# Suicide in the Australian Male Population

## Introduction

Suicide, surprisingly, ranks second of the leading causes of potential years of life lost in males in 2007 (Australian Institute of Health and Welfare [AIHW], 2010a). What is more, male deaths caused by suicide are more common outside major cities than in metropolitan areas (AIHW, 2010a). Male mortality due to suicide in rural Local Government Areas ("LGAs") was 56% higher than in cities in Victoria (Victorian Government Department of Human Services [VGDHS], 2008) The Australian Psychology Society ("APS") stated that significant grounds, such as geographical isolation, distance from health services, environmental hazards (bush fires and drought for example), lack of public infrastructures, and social and economic difficulties, could be experienced by men residing in rural and remote Australia (APS, 2009) and these are just some of the predicaments could add grave stress to men and could lead them into intentional harm and suicide (LIFE Communications [LIFE], 2007). In the Grampians Region, suicide rates are nearly as bad as the ones in the rest of Victoria; ranking seventh of the leading causes of male deaths and taking up almost three percent of the male mortality in the region 2001 according to the Victorian Health Information Surveillance System [VHISS] (VGDH, 2011). These suicide incidences peaked in boys aging 15 to 24 and remained relatively increased in men ages from 25 to 54 (VGDH, 2011).

This essay discusses about how a community nurse should deal with the suicide problems of the male population in the Grampians Region, Victoria, Australia. The study of this paper is focused on: (i) the factors that push the rural male population into committing suicide, (ii) the role of community nurses in suicide prevention and (iii) and the possible mental health services for the rural population that can decrease the rates of suicide in the Grampians Region.

## Risk Factors in Suicide in Males in Rural Australia

According to APS (2009), there are various and relevant risk factors why suicide in men is common. The stoical image maintained by the male gender, lower levels of help-seeking

behaviours, social and geographical isolation, mental health stigmatization, stressors (environmental and socio-economic), the lack of support services, limited access to mental health services, and easy access to vastly fatal ways of suicide are to name a few (APS, 2009). Men's health beliefs in health and healthcare services are different to those of women's because of natural and gender reasons (APS, 2011). They have decreased chances to take responsibility over ones health and are the ones who usually miss out on their diagnostic exams recommended for diseases (Murray-Law, 2011). It has also been reported by the Australian Government Department of Health and Aging [DHA] (2010) that men avoid seeking medical help even when they are unwell due to the traditional representation of men being strong and independent. Stress related to environment, mainly the climate change calamities brought up by global warming in whole Australia (flooding, drought, bushfires, and dust storms), has affected all Australians particularly the ones residing in rural parts of the country (Alston, 2010). Especially in Victoria where the state is considered to be the largest food and fibre exporting state (State of Victoria, Department of Primary Industries, [SVDPI]), 2011) and most families residing there have agriculture as their major source of income (Alston, 2010). This predicament is extremely difficult for rural men especially for the head of the families, for their capability to work in farms has been delayed (Alston, 2010). Alston (2011) also added that the image of being the family breadwinner and farm manager had been disfigured leading to a social issue in regional Australia. Most of suicides in male farmers were committed by the ones in old ages and the younger men that commit suicide are usually employees who work in farms, who lost jobs or have a possibly to lose jobs (Alston, 2010 as cited in Page & Fragar, 2002). A downfall in the financial status due to this predicament has a direct and significant effect on people in rural areas (LIFE, 2007) and unemployment and economic change leading to financial insecurity and vulnerability can also push rural men to self harm and suicide (National Rural Health Alliance [NRHA], 2009). Moreover, there is a relationship between unemployment and suicide according to the Victorian coronial data; Men ages 30 to 34 years, are among the Victorian population that commit suicide due to unemployment (VGDHS, 2006). Furthermore, people in rural areas tend to resist seeking for help due to the current negative and indifferent perceptions regarding mental health. (Staniford, Dollard & Guerin, 2009 as cited in Pollock, Deaville, Gilman, & Willock, 2002). Moreover, there are very few specialised mental health facilities available in many rural areas; most of these facilities are located in cities and do not offer home visit support (Staniford,

et al., 2009). The outcome for this is that rural people searching for mental health care visit their GP as an alternative (Staniford et al., 2009 as cited in Wright, Harmon, Bowman, Lewin, & Carr, 2005). This is possibly a reasonable alternative; however, this requires people to wait because there are a low number of practitioners in rural health centres (Staniford et al., 2009 as cited in AIHW, 2000). And again, there may be a limit in financial resources in the part of the people for paying professional services that contributes to the general problem (Staniford et al., 2009 as cited in Letvak, 2002). And in addition to the mentioned, another factor that pushes rural men into committing suicide is easy access to firearms (LIFE, 2007). Firearms and other violent ways of suicide is more available in rural and remote regions (Page et al., 2007) and a study by Skegg, Firth, Gray, & Cox (2010) has proved that the ease of access to means of self harm can lead to immediate death.

**Suicide in Youth Rural Males**

Suicide rates in young rural males were consistently higher in small country towns in Australia compared in metropolitan areas(Burke , 2007 as cited in Baume & Clinton, 1997; Dudley, Kelk, Florio, Howard, & Waters, 1998; Wilkinson & Gunnell, 2000), particularly in regions which number of residents go only up to 4000 (Burke, 2007 as cited in Kelk, 1995).

In the Grampians Region, it has been reported that the highest number of of all suicide incidents in 2001 in the region were by young men ages 15 to 24 (VGDH, 2011) and although the youth on-going transition from childhood to adolescence is a vulnerable phase for developing mental disorders (Boyd, Hayes, Wilson & Bearsley-Smith, 2008 as cited in Sawyer, Arney & Baghurst, 2001), there is still a lack of health policies and services to address the needs of these young people (Boyd et al., 2008 as cited in Shatki & Belfer, 2008). According to Boyd et al. (2008), there is limited access to suitable mental health care for rural youth due to various factors. There is a lack of qualified mental health personnel (Boyd et al., 2008 as cited in Judd & Humphreys, 2001). Also a lack of public transportation when residents are in need to travel from home to regional health centres for treatment (Boyd et al., 2008 as as cited in Green & McDonald, 2006). Moreover, the rural youth's perception among primary health care providers are not "youth-friendly" (Boyd et al., 2008).

**Nurses Role in Community Health and Suicide Prevention**

According to the book of Community Nursing in Australia, community nurses are highly visible in rural and regional areas (Francis & Chapman, 2008). There is a 'fish bowl effect' phenomenon in communities where nurses lack the anonymity due to being available for the community 24 hours a day and 7 days a week (Francis & Chapman, 2008 as cited in Blue, 2002). 'Visibility is a mixed blessing' as stated by Francis and Chapman (2008), and there are pros and cons that come along with it. The advantage is that nurses, being acknowledged as health care providers, are respected and welcomed in the communities they are serving (Francis & Chapman, 2008 as cited in Blue, 2002). Often, these nurses grew up in the same area and know most aspects of their community (Francis & Chapman, 2008). The downside, however, is that community nurses are usually faced with helping their own family members and close friends who are also members of the community (Francis & Chapman, 2008). In addition, nurses constantly have to balance their duties as professionals and their role as a members of the community (Francis & Chapman, 2008 as cited in McConnell-Henry, 2006; Evanson, 2006). Community nurses are usually the first line managers of care; they work and deal with all types of health problems including trauma and disasters (Francis & Chapman, 2008).

Moreover, nurses play a very important role in suicide prevention (Chan, Chien & Tso, 2009) mainly because they are the primary point of contact in the health care system in incidences of suicide (McCann, Clark, McConnachie & Harvey, 2006). They can be catalysts which can close the gaps in providing health care services and facilitators rather than leaders (Francis & Chapman, 2008) to empower the community members to unite and take action to improve their society's health. It is also the nurses' role to facilitate the community to accept and understand mental health, its possible infirmities and mental wellbeing (Woodhouse, 2010). Not only should they facilitate acceptance by acknowledging clients but also themselves and their responsibilities to promote, educate, consult and support the community about mental health (Woodhouse, 2010).

**Community Suicide Prevention Interventions**

Primary suicide prevention can prioritize on a general population or a specific high-risk group in the population (Fountoulakis, Gonda, & Rihmer, 2011). In this particular case, the study is about men but the author would like to focus on educating on both genders of the entire population of Grampians Region, because the incidence of suicide in the region occurs in both genders as well. Moreover, generalized psychoeducation strategies and specialized ones have been projected as effective strategies that reduces suicide rates (Fountoulakis et al., 2011). Once nurses have gathered the attention of the whole community, the members of the population who are at risk also tend to seek for help (Fountoulakis et al., 2011).

According to World Health Organization or WHO (2006), suicide prevention is not just the task of the nurse, the health care providers or the government, but of the whole community itself. Behavioural norms should be established in the society to help people grow healthy and positive. Positivity in the community may influence its members to restrain themselves from doing things that may cause harm (WHO, 2006).

For programs that are specific for the male gender, the aim should be encouraging help-seeking actions to remove the barriers that have been rooted in their ideas of masculinity (Government of Western Australia Department of Health [GWADH], 2009). These prevention activities should support men to grasp an understanding of their various stressors and emotions, as well as assuring them that seeking for help from professionals and developing self-help skills are acceptable and courageous ways to deal with their problems (GWADH, 2009). Furthermore, this can also enhance men's independence, confidence, and abilities and thereby improve their emotional health and wellbeing (GWADH, 2009). In additional, understanding men's protective factors promote mental health and wellbeing, they can also improve their self-worth and self-control. Some factors are social support, self esteem, norms and values, coping and problem-solving ability, religion, and cultural identity (GWADH, 2009).

Education is very important key in community suicide prevention, and aside from the conventional classroom type seminars with the people, it can be done by organizing a program with government and private institutions to discuss mental health and suicide in mass media such as television, radio and the Internet. Members of the younger population would be paying attention because they are most likely to be the ones using these types of medium. An Internet based community can also be assembled where any member of the public, especially those who want to maintain their anonymity, can be a part of to share their problems and seek support with other members. There must also be links on where and how to seek help for when members think that seeking help online is not enough. For the elderly, however, could be given reading materials, such as booklets, for them to read in any preferred place they choose. These would be handed out in places in the community where there are plenty of people of their age groups such as churches, markets, hospitals, and nursing homes.

More regional mental health centres should be established where people can have access to. This can encourage more people to seek help because the institution is just within their reach. Concerned citizens of all ages who are willing to volunteer in these centres will be given training to become emergency-help personnel for distressed individuals.

Suicide prevention can also be based from the framework of Asset-Based Community Development (ABCD), which is an approach and set of strategies developed by researchers Kretzman and McKnight to identify and use community assets for change in mental health (Boyd et al., 2008). The first step is to develop relationships with the members of the community with a prioritization on people in risk of suicide (Boyd et al., 2008 as cited in Kretzman, McKnight, Dobrowolski, Puntenney, 1996).

The second step is to involve the network of unions and local groups, whether it may be large, small, formal and informal, who can contribute to the program (Boyd et al., 2008 as cited in Kretzman et al., 1996), such as church groups, arts groups, outdoor adventure groups, football and netball clubs, farm associations, group of environmentalists, and local associations and auxiliaries (Boyd et al., 2008 as cited in Kretzman et al., 1996). The third step is to know the strategies to connect the clubs and associations and include them in public meetings and

newsletters and other community networks. Finally, including local organizations, community or mental health agencies, non-government agencies, schools and hospitals and local businesses to create a partnership among them that can lead to a community network (Boydet al., 2008 as cited in Kretzman et al., 1996). As a result, these social institutions and individuals can have an important role in suicide prevention creating social defence mechanism that covers preventive, therapeutic, and post-vention services in prevention of suicide (WHO, 2006).

**Conclusion**

In summary, males in the rural region have numerous reasons for committing suicide, the greatest part that affect them are socio-economical, environmental aspects and the limited health services in the area. The youth in the age groups 15-24 are the mostly vulnerable to depression and they are usually the ones to kill themselves. Clearly, more mental health policies should be created for this group to lessen if not eradicate the rates of suicide. Furthermore, community nurses play a very important role in creating health strategies in suicide prevention and they are often faced with challenges that confuse their role as professionals and as part of the community. In order for them to be successful in dealing with the issues of mental health they should not only knowledge their clients but also themselves and their responsibilities to promote, educate, consult and support the community about mental health. Moreover, the rural mental health policies should not only be focused on individual needs but it would be more successful if the whole community is hand in hand involved in suicide prevention.

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