was my friend. I got the gun and I threw it as far away as I could. I got help from a doctor initially. He referred me on to a counselling service and my friend helped me attend. That was going well until one day I had a complete meltdown. The next thing I knew I was in the back of an ambulance on the way to A&E. I wasn't brought into a private room - no humanity or sensitivity in it at all. The doctor was saying "this chap tried to commit suicide" - everyone could hear him. I just kept telling myself that someone was coming to get me, but then I just got up and ran out. I went back to counselling and they referred me on to [Men's Health Programme]. I haven't looked back since.

When you are sitting there chatting to lads with similar issues it makes you feel so normal. The first day after the programme I thought to myself: "Jesus, I haven't heard myself laugh in a very long time". For a group of men, the love and strength in the room was so intense. The wellness tools that we learned, the achievement thing, the cookery classes, the gratitude piece.

The template was fashioned to each specific group, so there was a flexibility and ownership to it. Can you imagine being part of a programme that is extremely structured and thinking: sure we ran this ourselves? We thought we were great lads. There was just a non-judgemental sense of peace from the lads, and even from the facilitator and the lady out the front making the tea. That was special.

To help men you have to listen to them, but really hear what they are saying. Now I look back on my career with pride and not sadness. I feel well and that is huge achievement for me. I can go to the pub, watch the horse racing, have a cup of coffee and go home.

BIOGRAPHY 10

Ian, a Victim of Domestic Abuse: “I couldn’t tell anyone about it though because I was so ashamed”

All people think men are big and strong, but my God my wife was lethal and vicious. She would hit me and the kids and say it never happened. I walked in the back door one day and she had a knife in her hand. I thought it was a joke until she tried to stab me. I couldn’t tell anyone about it though because I was so ashamed.

The emotional abuse was nearly worse. One day I came home and she said to me: “I could tell people you abused the children and they would believe me”. I said “I never touched the kids” and she said “I know you didn’t, but I could make life very awkward for you if I did”. It was a threat and that hit me like a sledge hammer. I could not live with someone saying I was abusing my children. I went into a severe depression. If I told somebody my wife accused me of abusing my children they would think there was something to it. I turned into a recluse after that. I didn’t give up on my children. I always went to see them, but I wouldn’t be with them on my own. During all of this, my mother died of cancer and I had lost my job - restructuring in the company. It was a combination of all of these things happening at once, you don’t know how to stop the slide.

Domestic violence - we think this doesn’t happen to men, but men don’t report it. If there was a domestic situation in the house, and I called the guards, I’d be the one asked to leave. The family court is one area which hugely favours women. It is the injustice. When a man comes in with a divorce case it is a damage limitation exercise. When a woman comes in it is how much can we maximise for her. If a man puts evidence forward it is not believed. The man loses everything; the house, access to the kids, paying maintenance to her - and she could be living with another guy. You are at your wits end, even though you have done nothing wrong. It is devastating.

I went to [support group] on the advice of my doctor. It was the sort of a place where you could openly talk about things like this. That saved my life. I learned so much there, and it was an outlet for me to go to every week - which I did without fail. An awful lot of men will not go to mental health services because they think there is a stigma attached to it, but they can be so helpful. There are other supports out there too, besides statutory services like the support group I attend.

I try to keep physically active and keep my brain active too. I like writing and learning a language - just to keep my brain ticking over. A good support network too, talking to friends is so critical. There are lots of other middle-aged men like me who have suffered domestic abuse. We need to be given a voice, but us men also need to start talking and listening to other men around us.

Similarly, Liam, an unemployed man, discussed misusing alcohol and described his only friend as being 'the bottle'. Indeed, GPs and statutory mental health service providers expressed grave concerns about middle-aged men who use alcohol to cope.

It was felt that adherence to masculine ideologies and suppressing emotions was another 'unhelpful' coping mechanism for men during times of psychological distress. However, it was noted that some men and service providers felt that stoicism and invulnerability can be useful as a coping mechanism - at least up to a certain level of distress, when it then became a liability. Withdrawal was another 'coping' mechanism which some men reported using, and this was also highlighted as being problematic (see section 4.1.3).

Many service providers and men felt that a significant amount of middle-aged men do not possess effective or sufficient coping skills to deal with the large amount of life stresses at middle-age. This was particularly true for men who had experienced a death of a family member or friend. Liam describes that by not adequately grieving the death of his son, these unresolved issues re-surfaced and became problematic when he became unemployed later in his life:

"...close ones dying, a son died in my arms years ago when I was young - I never dealt with that. When I stopped, all this stuff came into my head, that is when I really started to get ill - you have too much time to think". Liam, Unemployed Man



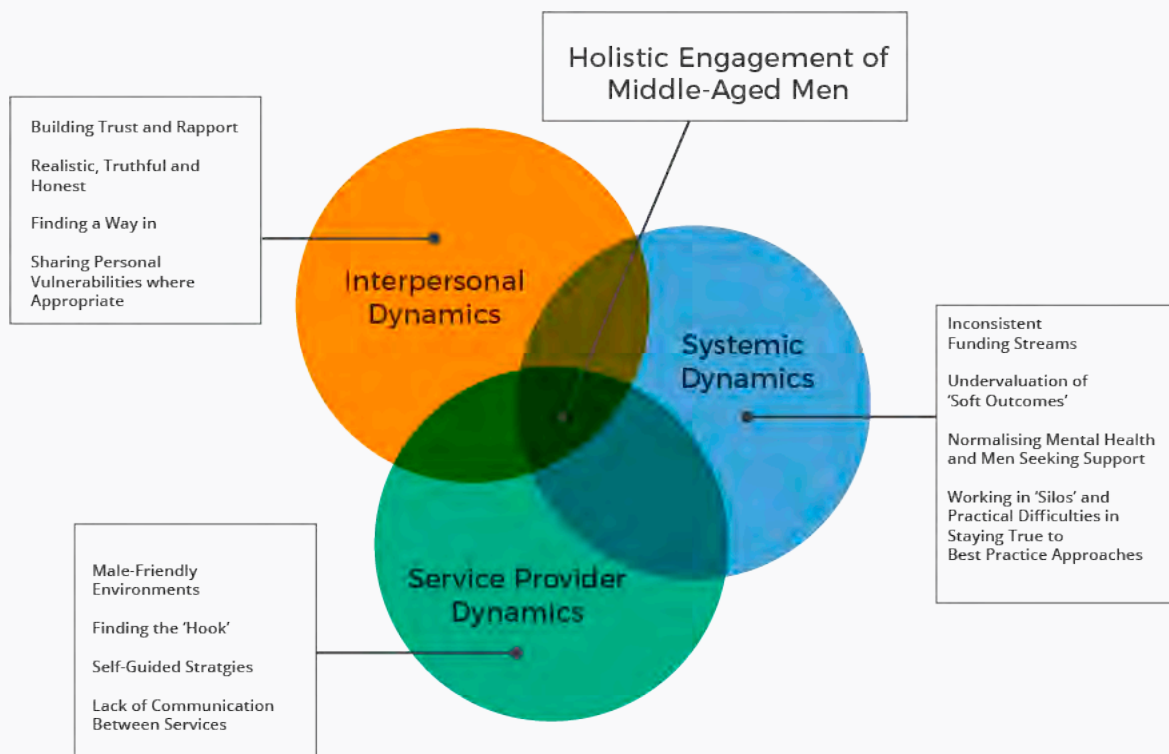
4.3 Negotiating the Dynamics of Engaging Middle-Aged Men

4.3.0 Introduction

The theme 'Negotiating the Dynamics of Engaging Middle-Aged Men' relates to the dynamics between men, service providers, services, societal structures and society more generally which influence men's engagement with services and social groups. These relationships are viewed through three lenses: interpersonal dynamics, service provider dynamics and systemic dynamics.

Section 4.3.1, Interpersonal Dynamics, explores factors that inhibit or facilitate effective relationships between men, and between service providers and men. Section 4.3.2 explores the dynamics which relate to the relationship between men and service providers (mental health organisations, statutory mental health organisations, voluntary and community sector organisations, primary care) and between service providers. Finally, section 4.3.3., Systemic Dynamics, explores the interactions between men and services within the wider context of societal and systemic structures - all of which influence men's engagement with services and support groups. Figure 14 gives an overview of 'Negotiating the Dynamics of Engaging Middle-Aged Men'.

Figure 14: Negotiating the Dynamics of Engaging Middle-Aged Men



4.3.1 Interpersonal Dynamics

Interpersonal dynamics encapsulated a range of factors which inhibited or enabled effective relationships between men and between service providers and men. Both men and service providers reported that the forging of strong relationships hinged upon 'finding a way in', establishing trust, being relatable, finding common ground, and gaining credibility. Conversely, factors that inhibited effective relationships included difficulty moving beyond trivial conversations, age and class differences, labelling men as a problem to be fixed, and lack of confidence or feeling inhibited to commit to relationships.

'Finding a Way In'

Service providers perceived the process of getting men to access their service or to 'outreach' to men as the most difficult part of their work with men. Adrian described how one must be respectful of a man's decision not to engage. Molly noted the importance of recognising and respecting resistance, but also being perceptive to pick-up on more subtle signs of interest and to follow-up on these soon afterwards.

Service providers described the need to 'find a way in' to conversations with middle-aged men, and recommended exploring common ground and interests such as sports, the weather, employment, children, etc. This preamble was noted as an important aspect of making men feel comfortable and at ease, particularly before engaging in conversations around mental health.

The importance of the 'cup of tea' was regularly cited by men and service providers, and seemed to be a symbol for comfort and welcoming, and acted as a facilitator of conversation and connection. Ciara describes the metaphorical warming-up effect of the cup of tea - as a way of easing into a conversation around mental health with men - as the most effective way of building meaningful connection:

"Get the tea on. Starting with a cup of tea, and just even the small talk to begin with about sports and the weather, is usually what I find good. If you try and launch into a conversation about mental health they will shut down". Ciara, Mental Health Organisation Service Provider

However, many community based service providers described their difficulty in moving past trivial conversations with men, whilst others recounted even more fundamental difficulties in striking-up casual conversations in the first instance. This was particularly pronounced where there were obvious differences in terms of age, class, or culture between service providers and men.

Building Trust and Rapport

Both service providers and the men described building trust and rapport as the most important factor for facilitating meaningful connection.

Service providers repeatedly stressed that trust was not something that could be built in one consultation, but was earned over time. Although acknowledged to be an organic process, they also felt that a certain skill-set was required to nurture and facilitate trust, and that trust had to be won by enabling men's voices to be heard, respected and valued.

Strategies that revolved around giving men ownership over the process, and prioritising peer-led approaches in programme delivery, were seen as fundamental to developing trust and helping men to feel more relaxed to be guided and moved to do things. Indeed, this approach was summed-up well by Dom in the Defence Forces, who perceived this to work better for middle-aged men compared to younger men:

"If there is a problem, you don't necessarily focus on the problem, you focus on the solution, and you engage with their solution or their best hope for that solution. Younger men are more likely to look for advice and direction, but with older men they might be looking to self-guide or self-direct. Give them back that sense of autonomy, especially within the culture of the Defence Forces... in a sense [that] empowers them, and that small conversation can be much better than what's wrong with you?" Dom, Defence Forces

Service providers reported that their credibility and integrity was inextricably linked with building trust and rapport with men. They described the importance of being truthful and honest with men on what could realistically be delivered as an integral component of facilitating effective relationships. Ciaran, articulates these points, and believes that the truthfulness and honesty of the service providers, and working in realistic and incremental steps, were what made a men's health programme successful:

"I suppose one of the successes of talking to those people [men in men's group]... is they [facilitators] were very honest and truthful with them. They didn't make exaggerated promises about what they could deliver. They didn't say your life will be turned around... It was always about the small realistic steps. They tried to tell them exactly how it is and reflect it back to them". Ciaran, Men's Health Expert

Service providers discussed sharing their own vulnerabilities and issues - where appropriate and without compromising service provider / service user boundaries - which appeared to build trust and remove power imbalances that exist between service providers and men. This clearly left an imprint on Paul who describes the connection, empathy and acceptance he felt when the facilitator of his men's group shared her own vulnerabilities:

"The facilitators were coming from a background that was similar to what we experienced... they would have opened-up as well, not at the same level as the rest of us... Some have suffered from depression and had similar issues to us [men]... that was huge. They were very human". Paul, Unemployed Man

Removing, or at least managing, power imbalances within men's groups was perceived to be a critical element in the engagement process. This was particularly relevant when new men joined a group, as service providers reported that, in situations where men felt inferior or excluded by other men in a group, there was a real risk of disengagement. Mark, a community based service provider, described that encouraging the group to include new members and regularly reviewing how the group is progressing, was one way to manage power imbalances.

Some men reported that sharing their own vulnerabilities, thoughts and psychological distress within a men's group created a sense of solidarity, support, connection and belonging. Martin describes how sharing his vulnerabilities elicited this feeling of connection and solidarity, whilst Paul describes how sharing his vulnerabilities normalised how he feels about his own psychological distress:

"I realise once I started sharing my thoughts and deep thoughts and crazy thoughts, whatever they were and just opening up and letting it all out. Then there was other people doing the same. It is like a connection. You feel connected to a person because they have a similar problem or issue as you. That is just amazing". Martin, Unemployed Man

"...when you are sitting down and you are chatting to people with similar issues it makes you feel normal. A lot of the time you don't feel normal. You feel like you are sick, like there is something wrong with you... but when you are talking to people with similar issues or worse issues it makes you feel better". Paul, Unemployed Man

4.3.2 Service Provider Dynamics

Service provider dynamics referred to factors which facilitated or inhibited an effective relationship between men and the service provider (mental health organisations, statutory mental health organisations, voluntary and community sector organisations, primary care) and between service providers. Both service providers and men noted the importance of the 'male-friendly' environment, utilising self-guided strategies to facilitate recovery, finding a 'hook' or incentive to engage men, and the advantages of pragmatic, partnership and community based approaches to engaging men. Barriers within the service provision dynamic included a lack of communication between services, stereotypical perceptions of the service by men, and a lack of resources (see section 4.1.3).

The Importance of a 'Male-Friendly' Environment

Both service providers and the men discussed the importance of the physical environment when engaging men around mental health issues. The most commonly used phrases to describe what constituted an appealing or attractive environment were 'non-medicalised', 'non-threatening', 'male friendly', 'safe', 'familiar' and 'comfortable'. Service providers argued that a non-medicalised environment, based in a community setting, reduces the stigma that many men have about seeking help, removes any unhelpful labels attached to health focused programmes, and allows men to more openly discuss their psychological distress:

"The environment is very important. That you are approaching them in an environment that they feel comfortable in. I find that if you are connecting with them on their grounds, you tend to get a lot stronger results. Somewhere that they are at ease with, it tends to open them up". Brian, Men's Health Community Based Service Provider

“If it has a non-medical feel to it, it tends to be more acceptable. It is not coming to address a specific issue, it is a group coming together in the community setting which doesn’t have any labels attached to it - that is very important”. Aine, Men’s Health Community Based Service Provider

Aine also noted that the environment is not generalisable for every group, and should be adapted for the particular group that is being targeted. Service providers who worked in more conventional health care practice settings noted that there was a lot more they could do to make their service environment (e.g. waiting room) more male-friendly. However, service providers within statutory mental health services noted some practical challenges in making changes in their setting, and recognised that their environment often acted as a barrier for men accessing their service:

“...in our setting, there are doors with codes on it, porters have to let you up, and people have to wait outside doors downstairs - it [engagement] can be lost in a setting”. Amy, Statutory Mental Health Service Provider

Utilising Self-Guided Strategies

Service providers reported that engaging with men in a partnership way to develop solutions to their own problems, and consulting with men about their preferred inputs to be delivered, were effective ways of increasing men’s sense of ownership of the process. This, in turn, increased men’s self-efficacy, made them feel valued, and increased the level of trust and rapport with service providers.

Aine, a men’s health community based service provider reported that consulting with men in the development of a programme increased the credibility and currency of her programme, thus maximising potential participation. Similarly, Damien, a men’s health community based service provider, reflects on the success of his men’s health programme where he prioritises men as equal partners throughout the whole process:

“We have changed the whole programme based on what men have fed back to us... We have men across all of the organisation, right at the national steering committee down to the local level, so they are making decisions as to how the programme should be developed. The space is truly theirs. It is our job to facilitate that... The men really appreciate that and see themselves as true partners”. Damien, Men’s Health Community Based Service Provider

Many service providers reported that a level of flexibility was required to allow for these self-guided strategies, but did not disregard the importance of also having a degree of structure and planned outputs. For example, Brian, a community based men’s health service provider, described how his programme’s outputs provided the hook for men to engage but, ultimately, the men decided how those outputs were achieved. Ciaran a men’s health expert, articulates this point of how the role of the service provider is to provide and facilitate a safe space and to ensure that there is a reason for men to be together:

“What we do is provide the opportunity and the reason for men to be together and then we provide a container to allow that to happen. The container is a kind of place that protects them from the outside world and allows them to immerse themselves in what is in it. There is opportunity, there is possibility and there is safety”. Ciaran, Men’s Health Expert

Having a sense of ownership within a defined structure clearly had a lasting impact on Paul, an unemployed man, who describes his sense of fulfilment and increased self-esteem through being enabled to guide his own recovery:

“It was a staged twelve week programme, and every week it added a little bit more to your toolbox... The group I was in, it was fashioned to us, and the next group it was fashioned to them... so there is flexibility and ownership to it... but there is also huge structure without being obvious. Imagine being part of a programme that is extremely structured and saying sure we ran that ourselves? Sure we thought we were great lads”. Paul, Unemployed Man

Finding the 'Hook' and Stimulating Conversation

Many service providers spoke of men needing a reason, or a specific context, to engage in social interaction or to join support groups because of pre-conceived notions that it is 'not for them'. Indeed, Christopher, a rural isolated man, felt that it was men's inexperience of social groups, and fear of what they might entail, that was the primary barrier for men not accessing support groups.

It was against this backdrop that all participants spoke about the importance of an incentive or 'hook' to entice men to join support groups. The most effective 'hooks' were seen as programmes, initiatives, or activities about which men were passionate. Amy, describes how engaging men in this way had the potential to give men a new role and purpose in life, whilst attempting to engage men otherwise was likely to cause disengagement:

"It is definitely about trying to engage men in something that he holds as valuable, because if you don't, and you try and put them in a programme or day centre that doesn't hold value for them, they are likely not to stick to it... finding a role that really suits them, and they can adapt to, and say this is my role in life now and they value, that is really important". Amy, Statutory Mental Health Service Provider

Examples of hooks included football training, learning music, learning life planning skills, walking groups and craft/DIY activities - many of which were offered to men as a result of consulting with local men in the development process. However, over time these incentives became incidental, and social connectedness became the primary motivator for attendance, as Mark describes:

"We have a men's group every Thursday. They learn music, but it turns out learning music is only the glue. One man said my only company would be the TV if I wasn't here. Another man - his dog. So the company was actually the biggest thing".

Mark, Community Based Service Provider

Besides the positive mental health benefits of social connectedness for middle-aged men, learning new skills and engaging in activities that were enjoyable were seen as increasing men's

self-esteem. Leonard, a rural isolated man, recognises the multi-purpose nature of his men's group as a place where he can learn new skills, socialise and have an outlet to share problems:

"...it is a place where you can come and do things and leave things. That is the idea of it, to get men to talk". Leonard, Rural Isolated Man

Some service providers also reported that these hooks provide men with an opportunity to indirectly discuss their psychological distress and worries. Aine, a men's health community based service provider, gives the example of a cookery class providing the platform for men to open up and support one another in a more organic and spontaneous way - essentially the activity of cooking becomes incidental to the knock-on effects of building connection and peer support in a safe and nurturing environment:

"...one of the sessions we run is a cookery class, and it is interesting because it provides a platform for the opening up, teasing out what was talked about in the health education workshops and it's kind of peer support... It is not about the cookery, per se, but it facilitates that continued opportunity where a group of men are in a room and anything unresolved gets aired". Aine, Men's Health Community Based Service Provider

Some service providers discussed how these men's groups were a good platform to deliver more formal physical and mental health educational workshops once the group had been well established. However, a key consideration was to carefully negotiate the boundaries between the informal and the formal, and not to contaminate what was working well. Sarah, a mental health organisation service provider reports that, within her organisation, there was a fear of scaring men off their support group by introducing health education workshops to what was, predominantly, a social group:

"...the unit feel they have to be very careful on how much of it they bring it [suicide prevention workshop] in. They don't want it to seem like we have brought you into what was predominantly a social group and now we are throwing mental health at you and this and that. So they are very nervous about what they provide, how much they provide and when they provide it... So even the people working with that age group are terrified about scaring men off". Sarah, Mental Health Organisation Service Provider

However, Sarah also believed that this particular unit was under-estimating men's interest in mental health, a view which was echoed by other service providers. Damien, a men's health community based service provider, described his surprise at how some men who were in psychological distress went on to start their own listening support service for other men in distress. Jean, a community based service provider, also reflected on incorrect assumptions that she had made in the past about men's interest or willingness to engage in support groups. Thus, some service providers were mindful of not falling into the trap of writing men off as potential participants in support groups.

Service providers reported that middle-aged men tended to favour approaches, activities or interventions which were pragmatic, task orientated, and which had a tangible outcome at the end. Justin, a community based service provider, found that men were more likely to return to the group when tasks were completed within the timeframe they had set out. Similarly, with psychotherapy or psychological interventions, some service providers reported that men had a preference for pragmatic approaches, such as cognitive behavioural therapy, to support their mental health. However, many service providers also noted that these pragmatic approaches were not generalisable to all groups of men, and that care must be taken to evaluate what works best for the specific group or man being targeted.



Lack of Communication Between Services

Many service providers reported on what they felt to be ineffective communication and collaboration between, and within, the community and voluntary sector, primary care, statutory mental health services and mental health organisations. Amy, a statutory mental health service provider, felt that lines of communication between mental health nurses, psychiatrists and other allied health professionals were inadequate, which resulted in men disengaging from services because of not having their needs adequately met.

Many believed that GPs were not sufficiently aware of the full range of support and social services within their localities, and were too quick to prescribe medication for men who were in psychological distress. However, GPs felt that there was a lack of adequate social supports for men, with Con expressing his frustration with the lack of resources open to him to 'treat' men for underlying issues of loneliness and isolation:

"The lack of support services can be a huge issue. You can identify the problem, but you can't do anything massively for it. We would have a lot of guys whose issues are loneliness, and you can send them to a counsellor if things are acute or give them medication, but you are not treating the underlying problem. I think it is knowing what to offer them beyond medication and that kind of standard thing that can be difficult". Con, GP

GPs also reflected on feeling severely overworked due to an insufficient amount of GPs in rural areas, which put further constraints on their capacity to collaborate with organisations in the community. Service providers discussed what appears to be the disconnection and misunderstanding between services in the community, primary care and statutory mental health services on appropriate routes of referral for men. This is particularly problematic when we consider that men predominantly reported the GP as their first port of call when experiencing psychological distress. Jean, a community based service provider, also noted that this can cause particular problems for primary care teams, which she believes are not functioning as they should:

"There is definitely an issue with primary care teams not functioning the way they should or the way that we would like them to function. There is definitely a struggle to get GPs to attend the one I sit on. There is a need for clarity on how these teams are supposed to function to keep people healthy in their communities without sending them to hospitals. The primary care team was supposed to be all the services wrapped around the person, but it is not happening that way".

Jean, Community Based Service Provider

Barry, a mental health organisation service provider, reported on the lack of collaboration and sharing of resources between mental health organisations as being particularly frustrating, and not providing the best possible support for those in psychological distress. He suggests that there is an unwillingness to work together, to refer men to other organisations, or to share resources out of fear organisations losing funding. He believes that there is a need for services to work together to identify their specialities and develop a roadmap of mental health services so clients can be referred to receive the best possible support:

“It almost seems, if we give our resources or information over to one group, we are possibly going to lose funding next year. If I offer a service I get funding and another organisation might not get funding, but this is not helping the people who actually need the support... If we could work together so that we could develop a roadmap to go, well this is where I [organisation] fit in, and this is where you [organisation] fit in, so we could refer people on and no matter what stage you are at we have something for you”. Barry, Mental Health Organisation Service Provider

Indeed, this more holistic and collaborative approach was stressed by many men’s health community based service providers as being the key to effectively supporting men during times of psychological distress. Aine, a men’s health community based service provider, described how linking in with the various agencies in her local community allowed her organisation to match men’s specific needs to appropriate referral options, without running the risk of men disengaging. Some service providers believed that a central funding body should be the link for the various service providers to work together, and that funding ought to be contingent on service providers placing inter-agency work as a core pillar of their work.



4.3.3 Systemic Dynamics

Systemic dynamics captured the interactions between men and services within the wider context of societal and systemic structures. Service providers predominantly referred to barriers at a systemic level which impeded engagement, with fewer references to facilitators of engagement at a systemic level. Almost all participants agreed that the primary barriers, at a systemic level, were the stigma surrounding mental health and the stigma of men seeking help (see section 4.2.1). It is important to stress that the issue of stigma was deeply ingrained at the systemic level.

Other reported barriers at a systemic level included pressures to deliver best practice approaches against a pre-determined set of outputs, under-valuing of 'soft outcomes', and inconsistent funding streams. These barriers all appeared to arise due to a disconnect between more systemic structures (government, policy makers, funding stakeholders) and more front-line organisations (mental health organisations, men's health organisations, community and voluntary sector). It is important to note here that these systemic barriers were highlighted mainly by participants within the men's health expert group and the men's health community based service providers. Most other service provider groups cited more direct barriers to engaging men within the interpersonal and service provision dynamics.

Whilst the focus of discussions was more on barriers than facilitators of engagement at a systemic level, most participants reported on their aspirations for change at a systemic level. Whilst almost all participants reported a cultural shift in mental health stigma in Ireland over the past number of years, there was also a recognition that more needs to be done - particularly in the context of middle-aged men.

The most commonly reported aspiration to overcome stigma and facilitate engagement at a systemic level included normalising mental health and men seeking support, but the means for doing this were less tangible and more ambivalent. However, some service providers proposed means to normalise mental health which included: national campaigns that are inclusive of all middle-aged men, raising awareness of middle-aged men's mental health through use of advocates, and up-skilling community members to listen and signpost.

Working in Silos - Fragmented and Disjointed Approaches to Engaging Men

Some service providers reported a perceived disconnect between the best practice approaches of engaging men and the modus operandi and expected outcomes of funders. As discussed previously, service providers reported on the importance of 'meeting men where they are at', allowing men to take ownership of the process, facilitating men to find solutions to their own problems, and facilitating connection. However, service providers reported many practical difficulties in staying true to these approaches; not least in terms of pressure to deliver against a pre-determined set of outputs, an undervaluation of 'soft' outcomes, and inconsistent funding streams which undermined their efforts.

Ciaran, a men's health expert, describes the difficulty in adapting to meet men's needs when funding is offered for a particular programme to achieve certain priorities:

"We have to start where the men are at, not where the programme is at or not where the funding is at. That is really difficult for service providers and policy makers though, because there are priorities already set, there is a budget set and the work needs to get done". Ciaran, Men's Health Expert

Damien, a men's health community based service provider, argued that local government is increasingly taking control of community development and, in so doing, leaving little room for advocacy work or for communities to develop solutions to their own problems. He also argued that this may be a result of a power struggle, with local government not wanting communities to have too much power in case they might challenge policy makers. Aine, a men's health community based service provider, reports feeling quite restricted as a result of this control which, she believes, flies in the face of best practice approaches to engaging men:

"It is about control [local government] and there is no flexibility, and you deliver against a pre-determined set of outcomes. It is tricky to reconcile with what we talked about the best practice approaches of openness, and letting men have their say, and a collaborative and partnership approach. It flies in the face of that really". Aine, Men's Health Community Based Service Provider

Ciaran, a men's health expert, reported that there was a propensity to fund programmes and initiatives that address a particular problem issue amongst men (e.g. unemployment programme or diversion programme) with more tangible outputs, rather than focusing on tackling the broader social determinants of men's health. He felt that 'soft' outcomes such as connectedness, increased self-worth and self-efficacy are often undervalued, but play a pivotal role in facilitating real change amongst men:

"If you can identify a problem group of men, who are creating disruption amongst themselves or other people, people will throw money at you to do it. Stealing cars at night, run a diversion programme... but when you have a programme that is about building your self-worth, connectedness, planning for the future... those are quite soft outcomes that are not valued, but are probably the most crucial. They underpin everything". Ciaran, Men's Health Expert

Indeed, there was also a perception amongst some service providers that the language of 'soft' outcomes was reinforcing the under-valuation of things such as connection, self-worth and self-efficacy. Larry, a men's health expert, believed that the language should be changed to something which better reflects the importance of these outcomes. Damien concludes that it is also the responsibility of service providers to collectively take responsibility, and to show where the value lies in these 'soft' outcomes and their potential for facilitating change among men:

"I think it is up to us as well to show value for money through things like the social return of investment. That we can start focusing more on hard and soft, but then valuing the soft outcomes and showing where the true value is and how they can be valued. I think that is our job to influence the policy makers and that, again collectively, not one agency doing it".

Damien, Men's Health Expert

Some service providers also reported difficulties in implementing sustainable models of practice, creating long lasting impacts, and planning for the future when funding streams operate on a short-term or year-to-year basis. Ciaran, a men's health expert, described how this often resulted in men's health programmes operating on a stop/start basis, which he believed to be detrimental to building connection and relationships with men. Indeed, this was a reality for Molly, a community based service provider, who described losing funding for her men's health programme three weeks into the initiative:

“We started a men’s health programme and we went around the community recruiting local men. It was hard to build the trust to get them in the room you know. Then our funding was cut three weeks later and we had to stop the programme. That has totally ruined our relationship with those men in the community”. Molly, Community Based Service Provider

Normalisation of Mental Health and Men Seeking Support

There was strong consensus that the normalisation of mental health and men seeking help were the biggest potential facilitators for engagement at a systemic level. However, the means to achieve these goals were often not reported or non-specific. It could be argued that this is indicative of a more general ambivalence or inertia with regard to suicide prevention in middle-aged men. Despite this, some service providers offered suggestions for achieving these goals. These aspirations related to approaches that were both top-down (policy, government, funding, within services) and bottom up (education and upskilling of community members, advocacy, an increased focus on communities developing solutions to their own problems, as well as nationwide and community based interventions). Overall, participants stressed the need for a holistic multi-faceted approach to tackling the issue of suicide in middle-aged men which is tailored to suit the needs of the particular group of men.

It was reported by many service providers that whilst significant strides have been made in the field of men’s health, much more work needs to be done around normalising mental health for men. There was a reported need to cascade models of effective practice across communities in Ireland in order to provide men with continued opportunities for connection and support. It was also felt that more work could be done with men to challenge ‘male conditioning’ and masculine stereotypes, and to normalise men’s challenges and perceived deficits in life.

Some service providers discussed the need to challenge the narrative that ‘men don’t talk’, which was perceived to be an outdated misrepresentation of men which only serves to reinforce negative stereotypes. Larry, a men’s health expert, stressed the importance of utilising a strengths-based approach with regard to promoting men’s health, and steering clear of viewing men through a deficit lens - which reinforces negative stereotypes of men. Ciaran, a men’s health expert, also notes that viewing men through this deficit lens is likely to make men feel like a problem to be fixed, which he believes will drive men away:


“Nobody wants to think that they are so broken that you need somebody to piece you back together again. And yet all the language, the strategies, the business plans we put together are about problems. It is about problem men; men coming out of prisons - how are we going to stop them re-offending? Not how do we create better lives for them, nor how do we give new opportunities and possibilities to explore who and what they are and contribute”. Ciaran, Men’s Health Expert

Indeed, many service providers cautioned against defining groups of men as ‘at risk’, as this might further stigmatise marginalised groups as well as reinforce negative stereotypes. They also suggested a need to change using the term mental health - as this, too, was seen as stigmatised. Adrian, a statutory mental health service provider, reported that many men he engaged with expressed a desire not to use the word mental health when discussing their psychological distress, and suggested that a ‘dressing up’ of the word such as mental fitness is needed. Conversely, many men felt that the word mental health should be used, and that we should avoid ‘beating around the bush’, which was believed to further stigmatise mental health.

Participants reported on the success of recent national mental health awareness campaigns such as the Little Things Campaign, and believed that it was hugely beneficial for reducing stigma and normalising mental health across Ireland. Many service providers and men suggested the need for a national awareness campaign specifically targeting the mental health of middle-aged men which could encourage these men to seek support during times of psychological distress. However, as Ollie, a Transgender man suggested, these campaigns need to include a more diverse and inclusive depiction of middle-aged men:

“There needs to be a campaign, but with a wider portrayal of middle-aged men beyond the stereotypical married with a couple of kids”. Ollie, Transgender Man

Some service providers believed that in order for any significant positive change to occur to support middle-aged men during times of psychological distress, policy approaches in this area need to be underpinned by research and evidence to encourage other services to specifically target middle-aged men.



Many men and service providers reported the need for advocates to promote middle-aged men's mental health issues both nationally and within their own local communities. It was believed that advocates should be those who are relatively well known, such as celebrities, representatives from marginalised groups, as well as middle-aged men who have accessed support and found it beneficial. Peter, a Defence Forces service provider, noted that middle-aged men within his organisation who were seen as popular, in positions of authority or thought of as 'hard men', would act as ideal advocates to normalise support seeking within the Defence Forces. Mark, a community based service provider, reports on the effectiveness of training local people to advocate for cancer, and believes that something similar for mental health would be worthwhile:

"We had advocates for cancer. Instead of facilitators, we had trained-up local people to knock on the doors and raise awareness about cancer. You have to go out and meet them. Then it is practical for all of us to do that so I think advocates is a great idea if we could get a core group". Mark, Community Based Service Provider

All participants stressed the importance of early intervention in normalising mental health and help-seeking among men. Therefore, interventions in schools - which focus on challenging male stereotypes and encouraging emotional expressiveness - were believed to be required.

Statutory mental health service providers reported the need to 'de-mystify' mental health services and the role of mental health professionals. Adrian, a statutory mental health service provider, described his experience of delivering workshops which outlined the differences between psychotherapists, psychologists and psychiatrists. He believed that the wider roll-out of such workshops had a key role to play in reducing stigma towards mental health services.

Service providers also discussed the importance of a whole community response to normalising mental health. This entailed delivering programmes on early warning signs of suicidal behaviour, increasing ability to be empathetic and to listen to those in distress, and signposting towards appropriate services.

4.4 Conclusion

Against a wider backdrop of grappling with the unique transitions of middle-age, and at a time of significant wider societal challenges, many groups of middle-aged men also reflected upon feeling rejected, discriminated against and stigmatised on the basis of different aspects of their identity. Not surprisingly, some actively sought to withdraw and retreat 'into themselves'. For many groups of middle-aged men, isolation and loneliness had a crippling effect on their lives. Indeed, the harsh reality for many middle-aged men was that rejection, withdrawal and isolation interfaced in multiplicative ways and were closely aligned to significant psychological distress in their lives - including, in some cases, suicidal behaviour.

The continued stigma associated with mental health, and with men accessing support for mental health issues, was a significant undercurrent to middle-aged men's approach to seeking support and coping during times of psychological distress. It was a cause of considerable concern that the most commonly reported trigger to seeking support was having reached a crisis point - a reality that was influenced by prevailing gender norms and men's past negative experience of services, which were generally seen as inadequate, over-stretched and over-medicalised. It was also felt that this age cohort of men had been reared on more traditional masculine values (such as being responsible, invulnerable, stoic and self-reliant) which conflicted with being seen as 'weak' or becoming a 'burden' by seeking support.

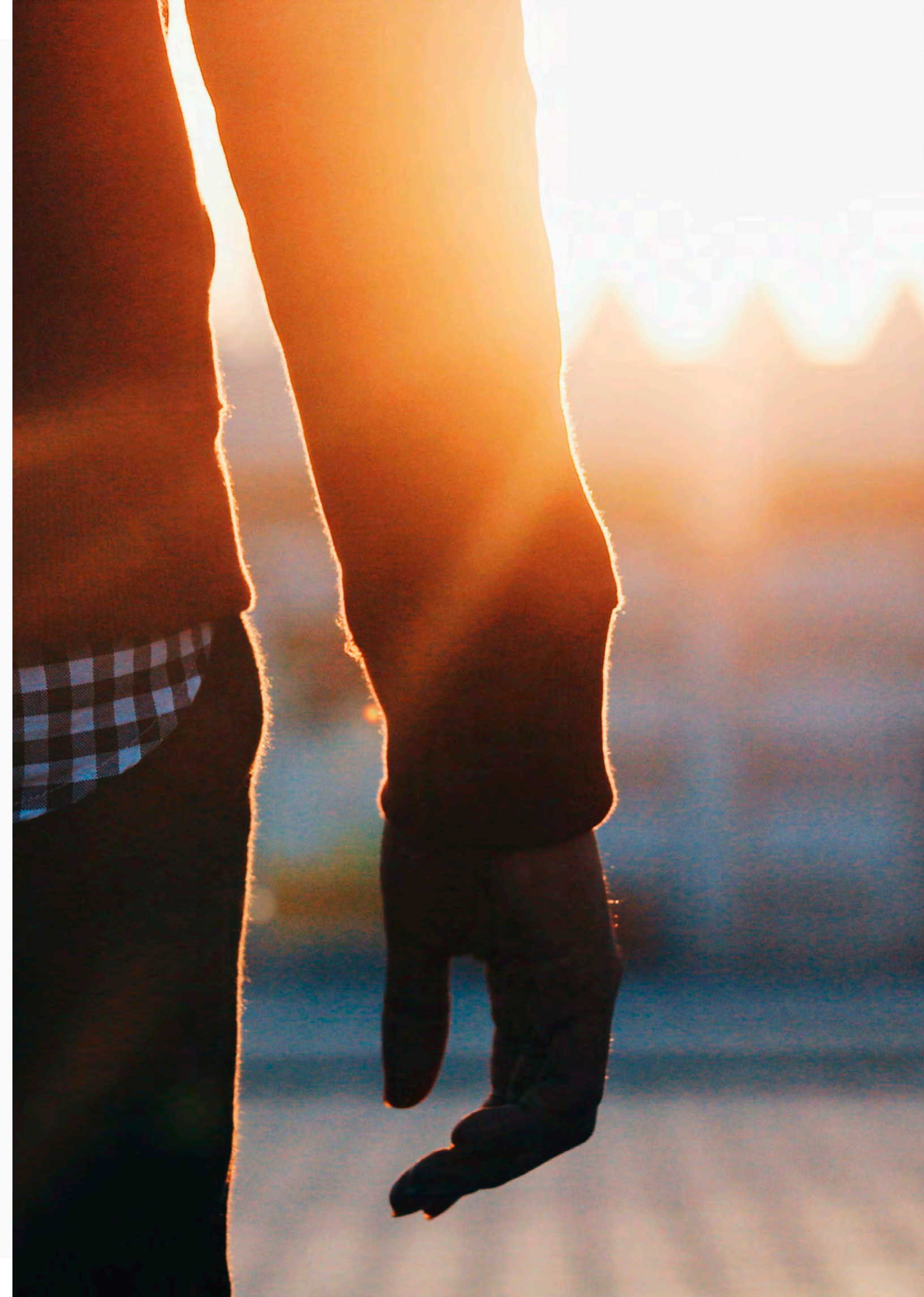
Whilst being in a stable environment, connection to others and self-awareness were identified as key supports that helped to keep middle-aged men well, the opposite was also true for some men; with alcohol use being highlighted as a particularly problematic 'coping' strategy for many men in psychological distress.

A range of factors had a bearing on the dynamics of engaging middle-aged men. At an interpersonal level, it was reported that the forging of strong relationships hinged upon establishing trust, being relatable, finding common ground, and gaining credibility. Conversely, factors that inhibited effective relationships included age and class differences, and the use of complex or stigmatised language.

At a service level, a number of positive approaches to engaging men were identified, including the importance of having a 'male-friendly' environment, utilising self-guided strategies to facilitate recovery, finding a 'hook' or incentive to engage men, and adopting pragmatic, partnership and community based approaches.

At a systemic or organisational level, stigma was also a recurring theme. So, too, was pressure to deliver best practice approaches against a pre-determined set of outputs, the under-valuing of what were described as 'soft outcomes' (such as connection, self-worth, and self-efficacy), and inconsistent funding streams.





5. DISCUSSION

5.0 Introduction

The purpose of this study was to explore the factors underpinning the high suicide rate among middle-aged men at risk of marginalisation in the Republic of Ireland, with a view to providing more effective and gender specific programmes, services, and resources that can support their mental health and wellbeing. Qualitative methodologies were used with: (i) 'at risk' groups of middle-aged men (n=34) who were selected on the basis of specific socio-demographic characteristics identified in the wider literature as being associated with a higher risk of suicide; and (ii) with service providers (n=35) who were in positions to provide support to men.

Findings were synthesised and presented under three broad themes: 'Marginalised Masculinities', 'Support Seeking and Coping Mechanisms' and 'Negotiating the Dynamics of Engaging Middle-Aged Men'. A series of biographies representing the lived experiences of middle-aged men at risk of marginalisation (MAMRM) was also developed.

The purpose of this section is to discuss these findings within the context of the wider literature, and to propose key recommendations and next steps to address the issues raised. The key findings of this study will be discussed within the context of a socio-ecological model of health as described in section 2.3.3.

A socio-ecological model of health recognises that health outcomes are intertwined with the physical and socio-cultural environments in which people live (Sallis et al., 2008). Researchers have segmented the environment into various levels of influence i.e. intrapersonal factors, interpersonal factors, institutional factors, community factors and public policy (McLeroy et al., 1988). It has also been proposed that interventions can be implemented at each level of influence:

- Intrapersonal factor interventions - to change attitudes, knowledge and beliefs of individuals.
- Interpersonal and institutional factor interventions - to create change in social relationships and organisational environments.

- Community factor interventions - to increase health services or empower groups.
- Societal factor interventions - implementing public policy or facilitating citizen advocacy.

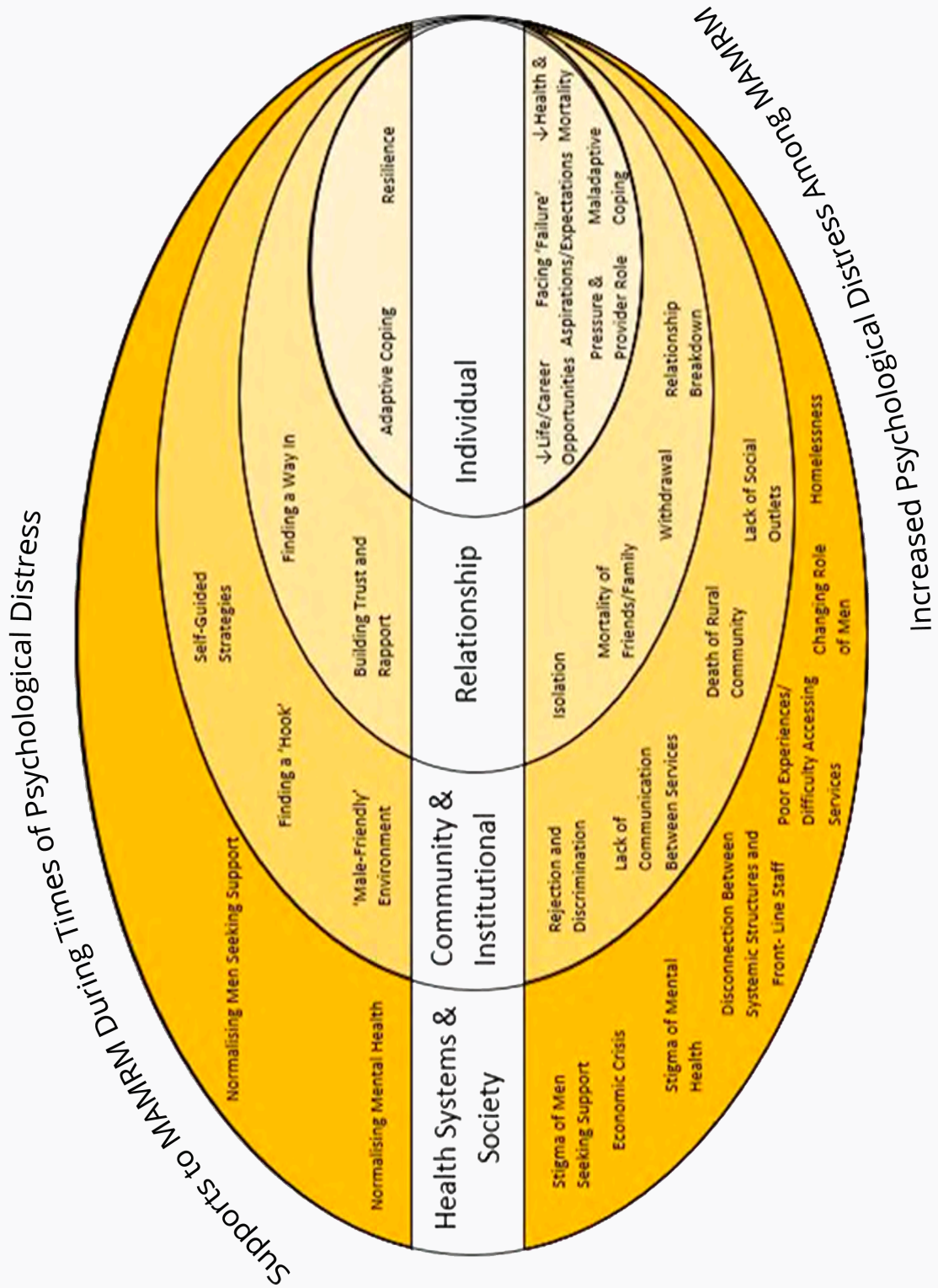
It has been shown that the most effective approach to creating long lasting health change is to target all of these levels simultaneously (Stockols, 1996). The WHO adopted a socio-ecological model to describe suicide risk factors which stratified the environment into four levels: individual, relationship, community, and health systems and society (WHO, 2014). However, neither of these models account for the experiences and skills of service providers working with individuals in the area of mental health and suicide behaviour.

For the purpose of this study, a socio-ecological model was developed which, hereafter, will be referred to as the 'Engaging Middle-Aged Men in Suicide Prevention' (EMAM-SP) model (see Figure 15). It was felt that the EMAM-SP model gives a more holistic representation of the factors underpinning suicide behaviour in MAMRM, which is inclusive of service providers' experiences. It is also proposed that this EMAM-SP model can be used as a roadmap to track suicide risk and protective factors at various levels of influence in order to develop interventions and recommendations which are specific to the mental health needs of MAMRM.

This EMAM-SP model has been adapted from the WHO's socio-ecological model on suicide risk factors WHO, 2014 and McLeroy et al's (1988) model as described previously. Thus, the EMAM-SP model comprises of four levels: (i) the individual level - where the focus is on creating change in individual MAMRM's attitudes, beliefs and behaviours (see Section 5.1); (ii) the relationship level - where the focus is on strengthening relationships and supporting stronger connection with MAMRM (see Section 5.2); (iii) the community and institutional level - where the focus is on creating change in organisational environments and empowering groups (see Section 5.3); and (iv) the society and health systems level - where the focus is on increasing access to health services, informing policy and increasing citizen advocacy (see Section 5.4).

The EMAM-SP model explores the factors associated with psychological distress among middle-aged men (which comprise the bottom half of Figure 15), and factors which can potentially support middle-aged men during times of psychological distress (which comprise the top half of Figure 15).

Figure 15: Engaging Middle-Aged Men in Suicide Prevention Model



5.1 Individual Level Factors and Suicide Prevention in Middle-Aged Men

The individual level relates to factors specific to an individual middle-aged man that can either be a source of increased psychological distress or can support him during times of psychological distress. At this level, the aim is to reframe what, for some men, might be unhelpful attitudes, behaviours and beliefs with regard to mental health, help-seeking and suicide. The findings suggest that a recurring set of challenges arise at mid-life that cause psychological distress for middle-aged men. These include declining health status and facing up to mortality, diminishing life and career opportunities, increasing pressures associated with the provider role, facing-up to the failure of unfulfilled aspirations and expectations, and the multiplicative effects of psychological distress at mid-life.

Many of these findings are congruent with the literature regarding the impact of these factors on middle-aged men's mental health. Unemployment has been shown to have a causal effect on suicide, with a stronger relationship for men compared to women (Platt, 2011; Qin et al., 2000). Traditional expectations about the male provider and breadwinner roles mean that unemployment and financial difficulty cause men to experience a loss of role and purpose (Shiner et al., 2009), with an additional dislocation of role within the family unit (Charles et al., 2008). The impact of unemployment seems to be more pronounced at middle-age.

It is at this stage of the life course, when the accumulation of investment in work life is often central to one's sense of self, that a loss of identity and increased vulnerability can ensue when unemployment occurs (Shiner et al., 2009; Turner et al., 1994). Indeed, for many of the men in this study, work - and the sense of compulsion to be in employment - was inextricably linked to their masculine identity. Unemployment, on the other hand, had significant implications for middle-aged men's mental health and often resulted in a loss of identity, role and purpose.

The men in this study reported an increased sense of responsibility and pressure to provide at middle-age whilst, at the same time, remaining stoic, strong and silent through various challenges they faced in living up to such responsibilities. This was perceived to be more prevalent among this generation of men, which often resulted in men having the façade of external contentment but internally struggling.

This links to the individual suicide risk factor of 'perfectionistic self-preservation' - self-promotion and the concealment of 'errors' to present a specific image - as described by Besser et al. (2010). Failing to live up to the provider role resulted in a dislocation of their perceived role of breadwinner in the household and to profound feelings of shame, embarrassment and emasculation. Many of the men felt that fewer employment opportunities existed at middle-age, particularly for those working in manual labour - many of whom felt discarded based on their diminishing physical abilities.

Having or, more importantly, openly acknowledging a mental health issue, was also seen as posing a threat to one's career progression or future employment opportunities; a finding which is consistent with previous studies (Sharac et al., 2010). Furthermore, particular groups of men described feeling discriminated against or rejected from employment opportunities on the basis of aspects of their identity (Traveller men, transgender men, non-Irish national men). This rejection from employment opportunities results in a decreased likelihood of unemployed middle-aged men re-entering the work force, and to increasing feelings of reduced self-efficacy and hopelessness the longer unemployment goes on. Indeed, hopelessness is reported to be a key risk factor in the suicide literature at the individual level (WHO, 2014).

The lack of stimulation and loss of routine (i.e. 'having nothing to do') appeared to be a key source of psychological distress for many men. Some men reported brooding over negative life events due to a lack of stimulation, whilst many others reported reverting to alcohol as a result. These brooding or 'ruminating behaviours', as well as alcohol misuse, are associated with increased risk of suicidal behaviour (Wyllie et al., 2012; WHO, 2014).

Engaging men in employment schemes, organised groups or other interventions which restore routine, instil a sense of purpose, and help men to regain a sense of control over life, should be a priority in suicide prevention efforts aimed at unemployed middle-aged men.

Relevant government agencies and institutions (e.g. banks) also need to be more aware of the potential impact that unemployment and financial stress can have on middle-aged men's mental health. This study found that initiatives which engage men most effectively are those which offer something that hold value for men. Thus, rather than offering employment schemes to unemployed men on a take-it-or-leave-it basis, increased efforts are needed to consult with men in this process and to empower them through initiatives which they are passionate about.

Many men felt that there were increased expectations to achieve particular milestones by mid-life such as having a family, a home, a relationship, and steady employment - milestones that were seen as the bedrock of masculine identity. Not meeting these expectations resulted in feelings of failure and shame for many men. This was also the case when these bedrocks were disrupted (e.g. redundancy, relationship break-up), which had implications not only directly to men's mental health, but in terms of a more deep-rooted sense of failure and the feeling of going backwards in life. This relates to O'Connor's (2007) research on links between social perfectionism and suicidal behaviour, which describes the perceived failure to meet the often unrealistic standards of others. This expectation coincided with a time of reflection at middle-age and a questioning of what one had achieved in life. Men questioned their life choices, the scale and value of their achievements, and their ability or capacity to achieve aspirations still outstanding.

Many men viewed middle-age as a watershed, and were left to confront the harsh realities of unfulfilled hopes and aspirations against a backdrop of diminishing opportunities associated with ageing. Those men who found themselves in this situation also typically experienced feelings of hopelessness for change for the future, which is also associated with suicidal behaviour (WHO, 2014).

The increased onset of physical health issues, allied to diminishing physical capabilities, was also reported to be a source of psychological distress for many men. This 'slowing down effect' was found to impede men's ability to work and to carry out habitual tasks. It also acted as a barrier to men engaging in physical activity, which was a coping mechanism and social support for some men.

Bodies are prime sites for performing or signifying gender identities (Wyllie et al., 2012). Thus, it has been proposed that diminishing physical health and functioning - weakness, increased dependency and decreasing sense of control - undermine the hegemonic or more dominant embodiment of masculinity, and negatively impact men's self-esteem (Kaminski and Hayslip, 2006). Decreased self-esteem has also been associated with suicidal behaviour (Kleiman and Riskind, 2013). It is also possible that diminishing physical health could be perceived as a physical representation of dwindling opportunities at mid-life and a reminder of impending mortality.

It is evident from the findings in this study that the transition to middle-age is difficult for many men. Although little can be done to interrupt the ageing process and the associated risk of increased psychological distress, the findings from this study suggest that more is needed to provide men with the necessary coping skills and resilience during these times. However, as noted by service providers in this study, men often lack effective or sufficient coping skills, and engage in maladaptive coping practices which often compound their issues. Maladaptive coping strategies such as alcohol misuse, repression of emotions, self-reliance and withdrawal were commonly reported by the men in this study. Alcohol consumption is often used by men as an alternative to seeking professional support for their psychological distress (Canetto, 1998), with alcohol misuse being widely associated with an increased risk of suicide (Beautrais et al., 1996).

Mahalik et al. (2007) also found that men's coping styles tended to rely on self-reliance and emotional repression, and avoidance of help-seeking in a bid to adhere to more dominant masculine norms. This is congruent with what was found in this study; with psychological distress often being construed as weakness and as a loss of control, whilst support seeking was seen as an acknowledgement of vulnerability. Another study reported on men withdrawing from societal settings as a form of coping which resulted in isolation and disconnection (Grace et al., 2016). A framework developed by Brownhill et al., shows how these socialised maladaptive coping strategies can escalate, to what they describe as the 'big build' and which, in turn, can lead to increased risk of self-harm and suicide (Brownhill et al., 2005).

Effective or positive coping strategies, and willingness to seek professional support, have been reported as protective factors against suicide risk and are believed to mitigate psychological distress (Sisask et al., 2008; Department of Health, 2015). Lifestyle choices that promote positive physical and mental health such as physical activity, emotional stability and connecting with others have also been identified as protective factors (Davidson et al., 2013). Indeed, many men in this study spoke of the important and positive impact of physical activity, volunteering and connecting with others in terms of combatting or coping with psychological distress. It has been shown that connecting with others elicits a sense of belonging, which is inversely associated with suicidal behaviour (Joiner et al., 2009).

However, service providers also stressed the importance of building these connections whilst in a positive mental health state - as it can be much more difficult for men to build and access these supports when in psychological distress.

Men also reported a sense of solidarity with others within the context of organised men's groups which helped them to normalise problems and to be more open to availing of support. These organised groups also acted as a platform for educating men around mental health and the use of adaptive coping strategies during times of psychological distress. This highlights the effectiveness of utilising spaces in which men feel comfortable and within organisations which have credibility with men.

Particular coping strategies were more evident among certain groups, such as religious beliefs in non-Irish national men and kinship among Traveller men. These coping strategies could be leveraged and highlighted among these groups to protect against suicidal behaviour. However, findings also indicate that many middle-aged men are unaware of how to cope effectively during times of psychological distress and often do not think about mental health until they are unwell. There is a clear need to highlight the negative effects of maladaptive coping strategies among MAMRM and to educate men on the benefits of adaptive strategies for coping.

5.2 Relationship Level Factors and Suicide Prevention in Middle-Aged Men

Relationship factors encapsulate the quality, or otherwise, of men's engagement with and connection to others, ranging from personal relationships with family and friends to more professional relationships or engagement with service providers. Interventions at this level are oriented towards strengthening both personal and professional relationships, so as to move men to greater levels of connection.

Isolation was to the fore in many of the transcripts of the men and appeared under many guises - geographical, rejection, withdrawal, lack of social supports for middle-aged men, mortality of friends and family, and relationship breakdown. Durkheim's Theory of Egotistic Suicide and Joiner's Interpersonal Theory of Suicidal Behaviour both recognise social isolation and lack of integration as pre-disposing factors to increased suicide risk (Durkheim, 2001; Joiner et al., 2009). Although suicide and social integration has been extensively researched, little is known about the sources or exact causes of isolation at middle-age (Joiner et al., 2009).

The findings from this study indicate that isolation was not just about a lack of social contact with others, but was often about feeling alone - even when surrounded by friends and family. This has also been found in other studies, with higher levels of perceived loneliness reported among men compared to women, even in the presence of strong social networks (Wyllie et al., 2012). It was reported by both the men and the service providers that middle-aged men have a propensity to 'disappear' at middle-age due to decreased social opportunities, social circles and social outlets. This is congruent with the literature on middle-aged men and isolation, which highlights that men's peer relationships tend to drop off after the age of 30, resulting in a fragmentation of social bonds at mid-life (Wyllie et al., 2012; Shiner et al., 2009).

Divorced men and victims of domestic violence appeared to be particularly vulnerable to isolation due to the negative impact of relationship breakdown on social circles. Geographic isolation was a primary issue for rural men due to a paucity of social outlets, fewer employment opportunities and a lack of access to support. The migration of rural dwellers to urban areas or beyond Ireland impacted the remaining community members through reduced social

interactions. A study focusing on rural suicide reported similar findings, and noted that geographically isolated individuals may face an increased risk of suicidal behaviour due to a lack of social contact, reduced availability of informal support during times of crisis, and the loss of primary relationships due to de-population (Hirsch, 2006). Men who lived in rural areas felt that the closure of rural pubs and tighter restrictions in relation to drink driving laws - although perceived as necessary - increased social isolation among middle-aged men in rural Ireland; with the pub being one of the few social outlets still available in rural areas.

More generally, it was perceived that there is a distinct lack of social outlets available for middle-aged men in Ireland, and that middle-aged men are often fearful, shy or intimidated about joining organised groups. Service providers noted that they often found it difficult to identify an appropriate social group to which they could refer men who were experiencing loneliness. However, men who were part of social groups, such as Men's Sheds or the Mojo Project, stressed the overall sense of solidarity, connection, and camaraderie that they experienced by being part of the group. Therefore, in terms of engagement, a key challenge lies with that first contact with middle-aged men and supporting them to overcome perceived barriers about joining organised groups.

These findings underline the importance of educating men and the general public on the effects of social isolation on middle-aged men's mental health, and encouraging connection and maintenance of social relationships among middle-aged men. A key priority should be to cascade models of effective practice in Ireland which encourage social participation and education (such as Mojo, Men's Sheds and the Larkin Centre's Men's Health and Wellbeing Programme). However, there is a need to specifically target middle-aged men and marginalised groups. It is crucial to consult with the intended target group in the development phase of this process to maximise potential engagement, empowerment and ownership over the process - in line with the findings from this study, the men's health literature (Robertson et al., 2015) and the community capacity building literature (Nutbeam, 1998).

Supportive factors that were found in this study such as strong relationships with family and friends, religious beliefs, and seeking timely support are also congruent with wider evidence of protective factors for suicide risk (Department of Health, 2015; WHO, 2014) which have been described in section 5.1.

Service providers reported that building trust and rapport with men were critical elements of engaging with MAMRM. This was predominantly done through giving men ownership, gaining credibility, being relatable, sharing vulnerabilities where appropriate, and ensuring that men feel valued and respected. Similarly, Roberston et al. (2014) found that the credibility of facilitators was a crucial component in building trust with men, which involved the facilitator being flexible and responsive to men's voices, engaged, committed and non-judgemental. It was also found that 'home grown' staff, as well as staff who shared similar experiences with men, were more positively received - which was linked with familiarity, trust and shared identity (Robertson et al., 2014). This highlights the potential of identifying male advocates or ambassadors to train for and promote middle-aged men's mental health issues within local communities.

Consulting with men in the development phase of a programme, giving men ownership over the process, and utilising self-guided strategies were key to developing trust and rapport with men - findings which are congruent with the wider literature on effectively engaging men (see section 2.3.1). It was also found that being truthful and honest about what could realistically be delivered was key to working with middle-aged men. These findings provide a strong rationale for gender-specific training to be made available for a range of service providers on best practice approaches to engaging middle-aged men. A critical part of this training should also relate to initiating conversations, making first contacts count, and community outreach to men.



5.3 Community and Institutional Level Factors and Suicide Prevention in Middle-Aged Men

A range of factors at community and institutional level can act as a source of psychological distress for middle-aged men or facilitate engagement with services and support organisations. Initiatives at this level focus on empowering groups and creating change in organisational environments.

The findings identified multiple causes of psychological distress among middle-aged men at this level. Among the more significant factors cited were: rejection and discrimination (particularly among gay men, transgender men, Traveller men, victims of domestic violence, and non-Irish national men); a lack of social outlets in communities; the 'death' of rural communities; and homelessness.

Many men reported feeling discriminated against and rejected from social participation, access to services, and access to economic opportunities. The wider literature has also reported that rejection, discrimination and stigmatisation of sub-population groups can evoke suicidal behaviour (WHO, 2014), particularly among gay and transgender people (Haas et al., 2011), and migrants (Kalt et al., 2013).

Although little evidence is available on the effects of discrimination and rejection on suicide among Traveller men, research has indicated that Traveller men's suicide rates are 6.6 times higher than the general population on the island of Ireland, and discrimination is reported as one of the main sources of stress for Traveller men (UCD, 2010). This rejection and discrimination often leads to feelings of isolation which, as discussed previously, is linked to increased suicide risk.

Social stress theory provides further insights into the links between discrimination and suicidal behaviour, and may be particularly relevant for middle-aged men. Social stress has been described as originating from the absence of resources to meet one's goals in life or to maintain one's current level of social functioning (Cohen and Willis, 1985). Exposure to multiple and chronic stressors can strain an individual's adaptive capacities and result in mental health disorders and suicidal behaviour (Peng, 2009).

Yur'yev et al. (2013) concluded that social exclusion and discrimination is a strong example of one such chronic stressor. This is particularly relevant in terms of the cumulative impact of long-term discrimination on sub-population groups of men by the time they reach middle-age. Indeed, the same can be said for any chronic stressor that impacts on any group of middle-aged men, Thus, in the context of men's 'failure' to achieve expectations or benchmarks associated with middle-age, it becomes clear how intersecting aspects of identity (gender, age, ethnicity, race, and sexual orientation) can create multiplicative effects on suicide risk among these population groups of middle-aged men.

The acculturation of ethnic minorities - such as Traveller men and non-Irish national men - has also been reported to generate feelings of isolation, depression, discrimination, and a mistrust of state-affiliated social and health care services (WHO, 2014).

Men who fail to match up to culturally normative or more dominant or hegemonic masculinity norms - within an Irish context typically defined as straight, white and able-bodied - are also perceived to fall short of being 'masculine' and face stigmatisation from other men (Gough et al., 2016). Thus, there needs to be a focus on reducing the stigmatisation of particular groups of middle-aged men in Ireland. Advocates that are representative of those groups facing stigmatisation should be supported to raise awareness of mental health issues and to actively combat rejection and discrimination that these groups face. Educating the general public by means of national campaigns could also be an effective way of achieving this goal, and could be run as part of a national campaign to reduce the stigma of mental health and men seeking help.

A lack of communication and collaboration between services was another factor within this level that had a significant bearing on middle-aged men's psychological distress. Service providers consistently reported the need for a more collaborative approach between community based

organisations, primary care teams, and statutory mental health services to address the mental health needs of middle-aged men. GPs discussed the difficulty of locating and referring men to social supports in the community, whilst community service providers believed that GPs were simply unaware of what social supports were available in the community.

Although policy, within Ireland and further afield, consistently calls for a more joined-up approach to tackle the issue of suicide and mental health among men (Richardson et al., 2013; Wyllie et al., 2012), it still appears that services are overstretched and working in isolation. Findings from this study highlight the urgent need for clear communications networks to be established between GPs, mental health organisations, community organisations, and statutory mental health services to share resources and best practice approaches to engaging men. There is a need for services to work together to identify their specialities and develop a roadmap of mental health services, so clients can be referred to receive the best possible support. This more holistic and collaborative approach was stressed by many men's health community based service providers as being the key to effectively supporting men during times of psychological distress. Ideally, this goal would be a priority within each Community Health Organisation (CHO) structure, with responsibility for acting on this goal being assigned to a senior CHO manager.

It was postulated that there may be an unwillingness within and between voluntary and mental health organisations to work together, to refer men to other organisations and/or to share resources - out of fear of organisations losing funding. It may be useful for central funding bodies to be the lynchpin for various service providers to work together, and to make funding contingent on service providers ensuring that inter-agency cooperation is a core pillar of their work.

Community and Institutional factors within services which were identified as being supportive to men during times of psychological distress included: using 'male-friendly' environments, finding a 'hook', and utilising self-guided strategies. All of these best practice approaches to engaging men around mental health are well established in the literature of men's health (Richardson et al., 2013; Grace et al., 2014; Lefkowich et al., 2015; Robertson et al., 2015). However, in the context of this study, it is clear that these best practice approaches have not filtered down to have an impact on middle-aged men.

Ireland is one of the few countries in the world to have an evidence-based national men's health training programme ('ENGAGE'; Osborne et al, 2016; Lefkowich et al, 2016). A model of training for engaging young men around suicide prevention is also well established and has shown to be effective (Grace et al., 2016). Careful consideration ought to be given to using this framework to develop a training programme for service providers on engaging middle-aged men around mental health and suicide prevention and promoting cultural and organisational change to support sustained engagement. Training should highlight the specific issues facing middle-aged men which predispose them to an increased risk of suicide, and encourage an increased focus on advocacy to meet the needs of middle-aged men in relation to mental health.

5.4 Health Systems and Society Level Factors and Suicide Prevention in Middle-Aged Men

This level of influence relates to wider societal and systemic factors that have been identified as either sources of psychological distress among middle-aged men or as supports to middle-aged men during times of psychological distress. Initiatives at this level focus on increasing access to health services, informing policy and increasing citizen advocacy. The factors that were identified as key sources of psychological distress included the stigma surrounding mental health and men seeking support for mental health issues, poor past experiences of services and difficulties with access to services, societal challenges (such as the changing role of men, economic austerity), as well as a disconnection between systemic structures and front-line staff.

The stigma attached to mental health and suicide can be a substantial barrier to support seeking (WHO, 2014). This stigma is intensified for men, as seeking support is often construed as a sign of weakness and judged as falling short of prevailing masculine ideology (Gough et al., 2016). This is congruent with the findings of this study, wherein the stigma of mental health elicited feelings of shame and embarrassment for men who experienced psychological distress.

Due to prevailing gender norms relating to men being invulnerable, stoic and autonomous, many men felt a 'double burden' whereby the act of seeking help was seen as compounding their 'failure' to deal with their own problems (Keohane and Richardson, 2017). Men also reported a difficulty with confiding in their family and friends out of fear of being burdensome. This is of particular concern, as perceived burdensomeness is a key element of Joiner's Interpersonal Theory of Suicide (Joiner et al., 2009).

However, it must be noted that many men contested and grappled with these gender stereotypes. Indeed, some argued that given the right environment 'men have no problem talking'. This highlights the need for using gender-specific approaches to engage men. It also highlights the potential for re-framing masculine values and norms so that help-seeking is seen as a strength, consistent with fulfilling - not compromising - masculine roles (e.g. as provider and protector) and, therefore, potentially interrupting the suicide process (Olliffe et al., 2012).

Findings overwhelmingly point to the need to reduce the overall stigma of mental health and of men seeking help for a mental health issue, with a particular focus on middle-aged men and marginalised groups. A national awareness raising campaign is needed to reduce the stigma of mental health, to challenge unhelpful masculine stereotypes, to reduce the stigma experienced by marginalised groups, to encourage middle-aged men to seek timely support and to raise awareness of the issue of middle-aged male suicide across the whole of society.

Initiatives such as Man Therapy (see section 2.3.1) which utilises multimedia platforms (TV, radio, print, online) could be used as a model on which to base such a campaign (IPSOS SRI, 2014). There is also a need for follow-up support in the form of online resources which men can access if they need further information. As mentioned previously, facilitating middle-aged male advocates - which are representative and inclusive of the diverse range of middle-aged men in Ireland - to raise awareness both publicly and within their communities may also be an effective way of normalising mental health and support seeking. Advocates at service provider level also have an important role to play.

Some men who did access services during times of psychological distress, particularly those who had attempted suicide, had a profoundly negative experience. Men reported feeling misunderstood, rejected, or that no genuine help was being offered. It should be noted that all research participants acknowledged that many services were over-stretched and at breaking point. It was also felt that there was limited access to adequate mental health

supports in a timely manner. Nevertheless, these findings support the need for increased outreach services for at risk groups of middle-aged men, as well as gender sensitive training delivered to front-line staff to adequately support middle-aged men during times of psychological distress.

The unprecedented socio-cultural, economic and political change that has been a feature of Irish society in recent times was also cited as a significant source of psychological distress for middle-aged men. Durkheim devised the term anomic suicide which describes suicide that is related to large scale societal crises (Durkheim, 2001). It has been reported that men at middle-age are caught between declining and emerging cultures - the traditional masculinity of their fathers and more individualistic masculinity of their sons - with increased demands for equality in relationships, open expression of emotions, and a more individualised culture where the person, rather than social structures, are responsible for shaping one's destiny (Wyllie et al., 2012). On the basis of the findings from this study, it would appear that many middle-aged men are caught between these two generations, lacking the social or emotional skills to negotiate such change (Wyllie et al., 2012; Brockmann et al, 2010). The move to a more service-based economy, coupled with lingering after-effects of economic recession, has resulted in great hardship for men in unskilled or semi-skilled occupations in particular.

Findings also revealed a disconnection between more systemic structures and front-line staff, which has resulted in service providers finding it difficult to deliver best practice approaches against a pre-determined set of outputs, a perceived under-valuing of so-called 'soft outcomes', and inconsistent funding streams which impede service providers' ability to create sustainable projects.

Middle-aged men's mental health needs should be prioritised and embedded in service plans at both national and local levels, and underpinned by an integrated and partnership approach. With due regard to the need for services and programmes to address key policy priorities and to represent value for money, consideration also needs to be given to the critically important 'soft outcomes' that address the broader determinants of health. Indeed, the language of 'soft' outcomes needs to be changed to better reflect their importance in achieving greater overall health outcomes.

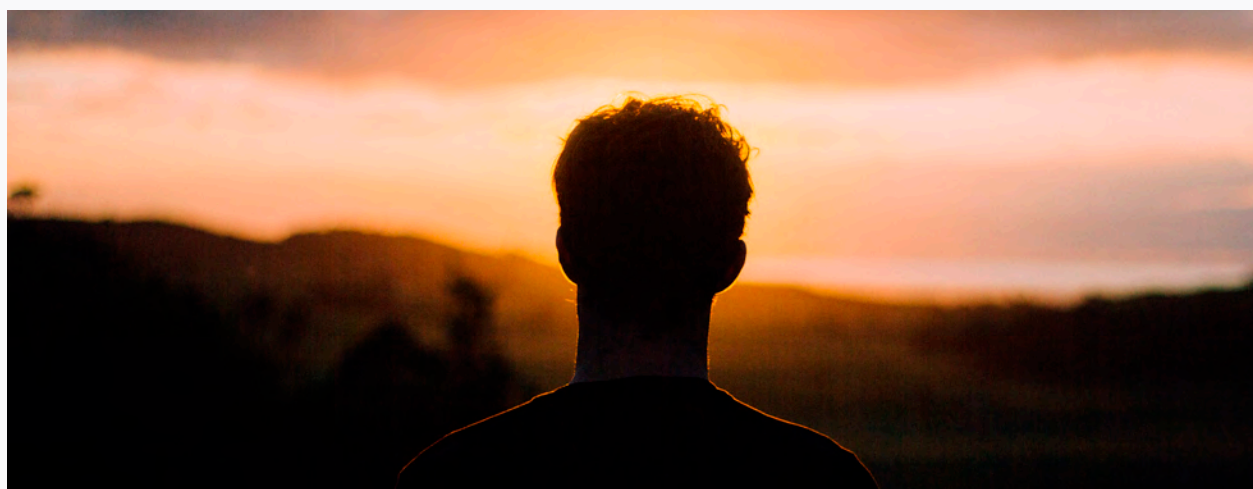


6. RECOMMENDATIONS

6.0 Conclusion

Despite the disturbing increases in suicidal behaviours among middle-aged men in the Republic of Ireland in recent years, and at a time of unprecedented socio-economic change, there has been an equally disturbing inertia and ambivalence at a policy and service delivery level in terms of addressing this issue. To compound the problem, middle-aged men's voices have largely not been heard in terms of advocating for their own mental health needs - historically, this age cohort of men have simply 'got on with it' and 'sorted out their own problems'. Sadly, this is having increasingly tragic consequences in terms of increasing rates of suicide and self-harm among middle-aged men.

The aim of this study was to explore the factors underpinning the high suicide rates of middle-aged men at risk of marginalisation with a view to providing more effective and gender specific programmes, services, and resources that support their mental health and wellbeing. In doing so, the study's findings respond to Action 2.4 of Ireland's National Men's Health Action Plan (Healthy Ireland - Men, Health Service Executive, 2016) which is to "support the implementation of the 'Connecting For Life' Implementation Plan by developing and implementing new initiatives (e.g. middle-aged men)".



The findings of this study indicate that a recurring set of transitions and challenges occur at middle-age for men which are the cause of significant psychological distress. These include: a declining health status and facing-up to mortality; diminishing life and career opportunities; increasing pressures at middle-age associated with the provider role; facing up to the 'failure' of unfulfilled aspirations and expectations at middle-age; and the cumulative and multiplicative effects of psychological distress at mid-life. These transitions and challenges coincided with significant societal change (changing role of men, economic recession), which compounded the difficulties facing middle-aged men. Furthermore, many groups of men felt stigmatised on the basis of different aspects of their identity (sexual orientation, race, ethnicity, gender identity, mental health status, employment status). This pushed many into a crippling sense of isolation and loneliness which, for some men, resulted in increased risk of suicidal behaviour.

The stigma associated with mental [ill]-health, and with seeking help for a mental health issue, clashed with more dominant masculine norms and impeded some men from seeking support in a timely manner. Some also reported using maladaptive coping mechanisms such as alcohol misuse and 'bottling it up', which compounded their mental health issues. Accessing organised men's groups and using social outlets, on the other hand, instilled a sense of connection, self-esteem and normality during times of distress.

Engaging men around mental health is contingent on establishing trust, finding common ground, gaining credibility, using male-friendly environments, finding a 'hook', using self-guided strategies to facilitate recovery, and working towards a partnership approach between community organisations. There is a need to improve communication lines between GPs, statutory and community services, and mental health organisations to better support men, to reduce stigma around seeking help for mental health issues, and to facilitate middle-aged men to build or strengthen relationships. The study's findings, therefore, make the issue of suicide in middle-aged men visible, by giving a voice to those more vulnerable and 'at risk' groups to have their say about the issues and challenges that impact on their lives. By also drawing on the experience of service providers (who are at the coalface in working with middle-aged men), the findings also signpost to both the challenges and opportunities in terms of engaging more effectively and reaching out to middle-aged men.

Much of the existing focus of health policy in Ireland and elsewhere is on behaviour modification and increasing personal capacity to effect change. However, it is imperative that policy also accounts for the wider social determinants of health that, in the context of this study, result in circumstances that push more vulnerable and marginalised groups of middle-aged men into isolation and increased risk of suicide. There is a need for both bottom-up and top-down approaches to create sustainable change, both in terms of culture change (to ensure society is more open to and accepting of MAMRM expressing their concerns) and structural change (to ensure that when men do seek help, it is available and accessible).

The hope or expectation for finding a magic formula that will be the panacea for addressing the high suicide rate among middle-aged men is not realistic - nor could it be in the context of the complexity and interplay of causes and risk factors for suicide. Finally, identifying recommendations and a roadmap to address the issues and challenges that have been raised is not the main challenge; mobilising the will and necessary commitment to translate these into tangible outcomes is.

6.1 Recommendations

The following recommendations were developed and refined through consolidating the study findings against the existing policy context and the aim of the project - as well as input from the Advisory Group. The EMAM-SP model (see Figure 15; Section 5.0) was used as a roadmap to guide the development of the recommendations and to ensure that all four levels of influence were being targeted. Based on this model, the aim of each level is to: (i) Individual Level - promote change to individual men's attitudes, beliefs and behaviours to support their mental health and wellbeing; (ii) Relationship Level - strengthen relationships and move men to greater levels of connection; (iii) Community and Institutional Level - create change in organisational environments and empower 'at risk' groups of middle-aged men; and (iv) Society and Health Systems Level - create change in access to health services and support organisations, inform policy and increase citizen advocacy.

Although this was used as a guide to inform the recommendations, it does not tie specific recommendations to one level, that is to say, some recommendations may address issues across numerous levels. As the groups of middle-aged men at risk of marginalisation are very different from one another, there is no 'one-size-fits-all' in terms of meeting their needs. Therefore, tailored approaches and resources are needed to suit diverse communities of interest, as well as a broad menu of options for action. Thus, it is vital to consult with the intended target group in the development of the interventions or initiatives in order to maximise participation, engagement and empowerment.

A key consideration in terms of approaches to implementing these recommendations is alignment with the key principles of engaging men: working in an informal environment and creating a safe space; adopting a strengths-based approach; using positive non-stigmatising language; finding the 'hook'; consulting with men; and adopting a partnership approach. These principles should be considered along with the evidence found in this study in relation to engaging middle-aged men.

Finally, the five broad categories that were identified in the literature review as potential sites for future suicide prevention work with middle-aged men might be useful vehicles to implement these recommendations. These included: (i) awareness raising campaigns; (ii) activity based programmes and support groups; (iii) education and training interventions; (iv) psychological support; and (v) use of technology.

Thus, it is against this backdrop that the following over-arching recommendations are presented in this report, that cover six key areas: **A**dvocacy, **C**onnection, **C**ommunication, **E**ducation and Training, **S**tigma Reduction and Awareness, and **S**upport (ACCESS). These ACCESS recommendations have been developed with due regard to the aims and objectives of this study and in the context of informing policy and practice approaches to reducing the risk of suicide faced by middle-aged men at risk of marginalisation.

R1: Advocacy

Identify and facilitate key advocates to drive the agenda on middle-aged men and suicide prevention in the Republic of Ireland.

- Facilitate and train local middle-aged men as advocates to act as mental health ambassadors and champions within their respective communities. Advocates should be representative of the diversity of middle-aged men in Ireland including, but not limited to, those that have been highlighted in this report. Their role should be to support awareness campaigns (see R5) and to combat the rejection and discrimination experienced by middle-aged men at risk of marginalisation.
- Appoint prominent ambassadors and champions within the statutory sector whose role will be to ensure that the needs of marginalised groups of middle-aged men are not overlooked at a policy and practice level. Local Community Development Committees (LCDCs) might be an appropriate gateway to achieve this. It is crucial that a lead statutory agency be identified to drive forward work which addresses middle-aged men's mental health issues and needs.

R2: Connection

Support middle-aged men at risk of marginalisation to build and strengthen relationships with friends, family and service providers.

- Develop new and expand existing initiatives and interventions (e.g. Larkin Centre's Men's Health and Wellbeing Programme; Men on the Move; IMSA's Sheds for Life; Mojo) which address the issue of isolation and promote connection among middle-aged men. These initiatives should be adapted to suit the diverse needs of specific target groups through consulting with men in the development process. They should be supported and resourced with consistent funding streams, and linked to existing structures such as local HSE Resource Officers for Suicide Prevention and Local Community Development Committees for implementation locally.
- Pilot initiatives with specific 'at risk' sub-population groups of men (e.g. Traveller men, rural isolated men) to test the efficacy of approaches and resources which seek to combat isolation and build connection.

R3: Communication

Increase lines of communication between services to better support middle-aged men's mental health and wellbeing.

- Establish clearer communication networks between GPs, mental health organisations, community organisations, and statutory mental health services to share resources and best practice approaches to engaging men. There is a need for services to work in partnership, identify their specialities, share resources, and develop a roadmap of mental health services, so clients can be referred to receive the best possible support. Ideally, this goal would be included and supported through both Healthy Ireland and Connecting for Life implementation structures which aim to support mental wellbeing and reduce suicide.
- Develop a national co-ordinating function with responsibility for co-ordinating and streamlining inter-agency work between statutory organisations (addiction services, mental health services, primary care, social welfare) and community/voluntary organisations (men's health organisations, mental health NGOs, community services, MABS). This inter-agency work should address the high level of suicide risk factors among middle-aged men with strategies which aim to reduce socio-economic and other inequalities. It should also be the lynchpin for various service providers to work together by making funding contingent on service providers placing inter-agency work as a core pillar of their work.
- Develop a Communications Plan to maximise the impact and reach of the report. Ensure that all political decision makers (e.g. TDs, MEPs, Senators and local Councillors) are made aware of the report and its key findings. Have a high-profile launch of the report findings and seek to enlist positive media coverage to raise awareness at all levels of society.



R4: Education and Training

Develop specific education and training programmes for both middle-aged men and service providers to support middle-aged men's mental health and wellbeing.

- Develop a training programme, as part of the National ENGAGE men's health training programme, for front-line staff on how to effectively engage with middle-aged men. There should be a focus on how to engage men at the individual level and relationship level, (see EMAM-SP model), and how to advocate at the societal and health systems level to drive an increased focus on middle-aged men's mental health. This training should also highlight the specific issues facing middle-aged men which cause psychological distress. This programme should be supported by the development of appropriate resources and toolkits to support service providers in the engagement process.
- Prioritise middle-aged men at risk of marginalisation as a target group for the delivery of existing suicide prevention and mental health awareness training programmes. This should include the development of a specific workshop on engaging middle-aged men for Suicide Prevention Resource Officers. A crucial component of these programmes should build resilience, highlight the negative effects of maladaptive coping strategies, and signpost effective coping strategies. It may be useful to consider how these training programmes might be adapted and integrated into existing programmes/services that men engage with, particularly those that have credibility within their community. This could include the development of a short booklet for service providers on guidelines for engaging middle-aged men around their mental health.
- Design and disseminate a 'Top Tips for Mental Fitness' toolkit for middle-aged men.



R5: Stigma Reduction and Awareness

Reduce stigma relating to mental health and to men seeking support for a mental health issue, and raise awareness across society of the issue of middle-aged male suicide.

- Develop and co-ordinate a national awareness raising campaign which specifically aims to: (i) reduce stigma in relation to middle-aged men and mental health, normalise men seeking support for a mental health issue, and challenge masculine stereotypes; (ii) challenge the discrimination and prejudice towards marginalised groups of middle-aged men; and (iii) increase awareness and seek the support of the general population to address the issue of high suicide risk among middle-aged men. This should be implemented over various forms of media such as radio, internet, television and print to maximise potential reach, and be in line with the Samaritan's media guidelines on reporting and discussing suicide to avoid the risk of contagion. Re-framing particular masculine values (for example control and responsibility) as a positive trait for help-seeking may be a useful approach.
- Provide follow-up support in the form of online resources which provide further information and signposting for middle-aged men. It may be useful to adapt existing models such as 'Man Therapy' to inform such an approach. Personal biographies, adapted from the case studies in this report, could also be utilised to raise awareness of the issues facing particular groups.

R6: Support

Extend the availability of statutory mental health services nationwide and increase the accessibility to services for marginalised groups of middle-aged men.

- Prioritise the needs of middle-aged men at risk of marginalisation at a suicide prevention policy level, and ensure that mental health services are adequately resourced and accessible to middle-aged men. Services should also give due recognition to the importance of what are known as 'soft' outcomes (connectedness, self-worth and self-efficacy). A change in language of so-called 'soft' outcomes is required to better reflect their importance.
- Provide specific and tangible support for middle-aged men. These could include seeking funding to replicate the 'Man Therapy' website for Irish users and to create a signposting / help-seeking phone app for men.
- Expand outreach services for at risk groups of middle-aged men, as well as gender sensitive training delivered to front-line staff to adequately support middle-aged men during times of psychological distress.
- Ensure that relevant government agencies and institutions (i.e. banks) are aware of and sensitive to the potential impact that unemployment and financial stress can have on middle-aged men's mental health. Services dealing with unemployed middle-aged men should exercise due care so as not to reinforce negative stereotypes that can potentially be associated with being unemployed.

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MIDDLE-AGED MEN AND SUICIDE IN IRELAND

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