The Men’s Health Forum

The Men’s Health Forum was established in 1994 by the Royal College of Nursing, as a national, independent and representative body which includes statutory and voluntary organisations, Royal Colleges, and those representing specific groups of men and decisions.

The Forum aims to provide a platform for interested organisations to discuss, disseminate and promote ideas and information on men’s health and the development of good practice. Membership is free and open to all organisations interested in men’s health. The full forum meets twice a year and publishes a quarterly newsletter. For more information, and a membership application form, please contact the Men’s Health Forum co-ordinator on 0171-647 3740.

This ‘Briefing Paper’ was written by Trefor Lloyd (Working With Men), who would like to thank the Steering Group of the Men’s Health Forum for making comments on drafts of this paper.

Young Men and Suicide

Why the concern about young men?

While definitions of suicide vary (1), concerns have been raised about coroners' records (2), and an overall reduction in incidence has taken place, suicides amongst young men have increased. Suicides fell from 5,655 in 1982 to 4,872 in 1996, a fall of 13.8% (3). However, while trends for men and women followed a similar pattern up until the early 1980's, they have significantly changed since then.

	1982	1996	change
men	3,557	3,640	+2.3%
women	2,098	1,232	-41.3%

As well as gender, age has been an important component within the increased figures for men. While suicides amongst the various age groups have gone up and down during the period 1974 to 1990, the overall increases are significant.

Change in male suicide by age 1974-1990 (rates per million population)

Ages	A'ge	15-24	25-34	35-44	45-54	55-64	65-74	75+
1974	95	58	106	114	154	159	188	221
1990	121	117	160	171	164	139	136	194
% + / -	+27	+102	+51	+50	+6.5	-13	-28	-12

Whilst male suicide continues to occur largely amongst men aged 75 and over, the increases in deaths of younger men have caused the most concern, in part because of the rises themselves, but also because of the years of life lost (4).

In contrast, 'deliberate self-harm' is three to four times more common in women than in men and more common in younger adults. The term is generally used to cover all acts of self-harm, self-injury or attempted suicide (5). There are an estimated 100,000 people per year referred to hospitals in England and Wales for deliberate self-harm, mainly involving drug overdoses or self-injury. Approximately 19,000 of these are young people (6). Self-injury is also thought to be twice as prevalent among women as it is among men. However, statistics on self-harm and self-injury are thought to be very unreliable, with many of these incidents (especially scalds, cuts and burns), being dealt with at home and therefore not appearing in the statistics.

As in most other mortality figures, there are marked social class differences in the suicide rates. While Social class 1 has seen a decrease, there is a progressive increase as we move down the social class groups, both in terms of actual incidence and over time (7).

	1970-72	1991-93
Social class I	16	13
Social class II	13	14
Social class IV	18	23
Social class V	32	47
Averages for		
England and Wales	15	22
(Rates per 100,000)		

Unfortunately, data correlating social class and age is unavailable.

In summary there has been an increase in male suicides, especially in social classes IV and V and amongst younger men below 44 years.

The methods used

Kelly and Bunting (2) have suggested that suicide methods are determined by ease of access, and possibly by fashion.

Main causes for all men in 1996	
Hanging and suffocation	34%
Poisoning by gases and vapour	23%
Poisoning by substance	20%
Drowning	5%
Other methods (as below)	18%

Hanging and suffocation have increased steadily for men since 1983 (especially for the 15-44 age group); poisoning by gases and vapours (especially motor vehicle exhaust gas) has also seen an increase, while poisoning by substance (especially drugs) is decreasing. The figure for 'other methods' includes firearms & explosives, jumping from high places and lying in front of moving objects.

It has been suggested that one of the primary differences in methods used by males and females is that of lethality. This is also thought to contribute to the suicide rate being predominantly male and the attempted suicide rate being predominantly female. The effectiveness of hanging as a method is much higher than drug overdoses (where the user needs to know something about the drug and the quantity required), while hanging is also a much quicker process, with the result that life-saving detection is far less likely to occur.

In summary men use more violent and lethal methods which are thought to contribute to the higher rate of actual suicide.

Causes of young men's suicide

Most analyses of causes make little distinction between age or gender, but most agree that causes are multi-faceted and could include:

Individual characteristics such as mental illness, drug use, gender identity issues and genetic or biological components;

Family issues such as child abuse, suicide in the family and family breakdown;

Social disadvantage and exclusion such as economics, discrimination, and school underachievement;

Life events such as relationship breakdown, confinement in mental hospitals and prisons, loss of a job, homelessness and development of physical illness or disability.

Significant relationships have been suggested between suicide and a number of factors. Those with particular reference to young men are:

psychiatric illness, particularly depression; schizophrenia; alcoholism; drug addiction; cerebal disorders (epilepsy, brain injury, mild dementia); personality disorder and neuroses. In some studies (albeit rather old ones), as many as 90% of those who committed suicide were judged to have some form of psychiatric illness (8).

While there appears to be a significant link between mental illness and suicide, this alone does not account for the differences in gender rates:

"All of the evidence - from surveys of the incidence of mental health problems in the community, and analyses of hospital admission rates - suggests that more women than men experience such mental health problems as anxiety and depression. The link here may be that men might be reluctant to admit to such problems, or that they express

mental health problems in a different way and so do not gain access to sources of help. Men also most commonly abuse alcohol and drugs, both of which are implicated in suicide" (5).

Estimates suggest that up to 60% of young men who commit suicide are suffering from a depressive illness (9). However, schizophrenia is thought to be the most significant factor for younger men, especially if they are also unemployed and have a previous history of acts of deliberate self-harm and depressive episodes (10).

While there is not a direct link between unemployment and young male suicide, there may be an indirect link from the effect of unemployment, especially poverty. Pritchard has suggested that *"a negative socio-economic situation worsens those already vulnerable and compounds any 'stress-related' situation, which increases the other psycho-social pressures linked to poverty and unemployment, of which suicide is one of the continuum. However, caution is necessary, as self-evidently the vast majority of unemployed people are not involved in suicidal behaviour, and unemployment is only one element in a complex equation" (4).*

How significant is the male element? Surprisingly little has been written about maleness in relation to the suicide incidence amongst men, although this is often mentioned by many as 'in the background'. Bradford and Urquhart concluded from a study of young men and women that *"Changing patterns of employment, (have) altered gender relations, new discourses of masculinity or femininity may undermine young men's sense of certainty and security, particularly when these are seen to damage opportunities for economic independence..... significant numbers of young men may need more support in finding their way on this rapidly changing terrain, and statistics on young men's suicide indicate that there is much work to be done to contain growing problems" (41).*

The link between masculinity and suicide is unproven, but writers such as Gilmartin (12) have argued that gender-role strain (difficulties for men to live up to the masculine demands of work, success, physical strength, independence and invulnerability) has been a repetitive theme within the literature on men and depression, suicide and even alcohol and drug abuse. While most commentators have taken this as fact (in the same way as the criminal justice system acknowledges 95% of their clients are male), they have failed to develop practice and intervention on the basis of this fact.

While suicides being male has been mentioned by a number of studies and articles (36), there have been few attempts to measure or really engage with this relationship. Stillion, McDowell and May (11) suggested that there are three aspects of masculine socialisation that may play a part:

1. Males show higher levels of aggression throughout their lifespan and, thus, aggression towards the self may also be seen to occur at a higher level, with males also tending to use more violent methods and lethal means of committing suicide than females;

2. Their orientation towards success, status and problem-solving leads males to 'succeed' in carrying out the job of taking their life (they offer the distress experienced by those men who have been unsuccessful in committing suicide as evidence of this);

3. The masculine norm of independence, which often leaves men alone with their problems and unable to ask for help until this escalates to the point of contemplating suicide.

Gilmartin (12) also speculates that, because adolescence and old age are the most sex-type times of life (becoming a man and 'masculinity fading away'), these high-risk developmental periods may be affected by feelings of not measuring up as a man.

In summary a number of factors have been suggested as significant contributors to suicide in men. However, because they are, on the whole, taken from analyses of those that have committed suicide, they are factors in that population, but do not provide us with a narrow enough list of factors to enable us to target a specific population. This list ranges from individual to environmental reasons, but fails to provide us with anything more than a growing awareness of possible contributing factors. The chains of causation remain elusive. Masculinity remains a relatively unexplored factor in young male suicides.

Explanations for suicide

As in most other areas of physical and mental health there are three primary perspectives to explain suicide, they are social, psychological and biological. Biological explanations range from the view that suicide 'runs in the family', and, while there are examples of this happening, studies of twins and child adoption suggest that these generational suicides may have more to do with social learning than with genetics. Alternatively, it has been noticed that many people who are clinically depressed have low levels of the neurotransmitter serotonin. Roy has suggested that this may play a part in suicidal contemplation (as he found that, as research subjects stopped thinking about suicide, the levels of the serotonin receptor 5-HT(2A) dropped to near normal levels) and that a blood test may be helpful in evaluating suicidal risk (22).

Inevitably, psychological explanations include the usual suspects. Freud suggested that there were two kinds of competing drives, one for life and one towards death, destruction and aggression, and that, while murder is aggression turned upon another, suicide is aggression turned upon the self (23). Menninger, Adler and Jung all build on this premise, and added their own spin. Menninger suggested that there were three elements to suicide, the last of which is the wish to die (suggesting that daredevil driving and

mountain climbing were reflections of this) (24). James Hillman stands out in his approach because he questions the negativity of suicide. He suggests that views on suicide are riddled with moralistic attitudes and with physicians' preoccupation with prolonging life and suggests that suicide can be a 'release' for some. Predictably, Hillman has been used to fuel the euthanasia debate (25). Karen Horney, while being an analyst by training, added environmental factors within her perspective of suicide, which she saw as a result of both personality and environmental characteristics (26).

Emile Durkheim (27) suggested that the causes were to be found in individuals' reaction to society. Most suicides occurred because the individual felt disconnected from their community, family and friends; they failed to adjust to social change (suggesting that this occurs during periods of economic depression); or resulted from the individual losing their personal identity and wishing to sacrifice their life for the 'community' (as in the case of 'cult' suicides). Durkheim and others have argued that the higher societal fragmentation, the higher the suicide rate. This fragmentation can take a number of forms, with the loss of a job, divorce, poor social networks and low community affiliation all highlighted as factors in suicide. This view, to some degree, underpins the current Government's view of social exclusion.

Other theorists have merged the social and psychological perspectives. Norman Faberow (28), for example, has argued that the definition of suicide needs to include self-destructive behaviours (often condoned by society) such as drug, alcohol and tobacco abuse, high-risk sports and even disregarding medical regimes, suggesting a continuum of risk-taking behaviours. Edwin Schneidman (29) has followed the same path, suggesting that *"death is hastened by the individual's carelessness, imprudence, foolhardiness, forgetfulness or some other psychological mechanism".*

In summary explanations for suicide have taken into account biological, psychological, social and environmental factors.

Recent Government policy

Predictably, changes in Government policy during this decade have reflected some of these different perspectives. The strong focus of the Conservative Government on clinical practice, early identification of individuals at risk and on mental health provision characterised the psychological approach to suicide. In contrast, the Acheson Report highlights a strong mix of social and psychological perspectives, placed within the public health framework (15 & 21).

One of the key areas of the Health of the Nation strategy was the reduction of deaths as a result of mental illness (13). Within this objective was the target of reducing *"the overall suicide rate by at least 15% by the year 2000"* (from the baseline of 1990). Some cynics, following a peak in

1990, believed that the Government anticipated a reduction in suicides of 15% (14).

The Government indicated elements of a strategy within the *Key Area Handbook on Mental Illness* (15). Suggestions included:

- identify the number of people with a severe mental illness and measure reductions in suicide rates amongst this group;
- use rolling averages to establish an initial baseline;
- correlate suicide with indicators such as socio-demographic background, ethnicity, age and sex;
- set up a multi-disciplinary review and audit in mental health services and primary care and liaise closely with the coroner's office.

This publication went on to suggest that interventions should include the 'improved management of depression' in general practice; the development of more community-based local services; changing the availability of means (exhausts, etc.) and introducing levels of supportive observation to those at risk. The establishment of targets in these areas was also encouraged.

The increase in suicide for young men was highlighted within the Chief Medical Officer's chapter on men's health (16), although the two paragraphs concentrated on incidence and possible correlation of factors.

A number of government-commissioned research papers followed, primarily looking at trends in suicide deaths (3), and factors that may lead to suicide (17). Other papers had appeared prior to the Health of the Nation targets, for example a review of literature on suicide and self-injury in prison from the Home Office Research and Planning Unit (18).

The CMO's yearly reports continued to mention developments in this area. The 1994 Report suggested that discussions and debate on suicide prevention had focused the attention of mental health teams, GPs and the general public and that risk assessment information had been distributed. Occupational groups thought to be at risk of suicide had continued to develop strategies to help their peers, with the Medical Research Council funding research and the Confidential Inquiry into Homicides and Suicides publishing a preliminary report (19).

The CMO's report of 1995 rehearsed primary, secondary and tertiary prevention strategies and mentioned the development of clinical practice guidelines and detailed protocols, with the first task being the introduction of risk assessment and management (20).

Pritchard suggested that *"unless there are new resources and innovative ways of meeting the needs of vulnerable people, the suicide targets will not be reached, and we are likely to see an inexorable rise in some preventable deaths"* (4).

The recent Acheson Report recommended that *"policies to prevent suicide*

among young people, especially among young men and seriously mentally ill people" be developed (21). Acheson stressed social class and age, and was bold enough to assert cause and effect, offering the following evidence:

"Suicide is associated with unemployment, alcohol and substance misuse, imprisonment, and mental disorder. Up to half of all people who commit suicide have a history of self-harm, and up to 1 per cent of people who self-harm go on to kill themselves. People who deliberately self-harm are also likely to have problems with a relationship, employment, education, alcohol, substance misuse, and / or finances.

Policies to prevent suicide include those aimed at the causes of social exclusion which may lead to suicide. These include: social support for parents (recommendation 23); pre-school education (rec. 5); the development of 'life skills' and the prevention of alcohol and substance misuse (rec. 6); provision of adequate housing (rec. 10,11, and 12); the relief of poverty and reduction of unemployment (rec. 8); the promotion of healthy workplaces (rec. 9); and policies which promote social cohesion.

The association of suicide with existing mental illness suggests that policies for the care of young people with mental illness also provide opportunities for the prevention of suicide. About a quarter of those who kill themselves have been in contact with specialist mental health services in the years before their deaths. A recent review on the promotion of mental health in high-risk groups reinforces the role of the primary health-care team both in identifying and co-ordinating the management of people at high-risk. Community mental health teams may be more effective than non-team standard care in preventing suicide in those who are already severely mentally ill. Both types of team, which may have considerable overlap, need to ensure effective working between different disciplines and agencies. An important component of the work of such teams is to address all the needs of the patient, including employment, housing and social support. Furthermore, particular strategies may be required to meet the needs of young people who either cannot, or do not, choose to access current services. These include people who default from follow-up, absent themselves from school, or are in prison or young offenders' institutions". (p28)

Since the Acheson Report, the Government has published Saving Lives: Our Healthier Nation (43), which includes the target of reducing the suicide rate by at least one-fifth by 2010, and the Mental Health National Service Framework (44), describing how this will be achieved.

Standard seven within the Framework highlights nine interventions to prevent and reduce suicide at a local level. Six of these target mental health services specifically, expecting local health and social care communities to tackle stigma; ensure high quality primary health care; ensure that everyone with a mental health problem can access local services; that those with severe mental illness have a care plan and safe hospital accommodation (if they require it); as well as ensuring that there is support for those caring for people with severe mental illness.

Support for local prison staff is mentioned, as is ensuring that staff generally have the competence to assess the risk of suicide. Local services are also encouraged to develop systems to learn from suicide audits.

While these are all important aspects in preventing suicide, they all hinge on the availability of, and access to, services either through primary health care or emergency secondary care (such as A & E). As mentioned earlier, we know that men generally - and young men in particular - are poor users of primary health care services.

In summary within the Government's public health framework, biological, psychological, social and environmental factors are all likely to contribute to the development of strategy and policy. While the prevention of suicide (especially in young men) remains a key target, the change of Government has brought a change in perspective. The individually-orientated health perspective of the Conservatives led to a strong focus on mental health frameworks for suicide prevention strategies, while the new Government has broadened this to include wider public health elements such as work, car exhausts, and reducing social exclusion. However, the recently published Mental Health National Service Framework remains the context for 'upstream' policies, and many of the important strategies are likely to have less impact on young men.

Common prevention strategies

A thorough review of the effectiveness of interventions aimed at preventing suicide has been carried out by David Gunnell (30) for the Health Care Evaluation Unit, and this section draws heavily on this work. Gunnell points to the lack of randomised controlled trials, as well as the difficulties in carrying out such trials, especially given the population sample required. In fact, one of the loudest conclusions he makes is the lack of evaluation of almost all interventions.

Gunnell concludes that:

> *"Interventions aimed at reducing suicide amongst those recently discharged from psychiatric care should also be evaluated. In addition, the effects of limiting quantities of over-the-counter and prescribed medicines, as well as the use of blister packs, should be quantified.*

Over 400 deaths a year result from overdosage of paracetamol and dextropropoxyphene / paracetamol combinations (co-proxamol). Prevention of parasuicide and repetition of parasuicide, themselves powerful predictors of future suicide risk, should be examined and new interventions assessed. It is essential that, despite the rush to achieve local and national targets for suicide reduction, all local initiatives are carefully evaluated".

Many of the most commonly used interventions are highlighted below, together with some comments about their effectiveness and their application towards preventing suicide amongst young men.

Training of GPs in recognition and management of depression and suicide risk - often based on a study carried out on the island of Gotland in Sweden. Gunnell (30) is of the view that Gotland and England are not comparable, and that this type of intervention requires fuller evaluation with a larger target population. In relation to young men, the obvious problem with GP training is that young men are known as the most unlikely group to attend a GP's surgery. Those arguing for this type of training often point to studies which suggested that a majority of those committing suicide have contact with a health care professional (usually a GP) in the week before. More recent studies suggest that this figure is more likely to be 20-25%, while approximately 40% have contact in the month before death (31). The increase in young men committing suicide and their poor use of primary health care (and GP's in particular) are both factors which are thought to have contributed to this change in data trends.

Guidelines on the treatment of depression and appropriate psychiatric referral - based on the view that those undergoing, or who have undergone, psychiatric treatment are more at risk, therefore drug therapy, identification of individuals, guidelines for clinical practice and improved referral systems would reduce the number of suicides. While this remains unproven, some studies have suggested that if the 'at risk' groups were more narrowly targeted or the treatment programmes more accurately matched, this approach may have value (32).

School-based programmes - while these have been very popular in the US, they have been less so in Britain. There have been some concerns that these programmes increase the number of suicides by making suicide behaviour more acceptable (33). However, when these programmes have taken a wider mental health approach, this has been less likely as an outcome and schools have seen an increase in referrals to school-based psychologists and counsellors. The advantage of school-based programmes is that young men are accessible within the school environment, although many have still found young men difficult to engage in this type of session (34).

Samaritans and suicide prevention centres - Gunnell concludes that *"..the Samaritans and similar centres, whilst offering a much used service (over 2.5 million contacts in 1992) attracting the suicidal and the distressed, have not been shown to have had a measurable impact on suicide and*

parasuicide rates. More research is needed to confirm possible age and sex-specific benefits and perhaps facilitate more effective targeting of resources" (30).

Some US Samaritans studies have found a reduction in suicide rates amongst white females who were also the most frequent users of those services (35). This may have been because of the higher incidence of attempted suicide in young women and their willingness to talk about difficulties. The Samaritans have seen an increase in calls from young men (36). While other studies have found men more willing to use helpline services (and the Internet), younger men have been less willing to use emergency or advice phonelines services (34).

<u>Multidisciplinary audits of suicide and parasuicide</u> - are thought to increase practitioners' awareness and recognition of the risk of suicide, and may help to identify possible preventative factors within primary and secondary care. Again, no thorough evaluations have taken place to measure their effectiveness in reducing suicides, but they may be a part of a strategy that underpins other components. There are no specific implications for young men.

<u>Method availability and lethality</u> - changes in coal gas to domestic gas are highlighted as one of the most significant interventions in suicide prevention. Based on a view that suicidal impulses pass quickly, if the methods of suicide are less accessible, then the impulse may pass. Clarke and Lester have supported this view, highlighting studies from New York (high buildings and the availability of guns), although some are uncertain whether substitutions are quickly found, as in the case of the increase in car exhaust fumes in countries where natural gas has replaced coal gas (3). This has led to calls for improved prescribing (especially of toxic drugs and multi-drug prescriptions), and substitution by blister packaging.

Safety measures on underground railway systems have also been promoted, with 'suicide pits', camera surveillance of platforms, slower trains (especially near to stations) and the relocation of psychiatric hospitals away from railway stations also being suggested (37). Other safety measures at suicide 'hotspots', such as telephone helplines near bridges and internal designs of prisons to make hanging more difficult, have also been recommended (38). Redesigning car exhaust outlets (to hinder the attachment of tubing) and ventilation holes in plastic bags, are also encouraged as significant safety measures. Such measures contain no specific implications for young men.

<u>Aftercare following parasuicide</u> - Gunnell (30) concluded that *"..there is little evidence that efforts to reduce the risk of deliberate self-harm are successful, although a few interventions have been shown to be of marginal benefit in a number of small trials on sub-groups of those at increased risk."* Canetto (39) has argued that men who survive a suicidal act not only feel as though they have 'failed', but consider themselves as unmasculine, and he also found that *"males are most critical of other*

males who express suicidal feelings. The assumption implicit in this terminology and these theories is that men who survive a suicidal act not only fail at suicide, but also at masculinity." He goes on to argue that suicide behaviour is perceived by many men as a female activity.

General improvement of mental health and support services - it has been argued that the more safety nets and mental health infrastructures there are, the more likely individuals who may commit suicide can be identified and offered treatment (14). While this may have been true in the 70's and 80's, unless these services are able to target and access young men, their existence is unlikely to have the expected outcome. Men (and young men in particularly) are notoriously poor users of most primary health services (40) and are more likely to access mental health services through compulsion rather than by voluntary means.

In summary there are very few interventions that have directly reduced the number of suicides, especially in young men. Even fewer have been evaluated, let alone through randomised control trials. There appears to be general agreement that any strategy needs to be multi-faceted and some of these will need to be experimental in nature.

Existing and developing practice around young men

To enable us to look at the practical dimension of this issue, Directors of Public Health were written to and asked to provide their strategy documents addressing young men and suicide and any information about specific local initiatives tackling the issue.

Thirty nine replies were received (40%). Of these, only six Directors had a stand-alone suicide strategy (another was in the process of developing one), eight said they had no strategy at all, while 24 said that suicide prevention was within their broader mental health framework. However, only one of the 39 said that suicide was not an important local issue. Almost half of the respondents described initiatives they were taking with young men. These included school-based emotional literacy work, bullying strategies, drama-based work and relationship and sexual health modules within schools and youth provision.

Those authorities who mentioned specific projects targeting young men were contacted by telephone. What emerged from these calls was a series of barriers and issues that had inhibited or stopped projects from being developed. These have been highlighted through direct quotes from respondents:

> *"The pressure is so strong that our health authority are only really going for those priorities which are being closely monitored by the*

Department of Health (such as waiting lists), or those they might be fired for, so suicide is a relatively low priority".

- The introduction of suicide prevention targets that will be monitored by the Department of Health will help ensure that suicide is addressed (42). However, we are of the view that incentives also need to be made available to health authorities to ensure that strategies go wider than existing health services.

"While most people see it (suicide prevention) as important, it is just horrible to face suicide. If they end up doing it, you feel such a failure, the risks are too high".

- Comments such as these suggest a lack of confidence in too many professionals to address the issue, as well as concerns about whether mental health strategies address the issues well enough.

"Working together is much easier to say than to do. There have been exceptions, but multi-agency work hasn't really developed very well in our authority".

- While these comments were usually made about multi-agency work generally, they were too often made by those in public health, and too often referred to mental health teams holding onto the strategy reins and failing to involve other organisations and other parts of the health service.

"Health services have no expertise in working with young men - we don't really know them, and even if we did, suicide affects such small numbers, and how do you find them?".

- We know that, compared to young women, young men do not use primary healthcare services, mental health services or counselling agencies voluntarily (34, 42). Young men's poor use of services has resulted in many professional workers having very little experience of working with them. With too many health agencies developing expertise with only those groups that demand their services, getting young men through the door is difficult enough for some agencies.

"Our Public Health Department has analysed the dangers and the risks and even identified the groups at risk. However, developing strategies and turning this data into practice is much, much harder".

- We found that health authorities required a number of components in place before they could develop effective practice, and then they needed a particular number of skills (which include targeting, effective clinical intervention and knowledge of young men) which were rarely present. A number of steps are required to ensure that effective practice develops. These steps include:

1. a suicide strategy;
2. available funding;
3. an initiating agency;

4. an active targeting strategy;
5. access to young men;
6. delivery of services;
7. an effective evaluation;
8. knowledge of how and why it worked.

While looking for good examples of practice, we rarely came across health authorities that had reached stage four, and only found three agencies that had develop pieces of work that were shown to work effectively.

The one exception to this was Dorset Health Authority. Dorset has a rural population, with only 1 job vacancy to every 6 job seekers, and a suicide rate slightly above the national average. In 1994, the Health Promotions Department mounted a local media campaign in the lead-up to Christmas, targeting young men with a strap line of 'You've got to be tough to tell someone what's up. Talk about your problems - that way they'll get sorted'. 1995 saw a series of small initiatives culminating in a well-attended multi-disciplinary conference in December. From this conference, an action plan was drawn up and lead agencies identified. The 28-point strategy continues to be actioned and monitored. The diverse strands include strengthening the delivery of services; planned interventions after a suicide; research and evaluation of services; the development of local crisis centres and helplines; as well as broader issues such as the reduction of social isolation, work in schools on mental health, drugs and alcohol abuse, use of custody training for magistrates and strategies for dealing with unemployment.

The strengths of Dorset's strategy are that its context is much broader than mental health; it involves a number of agencies, many of which lead on specific strategy targets; and professional workers have been provided with opportunities to test their beliefs and practices. Actions have been written into work programmes; an understanding of gender and masculinity informs the approach; and the strategy is monitored and many of the initiatives evaluated.

Dorset provides a good example of a strategy where effective practice has developed. Dorset has also seen an overall downward trend in suicide rates for those between 15-24 years of age.

Proposed context and recommendations

While it is appropriate for suicide prevention to be placed within a mental health context, this has tended to overshadow the gender element. Too often, research and policy has taken the gender element simply as fact, and failed to explore its implications. Young men's experiences need to be placed more at the centre of a suicide strategy than is mainly the case to date for two reasons:

Firstly, because most suicide strategies make a number of assumptions about 'at-risk' individuals and groups which are not appropriate

assumptions to make about young men. We know, for instance, that men do not use primary health care in the same way as women (and this is particularly the case for young men) (40); that counselling and advice services are used at least three times more often by women than men (42); and that young men, in particular, are poor users on a voluntary basis of virtually any services (40).

Secondly, because aspects of being a man inevitably play a part in men's decision-making. So, for example, we know that men (and particularly young men) take more risks with their physical and mental health than women (16, 34); that to show vulnerability, ask for help and to acknowledge problems flies in the face of many young men's socialisation as men (34); and that loss of role, poor health and identity issues relating to being a man all have a part to play - especially unemployment, fathering, terminal illnesses, sexuality and imprisonment (12).

We therefore recommend that:

1. Local health authorities consider the gender implications in data collection, planning, delivery of services and clinical practice;

2. Suicide prevention (even if it is within a mental health framework) should involve a much broader range of settings and disciplines. These should include education, voluntary sector (especially the Samaritans), probation, youth and careers services, community organisations and accident and emergency departments.

3. Gender-specific strategies targeting young men are developed within the mental health framework to ensure that more general initiatives can be more effective. These should include:

a. The provision of school and youth service-based programmes where young men can develop 'emotional skills' such as help- seeking strategies, emotional literacy, communication skills, explorations of what it means to be a man, looking after yourself and independence.

b. Existing mental health, support and advice services should develop strategies to target those young men they do not currently reach. This will involve both making services more appropriate and attractive to young men, and also ensuring that staff have a positive approach and understanding of young men. Recent studies (34, 42) suggest that too many services operate on a stereotyped view of young men and that young men are reluctant to use services that they do not know. Most high-risk groups of young men are also socially excluded and least likely to use traditional services voluntarily.

c. The most pronounced difference between men's and women's health is the higher levels of risk-taking by men. This is particularly the case for young men. They are often reluctant to listen to suggestions that they stop taking risks, and health education messages have often been ineffective because of this. A recent study found that young men were much more willing to discuss and engage with the issue of risk-taking

generally, and that they often saw a direct relationship between their risk-taking and levels of responsibility (34). We would recommend that this becomes a theme within health-related work with boys and young men, particularly in relation to alcohol and substance abuse.

d. Health promotion departments should identify the health messages that have attracted young men's attention, analyse why these messages have worked, and replicate these in the promotion of available services and within mental health campaigns specifically targeted at young men.

e. Health authorities should identify the groups of young men most at risk within their local communities, and find out and understand more than their mental health experience. Most research suggests that a number of factors make an individual 'at-risk'. So, for example, while a psychiatric diagnosis is a risk factor, unemployment, poor communication skills and social isolation will increase this risk. Anecdotal evidence suggests that previously unidentified groups as diverse as refugees and coal miners may also be new 'at risk' groups.

f. Health authorities should carry out an audit of young men's use of local services. Future initiatives should be pursued via those services that already access the young men at risk. Those services that do not already access young men should develop targeting strategies to ensure that they do.

4. The Department of Health should consider the following:

a. funding the evaluation of initiatives being taken with young men that may be replicable elsewhere;

b. taking a lead role in identifying examples of good practice (especially in terms of gender work) and ensuring that these are made available to local health authorities;

c. producing inspirational guidelines for local health authorities which include the targeting and engaging of young men and examples of effective practice.

References

1. Suicide has been defined as ‘suicide and deaths from injury and poisoning undetermined whether accidentally or purposely inflicted’ (World Health Organisation definition). Holinger has suggested that “self-imposed risks and self-destructiveness appear to underlie many violent deaths. Unless self-imposed risks are reduced and strategies for understanding and curbing self- destructiveness are established, the mortality rates and years of expected life lost due to violent deaths will not be significantly improved”. Holinger P. ‘Violent deaths as a leading cause of mortality. An epidemiological study of suicide, homicide and accidents’ in American Journal of Psychiatry 1981;137:472-476.

2. Most of this discussion has been about those ‘undetermined deaths’ which are widely accepted as being suicides, although Sue Kelly and Julia Bunting (‘Trends in suicide in England and Wales, 1982-96’ in Population Trends, Summer 1998) suggest that “nearly all these cases that are resolved turn out to be homicide”). There were 2,185 undetermined deaths in 1995.

3. Charlton J, Kelly S, Dunnell K, Evans B, Jenkins R, Wallis R. ‘Trends in suicide deaths in England and Wales’ in Population Trends 69, 10-16, HMSO, 1992.

4. Pritchard C. ‘Psychiatric targets in Health of the Nation’ in Royal Society Health Journal, April 1995.

5. MHF Briefing No 1. ‘Suicide and deliberate self-harm (the fundamental facts)’. The Mental Health Foundation, London. 1997.

6. Hawton K & Fagg J. ‘Deliberate self-poisoning and self-injury in adolescents: a study of characteristics and trends in Oxford, 1976-1990’ in British Journal of Psychiatry. 1992;161;816-823.

7. Drever F, Bunting J, ‘Patterns and Trends in male mortality’ in Drever F, Whitehead M, eds. Health Inequalities: decennial supplement: DS Series no. 15, London: The Stationery Office, 1997.

8. Barraclough, B.M, Bunch, J., Nelson, B. and Sainsbury, P. ‘A hundred cases of suicide: clinical aspects’ in British Journal of Psychiatry, 125, 355-373. 1974.

9. Lesage AD, Boyer R, Grunberg F, Vanier C, Morissette R, Menard-Buteau C, Loyer M. ‘Suicide and mental disorders: a case-control study of young men’ in American Journal of Psychiatry 1994;151:1063-8.

10. Watts, D. and Morgan, H.G. ‘Malignant alienation’ in British Journal of Psychiatry, 164, 11-15. 1994. Williams R and Morgan H, G. eds. Suicide Prevention - The Challenge Confronted. NHS Health Advisory Service, HMSO, London. 1994.

11. Stillion, J.M., McDowell, E. E., and May J. H. Suicide across the life span: Premature exits, Hemisphere, New York. 1989.

12. Gilmartin. C. T., The Masculine Self, Macmillan, New York. 1994

13. The Health of the Nation: a strategy for health in England. London: HMSO, 1992.

14. Wilkinson G. 'Can suicide be prevented? - Better treatment of mental illness is more appropriate aim' in British Medical Journal, Vol. 309. 1st October 1994.

15. Health of the Nation. Key Area Handbook Mental Illness. Department of Health, HMSO. 1993.

16. On the State of the Public Health 1992, HMSO, London, 1993.

17. Charlton J, Kelly S, Dunnell K, Evans B, Jenkins R. 'Suicide trends in England and Wales: trends in factors associated with suicide deaths' in Population Trends 71, 34-42, HMSO 1993.

18. Lloyd, C. 'Suicide and Self-injury in Prison: A Literature Review'. Home Office Research Study No. 115. Home Office, HMSO, 1990.

19. Confidential Inquiry into Homicides and Suicides publishing a preliminary report. 'On the State of the Public Health'. HMSO, 1994.

20. 'On the State of the Public Health'. HMSO, 1995.

21. Independent Inquiry into Inequalities in Health Report, The Stationery Office, London, 1998. p107.

22. Roy A. 'Genetics, biology and suicide in the family' in Maris RW, Berman AL, Maltsberger JT and Yufit RI (eds). Assessment and Prediction of Suicide. Guilford, New York, 1992.

23. Freud S. Mourning and Melancholia. Collected Papers Vol. 2. Hogarth. 1953

24. Menninger K. Man Against Himself. Harcourt Brace & World. 1938

25. Hillman J. see Jamison S. Assisted suicide. Jossey-Bass, San Francisco. 1997.

26. Horney K. The neurotic personality of our time. Norton, 1937

27. Durkheim E. Le Suicide. Routledge & Keegan Paul. 1952

28. Faberow NL. The many faces of suicide. 1980

29. Schneidman ES. Definitions of suicide. John Wiley & Sons. 1985

30. Gunnell, D. The Potential for Preventing Suicide (a review of the effectiveness of interventions aimed at preventing suicide) Health Care Evaluation Unit, University of Bristol, 1997.

31. Vassilas C, Morgan HG. 'General Practitioners' contact with victims of suicide' in British Medical Journal 1993;307:300-301

32. Billings JH. The efficacy of group treatment with depressed and suicidal individuals in comparison with other treatment settings as regards the prevention of suicide. Diss Abs. Int 1976;36(12-B, Pt 1):6369.

33. Herbert M. 'The Fairfax County Suicide Prevention Program: a public school system responds' in Garfinkel B, Northrup G, eds, Adolescent Suicide: Recognition, Treatment and Prevention. Haworth Press, New York. 1989;89-96.

34. Working With Men. Running the Risks: young men's perceptions of risk-taking, health and local services in Birmingham. Birmingham Health Authority, Birmingham. 1998.

35. Miller HL, Coombs DW, Leeper JD, Barton SN. 'An analysis of the effects of suicide prevention facilities on suicide rates in the United States' in American Journal of Public Health 1984;74(4):340-343.

36. The Samaritans. The costs of suicide: ripples on the pond. The Samaritans, London. 1993.

37. O'Donnell I. Farmer RDT. 'Epidemiology of suicide on the London underground' in Social Sciences Medical Journal 1994;38:409-418.

38. Atlas R. 'Reducing the opportunity for inmate suicide: a design guide' in Psychiatric Quarterly 1989;60:161-171.

39. Canetto SS. in Sabo D. & Gordon DF. Men's Health and Illness. Sage, London. 1995.

40. Lloyd T. Men's Health Review. Men's Health Forum, London. 1996.

41. Bradford S. & Urquhart C. 'The making and breaking of young men: suicide and the adolescent male' in Youth & Policy: 61.

42. Davidson N and Lloyd T. Young Men's Use of Counselling and Advice Services in Central London. Working With Men, 1997.

43. Saving Lives: Our Healthier Nation. Department of Health, London, 1999.

44. Mental Health - national service frameworks. Department of Health, London, 1999.

Men’s Health Forum Briefing Paper

Young men and Suicide