Gender Difference When Processing Death by Suicide: Attitudes Amongst Third Level Students Aged 18-25 Attending Cork Institute of Technology and College Support Professionals

Sandra Conroy
_Cork Institute of Technology_

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‘Gender Differences When Processing Death by Suicide: Attitudes Amongst Third Level Students Aged 18-25 Attending Cork Institute of Technology and College Support Professionals’

Sandra Conroy

Thesis submitted in fulfilment of the requirements for the Research Master of Arts

Department of Applied Social Studies

Supervisors: Dr Áine de Róiste & Ms Moira Jenkins

Submitted to Cork Institute of Technology

January, 2015
I declare that this thesis and research involved in completing it is entirely my own work

Sandra Conroy

I declare that this thesis and research involved in completing it is entirely the work of Sandra Conroy under my supervision.

Moira Jenkins

22.01.2015
Abstract

Rationale behind research:
Survivors of suicide/ suicide bereaved face unique challenges in their grief, resulting in a greater risk of conditions such as complicated grief, PTSD and suicidal ideation developing (Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakuriti & Zisook, 2012). In dealing with or 'processing' the loss of a loved one by suicide, Wertheimer details that, “suicidal thoughts are not uncommon during the early months of bereavement” (1991: 178). The incidence of young men dying by suicide is notably higher than that of women in this country; a stubborn gender difference persists in Ireland with males representing on average 80% of all suicides over the past nine years (www.cso.ie). Therefore it is questionable if those that have experienced a death by suicide are placed at an increased risk of suicidal ideation. It has been noted in the Reach Out report (2005) that “third level institutions have the opportunity to influence attitudes to mental health and help seeking among all students” (National Office for Suicide Prevention, 2005: 25).

Research aims:
This research study endeavored to understand what it is like for CIT students to respond to a death by suicide by means of their awareness, attitudes and usage of supports and establish if gender trends exist. This research also aimed to look at what further initiatives/ support services could be developed and introduced to help promote positive mental health of students attending CIT.

Research method:
A purposively developed questionnaire entitled ‘Suicide Awareness’ was administered to a total of 325 students attending CIT (of which 299 responses were used as part of this research). For added breadth and depth across the research themes, seven interviews were conducted with key informants consisting of student support professionals and an external professional.

Research findings:
The most striking finding was that of the 299 questionnaires completed, a total of 58 respondents (21.5% of males (43), 15% of females (15)) expressed suicidal ideation concerns applying in respect to 104 fellow peers. This potentially reveals the sheer volume of students thought to be in a vulnerable position by fellow peers. Just under half of questionnaire respondents reported experiencing a death by suicide of which a mere 6% of males and 12.5% of females indicated they sought professional support. An overwhelming majority of student respondents indicated that they would be more inclined to seek support via the internet (m = 87.5%, f = 87%). However, a majority of interviewees proved reluctant to embrace such an initiative and were cautious that it might replace ‘face to face’ counselling which was viewed as a negative outcome.

Significance of research:
This research identified a notable number of students are concerned for the welfare of their peers as a result of perceived suicidal ideation. Various gender differences and similarities were identified in CIT students’ attitudes and usage of support services in response to mental health issues. The research identified that student’s perceive low threshold support (e.g. CIT Lecturers) as the most helpful source of support for personal problems rather than formal professional support services (e.g. Counselling). The research identified areas of potential progress to further promote and maintain positive mental health amongst CIT students.
Acknowledgements

There are a number of people for whom I am grateful for their assistance in enabling me to complete this study:

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1. Introduction

Suicide is a phenomenon which remains unique to humans. “Suicidal behaviour represents a global public health problem and its prevention continues to provide a major challenge to health and social services at all levels of Irish society” (National Office for Suicide Prevention, 2005:4).

The word ‘suicide’ appeared in the English language only in 1635 (Alvarez, 1990, pp.59-93). There was a time, not so long ago in Ireland, when suicide was not discussed amongst people in an open manner. It was regarded as a sin and shame would be brought upon the family if a person was found to have committed suicide. Suicide was condemned by people of previous generations so much so that in some parts of Western Europe, “the remains were publicly dishonoured, e.g. burying the dead face-downwards, doing so at a crossroads and driving a stake through the heart” (Kelleher, 1996: 9). There were different ways by which the family were made to feel disgraced because a member of their family had committed such a tragic act of suicide. As suicide was considered such a sin in Ireland, those who were convicted of committing suicide were unable to be buried in the traditional catholic manner. This would have been extremely stressful, embarrassing and upsetting for the surviving family. However, “if suicide victims were said to be insane at the time of the act they were exempt from religious and legal punishments” (Stein & Wilkinson, 2007: 142). The words ‘convicted’ and ‘committed’ suicide are used because death by suicide was in law, a criminal offence. “Ireland was the last country in Europe to decriminalise suicide with the passing of the Criminal Law (Suicide) Act, 1993.” (National Suicide Prevention Office, 2006: 11).

Since the decriminalisation of suicide, Ireland has progressed greatly in relation to provision of relevant support services available to the public. In fact it is almost impossible to keep track of all the different agencies, services and governmental bodies that are developing new initiatives to tackle the alarming rate of suicide deaths in Ireland. This plethora of response has been commented on: “It is estimated there are several hundred support groups or counselling organisations offering services in different parts of the state” (O’ Brien, 2013: 5). However, in 2010, the World Health Organisation (WHO) stated that relatively few suicide prevention programmes have been rigorously evaluated for their effectiveness in reducing suicide and related risk factors. This is not to suggest that available services are ineffective but rather that there is a lack of published evidence showing the evaluated benefits of these initiatives.
1.1 Background

The incidence of young men ‘committing’ suicide is notably higher than young women in this country. This gender pattern or imbalance is not unique to Ireland and has become apparent/ evident in most Western countries for the past fifty years (Cutright & Fernquist, 2000). What is viewed as the traditional male gender role can undermine men’s mental health by deterring protective factors such as help seeking and social support. “Some aspects of traditional masculinity are detrimental to health and progress for men” (Cleary, 2005:7). It has been argued that some men do not want to let their guard down, may not want to discuss emotions that may cause tears, or create a sense of fear and a loss of their masculine identity. Research to date shows that men are less likely than women to seek help for both mental and physical health concerns: (see, for example, Chrisler & McCreary, 2010). What is distinctive as an Irish suicide phenomenon was noted in the 2006 research, published by the National Suicide Prevention Office, *The Male Perspective, Young men’s Outlook on Life*. This pioneering report noted: “in most countries that return data to the WHO, the suicide rate increases with age. In Ireland, the rate of suicide peaks among young men and in this way trends in Irish suicide are fairly unique” (NSPO, 2006:8).

It has been noted, in the *Reach Out* report that: “Third level institutions have the opportunity to influence attitudes to mental health and help seeking among all students” (National Office for Suicide Prevention, 2005:25). The purpose of this study is to gain a better understanding of what it is like for CIT students to respond to a death by suicide, their use of support services and to find out if there are gender differences in their response. The research aims to find out what professional college supports CIT students are aware of and further, if there is a gender difference in relation to their attitudes to and usage of them. The research aims to look at what further initiatives/support services could be developed and introduced to help the mental health of students attending CIT.

Current governmental policy on mental health, *A Vision for Change*, has also noted that whilst Ireland has one of the highest levels of participation in third level education within the EU, “it also has a high percentage of students experiencing mental health difficulties including depression, anxiety and loneliness, substance misuse and suicidal behaviour” (*A Vision for Change*, 2006:95). There appears to be an obligation on higher education institutions to establish what students’ perceptions and experiences are of suicide, so that they can take appropriate actions to support them in a positive manner.
By conducting this research an opportunity is created to gain a better understanding of some students’ responses and attitudes to death by suicide. There is an opportunity for change and development in college supports to increase effectiveness of response to this complex phenomenon.

1.2 Thesis Overview

This thesis is comprised of four predominant sections: Literature Review; Methodology; Results and Discussion. The scope of each is briefly detailed here.

The Literature Review provides an overview of certain Suicide Issues and Mental Health Policy and Promotion in this country. There has been a great deal written about the infinitely varied motives for suicide, however, as the most informative individual can no longer be questioned information on an individual’s causes/motives to die by suicide are difficult to obtain. The areas covered throughout the Literature Review are not offered as an exhaustive list of factors as that list may be endless; however, it attempts to recognise the complexity of suicide and acknowledge the difficulties in identifying key factors associated with suicide. Some of the factors identified as key and addressed are: Gender and Sexuality; Social and Community Factors; Alcohol Misuse; Third Level Mental Health Initiatives and Government Legislation. The structure of the Literature Review is further detailed in Section 2.1 Literature Review Introduction.

In seeking an appropriate methodology for this research, a preliminary issue was to decide on an appropriate research design for such a study which required an inclusive format of research from both the student population and internal and external ‘professionals’. The term ‘professional’ is used loosely in this research as it is questionable if Student Union Welfare Officers are recognised ‘professionals’. Whilst they are paid for their role and also receive training, there is no available qualification to become a working SUWO. It seems untenable then that the Director of the National Suicide Research Foundation and a SUWO are categorised in the same group of ‘professionals’, however it was decided for the purpose of this study such a designation was permissible as SUWO’s are viewed as a ‘professional student support’ within third level settings, in which this research is based.

Bassey defines research as “systematic, critical and self-critical enquiry which aims to contribute to the advancement of knowledge and wisdom” (1999:38). Across disciplines (and within) there are varying views of what research is and how it relates to the kind of
knowledge being sought. This research was of an investigative and interpretative nature and thus the framework of ‘grounded theory’ appeared to align itself with this purpose. In light of the intended participatory, community-centred sampling strategy, it was determined that a grounded theory approach captured the researchers intentions. Creswell describes grounded theory as “a qualitative strategy of inquiry in which the researcher derives a general abstract theory of process, action, or interaction grounded in the views of participants in a study” (2009: 13). In this sense, the research aimed to draw on the views and opinions of students and professionals to help identify how best to improve college supports services to address the students’ needs arising from suicide in those known to them and others.

This design is reflected in this research by using both quantitative and qualitative methods to address the cultural complexity and diverse needs of community members within CIT. By combining both quantitative and qualitative approaches in a mixed method approach, the researcher hoped to add a more profound insight into the area researched. Burton, Bundrett and Jones state that “combining evidence from these forms can significantly add to the strength and depth of an argument” (2008: 146).

Paradigms guide how we make decisions and carry out research. Kuhn defined paradigms as “universally recognised scientific achievements that for a time provide model problems and solutions to a community of practitioners” (1970: viii). Simply put, a paradigm is a pattern derived from a belief system (or theory) that guides the way we do things, or more formally establishes a set of practices for a period of time. The mixed methods approach has emerged as a ‘third paradigm’ for social research. It has advanced to the point where it is “increasingly articulated, attached to research practice, and recognised as the third major research approach or research paradigm” (Johnson, Onwuegbuzie & Turner, 2007: 112).

Whilst a primarily qualitative design was considered on balance a mixed method was adopted for a number of reasons. A quantitative approach to research may be defined as “explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics) (Muijs, 2011: 1). Quantitative research evidence provides an indication of the scale of an issue, it provides a study with impact and grabs the reader’s attention, according to Burton, Bundrett and Jones (2008). Adopting this approach a questionnaire was distributed amongst a diverse range of students (325) attending Cork Institute of Technology. This was decided as a suitable method as it focused on the specific
target group for the research and, as stated, was hoped to capture something of the scale of the issue, albeit within a small sample and a single representative community of students.

In turn some depth of insight was aimed for. A qualitative approach to research may be defined as the “study of things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 1994:2, cited in Needgaard & Ulhøi, 2007:5). Qualitative research is often seen as more flexible and fluid in its approach. This approach was applied in interviews conducted with professionals within CIT and externally that were primarily involved in student supports. This group of interviewees was determined due to their expertise in the area and their involvement with students in relation to the research topic. In addition to this an initial plan was to hold two focus groups of approximately 6 students each, to provide greater depth of qualitative material. Further detail on the field work conducted is outlined in Section 5, Methodology.

The results were presented in the format by which they were conducted: interview results; questionnaire results. The researcher purposefully decided on this format of presentation to allow the reader to see this topic from a ‘professional’ perspective and thereafter from the student perspective. According to Burton, Brundrett and Jones “Qualitative data, by its very nature requires the identification of emergent key themes for it to be organized and collated and interpreted (2008: 147). This approach was adopted by theming the interview from the questions identified in the interview schedule. This was a reliable format and could be followed by any other researcher, in that the qualitative data was categorised according to the question asked.

Quantitative data provides ones research study with impact and comparisons are primarily self-evident. However, Burton, Brundrett and Jones suggest “the data does need to be explained and interpreted and contextualized, do not expect the numbers alone to be sufficient” (2008: 149). Once all the questionnaires were completed and collected, the researcher set about analyzing the data though the use of IBM SPSS Statistics. Further analysis was then conducted by creating linkage between the themes from the qualitative data analysis and the statistics from the quantitative data analysis. For example, in relation to online counselling, four out of six student support providers reluctantly acknowledge value in such an initiative, in contrast an overwhelming majority of questionnaire respondents stated that they would be more inclined to seek support for personal problems were counsellors
available online with 87.5% of males and 87% of females stating such. Further details on the results are presented in Section 6, Results.

The discussion section determines the extent to which the findings detailed in the previous section provide the answers to these research questions that were identified at the onset of this research:

- What are CIT student attitudes and responses to suicide? Are there gender differences in there?

- How aware are students of the supports available to them in dealing with mental health problems (of self and others) and what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?

- What changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (of self and others)?

The discussion explores what have been identified as the ‘key findings’ of this research, in line with other published research and reflects on issues/areas raised throughout the Literature Review through the lens of the perspective/s gained in the study. The last part of this section aspires to draw on a conclusion as to the contribution this study makes to our knowledge of the topic ‘suicide’ and identifies strengths and limitations of the research in a reflexive exercise, which in turn informs recommendations for further research.

1.3 Introduction Conclusion

It is hoped that from this study more insight will be gained into how CIT (and perhaps other third level colleges) can do its best in supporting students who are struggling with mentally distressing problems, primarily related to suicide bereavement. From the results of this research it is hoped that a number of new initiatives, such as those referred to in the recommendations, could be developed and piloted with the support of all professional support services at CIT for a period of time and rigorously evaluated to establish what (if any) benefits students acquired from the initiatives introduced.
2. Literature Review

2.1 Literature Review Introduction

“Suicide means the fatal, and suicidal attempt the non-fatal act of self-injury undertaken with more or less conscious self-destructive intent, however vague and ambiguous” (Stengel, 1973: 14).

There has been a great deal written about the different, and infinitely varied, motives for suicide. Information on an individual’s causes/motives to die by suicide are difficult to obtain, as the most informative individual can no longer be questioned. As the causes of suicide are complex, there is no single intervention or approach that will adequately eliminate the problem. Motives usually involve psychological, biological, social and environmental factors. Each of these may take different effect depending on the individual’s negative experiences over a lifetime. (National Office for Suicide Prevention, 2005: 4).

A recent study conducted by the Men’s Health Forum in Ireland (2013), ‘Young Men and Suicide Project: A Report on the All-Ireland Young Men and Suicide Project’, suggests 7 main causes of suicide:

- **Mental illness**
- **Alcohol and substance misuse**
- **Use of health care** i.e. reluctant to seek help during times of distress.
- **Sexuality**, in terms of stigma and shame associated with one’s sexual orientation.
- **Social and community factors** e.g. rapid societal change, changing gender roles and the socio-economic impact of recession.
- **Marital and parental status** in terms of higher risks associated with those who are divorced/widowed.
- **Other social and community factors** such as living and working conditions, unemployment and socio-economic status.

(Richardson, Clarke & Fowler (hereafter YMSP), 2013: 35).

These areas identified as the main causes of suicide are, however, not the only causes of suicide deaths, as one individual’s causation will vary to the next in accordance with their own life experiences. These main causes, as identified, have been acknowledged and adapted
for the purpose of this literature review. However, this structure is supplemented with other relevant areas and factors/causations specific to this particular research. The other areas that have been introduced are:

- Suicide Rates/Statistics
- Gender
- Legislation and Government Policies
- Third level students in contemporary Ireland
- Third level mental health initiatives

The areas that are covered throughout the Literature Review are still not offered as an exhaustive list of factors as that list may be endless. In attempt to structure the varied areas identified that impact on self-harm and suicide, the literature review is divided into two sections: Suicide Issues, Mental Health Policy and Promotion.

2.2 Suicide Issues – an overview of some relevant research on impact and causes

Throughout this thesis, gender is used as a type of lens or looking glass, the ‘gender lens’ attempts to bring dimensions of suicide and suicide bereavement into view. As the statistics indicate a higher incidence of male suicides than that of female suicides in this country over several years (www.cso.ie), it is now possible to state that a pattern exists that one sex is more inclined to take their own life than the other. Therefore, the challenge presents that comparisons must be made between the two genders in attempt to establish why that is the case.

‘Gender’ describes the expected behaviours of the two sexes and society’s attitudes and perceptions of them. Gender can be defined as “a social construct based on a group of emotional and psychological characteristics that classify an individual as feminine, masculine, androgynous (may not identify with either side of the gender binary male/female) or other” (Erickson Cornish et al., 2010: 419). Many people assume that gender flows naturally from biological sex and view ‘gender and sex’ in the same category e.g. a male will consist of male sex and have a male gender (Maretti et al., 2012). However, many sociologists and psychologists see ‘gender’ as much more than the traditional biological distinction between male and female. ‘Transgender’ is still evolving definitively and remains misunderstood by many, there is a sense of ‘fear of the unknown’. It (transgender) is still “in the American Psychiatric Association’s catalogue of mental disorders” (2009: 05). ‘Transgender’ may be identified whereby an individual’s gender identity differs from their
sex. Transgender people may be heterosexual, homosexual, or bisexual, research suggests that sexual orientation is not directly linked to whether an individual is transgender or not (UNESCO, 2012).

Standards of masculinity vary from time to time, from culture to culture. However, masculinity always defines itself as different from, and often superior to, femininity, “centrally connected with the institutions of male dominance, not all men practice it, though most benefit from it” (Howson, 2006:03). “Some aspects of traditional masculinity are detrimental to health and progress for men” (Cleary, 2005:7). What is viewed as the traditional male gender role can undermine men’s mental health by deterring protective factors such as help seeking and social support. Research shows that men are less likely than women to seek help for both mental and physical health concerns: (see, for example, Chrisler & McCreary, 2010) suggesting some gender differences. This topic is returned to in Section 3.1 Gender.

In relation to the negative effects of stigma associated with sexual orientation, Dr. Tony Bates, Founding Director of Headstrong says “It’s not their sexual orientation that’s making them feel suicidal, it’s what comes with that” (Hunt, 2012: 5b). Allport (1954) theorised the personality characteristics that develop in individuals who are targets of prejudice and described these characteristics as coping mechanisms which people may develop initially in response, but they have the potential to become relatively stable personality traits.

Headstrong’s recent large-scale study with University College Dublin, ‘My World Survey’ has some alarming findings. My World Survey is a national study of youth mental health in Ireland with a sample size of approximately 15,000 participants, aged 12-25. This study found that those who were still unsure of their sexual orientation had one of the highest self-harm rates of 43% (Dooley, B. & Fitzgerald, A. 2012). Over all, participants that were not heterosexual had a higher self-harm rate than others. “Those who reported their orientation as bisexual had a self-harm rate of 56%. Meanwhile, the rate of those who were heterosexual was 19%” (Hunt, 2012: 4b).

Ireland was recognised as having one of the lowest rates of suicide deaths at one time, however, the true historical rate is unknown due to criminalisation and under reporting (Kelleher, 1996). When looking at the statistics of Irish suicide the reliability of recording must be considered with a number of notes of caution. Reported incidence demands to be examined with regard to: under reporting of suicide deaths in previous years; trends that have
developed since suicide has become more recognised; the comparisons between Ireland’s suicide rates and the rest of Europe. The incidence of men committing suicide is notably higher than that of women in most Western countries (Cutright & Fernquist, 2000; Lee, Collins & Burgess, 1999). As noted previously, Ireland is unique in the fact that the rate of suicide peaks amongst young men, whereas in most countries the suicide rate increases with age (NSPO, 2006).

As gender ideation is argued to be a societal construct a wider context in terms of societal change must be noted both in terms of gender labelling and interface with suicide. As explored in greater depth below, Durkheim was the first to insist on a sociological explanation for suicide. His study showed that even a highly personal act such as suicide is influenced by the social world (Durkheim, 1952 [1897]). “Durkheim sought to analyse how social order is established, maintained and in particular, after a period of severe and rapid social change, re-established” (Slattery, 2003:72). In this regard it is trite to observe that there has been rapid change in the Republic of Ireland in recent times, with a breakdown of authority. In relation to the Catholic Church, all the recent reports of abuse, e.g. Ferns Report 2005, reports on the ‘Magdalene Laundries’, the Ryan Report 2009 have had an effect of diluting the strong social community of the Catholic Church. Another example of the dilution of social order in Durkheim’s terms would be in how Haralambos & Holborn suggest or argue that marriage integrates an individual into a stable relationship, thus, leaving single people more isolated within society (2008). It is more accepted for parents to have a child out of wedlock, with 34% of unmarried women giving birth in 2010 and 2011 (www.cso.ie). It could therefore be questioned if these developments, as part of a wider dynamic, are resulting in these individuals to feel less stable or secure in their relationship and indeed within society. However, on the other hand, it must be acknowledged that growing up in the homogeneity of the Catholic 1950’s Ireland could also have been isolating for some individuals. The beliefs held were for example, that a man and a woman married and had children, but if you were part of, what is today referred to as the ‘LGBT’ (Lesbian, Gay, Bisexual, Transgender) group there was potential for you to almost become the ‘outcast’.

As this study is based on gender differences when ‘processing’ i.e. coming to terms or dealing with a death by suicide, a section of this literature review will examine what it is like to be bereaved by suicide. Death, especially by suicide may shake the very foundations of youths. “Sudden unexpected deaths, represent a special risk to mental health even in the absence of other vulnerability” (Parkes, 1998: 129). There are many different ways that a
death by suicide can affect an individual, some of these are explored here in line with gender differences in grief.

A further acknowledged factor contributing to suicide is alcohol. Alcohol is known to play a significant part of the college life in Ireland. “In over half the cases of suicide, alcohol is a key factor” (http://www.irishtimes.com/newspaper/ireland/2011/1104/1224307039518.html). If students are feeling low, down or depressed about something, many appear to turn to alcohol as it is seen as an escape route to try and forget. Unfortunately the old Irish solution to mental dis-ease has still managed to hang on: ‘head out for a pint’. The problem here is that if an individual is in a depressive state and then drinks alcohol which is a depressant there is potential created for serious self-harm. “Alcohol often transformed an unhappy state into potential death” (Cleary, 2005: 8). Alcohol and binge drinking may not only be an individual act but in some ways also connected to the society in which he/she resides. This aspect is further explored in Section 3.5.

2.3 Mental Health Policy and Promotion Overview

An audit of Mental Health Policy and Promotion herein focuses primarily on: legislation, Government policies and third level students’ polices regarding mental health and mental health promotion. As mentioned above, Ireland was the last country in Europe to decriminalise suicide and today the only specific piece of legislation specific to suicide is the Criminal Law (Suicide) Act, 1993. However certain policies and strategies have been introduced that focus on mental health, therefore inevitably focussing in part on suicide. The principal national strategies and initiatives are identified as follows:

A Vision for Change (AVFC) is a policy that was introduced in 2006 as the basis for future development of mental health services in Ireland. It describes a framework for building and fostering positive, holistic mental health services across the entire community. However, over 6 years after this policy was introduced, numerous reports identify the lack of implementation. For example, it was reported by the IMG (Independent Monitoring Group) in 2010 that “The challenge of implementing AVFC by the HSE, Independent bodies and Government Departments has been hindered by the lack of resources available to mental health, the imposition of the public sector moratorium and a lack of dedicated corporate leadership” (www.dohc.ie). The aims or intentions of A Vision for Change are admirable however it is evident that the full implementation of AVFC has been put in jeopardy due to our current economic status and a lack of political priority.
The second national initiative of note is *Jigsaw*, an umbrella organisation which brings community services and supports together around young people in order to better meet their mental health needs. Jigsaw is, a sub-section of *A Vision for Change*. The IMG has welcomed the continued development of the ‘jigsaw’ model for youth mental health. A new approach was required and this has been provided in some counties thus far. “The focus of the initiative was on bringing mental health services to where the teenagers and children were, rather than wait, probably in vain, for the most vulnerable to access help themselves” (McDonagh, 2013: 5). However the implementation of Jigsaw in a community is complex, people within a community must be willing to work together. Each community will work slightly different (as each community is different) but they will all have the same common ambitions and goals.

The third endeavour of note is *Reach Out*, an Irish National Strategy for action on suicide prevention. It was published in 2005 and is to run through until 2014. *Reach Out* is an action based strategy which aims to ensure continuous quality improvement through many areas such as support of the family, in educational settings, youth organisations, sports clubs, work places, religious organisations and the media. It was hoped to bring about a positive attitude change towards mental health. There were unfortunately, concerns raised in relation to staffing and resources with the implementation of the plan. In 2010 the total funding available for mental health services was €970m, of which €1 million went to 26 local projects in line with the implementation of *Reach Out*. The actions of the Irish Government shout that mental health is secondary and optional. The divergence between eloquent policy aims and action taken is a disjunction discovered throughout the published evidence.

A further development of importance is *The Health and Social Care Professionals Act (2005)* an act which addresses the need to register certain professionals working with those who are vulnerable in society. Whilst praise must be given for the fostering and over-due regulation of high standards of professional conduct, education, training and competence among registrants, there are only 12 professions that are included, gaps remain and some have criticised the exclusion of counsellors and psychotherapists. Dan Neville T.D. (FG, Limerick) stated that “the current position does not lend itself to good clinical governance and the maintenance of high standards of patient care” (http://www.irishtimes.com/newspaper/ireland/2012/1004/1224324837534.html). This poses questions as to who is at the end of these helplines that the public are consistently being
advised to call if in need of support and, how effective is the care they provide to those most vulnerable?

As this research is based in a third level setting in Ireland it is imperative to identify what the college experience is like for third level students in Ireland. A recent large-scale study entitled ‘My World Survey’ conducted in Ireland 2012, provided the first national study of youth mental health in Ireland from age 12-25. This vital report provides insight into young people’s mental health and how they conceptualise their experience as well as addressing a significant research gap. ‘My World Survey’ (2012) identified that 43% of the 8,221 participants (aged 17-25) reported that they had thought that their life was not worth living at some point. Just over half of the sample (51%) indicated having experienced suicidal ideation, with a further 21% indicating self-harm without wanting to take their life. Also it must be acknowledged that due to our current economic climate, young adults are making the decision to stay in education longer than they perhaps would have, had circumstances been different. As there has been a steady increase in student enrolment, increased pressure is placed on all aspects of services in third level.

Two colleges have recently introduced policies that provide guidelines for staff and students on how to deal with both acute and non-acute mental health issues that may arise amongst the third level student population. Whilst only two colleges have specific Mental Health Policies (the scope and impacts of which are examined in detail in this study), the majority of third level education settings have some form of student mental health support services in place. An absence of a published strategy does not mean that there is nothing in place with regard to mental health and conversely a published strategy/policy does not mean effective services are available on the ground.

Looking to the future of third level education in Ireland, our stumbling economic climate is resulting in many students working a part-time job to support themselves through college, college work is also increasingly demanding and many students end up working a 7 day week. “Both traditional and non-traditional students today have busier lives than students of the 1960’s to the 1980’s” (Hoffman, 2011: 63). Discussion continues as to the accessibility of distance learning and online courses (such are relevant also to debate about online counselling) and such provision can become appealing as they do not require attendance at a given time, there is no need for transport and there is no need for accommodation. However, third level institutes can be considered a microcosm of society where students build
friendships, relationships, learn about preparation, how to survive in the economic world and be a part of something, for example a community/society. If students are missing out on the social aspect of learning are they becoming isolated?

Looking forward, if we are to reduce the impact of mental disorders, self-harm and potentially the suicides of Ireland’s young people, transformational change and service redesign is necessary. This next section identifies recent initiatives in relation to youth mental health in Australia and the United Kingdom. Both have a similar approach in so far as providing various methods of service, i.e. drop in centres, online support, telephone support, housing support. However Mind (United Kingdom) is a long established charitable organisation which has placed emphasis on media publication of mental health in a positive light to reduce the stigma through awards. This is the 20th year that Mind have celebrated media awards with a high presence of celebrity fronted programmes (www.mind.org.uk). It proves to be an ever developing initiative and one that can be admired.

As noted above there are many different factors involved in this complex phenomenon. Any listing of topics associated with suicide will fail to be exhaustive, this literature review aims only to be indicative of commonly identified causes and seeks to provide some context for the study in identifying and praising pertinent research previously conducted.
3. Suicide Issues

3.1 Gender

Throughout this thesis, gender is used as a type of lens or looking glass. Like a biologist uses a microscope to analyse cells, or an astronomer uses a telescope to bring distant planets into view, the gender lense attempts to bring dimensions of suicide and suicide bereavement into view. With statistics showing a stark sex differential; the rate of male suicides is remarkably higher in this country compared with female suicides (as detailed further in the next Section Suicide Rates/Statistics), consideration must be given as to why or what causes young men in particular to be more vulnerable or susceptible to suicide than young women.

According to Gerda Lerner, in The Creation of Patriarchy, gender is the "costume, a mask, a straitjacket in which men and women dance their unequal dance" (1987:238).

‘Gender’ describes the expected behaviours of the two sexes and society’s attitudes and perceptions of them. Gender can be defined as “a social construct based on a group of emotional and psychological characteristics that classify an individual as feminine, masculine, androgynous (may not identify with either side of the gender binary male/female) or other” (Erickson Cornish et al., 2010: 419). Many people equate gender with biological sex and consider that a male will automatically consist of male sex and have a male gender (Maretti et al., 2012). However, ‘gender’ is much more than the traditional biological distinction between male and female. Rather, “it defines a relational system and, in many cultures, is usually seen as a binary term (man and woman) that refers to a division in roles as part of a stereotyped social imaginary” (Maretti et al., 2012: 1).

There is a level of expectation of both males and females within a society regarding proper behaviour, attitudes, and activities. “Expectations around male behaviour and emotions are quite rigid and this often prevents young men from seeking help” (Cleary, 2005:9). Standards of masculinity vary from time to time, from culture to culture. However, masculinity always defines itself as different from, and often superior to, femininity, “centrally connected with the institutions of male dominance, not all men practice it, though most benefit from it” (Howson, 2006:03).
3.1.1 Gendered Identities

Gender identity can be described as “the inner sense of being a man, a male, a woman, a female, both, neither, butch, femme, two-spirit, bi-gender, or another configuration of gender” (Erickson Cornish et al., 2010: 419). Gender identity usually matches one’s physical anatomy (e.g. one’s biological sex is male and one’s gender is male) but sometimes it does not. Gender identification helps to describe and explain a wide range of people whose gender identity does not ‘conform’ to societal expectations of their assigned sex (e.g. one’s biological sex is male, but their gender is that of a female).

“I was born a man, but never felt comfortable living as a male, wearing men’s clothing and conforming to male gender roles” (UNESCO, 2012: 24).

Below are some brief definitions and explanations of various gender identities. However, gender identity is a conceptual area still being developed, and as can be seen below, the confusion for an individual experiencing crises with gender identity must be quite striking.

_Cis-gender_

Cis-gender describes what can be referred to as a ‘match’. Cis-gender depicts that there is harmony/ conformity “between one’s sex assigned at birth and one’s gender identity, behaviour and expression” (Erickson Cornish et al., 2010: 419).

_Transgender_

Transgender or Trans is a term used to describe those “who transgress social gender norms; often used as an umbrella term to include transsexual, genderqueer, gender nonconforming, cross dressers, and so on” (Erickson Cornish et al., 2010: 419). It could be argued that ‘Transgender’ is currently the most recognised minority gender identity groups in Ireland as it is embedded in the LGBT group. A transgender person’s gender identity differs from their sex; transgender people may be male sex with female gender or female sex with male gender. Put plainly, persons with an alternate gender identity (how you feel) and/or gender expression (how you look and act) often get referred to as transgender. Today, women wear suits and other clothing that are practically identical to that of men’s, and this is currently accepted by many societies. Similarly men in Scotland wore kilts, and still do for certain occasions i.e. marriage, and this is currently accepted. However, Herman states that in many if not all societies today “when a man puts on the clothes of a woman he is immediately presumed less capable” (2009: 05). It is because of stigmas such as these that many transgender individuals experience safety concerns, societal stigma and prejudices.
Genderqueer/ Fluid Gender

Genderqueer or fluid gender is a term used by some to describe people who may or may not fit on the spectrum of trans, rather, they “identify their gender and sexual orientation to be somewhere on the continuum in between or outside the binary gender system altogether” (Erickson Cornish et al., 2010: 419). The use of the word ‘between’ in this instance suggests an overlap or ‘fluid’ transition between distinguished male and female genders, ‘outside’ here is reflective of one being ‘without’ gender or gender neutrois.

Gender Neutrois

“Neutrois is an identity used by individuals who feel they fall outside of the gender binary code”, i.e. neither feminine or masculine. (Maretti et al., 2012: 10). Neutrois is considered by some as “a (independent) gender, like a third gender, while others feel agendered (gender null or without gender).

Pangender

Pangender is somewhat similar to neutrois as such individuals feel they cannot be labelled as male or female in gender. Pangender can be defined as those “who do not fit neatly into binary genders and may better identify as a mixed gender (both male and female) or as a third gender altogether” (Maretti et al., 2012: 10). Pangender is used as an all-inclusive term meaning “all genders” (Maretti et al., 2012).

In Ireland, a large study Stonewall (2008); cited in UNESCO (2012), established a clear link between homophobic bullying and thinking about suicide amongst lesbian, gay, bisexual and transgender young people. Part of the stigma around gender identities descends from the fact, says Herman “that gender identity disorder is still in the American Psychiatric Association’s catalogue of mental disorders” (2009: 05). This in itself generates stigma as it is viewed as a disorder and of ill health origin, this behaviour can also be described as ‘Transprejudice’ – discrimination against transgender people (Singh, 2012). The United Nations Educational Scientific and Cultural Organisation (hereafter UNESCO) released a booklet entitled Education Sector Responses to Homophobic Bullying (2012), with the aim of enabling teachers, administrators, policy makers and other education stakeholders to develop concrete actions to make education safer for all.
3.1.2 Gender and the Family

“Gender relations and family life are so intertwined that it is impossible to understand one without paying attention to the other” (Coltrane & Adams, 2008: 1). Whilst it may not always be obvious, when we discuss family values we are also talking about gender values and vice versa. For example, the gender issue of whether men should be paid higher wages than women is reflective of family issues whereby a ‘yes’ answer implies the male figure (husband/ father/ stepfather/ partner) should be the family breadwinner. The family unit plays a critical role in gender socialisation. UNICEF (2007) defines gender socialisation as “the process by which people learn to behave in a certain way, as dictated by societal beliefs, values, attitudes and example” (http://www.unicef.org/earlychildhood/index_40749.html). Early gender socialisation starts at birth and it is a process of learning cultural roles according to one’s sex, this is explored further below.

A start example of societal constructs of gender within concepts of the ‘family’, in this State is how ‘the family’ is referred to in Articles 41 & 42 of the Irish Constitution as the natural primary fundamental unit group of society’ and as a ‘moral institution possessing certain inalienable and imprescriptible rights’, but is not defined. The Irish courts have defined the ‘family’ as that based on marriage (State (Nicolaou) v. An Bord Uchtala 1966. IR. 567) and that a valid marriage cannot be contracted by persons of the same sex (Zappone and Gilligan v. Revenue Commissioners and Others 2006. IEHC. 404). Whilst legislative rights have been provided to non-marital families and same-sex civil partnerships (for example The Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010) constitutional protection of the ‘family’ remains founded on the traditional nuclear, binary-gender model.

The United States Census Bureau defines the family as a group of ‘two or more people (one of whom is the householder) related by birth, marriage, or adoption” (http://www.census.gov/hhes/www/income/about/faqs.html). This definition captures something important about the legal institutions of marriage and parenthood; these are considered the norms of a family construct. It can be argued that the word ‘family’ is used in political rhetoric to claim the moral high ground, for example where a homophobic individual suggests that two gay men who want to get married are denigrating the ‘family’ construct.

However in any case, the word ‘family’ can mean many things to many people. Today, these are so many different types of families and people are increasingly likely to experience changes in their own family and household structures. Coltrane and Adams argue that
“kinship must be earned by making regular connections with people – seeing them regularly, writing or phoning them, giving or receiving help” (2008: 6). Different versions of fatherhood/ motherhood or other family relationships are not necessarily accorded with birth or marriage. For example, children living with a stepfather are more likely to identify him as a member of their family rather than their non-resident biological father (Furstenberg & Nord, 1985).

A child’s earliest exposure to what it means to be male or female comes from parents (Lauer & Lauer, 1994; Santrock, 1994; Kaplan; 1991). In Ireland and indeed many Western cultures, from the moment a child is born, sons and daughters are dressed in gender specific colours; (boys in blue and girls in pink), thereafter, the ‘family’ provide gender differentiated toys e.g. boys receive tractors and girls receive dolls. “For children, the actors in the world are not political leaders and heads of development agencies, but the parents and care-givers who make crucial household decisions each day” (Coltrane & Adams, 2008: 16). Parents/ care-givers play an inescapable role in children’s learning of gender/ gender roles/ gender expectations. It can be argued that the strongest influence on gender role development occurs within the family, however it is undoubtedly reinforced by culture and society. As noted by Coltrane and Adams “the little rules and expectations that govern our everyday actions (as male/female) are learned through interaction with other people” (2008: 2).

3.1.3 Gender Culture: Changes in Gender Roles

On a global scale, the UN reports that women perform 66% of the world’s work, produce 50% of the food but earn 10% of the income and own 1% of the property (UNICEF, 2007). From a generalised perspective one could argue that gender inequality still profoundly exists, however, there have been changes in gender roles throughout the ages and this may be due to the fact that “gender is arbitrary, flexible, and based in culture” (Goldstein, 2001: 2). Simply put, ‘gender’ is not a fixed or rigid concept and has the potential for change if there is a change within society.

The social constructivist approach to studying people, culture and society has a long and varied history which is also further explored in Section 3.3 Society. The social world seems relatively fixed and outside of us, however – we are constantly engaged in recreating social meanings simply by following our normal daily routines, for example even in what we mean as something being masculine or feminine. “When we encounter something that does not fit with our social expectations, we either find a way to make ‘normal’ sense of it, or we forge a
new understanding of it by checking in with the people around us” (Coltrane & Adams, 2008: 3). The ways that we interpret thoughts, feelings and behaviours depend on a shared understanding of what is going on. Research anchored in this recognition emphasises the value of exploring people’s understandings usually via qualitative research.

In relation to this research, “a male pessimism about society has emerged, resulting from socio-economic changes and changes in our social values” (National Suicide Prevention Office, 2006:5). Social change in traditional gender roles may be a contributing factor to the high rate of young male suicides in Ireland. “There is a certain increased vulnerability associated with being young and male in Ireland today compared with the past, this can sometimes manifest in unhealthy and anti-social behaviours. Sometimes these behaviours are extremely self-destructive” (National Office for Suicide Prevention, 2005:42). It could be observed that some men do not want to let their guard down, they do not want to discuss emotions that may cause tears, create a sense of fear and a loss of their masculine identity. “Some aspects of traditional masculinity are detrimental to health and progress for men” (Cleary, 2005:7). What is viewed as the traditional male gender role can undermine men’s mental health by deterring protective factors such as help seeking and social support.

Research shows that men are less likely than women to seek help for both mental and physical health concerns: (see, for example, Chrisler & McCreary, 2010). A recent study by the Men’s Health Forum (2013) argues that “Although women are diagnosed with depression about twice as often as men, men are approximately twice as likely to die from suicide” (YMSP, 2013:26). However, this is not to say that those men did not suffer from depression, one must acknowledge there is a greater opportunity for those women to be diagnosed with depression as they sought help where as men would be less inclined. “Whilst there are higher rates of mental illness diagnosed in women, men are less likely to seek help; with male depression often being suppressed and manifested through more ‘acceptable’ male outlets, such as alcohol abuse and aggressive behaviour” (YMSP, 2013:9).

If, in an attempt to prove/preserve masculinity, some men are risking their health, it would seem reasonable to ask what strategies may be introduced that would not threaten their idea of masculinity. Conceptualising how young men view and weigh up the associated pros and cons of seeking support in relation to mental health provides a useful means to help men who otherwise may not come forward to seek support. A recent report suggests that help seeking should be viewed as “a masculine norm of being strong, gallant and rational” (YMSP, 2013:50), but how best to achieve this in Irish society is still open to debate.
3.1.4 Gender Differences in Support Seeking

“Across measures, the core elements of masculinity appear to include instrumentality or agency, restricted emotional expression, and rejection of all things feminine, and the core elements of femininity appear to include passivity, emotional expression, and a concern for others’ well-being” (Smiler & Epstein, 2010: 150). Various components that are associated with masculinity/ femininity distinguish them as two separate and different constructs.

“Masculinity was connected to strength and being a successful man involved maintaining a strong masculine image” (Cleary, 2005:8). Research (see Cleary 2005; YMSP, 2013) suggests that many men still view any ‘feminine’ characteristics as weak including calling for emotional support, expressing feelings that are not masculine; crying and displaying fear. It can be speculated that this contributes to the young male’s lack of willingness to seek support when going through the loss of someone by suicide. “Being tied to rigid forms of masculinity which prevent disclosure of fears as well as discussion of emotional needs places some young men in an unhealthy environment both socially and psychologically” (Cleary, 2005:50). It appears that men do not want to be seen in a vulnerable position of ‘help seeking’ as it seems that is ‘displaying weakness’ on their part, it is not something that men do. Patros and Shamoo tackle the idea of help seeking and the vulnerability associated with it and suggest a shift in perception, “emphasis should be on seeking help as strength, not as weakness” (1989: 149). That may be desirable but how is it to be achieved? Balk (2011) suggests that reframing “seeking help” as “problem solving” has proven successful with some college men. It is evident here that there needs to be a reform on perceptions of seeking help so that it is viewed as a sign of strength, not a weakness and the following example shows the work of one athlete, Mr Cusack in his attempt to do so.

A recent blog ‘Depression is a friend, not my enemy’ (November 2013) was released by an admired prominent male GAA Cork hurler Conor Cusack, whom is to date the first individual in the public eye (in Ireland) to come forth and tell their story of depression and their battle with suicide so openly. Mr Cusack identified with many aspects of his life; work; family; friends, and talked about how they were affected by his depression and battle with suicidal ideation. He admits what was happening for him with exquisite detail and honesty and his contribution had a great impact nationally. However Mr Cusack has acknowledged masculinity and the masculine image and tackled it head on, he states:

“It is an act of courage and strength, not weakness, to admit you are struggling.
It is an act of courage to seek help.

"It is an act of courage to face up to your problems"

(http://ccusack111.blogspot.ie/2013/10/depression-is-friend-not-my-enemy_28.html).

The last line quoted identifies that it is not only in relation to suicide or depression but whatever the problem may be, i.e. the loss of another through suicide.

The ‘Young Men and Suicide Project: A Report on the All-Ireland Young Men and Suicide Project’ (YMSP, 2013) suggests that “Young men need to see emotional expression as a skill that improves with practice” (YMSP, 2013: 9). Using a phrase such as ‘mental fitness’ instead of ‘mental health’ has potential to make a difference, as detailed by the GAA. The GAA in partnership with St Patricks Mental Health Foundation recently (April 2014) launched an innovative resource ‘Play in My Boots’. The initiative has two primary aims:

- De-stigmatise mental health by speaking to players in a sporting language familiar to them, i.e. using the term ‘mental fitness’ to emphasise the positive nature of mental health.
- Reminding individuals that maintaining ‘mental fitness’ requires work and skill development in the same way as maintaining physical fitness does.

However, this initiative/resource has only been introduced in April 2014, so as of yet, the benefits of it cannot be fully measured. Pre-existing research evidence in the field of gender established that there is a gender difference for individuals, when seeking professional help (Chrisler & McCreary, 2010). Balk argues that college support programmes/services “need to appreciate the press for young college males to conform to visions of masculinity that abhor appearing out of control or vulnerable; create places males see as safe and yet that offer challenges for growth and development” (2011: 25). This topic is discussed further in section 3.4.3 on Gender differences in grief.

3.1.5 Sexual Orientation

Sexual orientation can be defined as “a person’s capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender” (UNESCO, 2012: 06). It is argued that sexual orientation has no relation to whether an individual is transgender or not. “Transgender people may be heterosexual, homosexual, or bisexual” (UNESCO, 2012: 06). Herman was a man and uses herself as an example: “I am still attracted to women in my new life while my two best friends, also trans women, are now attracted to men” (2009: 04). Notably,
homosexuality was removed from the American Psychiatric Association’s catalogue in 1973 but it is surprising that transgender has been left behind.

The process of defining oneself as gay, in line with the additional act of ‘coming out’ publicly, can create dramatic and profound events in the lives of those living in a hostile society. “Learners who are subjected to homophobic bullying at school are more likely to think about harming themselves and more likely to commit suicide than young people overall” (UNESCO, 2012: 22).

There is no doubt that Ireland has moved on dramatically in relation to sexual orientation and outdated notions of those who are bisexual/homosexual. This can be seen in passing of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010 by the Dáil and the Seanad in July 2010 (http://www.irishstatutebook.ie/2010/en/act/pub/0024/). There is however still stigma attached and while some have moved on, others still remain with oppressive ideations of the LGBT community. Dr. Tony Bates, Founding Director of Headstrong says: “It’s not their sexual orientation that’s making them feel suicidal, it’s what comes with that: the challenges it poses to fitting in, the threat it poses to being bullied, discriminated against and being rejected” (Hunt, 2012: 5b).

Allport (1954) theorised the personality characteristics that develop in individuals who are targets of prejudice and described these characteristics as coping mechanisms which people may develop initially in response, but they have the potential to become relatively stable personality traits. Headstrong’s recent large-scale study with University College Dublin, ‘My World Survey’ has some alarming findings. ‘My World Survey’ is a national study of youth mental health in Ireland with a sample size of approximately 15,000 participants, aged 12-25. It found that those who were still unsure of their sexual orientation had one of the highest self-harm rates of 43% (Dooley, B. & Fitzgerald, A. 2012). Over all, participants that were not heterosexual had a higher self-harm rate than others. “Those who reported their orientation as bisexual had a self-harm rate of 56%. Meanwhile, the rate of those who were heterosexual was 19%” (Hunt, 2012: 4b).
3.2 Suicide Rates/Statistics

This section will portray suicide death patterns, some issues linked to a death by suicide and present a brief introduction to the severe stigma that was once attached to the surviving family. To fully understand the patterns of suicide deaths in this country and worldwide we must look at the recorded statistics, however one must be cautious when doing so, as that which is reported is not always that which took place.

3.2.1 Problems with Reported Figures

Ireland had the lowest rate of suicide in Europe at one time. Unfortunately, this may not be due the fact that they weren’t occurring. It was “assumed that there was a great tendency among the Irish, to label suicides as accidental deaths” (Kelleher, 1996:15). Historically, research suggests that suicide has been under reported. One study in Dublin over 40 years ago aimed to estimate the discrepancy between coroners’ verdicts, the national suicide statistics compiled from them and the clinical assessment of probability of suicide by psychiatrists examining the same records. This research found that while Irish suicide rates were low, they were not as low as national statistics suggested (McCarthy & Walsh, 1966). “Some coroners may be less inclined than others to pass verdicts of suicide (Keir, 1986 cited in Wertheimer, 1991:2). An attempt is made to ‘protect’ relatives from what is sometimes considered to be a highly distressing and unwelcome verdict.

A conjoint study by the CSO and the Southern Health Board “suggests that the official suicide rate may be under-reporting the true rate by 15% to 20%” (Kelleher, 1996:16). It is noted that there was an increase in suicide rates, particularly among young men, since the 1970s. While there is clearly a gender difference in suicide rates in Ireland, it is debateable just how much suicide rates have increased. This is primarily as a result of very little focussed research on the topic in the past, in comparison to a great deal of recent research. The following table suggests that it is only since 2008 that we have gained some reliable indication of the actual suicide deaths in Ireland.
Table 3.1 - Recorded suicides V’s unrecorded suicides in Ireland.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of suicides recorded</th>
<th>Actual suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>486</td>
<td>???</td>
</tr>
<tr>
<td>2001</td>
<td>448</td>
<td>???</td>
</tr>
<tr>
<td>2002</td>
<td>451</td>
<td>???</td>
</tr>
<tr>
<td>2003</td>
<td>444</td>
<td>???</td>
</tr>
<tr>
<td>2004</td>
<td>457</td>
<td>???</td>
</tr>
<tr>
<td>2005</td>
<td>442</td>
<td>???</td>
</tr>
<tr>
<td>2006</td>
<td>405</td>
<td>???</td>
</tr>
<tr>
<td>2007</td>
<td>460</td>
<td>???</td>
</tr>
<tr>
<td>2008</td>
<td>429</td>
<td>600 approx</td>
</tr>
<tr>
<td>2009</td>
<td>527</td>
<td>600 approx</td>
</tr>
<tr>
<td>2010</td>
<td>486</td>
<td>600 plus</td>
</tr>
<tr>
<td>Total</td>
<td>5035</td>
<td></td>
</tr>
</tbody>
</table>

(http://www.sosadireland.ie/facts/facts.htm)

The actual statistics today may still be underestimated due to the number of ‘cause undetermined’ deaths recorded every year. According to the National Office of Suicide Prevention’s 2012 Annual Report between Jan 2004 and Dec 2010, 696 ‘undetermined’ deaths were recorded. “It is likely that a proportion of the deaths classified as undetermined were actually deaths by suicide” (NOSP, 2013: 52).

The Irish Water Safety reported in 2012, water death figures of 147 “Suicide Drownings of 44 and 33 Drownings whose cause was undetermined” (www.iws.ie). What is intriguing is what follows next, the Irish Water Safety reported that “it is suspected that a percentage of Undetermined Drownings were as a result of suicide” (www.iws.ie). This concurs with what was identified by the NOSP’s 2012 Annual Report.

Without a fuller understanding of the rate of suicide deaths in Ireland, an issue which can only be addressed by further research into undetermined deaths, resources to address the problem will not be realistic. Currently, “it is not possible to calculate the proportion and it is not possible to say whether the proportion remains the same each year” (NOSP, 2012: 52). So
while it has been noted that there has been diverse research conducted in the area of suicide deaths, unanswered questions still remain as to correct incidence.

3.2.2 Gender and Suicide: The Statistics

As previously noted the incidence of young men dying by suicide is evidenced as remarkably higher than young women in this country. This gender pattern is not unique to Ireland and has become apparent in most Western countries for the past fifty years (Cutright & Fernquist, 2000; Lee, Collins & Burgess, 1999). “In all countries, suicide is one of the three leading causes of death among 15-44 year olds, particularly among males (YMSP, 2013: 29). However a significant report in 2006 produced by the National Suicide Prevention Office ‘The Male Perspective’ noted that “in most countries that return data to the WHO, the suicide rate increases with age. In Ireland, the rate of suicide peaks among young men and in this way trends in Irish suicide are fairly unique.” (NSPO, 2006:8).

The Male Perspective research indicated that men are less likely to seek help or to avail of services when offered and concluded that expectations around male behaviour remain which dissuade men from disclosing problems. Such expectations may include maintaining a strong masculine image, i.e. being a successful man, showing strength (Cleary, 2005). The YMSP (2013) research study argues that “Although women are diagnosed with depression approximately twice as often as men, men are approximately twice as likely to die from suicide” (YMSP, 2013: 26). This is not to say that those men did not suffer from depression, one must acknowledge there is a greater opportunity for those women to be diagnosed with depression if they sought help. The point bears emphasis that “whilst there are higher rates of mental illness diagnosed in women, men are less likely to seek help; with male depression often being supressed and manifested through more ‘acceptable’ male outlets, such as alcohol abuse and aggressive behaviour” (YMSP, 2013: 9). The issue of ‘help seeking’ amongst males can broadly be considered to be associated with how individuals become aware of, and respond to health concerns against the background of social norms. This is addressed further in the next section, 3.2 ‘Gender’. The following chart illustrates the male suicide pattern in Ireland, according to their age, over three previous years:
While this chart demonstrates a slight increase in age, in relation to the peak of suicide rates in Ireland over three previous years, this does not eliminate the fact that suicide rates among those aged 15-24 are still extremely high. Ireland’s rate of youth suicide still remains the 5th highest in Europe (HSE, 2008). In addition, in 2007 nearly 11,000 people presented self-harm injuries in emergency departments, according to the National Office for Suicide Prevention.

The figures from the Central Statistics Office for suicide deaths in 2003 were 444 suicides, which consisted of 81% male and 19% female. It was also noted that “this was the biggest cause of death in the 15-24 age group at 29%” during this year (www.cso.ie). Eight years later the figures by the Central Statistics Office for suicide deaths in 2011 remained similar in relation to gender ratio. In 2011 it was reported that there was 525 suicides, of which 84% were male and 16% were female. From 2001-2006, for those aged less than 35 years, the ratio was almost 6:1, men to women (National Suicide Prevention Office, 2006). Not much has changed in the pattern in the last 4-5 years. In 2009 there were 527 suicides registered. In 2010 there were 486 suicides registered, a decrease of 7.8% from the previous year. There remains a stubborn gender difference in suicide deaths in Ireland with males representing on average 80% of all suicides over the past nine years. In 2003 81% of suicides in Ireland were
male, eight years later, there are similar reports of incidence with males representing 84% of suicide deaths.

Fig. 3.2 - Recorded suicide deaths in Ireland 2003-2011.

In relation to suicide prevention strategies, the World Health Organisation (WHO, 2010) stated that relatively few suicide prevention programmes have been rigorously evaluated for their effectiveness in reducing suicide and related risk factors. This is not to suggest that available services are ineffective but rather, there is a lack of published evidence showing the evaluated benefits of these initiatives. The WHO indicates suicide prevention efforts that have been classified into three levels: Universal; Selective; Indicated (WHO, 2010). ‘Selective’ in this instance represents subgroups at particular risk of suicide, they are identified as at particular risk if they are/ have experienced “mental illness, substance abuse, financial debts, unemployment, study stress and access to suicide means” (US Department of Health and Cuman Services, 2001; Cited in World Health Organisation, 2010: 6). All of the above experiences are commonly known to affect third level students to some degree, the My World Survey (see Chapter 4) revealed excessive drinking was reported, money was identified as a top stressor and 43% of the 8,221 participants aged 17-25 reported that their life was not worth living at some point (Dooley & Fitzgerald, 2012).
In an attempt to tackle these suicide risk factors, the WHO suggests a low threshold approach “gatekeepers training for teachers, general practitioners, and community stakeholders who may identify and provide early intervention to people with possible suicide risks during their daily work” (US Department of Health and Cuman Services, 2001; Cited in World Health Organisation, 2010: 6). The feasibility of introducing this low threshold approach is addressed further in Section 7 – Discussion. However, it must also be noted here that the evaluation on the prevention of something that someone may or may not do i.e. choose to die by suicide, can understandably be argued as a difficult task.
3.3 Society

3.3.1 Durkheim and Social Cohesion

One of the classic sociological studies that explores the relationship between an individual and the society in which he resides, is Émile Durkheim’s analysis of suicide (Durkheim, 1952 [1897]). His theory was that human behaviours occur, not through exercising choice and free will but rather, it is socially moulded and formed. Durkheim’s study showed that even a highly personal act such as suicide is influenced by the social world. “Durkheim established empirically that the rate of suicide is a social phenomenon that is typically both stable (over long periods in a given society) and variable (from one society to another)” (Corcoran, 2013: 12).

3.3.2 Sociological Explanations for Suicide

Durkheim was the first to insist on a sociological explanation for suicide. Sociology can be described as the scientific study of human society and its origins, development, organizations and institutions (Giddens, 2006). Giddens addresses the concept of social structure and its importance within sociology. It refers to the social contexts of our lives, stating that they are structured or sequenced in distinct ways, they are not just a random assortment of actions/events. There are regularities in the ways we behave and in the relationships we have with one another. “Our activities both structure the social world around us and at the same time are structured by that social world” (Giddens, 2006: 8).

“According to Durkheim, suicide was a social fact that could only be explained by other social facts” (Giddens, 2006: 15). In particular, Durkheim believed that suicide rates were determined by the relationship between individuals and their society, furthermore the extent to which individuals were integrated into society and social groups, and also, the degree to which society regulates individual behaviour. On this basis he distinguished four types of suicide:

- **Altruistic**: Excess integration – social bonds are too strong, the individual values society more than himself/herself.
- **Egoistic**: Insufficient integration – individual is isolated, or if his/her links with a group become diminished.
- **Fatalistic**: Excess regulation – feeling of powerlessness before fate or society.
Anomic: Insufficient regulation – lack of social regulation, i.e. in times of economic upheaval or in personal struggles like divorce. (Haralambos & Holborn, 2008: 796; Giddens, 2006).

The type of suicide this study anticipates it will mainly be focusing on is Egoistic. Such suicides are identified by low integration in society and it can be argued that there has been disruption to the social cohesion to the Republic of Ireland and a student can become isolated during the transition into third level education. An egoistic suicide would usually occur if an individual’s ties to a group were weakened or broken or when he/she has become isolated (Giddens, 2006). A student that has moved to a different part of the country for college, where no acquaintances have been made creates the potential for the student to become isolated at an early stage.

3.3.3 Social Cohesion and Religious Influences

Durkheim found religion had a moderating influence on suicide, primarily because it is a force for social cohesion whether positive or otherwise. Durkheim argues that stronger social control and levels of integration among Catholics resulted in lower suicide rates than that of Protestants (Durkheim, 1952 [1897]). Durkheim argued that the Catholic religion integrated its members more strongly into a religious community and the low rates of suicide among Catholics might be explained by their strong social community. “The long established beliefs and traditional rituals of the Catholic Church provided a uniform system of religious belief and practice into which the lives of its members were closely intertwined” (Haralambos & Holborn, 2008: 797).

This strong social community has been broken with the outrage caused by many recent reports on child abuse in the Catholic Church, see for example Ferns Report 2005. This report was an official Irish Government inquiry into the allegations of clerical sexual abuse in the Irish Catholic diocese of Ferns. “It identified more than 100 allegations of child sexual abuse made between 1962 and 2002 against twenty one priests operating under the aegis of the diocese of Ferns” (http://www.ferns.ie/FernsReport.shtml). Other reports, such as Ryan Report 2009, Murphy Report 2009 have evidenced wide spread horrific child abuse and, at best a failure of church authorities to take robust immediate action on reports. The priests and nuns who were highly respected and often feared by many have lost that status. These revelations have forced disruption and disturbance amongst Catholic Hierarchies and followers. This was not the only report to cause such re-percussions as many individuals also
came forward with their own stories of abuse. There have been media documentaries such as reports on the Magdalene laundries in Ireland, triggering further public debate and interest. It could be argued that this created a crisis of faith in the Catholic Church i.e. the numbers attending Church have decreased rapidly therefore people are not integrated into this strong social community anymore, it has been severely damaged and its influence diminished. Derived from Durkheim’s belief that social integration/inclusion via religion is beneficial in relation to suicide issues, one is lead to question whether the ‘downfall’ of the Catholic Church in Ireland will have impacted current suicide rates in Ireland, a theory that is challenged by some (Van Popple & Day, 1996; Kushner & Sterk, 2005).

As noted previously in Section 3.2.1 Problems with Reported Figures, suicide rates in Ireland were unreliable (and possibly still are) for a period of time due to questionable underreporting. The actual statistics today may still be underestimated due to the number of ‘cause undetermined’ deaths recorded every year, “it is likely that a proportion of the deaths classified as undetermined were actually deaths by suicide” (NOSP, 2013: 52). Van Poppel and Day (1996) voice the argument of suicide reporting issues as a flaw in Durkheim’s Suicide, “if rates for a particular phenomenon in one population are based on definitions or recording practices that differ from those in another population, comparisons will be biased and any claim of a difference between the two will be flawed” (Van Poppel & Day, 1996: 501). Where trends are recorded differently, it is not feasible to accurately establish comparisons (if any). Van Poppel and Day challenge the validity of Durkheim and other sociological explanations of suicide, as data acquired from the Netherlands 1905 – 1910 presented “a unique opportunity to test the statistical support for Durkheim’s theory about religion and suicide, using data essentially contemporaneous with those used by Durkheim himself” (Van Poppel & Day, 1996: 503). It is suggested by Van Poppel and Day (1996) that Protestants reported more suicides than their Catholic counterparts, aiding the perception that more Protestants died by suicide than Catholics. Catholics presented their reports under different headings such as ‘sudden death’ rather than suicide. (Van Poppel & Day, 1996). The suicide trends are recorded differently within opposing religious populations (Catholic, Protestant) which creates a flaw for comparison purposes. Van Poppel and Day conclude “a sociological explanation receives no support from these data: The data, although roughly contemporary with and similar to those used by Durkheim, are far superior to his because they are not subject to the risk of committing the “ecological fallacy” (Van Poppel & Day, 1996: 506).
Durkheim also related egoistic suicide to ‘domestic society’. Marriage integrates an individual into a stable social relationship, while single people remain more isolated within society (Durkheim, 1952 [1897]). Haralambos and Holborn argue that the single person has “less responsibility for others and as a consequence were more prone to egoism and a high suicide rate” (2008: 797). When the Catholic Church had more power and control over the Irish people and it was highly frowned upon for a woman to have a child out of wed-lock, she would usually become engaged and marry the father of the child before anyone would know of the pregnancy. There were, of course, other options, but this would have been the norm. This has also changed in recent years. In 2011 and 2010 the percentage of women who were married that had a child was 66%, the percentage of women that were unmarried that had a child was 34% (www.cso.ie). While married parents still form the largest cohort, it is becoming more accepted for parents to have a child but perhaps live together outside of wedlock. Is this allowing for individuals to feel less stable or secure in their relationship and indeed within society? “For Durkheim, social cohesion, especially traditional family life, provided the best protection against self-destructive behaviour” (Kushner & Sterk, 2005: 2).

Further challenges on Durkheim include Kushner and Sterk (2005), who argue that with high levels of social integration, the incidence of self-destructive behaviours, such as suicide are often at the greatest. “Durkheim’s evidence supports the opposite conclusion, that is, that the incidence of suicide is greatest among those most subsumed in social groups.” (Kushner & Sterk, 2005: 2). They believe that we must remain hesitant about current claims that increased submersion in community activity will improve health outcomes and reduce mortality. “The quality of relationships is always paramount, and participation alone does not necessarily translate into acceptance, trust, or reciprocity” (Kushner & Sterk, 2005: 4). What is being said here by Kushner & Sterk is very interesting in so far as, participating and going through the motions is not adequate although many of us would like to believe it is. For example, if a student is involved in a sports team, part of a society, participates well in college, one might assume that he/she is well integrated but in fact he/she might not be and might actually feel very isolated and alone. It will be important to remember this when addressing the development of support services within third level institutes as a means of enhancing social cohesion and this point will be returned to in discussing both methodology and findings.
3.4 Bereaved by Suicide

“Suicide appears to be the most personal action an individual can take yet... it has a profound social impact” (Stengel, 1973:13). A single act of suicide can profoundly affect such a wide circle of people: immediate family, other relatives, neighbours, friends, perhaps strangers that come across the incident, the guards that may have to inform the immediate family, other officials such as the coroner and the pathologist and the community. Adolescent suicides, for example, can involve many such secondary survivors. The suicide rate among young adults, especially young men will often have a serious impact on other young people (Wertheimer, 1991). “Sudden unexpected deaths, represent a special risk to mental health even in the absence of other vulnerability” (Parkes, 1998: 129). While any unfamiliar or unpredictable situation is potentially alarming or distressing, there are certain types of situations that are especially so. In the event of a suicide death, the death is sudden and unexpected to survivors, however, it was indeed a planned and structured death and is therefore unnerving and unsettling to those left behind.

As previously noted, there was a time in Ireland, when suicide was neither deliberated nor discussed amongst people in an open manner. It was regarded as a sin by the Catholic Church and those who were convicted of ‘committing’ suicide were unable to be buried in the traditional catholic manner (Kelleher, 1996). This was one among some of the various ways by which the surviving family were made feel disgraced. The additional shame that presented with a death by suicide lead to certain outcomes - “some coroners may be less inclined than others to pass verdicts of suicide” (Keir, 1986 cited in Wertheimer, 1991: 2). Also, a finding of suicide/ self-destruction can void some life insurance policies leaving surviving family members in a financial crisis as well as an emotional one. An attempt was made to protect relatives from what is sometimes considered to be a highly distressing and unwelcome verdict. Similarly, “if suicide victims were said to be insane at the time of the act they were exempt from religious and legal punishments” (Stein & Wilkinson, 2007: 142). The words ‘convicted’ and ‘committed’ suicide are used because (as previously noted) death by suicide was in law a criminal offence. “Ireland was the last country in Europe to decriminalise suicide with the passing of the Criminal Law (Suicide) Act, 1993.” (Suicide Prevention Office, 2006: 11).

“Until recently, society dictated that their grief be silent, hidden and full of shame. This is beginning to change. Suicide has been decriminalised and self-help groups have emerged”
Since the decriminalisation of suicide, Ireland has taken valiant strides in relation to relevant support services available to the public. Such groups are endeavouring to organise their own response to suicide. “Having someone to talk things over with can help survivors” (Wertheimer, 1991:48) It can help the bereaved to sort out what it is they want to do from this point and can help them reach a decision which is based on their own feelings.

It is now, almost impossible to keep track of all the different agencies, services and governmental bodies that are constantly developing new initiatives to tackle the alarming rate of suicide deaths in Ireland. This plethora of response has been commented on: “It is estimated there are several hundred support groups or counselling organisations offering services in different parts of the state” (O’ Brien, 2013: 5). Arguably, this creates competition, variation and choice for those seeking help, however when one main organisation is recognised as the leading source of support, people have security in the fact that they are going to a service which has been recognised and identified as the best.

3.4.1 Suicide Bereavement

Like all those who are bereaved, survivors of a death by suicide are faced with a major loss, and having to accept that the loss is permanent. However, Young et al. (2012) suggests that “suicide survivors face unique challenges that can impede the normal grieving process, putting survivors at increased risk for developing complicated grief, concurrent depression, PTSD and suicidal ideation” (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/). In the case of suicide, the survivor has to live with the thought that the death was self-inflicted and may have been self-chosen. “It is estimated that as many as three quarters of all suicide victims will have announced their intention to commit suicide, either directly or indirectly” (Litman, 1970a; Stengel 1972; Keir 1986 cited in Wertheimer, 1991:53). Unfortunately, it is because of this that survivors commonly experience added feelings of anger and guilt. The anger usually includes a view that the health service has failed them, Lukas & Seiden comment “The mental health profession, to which they have turned to for help in the past, seems to have failed them, and have failed them terribly. It did not keep their loved one alive” (1987:160). This may be one of the factors that deters survivors of suicide to seek support, another contributing factor may be the feeling of guilt. Some survivors of suicide can question themselves and the actions they took. “Survivors who are blaming themselves for the suicide may feel unworthy of other people’s care and support” (Wertheimer, 1991:154). If support is not sought and potential conditions associated with suicide bereavement, identified
by Young et al. (complicated grief, concurrent depression, PTSD and suicidal ideation) are left untreated the potential negative outcomes may be fatal.

“Survivors of suicide may be left to struggle with their own suicidal ideation, while seeing that the deceased escaped the anguish and put an end to their suffering” (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/). Crosby and Sacks cited in Young et al. (2010) reported that people who had known someone who died by suicide in the last year were “1.6 times more likely to have suicidal thoughts, 2.9 times more likely to have a plan for suicide and 3.7 times more likely to have made a suicide attempt themselves” (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/). The pain of processing the loss of a loved one by suicide coupled with shame, rejection, anger and perceived responsibility may sometimes become overbearing, resulting in perceiving suicide as the only way to end the pain. Further, Young et al. suggests that “some may feel closer to their loved one by taking their life in the same way” (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3384446/).

Balk suggests that “many college students faced with the death of someone they care for are thrown into a maelstrom of emotional and cognitive confusion that challenges core assumptions on what life is about and what it means to live in a moral world” (2011: 3). Cognitive impacts of bereavement (not specifically suicide) can threaten student’s grades and as a result the vision of their career should their grades drop. “Difficulty concentrating or remembering are common cognitive impacts of bereavement” (Balk, 2011: 33). As previously identified some individuals may struggle with their own suicidal ideation whilst coming to terms with suicide bereavement, therefore it is understandable that some students may feel incapable of accomplishing things that matter to them and struggle to see the benefits and value in continuing in education. It was therefore worthwhile to identify what strategies (if any) are in place in third level educational institutes, including the Cork Institute of Technology, to support students academically that are grieving.

3.4.2 Cluster Suicides

As noted above, “Suicidal thoughts are not uncommon during the early months of bereavement” (Wertheimer,1991:178). It’s thought that one suicide in a closely knit group may serve as the trigger to a cluster of suicides within that community. So called ‘Suicide clusters’, “occur predominantly among teenagers and young adults” (Blumenthal & Kupfer, 1990: 521).
“If you have suicidal instincts and somebody in your immediate circle kills himself, it’s hard not to think, whether consciously or not, ‘he had the courage to do it – why shouldn’t I?’ ” (Behrens, 1988:194)

Cluster suicides appear to be a result of numerous factors, as are non-cluster suicides, but research suggests that imitation and identification are factors hypothesized to increase the likelihood of cluster suicides. The route of exposure to the model may be direct or indirect. Indirect exposures would include watching the news coverage of a prominent person’s suicide or hearing about a suicide by word of mouth. (Blumenthal & Kupfer, 1990). The type of exposure mainly focused on for the purpose of this research is direct exposures. An example of this “would include close friendship with suicide or observing a suicidal act” (Blumenthal & Kupfer, 1990: 522). There have been a spate of recent incidents of such clusters in the Cork area. “Research by the National Suicide Research Foundation (NSRF) found a suicide ‘cluster’ involving 18 people – mainly adolescent and young men in a small area in Cork between Sept 2008 and March 2010” (http://www.irishexaminer.com/ireland/study-reveals-suicide-cluster-in-area-of-cork-157678.html).

Dr. Ella Arensman, Director of research at the NSRF has said that there are indicators in recent years that more such clusters are occurring. Arensman has also said that “identifying potential suicide clusters early could prevent future deaths by providing early counselling and support to the peer or community of a young person who dies by suicide” (http://www.independent.ie/national-news/cluster-suicide-trend-sparks-concern-2621805.html). This suggests that there is a need for pro-active support, care and attention for individuals who have lost a peer to suicide. The second report of the Suicide Support and Information System (SSIS, 2013) details results of investigations into subgroups and cluster suicides on 307 cases of suicide in Cork City and County between September 2008 and June 2012. One of the key outcomes noted in this report was “Proactive facilitation of bereavement support resulted in a significantly higher uptake of support by families/ friends bereaved by suicide compared to a non-proactive approach” (Arensman et al., 2013: 5). The Senior Research Psychologists (SRP’s) facilitated support for families bereaved by suicide. Proactive facilitation of support was achieved in this instance through:

1. Letter sent to the family explaining about the SSIS and offering support.
2. SRP’s made contact via telephone within 10 days of having sent the letter (once it had not been indicated that the family did not want to be approached further).
   - During the telephone call, the SRP’s assessed the needs of the family in relation to support.
3. If required, the SRP’s liaised with representatives from an appropriate bereavement support service for bereaved families.
4. A bereavement support pack with details of bereavement support services was posted. 
   **Note:** Facilitation of support started at the 2 week follow up. (Arensman et al., 2013: 12).

There was a non-proactive approach also taken which consisted of both part 1 (the letter) and part 4 (the bereavement support pack). The results in this instance speak for themselves with an uptake of bereavement support by a staggering 39.5% of participants where proactive bereavement support was offered and a mere 3.8% of the participants where a non-proactive approach was adopted. (Arensman et al., 2013). This is recaptured in the discussion chapter when examining the results of this study in context.

In relation to taking action, Patros and Shamoo address the unique position and potential that a learning institution has to teach students about life and death. “Since children (as well as adults) find suicide a difficult topic to discuss, the school must take the initiative that will allow for open discussion/students must be given the opportunity to discuss openly their thoughts and feelings” (Patros & Shamoo, 1989: 150). It was therefore seen to be worthwhile to identify what (if any) further initiatives in CIT support services could be developed or introduced to best help students respond to and cope with suicide in an open and appropriate manner. The ease with which survivors are able to find and utilise the support they need to deal with a death by suicide can depend on a number of different factors such as “the availability of appropriate services, how well those services are publicised, and whether there is a key referral system” (Wertheimer, 1991:152).

**3.4.3 Gender Differences in Grief**

As previously acknowledged in Section 3.1 on Gender society has a profound effect on shaping our attitudes and behaviours about gender, being taught to ‘be a man’ or ‘act more ladylike’. Similarly, society portrays gender differences in grief as detailed by Doka and Martin, “differences in affect intensity [in grief] found between men and women highlight both basic biological differences and sex role socialization experiences” (2010: 123).
Female grief reactions have been viewed as appropriate and more beneficial for processing grief, with the grief reactions that are often found in males (e.g. inexpression of emotion) being considered inappropriate and unhealthy responses to loss (Martin & Doka, 1996). “Women typically seek vocal expression of their grief, whereas men seem much less inclined to talk about their feelings. Men seem much more inclined to become introspective and do things rather than talk about what they are experiencing” (Balk, 2011: 33). ‘Self-reliance’ is something which is valued by the traditional male gender role, therefore some males are inclined to be reluctant to share their grief with others and instead take active roles, or involve themselves in activities in the aftermath of a loss (Martin & Doka, 1996). However, Parkes insists that “one way or another, women usually come out of bereavement with more psychological problems than men” (1998: 124). A Harvard Study in line with bereavement which was conducted revealed that the women participants “psychological and social adjustment a year later was less good” than that of the male participants (Parkes, 1998: 124).

There are no quick-fix techniques to help a survivor cope with a traumatic loss such as suicide. Doka (1996) suggests sensitivity, compassion and enduring support from immediate family and large groups i.e. church/ sports team/s, will help survivors develop a new life strategy and heal. For survivors of suicide, who may be experiencing extreme shock and horror, writing may be a means of exercising a measure of control over potential overwhelming emotions. Anthony Storr in his book Solitude, suggests that the creative act of writing “is one of the ways of overcoming the state of helplessness… a coping mechanism, a way of exercising control as well as a way of expressing emotion” (1989: 129). Similarly, Balk and Corr (2009) suggest that keeping a journal may be helpful for those bereaved by the suicidal death of a loved young person. This requires further inquiry whilst looking at ways (if any) to improve professional support services for students at CIT.
3.5 Youth and Alcohol Abuse

“Alcohol often transformed an unhappy state into a potential death” (Cleary, 2005: 8).

Strong links were found between excessive drinking and suicidal behaviours in the *My World* Survey, “young adults classified as possibly alcohol-dependent were significantly more likely to have thought their life was not worth living, and to have reported self-harm and having made an attempt on their life” (2012: 99). It is startling to see it reported that young adults attending third level are being classified as ‘alcohol-dependent’. Young people’s consumption of alcohol is recognised as an on-going problem (Cox et al., 2002; Cox and Blount, 1998; Carey, 1995). Similarly its relationship to mental well-being cannot be ignored. Alcohol Action Ireland indicates that “alcohol can contribute to the development of mental health problems as well as exacerbating pre-existing mental health difficulties” (http://alcoholireland.ie/policy/policy-documents-1/). Many people drink alcohol to help them cope with emotions or situations they would otherwise find difficult to manage. Walsh and Walsh (2012) suggest that the link between alcohol use and suicide has been well established, although it must be noted that many factors are involved in suicide.

3.5.1 Effects of the Transition into Adulthood in Relation to Alcohol

For young people in Ireland, alcohol consumption typically develops during adolescence. The critical developmental transition from adolescence to young adulthood is characterised by an increase in new and demanding social opportunities and expectations (Bachman, Wadsworth, O’ Malley, Johnston & Schulenberg, 1997:8). The College Lifestyle, an Attitudinal National Survey conducted in Ireland in 2005, found that the average age to start drinking was 15 years (Hope et al., 2005). This survey was carried out amongst college students with an average age of 21 years.

There is a big change in an adolescent’s life when they start college. There is an image of freedom associated with it, which involves doing things that they would not normally do at home such as excessive drinking, smoking etc… “College students show greater than average increases in alcohol use” (Bachman, Wadsworth, O’ Malley, Johnston & Schulenberg, 1997:81). Many young (and not so young) adults drink alcohol excessively in binges, often resulting in serious negative consequences. Drinking to intoxication appears to be a key feature of the drinking habits of young people in Ireland. An international study among university students in 21 countries found that Ireland has the highest proportion of (both male
and female) binge drinkers (Dantzer et al., 2006). One of the biggest concerns in relation to the high rate of alcohol consumption amongst young adults is this: young adults use alcohol not only to get intoxicated, but also they believe that it will help them feel more confident, relaxed and boost their mood (Boys et al., 2001). Using alcohol to control negative emotions or drinking to suppress depression or anxiety is an example of using alcohol to cope (Cooper et al., 1995). Students who drink alcohol for coping reasons tend to be frequent users, often drink alone and are more likely to binge drink (Cooper, 1994; Cooper et al., 1995; Williams and Clark, 1998).

### 3.5.2 Effects of Alcohol

When students are feeling a bit low, depressed or having suicidal thoughts and then drink alcohol, with the notion that it will boost their mood, there is a problem: “In over half the cases of suicide, alcohol is a key factor. That unfortunate young man who died in awful circumstances in Ballina brings it home to everybody.” (http://www.irishtimes.com/newspaper/ireland/2011/1104/1224307039518.html). This quote from Minister of State for Primary Care Róisín Shortall, is where she was referring to the case of David Higgins (19), from Ballina, Co Mayo, who took his life in March after a house party by jumping into the river Moy. (www.irishtimes.com).

It has been shown that chronic alcohol consumption amongst adolescents may increase feelings of depression, because it causes serotonin levels to decrease. Pullen (1993) found that anxiety, depression, low self-esteem and lack of success in attaining life goals were associated with drinking (www.drugsandalcohol.ie). “Alcohol consumption is key to understanding how the suicidal thought is translated into action” (Cleary, 2005:30).

A recent report stated “Alcohol and substance misuse were repeatedly cited by stakeholders as a hugely significant problem among young men” the report enumerated the problems as patterns of binge drinking; the links between drinking and increased suicide risk, drinking as a means of coping with distress; the confounding links between drinking and social disadvantage; drinking as a means of railing against authority and concluded “which results in a diminished sense of responsibility and anti-social behaviour” (YMSP, 2013: 71).
4. Mental Health Policy and Promotion

4.1 Legislation and Government Policies

4.1.1 Criminal Law (Suicide) Act, 1993

“Ireland was the last country in Europe to decriminalise suicide with the passing of the Criminal Law (Suicide) Act, 1993.” (Suicide Prevention Office, 2006: 11).

The main legislation specific to suicide in Ireland is the Criminal Law (Suicide) Act, 1993. It is an act stating that suicide ceases to be a crime, however to be an accomplice to a suicide in any form still is a crime (www.irishstatutebook.ie). The first Act that addressed suicide, other than in a criminal context, in Ireland was the Mental Health Act 2001. The primary purpose of this act is to provide protections for patients who are involuntarily admitted to treatment. However, it does not afford rights to those who are voluntarily admitted but who may require some form of advocacy on their behalf. The Mental Health Act is limited in terms of providing a broader set of rights around access to services and supports for people with mental illnesses (www.mentalhealthreform.ie).

When suicide was decriminalised in Ireland, it facilitated the need to research suicide openly and to develop strategies for suicide prevention. These are some of the strategies that are in place in Ireland today:

- **A Vision for Change** – a comprehensive policy and model of mental health service provision for Ireland.
- **Jigsaw** – an umbrella organisation which brings community services and supports together around young people in order to better meet their mental health needs.
- **Reach Out** – the National Strategy for action on suicide prevention.

The following summaries address the purpose and key elements of these initiatives, together with highlighting commentary and analysis on the implementation and success or failure of each initiative.

4.1.2 A Vision for Change

In January 2006, the government adopted the report of the expert group on mental health policy A Vision for Change (AVFC) as the basis for the future development of mental health services in Ireland. In March of that same year, the Minister for Health and Children Mr. Tim
O’ Malley TD, in line with the recommendation in AVFC, established the first Independent Monitoring Group (IMG) for a three year period to monitor progress. In June 2009 the Minister for Equality, Disability and Mental Health, Mr. John Moloney TD appointed the second IMG. The purpose of the IMG is:

- To monitor and assess progress on the implementation of all the recommendations in AVFC.
- To make recommendations in relation to the manner in which the recommendations are implemented.
- To report to the Minister annually on progress made towards implementing the recommendations of the report and to publish the report. (www.irlgov.ie)

The aims of this policy are as follows, “A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness” (www.dohc.ie). This policy came at a highly appropriate time, with rising demand for mental health services in the community and rising concern over youth suicide. The mental health reform is an organization where membership is open to all not-for-profit, non-governmental organizations who wish to work with member through education, information, support and training to help bring about structural and cultural changes in mental health in Ireland. As it is non-governmental it is beneficial to note their view points on AVFC as they would most likely be unbiased.

- “AVFC proposes a holistic view of mental health and recommends an integrated, multi-disciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems” (http://www.mentalhealthreform.ie/home/mental-health-in-ireland/). In other words it proposes a person-centered treatment approach which will address each of these elements through an integrated care plan.

- AVFC also proposes that special emphasis should be given to the necessity to involve service users and their families and carers at every level of service provision. “Interventions should be aimed at maximizing recovery, and building on the resources within service users and within their immediate social networks to allow them to
achieve meaningful integration and participation in community life”  
(http://www.mentalhealthreform.ie/home/mental-health-in-ireland/).

- AVFC also proposes a transfer of resources from hospital and institutional services to community services and “recommends that 8.4% of the overall health budget is dedicated to mental health services to achieve full implementation” (http://www.mentalhealthreform.ie/home/mental-health-in-ireland/).

It was reported by the IMG in the 5th Annual Report on implementation of AVFC, 2010 that:

“Overall, it is the view of the IMG that slow progress was made during 2010. The challenge of implementing AVFC by the HSE, Independent bodies and Government Departments has been hindered by the lack of resources available to mental health, the imposition of the public sector moratorium and a lack of dedicated corporate leadership” (www.dohc.ie). This suggests that there are multiple reasons as to why A Vision For Change is having difficulty in being implemented, however, it is the last noted point that appears most needed ‘dedicated corporate leadership’, once leadership has been established, further advances can be addressed.

In 2012 “less than half of the promised posts aimed at boosting mental health and suicide prevention services” were in place (O’ Brien, 2013: 5). These staff positions were to be used to fill gaps in community mental health teams, improving psychiatric services and services for those with intellectual disabilities. The Capital Development Scheme whereby “€50m per annum is to be made available from the sale of old psychiatric hospitals and lands”, has been declared not possible due to our changed economic environment this has therefore had a further impact on the implementation of AVFC (www.dohc.ie).

“More than €50 million allocated by the Government to develop mental health and primary care services this year is to be used to offset the deficit in the Health Service Executive” (Wall & Cullen, 2012: 1). Yet, despite this diverting of funds from mental health, developments in mental health services are still promised by the Irish Government. The Department said: “The intention is that the developments will proceed in the latter part of 2012 and into 2013. In this regard, preparations continue for the roll-out of the service developments.” (Wall & Cullen, 2012: 1). A spokeswoman for Minister of State for Mental Health Kathleen Lynch, stated that “In the interim, the HSE continues to implement A Vision For Change, with substantial additional funding provided in 2013, and reports on this on a monthly basis, through the HSE national service plan” (O’ Brien, 2013: 5).
It was the view of the Independent Monitoring Group (IMG) that AVFC will only be fully implemented when there is: Additional resources; Redistribution of resources; Change in how services are delivered; Cultural shift of attitude; Improved practice by service providers (www.irlgov.ie).

The IMG’s role was to be formally reviewed after seven years and they were due to issue a final report. “A replacement group has not been appointed and there are no plans for a final report, according to members of the expert group” (O’ Brien, 2013: 5). This would make one question the commitment to implementation of AVFC if no evaluation of implementation body is in place.

However, despite this, a study by the National Service Users Executive in 2012 showed that “most patients felt there was a change in staff attitudes, and half said they felt involved in care planning”, despite the funding pressures facing the mental health sector (O’ Brien, 2013: 5). Nevertheless, there were also many that complained that they were not being listened to. “A substantial number felt they were provided with only partial information on their medication” (O’ Brien, 2013: 5). This suggests that there is still much work and development needed.

It is evident that the full implementation of AVFC has been put in jeopardy due to our current economic status and Government priorities. Des Kavanagh (general secretary of the Psychiatric Nurses Association) spoke on RTE’s Morning Ireland Programme “acute beds have been cut and cut and cut/ we’ve been the worst hit of any frontline service in this country” (Hunt, 2012: 17b). Whilst the “Libertarian approach”, as it was put by Mr. Kavanagh “is now demanded by patients and advocacy groups alike; as patients reside in single rooms and demand a dignified say in their treatment, the lack of staff and money needed for this type of care is putting some patients and no doubt staff at great risk” (Hunt, 2012: 17b). These are indeed worrying observations. The AVFC has brought most welcome changes in attitudes to mental health with an emphasis on recovery and prevention and in turn the holistic approach advocated has engendered a person centered focus. But all the positives have, regrettably, been undermined by not only a failure to further fund the crucial initiatives called for but a blatant diverting of funds from mental health to the rest of the health service. The actions of Government show that mental health is secondary and optional whereas AVFC mandated that mental health is integral to well-being of us all. This divergence
between eloquent policy aims and action is a disjunction, discovered throughout the published evidence but nowhere more starkly exemplified than with regard to AVFC.

4.1.3 Jigsaw

“Between 2005 and 2007 a number of teenage students died by suicide/not one had previously come to their attention, none were linked into the mental health services and none had been identified by their schools as being particularly at risk” (McDonagh, 2013: 5). Reports from Jigsaw show that 1 in 4 young people identified going through difficult times (http://www.jigsaw.ie/). Illback and Bates (2011) argue that “young people in the Republic of Ireland do not have access to appropriate mental health services and supports, necessitating transformational change in delivery systems” (http://onlinelibrary.wiley.com/doi/10.1111/j.1751-7893.2010.00236.x/abstract). It is suggested that there is a need for change in the manner of which mental health services and supports are delivered to young people. “Effective change initiatives require vision and leadership, competence- and capacity-building, participative planning and engagement, adequate and thoughtfully deployed resources, and a comprehensive change management approach” (http://onlinelibrary.wiley.com/doi/10.1111/j.1751-7893.2010.00236.x/abstract). A new approach was seen to be required, which involved interventions and programmes that were available and easily accessible. Jigsaw presented itself as such an initiative.

The stated aims of Jigsaw include the following:

- Advocacy—rights of young people to access better mental health systems: “If our youths can access better mental health systems, have early interventions and not wait until they are at or beyond breaking point before seeking help, it could save the lives of many” (http://www.jigsaw.ie/).

- The implementation of Jigsaw in a community: This is complex as there is a range of participants. “People within a community must be willing to work together for Jigsaw to be successful” (http://www.jigsaw.ie/). With such high rates of suicide in our country it would not be surprising that people would become involved willingly.

- Community specific initiatives: Each community will work slightly different as each community is different, but they will all have the same common ambitions and goals.

- Country wide reach: Jigsaw aims to be available in every county by 2016. (www.jigsaw.ie).
“Jigsaw works by engaging young people, organisations, families and other support agencies in the community, so that we are all better able to respond to the mental health and well-being needs of young people aged 12-25” (www.jigsaw.ie). Jigsaw originated from an organisation known as ‘Headstrong’ which started 6 years ago. “The focus of the initiative (Jigsaw) was on bringing mental health services to where the children and teenagers were, rather than wait, probably in vain, for the most vulnerable to access help themselves” (McDonagh, 2013: 5).

“Jigsaw is a network of programmes across Ireland (Dublin 15, North Fingal, Tallaght, Clondalkin, Galway, Kerry, Meath, Donegal, Roscommon and Offaly designed to make sure every young person has somewhere to turn to and someone to talk to” (http://headstrong.ie/jigsaw/jigsaw-centres-across-ireland/). Whilst it can be questioned just how available and accessible this service is to young people across the Republic of Ireland as a whole, there is a resounding positive response from areas where it has been implemented (see for example, Fitzmaurice, 2012; Walsh, 2014).

The Independent Monitoring Group’s (IMG) report in 2010 did identify some progress in AVFC. The IMG welcomed the continued development of the ‘Jigsaw’ model for youth mental health (www.irlgov.ie). This suggests that Jigsaw has had a progressive positive outcome since its introduction. A notable outcome of Jigsaw was identified by Fitzmaurice, “one of the most heartening things about Jigsaw to date is the level to which young males have engaged with the service – 53 per cent of service users are male” (2012: 27). Such a gender similarity in take up of services is promising. Fitzmaurice suggests that there are number of reasons why this is so: “young people’s direct involvement in the planning, design and delivery of the service; the quality environment and supports on offer; ease of access; and, most importantly, word of mouth” (2012: 27). These causations of students increased uptake of services as a whole, with minimal gender differences are at the very least informative and will be further addressed in the Section 7 – Discussion in line with results acquired from this particular study.

4.1.4 Reach Out

Reach Out is an Irish National Strategy for action on suicide prevention. It was generated in 2005 and is to run right through until 2014. The mission of Reach Out is “of a society where life is valued across all age groups, where the young learn from and are strengthened by the experiences of others and where the needs of those who are going through a hard time are met in a caring way” (National Office for Suicide Prevention, 2005:8).
It is an action based strategy which aims to ensure continuous quality improvement so that:

- The mental health and well-being of the whole population is valued;
- Mental illness is more widely recognised and understood and those experiencing difficulties are offered the most effective and timely support possible;
- The abuse of alcohol and other drugs is reduced considerably;
- Everyone who has engaged in deliberate self-harm is offered the most effective and timely support possible;
- Those affected by a suicide death or deliberate self-harm receive the most caring and helpful response possible (National Office for Suicide Prevention, 2005:8).

This strategy can be seen as complementary to and implementing of AVFC with a specific focus on preventing self-harm.

*Reach Out* aims to target the general population through many areas such as: the family; educational settings; youth organisations; sports clubs; workplaces; religious organisations and the media. Promoting mental health and improving support services in these areas would hope to bring about a positive attitude change towards mental health. (National Office for Suicide Prevention, 2005).

However, there are flaws with this strategy as well as other mental health provisions; total funding available for mental health services in 2010 was c. €970m, of which:

- €1 million went to Jigsaw
- €1 million went to the National Office for Suicide Prevention
- €1 million went to 26 local projects which “will enhance the ability of communities to prevent suicidal behaviour at all levels of risk, and are consistent with 'Reach Out – the National Strategy for Action on Suicide Prevention (2005)' (www.dohc.ie). Out of €970 million, €3 million is a very small sum to be awarded to recognised mental health strategies.

The head of the HSE’s National Office for Suicide Prevention, “Dr Stephanie O’Keeffe, has resigned after only three months” (Wall & Cullen, 2012: 1). Dr O’Keeffe is moving to a new post in the Department of Health. Her predecessor, ‘Geoff Day, took early retirement only last September shortly after raising concerns over resources and staffing” (Wall & Cullen, 2012: 1). There appears to be a quick turnover of staff in this position which raises concern.
Despite the fact that AVFC and other strategies have not been fully implemented, Ireland recently launched on (28/03/2013) ‘Healthy Ireland’, which is a framework for improved health and well-being 2013-2025.

An Taoiseach, Enda Kenny TD, stated "In Ireland, our health really is our wealth. Just as we are working to get our economy back in the best possible shape, through ‘Healthy Ireland’ we're working to get our people into the best shape too – physically, emotionally and psychologically" (http://www.dohc.ie/press/releases/2013/20130328.html). It was consistently found reviewing the literature that one of the main causes as to why previous strategies have not yet been fully implemented is due to lack of resources, yet they have decided to introduce a new strategy. The unavoidable conclusion is that we are better at policy strategy development than delivery in mental health.

The Minister for Education and Skills, Ruarí Quinn comments, “Healthy Ireland will bring further impetus to the existing programmes and strategies in place right across the education sector to improve the health of our young people, their teachers and families. We look forward to progressing education actions with other Government Departments and wider partners as part of implementing Healthy Ireland” (http://www.dohc.ie/press/releases/2013/20130328.html).

4.1.5 Counselling and Psychotherapy: The Health and Social Care Professionals Act, 2005.

The Health and Social Care Professionals Act 2005 is an Act to provide for the establishment and functions of the health and social care professionals. It addresses the need to register certain professionals working with those who are vulnerable in society. 27.-(1) “The object of the registration board of a designated profession is to protect the public by fostering high standards of professional conduct and professional education, training and competence among registrants of that profession” (Health and Social Care Professionals Act 2005).
There are 12 professions that are being discussed here which are as follows:

Table 4.1 – Professionals to be registered

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<td>Social Worker</td>
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<td>(l)</td>
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</table>

Section 4_._(1) (Health and Social Care Professionals Act 2005).

From this it is evident that there are still some gaps and other professions need to be included to fully ensure that the public are protected and provided with the best service possible. Dan Neville (FG, Limerick) criticised the exclusion of counsellors and psychotherapists stating that “the current position does not lend itself to good clinical governance and the maintenance of high standards of patient care” (http://www.irishtimes.com/newspaper/ireland/2012/1004/1224324837534.html).

Mr. Neville further cautioned about short courses being available in these areas, following the example of a “diploma qualification on eating disorders that could be obtained over a number of weekends” (Cullen, 2012:7). He also gave the example of a weekend course that was available “leading to a higher diploma in suicide studies” and said “it is highly dangerous for people to counsel those who have suicidal ideations after such a short course, when they are not fully trained” (http://www.irishtimes.com/newspaper/ireland/2012/1004/1224324837534.html). The lack of professionalization of these crucial areas raises further questions about the adequacy of training, supervision and accountability of people providing advice and support to people in crisis – whether it is at the end of a helpline or in more structured long term therapeutic care.
The Health and Social Care Professionals Act 2005, section 4(3) states “A health or social care profession is any profession in which a person exercises skill or judgment relating to any of the following health or social care activities:

(c) the resolution through guidance, counselling or otherwise, of personal, social or psychological problems”.

The most worrying factor is that it is some of the most vulnerable people will be going to a counsellor/psychotherapist for guidance and support in their time of distress. Waterford Labour TD Ciara Conway states “it is alarming to think someone is masquerading as a qualified therapist and engaging in serious intervention with very vulnerable people” (http://www.irishtimes.com/newspaper/ireland/2012/1004/1224324837534.html). Mr. Neville pointed out at a recent conference held in Tullow Co. Carlow that “an absence of proper regulation had caused situations where some mental health patients suffered severe damage” and also that “those involved in both sectors (counselling & psychotherapy) were now agreed on the need for regulation” (Cullen, 2012:7). Yet, Dr. Reilly persists and states “that nothing will be done about any other profession until the 12 professions are designated” (http://www.irishtimes.com/newspaper/ireland/2012/1004/1224324837534.html).
4.2 Third Level Students in Contemporary Ireland

*Vision for Change* noted that whilst Ireland has one of the highest levels of participation in third level education within the EU, “it also has a high percentage of students experiencing mental health difficulties including depression, anxiety and loneliness, substance misuse and suicidal behaviour” (*Vision for Change*, 2006:95).

A widely welcomed, recent large-scale study entitled ‘*My World Survey*’ conducted in Ireland 2012 (the first national study of youth mental health in Ireland from age 12-25) provides insight into young people’s mental health in Ireland and conceptualises their experiences. A total of 6,085 adolescents from 72 random second-level schools and 8,221 young adults from every University in the Republic of Ireland, five Institutes of Technology and one college of education participated in the research (Dooley & Fitzgerald, 2012). ‘*My World Survey*’ (2012) identified that 43% of the 8,221 participants (aged 17-25) reported that they had thought that their life was not worth living at some point. Just over half of the sample (51%) indicated having experienced suicidal ideation, with a further 21% indicating self-harm without wanting to take their life.

It is alarming that just over half of the participants (aged 17-25) felt that life was so difficult, they were brought to a point of questioning its value; their own value, “(51%) thought about taking their life though ‘they would not do it’” (Dooley & Fitzgerald, 2012: 58). This again shows a worrying number of students in our country that have considered suicide ideation. “About 90% of unplanned first attempts and 60% of planned first attempts occur within 1 year of the onset of suicidal ideation” (American Psychiatric Association, 2006: 1433).

Similarly, Kessler et al. examined the lifetime prevalence of suicidal ideation and suicide attempts in a sample of 5,877 individuals aged 15-54 years as part of the National Comorbidity Survey. The following are some of results that were found:

- The cumulative probability of moving from suicidal ideation to an unplanned attempt was 26%.
- The corresponding cumulative probability for transitioning from suicidal ideation to suicidal plans was 34%, with a 72% cumulative probability for going from a suicide plan to an attempt. (Kessler et al., 2003).

This indicates that there is a need for pro-active support, care and attention for individuals with suicidal ideation, which is evidenced as almost half of the young adult survey participants according to the *My World Survey* (2012).
In relation to help seeking behaviour for mental health issues, the participants of the ‘My World Survey’ indicated that “a fifth (20%) had problems but did not seek professional help despite feeling that they needed it” (Dooley, B. & Fitzgerald, A., 2012: 61). It is positive that the students were aware that they were in need of professional help but the question then remains, why not seek it?

4.2.1 Support Seeking in Young Adults

The ‘My World Survey’ revealed that “over three-quarters (77%) of participants reported they would be likely to use the internet as a source of help” (Dooley, B. & Fitzgerald, A., 2012: 61). This is an extremely high percentage of participants that indicated interest in a new direction for support service. “Both telephone and online counselling services have developed a foothold in the delivery of support for young people” (Hanley et al., 2013: 36). This is not surprising as the telephone has been strongly advocated as a primary source of support i.e. Childline and The Samaritans amongst others. Through the development of technology and the use of the internet, it seems understandable that people search the web for support and answers to their problems. There is a significant body of evidence developing which suggests that young people, sometimes described as ‘digital natives’, will access and are using online counselling services.

‘Kooth.com’ an award winning online counselling service for 11-25 year olds based in the UK reports that “82% of users rate the service as either good or excellent” (http://www.xenzone.com/pdf/kooth_info.pdf). The service provided is free. Young people who use ‘Kooth’ see it as “cool, credible and trustworthy, they can talk about difficult issues with counsellors and their peer group whilst remaining anonymous” (http://www.xenzone.com/pdf/kooth_info.pdf). In 2009/2010 Kooth counsellors helped 337 young people. In a 12 month period 8,100 online counselling sessions took place (Xenzone, 2011).

On the other side of the world, ‘Kids Helpline’ is Australia’s only 24/7, private and confidential counselling service for youths aged 5-25. Email counselling began in 1999 and real time web counselling began in 2000 (Kids Helpline, 2011). In the Kids Helpline 2011 overview, it was noted that a total of “8,941 real time web counselling sessions were provided and all of the 19, 121 email contacts received a reply” (Kids Helpline, 2011: 9). The expressed high demand shown for online support gives precedent to questioning third level students (in CIT) their views on the option as a source of support.
In Ireland there are new and novel online supports available at Turn2me.org. The ‘Engage Programme’ at Turn2me offers weekly 1 to 1 online counselling sessions with a professional counsellor or therapist which are held over an 8 week period for persons aged 18+. These sessions are combined with an Online Support Group (participants are required to attend once a week), and Daily ‘Thought Catcher’ Entries (participants are required to complete entries at least 5 out of 7 days per week) (Turn2me, 2009). Taking part in all three services aims to help both the client, as well as staff, to track patterns in the clients thinking, mood and behaviour which may be maintaining their difficulties (Turn2me, 2009).

Indeed the Engage Programme acknowledges that it is not thought to be suitable for all types of problems in a persons’ life and that people experiencing any of the following should seek professional face-to-face support elsewhere:

- At risk of seriously harming yourself.
- Experience severe and/or long-term anxiety/ depression.
- Experience personality disorder, bi-polar disorder or psychosis e.g. schizophrenia.
- Suffer from substance abuse.
- Experienced childhood abuse/ neglect or severe adult trauma.
- Not comfortable/ familiar using the internet.
- Under 18 years of age (https://www.turn2me.org/engage-over-ride).

It must be noted that whilst these guidelines exist and strive to be adhered to, due to the nature of online programmes, anonymity can be upheld and therefore the individual may not identify themselves as a sufferer, for example, of childhood neglect and continue to use the programme. Denial and concealment, is a potential issue with all online support services. However, as mentioned above, the purpose of the three services being used collectively strives to eliminate the misuse of the support and ensure participants wellbeing.

Bereavement; coping with traumatic events; coping/adjusting with change; depression; general personal development are some of the common issues that have been identified/ addressed in one to one Online Therapy thus far (Turn2me, 2009). These are issues that are common for third level students to experience and further emphasis needs to be placed on supporting students in such distress. Since 2009, over 25,000 registered members registered with the ‘Engage Programme’. An evaluation strategy is in place where by those taking part “complete various questionnaires and outcome measures to ensure that we can evaluate progress over the course of therapy (as well as being able to evaluate our service over time)”
(https://www.turn2me.org/engage-over-ride). However, while it is acknowledged that evaluation is being sought, there is no evidence of what the evaluation on the site is detailing, for example, is there positive or negative feedback from programme users.

Focusing more closely on third level colleges, Freja Petersen and Amy Colla presented ‘The integration and experience of structured online supported programmes in Student Counselling at Trinity College Dublin’ at the Technology for Well-Being International Conference, Dublin 2013 (http://ie.reachout.com/wp-content/uploads/2013/09/Integration-and-experience-of-structured-online-support.pdf). SilverCloud originated from a TCD project on technology and mental health and the TCD student counselling service were also involved in designing the platform and writing programmes so that confidential, interactive online programmes with weekly support and feedback from counsellors would be available to TCD students.

Like the ‘Engage Programme’ SilverCloud in TCD is concerned about use of the platform by students at risk (http://ie.reachout.com/wp-content/uploads/2013/09/Integration-and-experience-of-structured-online-support.pdf). To ensure students safety, precautions are taken at the outset. When a student would sign up for one of the three available programmes: ‘Mind Balance’; ‘Mind Balance Anxiety’; ‘See Myself’, students would fill out a preliminary form/questionnaire, and where there are risk indications the counsellor calls the client to further assess and offer face to face screening if it was deemed necessary.

Some of the reasons why students stated they chose to utilise SilverCloud as a support service was because:

- They saw obstacles in attending face to face counselling,
- It was more flexible,
- General preference for online (felt more comfortable),
- Suggested to them (students were informed of the service via email),
- Embarrassed seeking help face to face (didn’t feel that there problem was that bad),

Some students detailed that the reason why they chose to utilise the SilverCloud support service was because it was suggested to them, this is reflective of the second SSIS report (as detailed in section 7.2) that students were more inclined to take up the support service when it was pro-actively offered to them.
Some of the reasons that Counsellors like to utilise SilverCloud was because:

- It is a break from face to face work,
- They have time to think before responding,
- It is easy to use for therapists,
- Time per review (6-8 reviews can be done in under an hour)

Some challenges that the counsellors faced:

- The feeling of sending into a void,
- Not working in depth,

One TCD Counsellor stated “I don’t think it’s a substitute for one to one therapy, but I do see it as an extremely valuable resource for the students who will not attend one to one therapy for whatever reason”. It is evident that the positives of this online support initiative far outweigh that of the negatives, in terms of reach - whilst it is hard to over-state the importance of face to face counselling and building a relationship between a therapist and the client, it is imperative, as noted by the TCD counsellor, that there is another form of support for students that will not attend one to one therapy and are struggling with minor issues.

Examples are also detailed (see Trinity College Dublin, 2013) of three different ways whereby the online support was successful: its initial purpose; bridging a student from online to face to face online counselling; the integration of both face to face and online support for during the summer months.

4.2.2 Future Prospects

People are brought up with the ideal or notion that if they do well in school and proceed to do well in college then, they will have a good career that will be life fulfilling, however that can be a far cry from the reality today. “It is widely believed that children no longer grow up in a secure environment with the prospect of a permanent job if they do well at school,” said Roger Singleton, senior director of Barnardos (http://www.independent.co.uk/news/todays-generation-forced-to-face-the-hard-facts-of-life-1586205.html). A careers guidance counsellor has told delegates at the Association of Secondary Teachers Ireland conference in Wexford that “Rising levels of depression among students is a “reasoned response” to dwindling career options, declining living standards and “a complete lack of hope”,” (http://www.irishtimes.com/news/education/student-depression-is-reasoned-response-to-lack-of-career-options-conference-told-1.1348974). The My World Survey also states that of those
participants that did not seek professional help in spite of feeling the necessity for it, they “reported very severe levels of depression” and were also “much more likely to indicate very severe levels of anxiety and stress” ((Dooley, B. & Fitzgerald, A., 2012: 71).

Due to our current economic climate, young adults are making the decision to stay in college longer than they perhaps would have, had circumstances been different. There are also many that have returned to college due to different circumstances. These trends can be seen in the following table:

**Fig. 4.2 – Total Undergraduate Enrolment (2006/ ’07) – (2010/ ’11).**

(Data acquired from www.hea.ie).

It is evident from the table above that there has been a steady increase in student attendance over previous years. This is putting increased pressure on all aspects of services in third level education. It must be questioned if the student experience as a whole has changed in recent times. Has the sense of ‘college life’ and all that goes with it shifted due to our current economic struggle? Are students that are attending college today losing out on the overall ‘student experience’? There appears to be a much higher level of competitiveness for students today with perhaps a slight decrease of peer support.

Third level institutions can be viewed as a microcosm of society. “The school is a microcosm of society at large. At school we teach children how to co-exist within the social world of
friendship and relationships, how to prepare for work, how to survive in the economic world and how to be part of society with its boundaries and rules” (Leicester, Modgil & Modgil, 2000: 179). It therefore is necessary to research what the overall student experience is like in CIT, i.e. positive/negative. There is an opportunity here for development and growth for the society that is CIT to further integrate students, develop the student experience as a whole. Discover why/why not CIT is a comfortable place where students can feel content while conducting their studies.

“Both traditional and non-traditional students today have busier lives than students of the 1960’s to the 1980’s” (Hoffman, 2011: 63). Personal computers, mobile phones, media players and wireless networks have created ever-present computing in developed nations. Due to our stumbling economic climate many students are working a part-time job to support themselves through college, college work is also increasingly demanding and many students can end up working a 7 day week. Online courses can become appealing to such a student. “People strapped for time are particularly likely to be drawn to online courses” (Hoffman, 2011: 63). Courses that do not require attendance at a given time and at a given place can offer some advantages to students such as:

- They do not need transport
- They do not need to pay for parking
- They do not need accommodation
- They are not provided with a daily schedule (Hoffman, 2011).

However online courses or distance learning and its benefits can be questioned. The majority of these benefits appear to be financial. The student will need to have access to a personal computer and internet access. The individual will need a personal life flexible enough to tolerate blurring lines between school and home. “We need places where people are expected to think, innovate, study, explain, and question” (Hoffman, 2011: 69). Are students losing out on the student experience, losing out on networking? As previously mentioned third level instituted can be considered a microcosm of society where students build friendships, relationships, learn about preparation, how to survive in the economic world and be a part of something, a society. If students are missing out on the social aspect of learning are they becoming isolated?
4.3 Mental Health Promotion at Third Level Education in Ireland

“Mental health is a state of emotional and social well-being in which the individual can cope with the normal stresses of life and achieve his or her potential” (Elder et al. 2009:120).

Seeking help, not only in relation to suicide but for mental well-being, needs to become more familiar to us. It is worrying that it is reported: “Less than half (41%) of young male suicides (under 35 years) who take their own life have been in contact with a GP in the year before death” (unpublished study data from Departments of Public Health, 2001 cited in National Office for Suicide Prevention, 2005:42). A recent newspaper article suggests that there has been some development in relation to help seeking but this data is not gender specific. “80% of suicide victims were in touch with GP” (O’ Halloran, 2012: 1).

When suicidal behaviour occurs in a third level setting, the response of the college is obviously important in supporting vulnerable students who may be affected by the incident. “Students and teachers can play a vital role by identifying early warning signs of an emerging mental health issue and encourage the young person to seek help as soon as possible” (http://www.imt.ie/news/research-and-education/2010/01/ucc-policy-targets-student-mental-health.html).

“The importance of promoting positive mental health among this large third-level student population cannot be underestimated, with recent research showing a high percentage of students experiencing mental health difficulties including depression, anxiety, loneliness, substance misuse and suicidal behaviour” (A Vision For Change, 2006:95).

It is now recognised in government policy and student services development that third level institutions have the opportunity to influence attitudes to mental health and help seeking among their students. Reach Out mandates that third level education organisations should: “Review, adapt if appropriate, and disseminate mental health promotion, suicide prevention and critical incident management materials and resources for third level colleges (such as The Mental Health Initiative, 2003, Trinity College Dublin and the Northern Area Health Board)” (National Office for Suicide Prevention, 2005:24). Therefore there is a stated governmental priority and delegation of obligation on higher education institutions to establish what students' perceptions and experiences are of suicide, so that they can take appropriate actions to support them in a positive manner. The National Office for Suicide Prevention introduced ‘Reach Out’ – A National Strategy for Action on Suicide Prevention in 2005, setting out a
range of actions for governmental and non-State bodies in this regard until 2014 and support initiatives at third level should be viewed as part of that larger drive.

Mental health and the development of allied community supports have received greater focus at policy level in recent years. Third level education providers have further addressed mental well-being of the student community in recent years. “Students’ mental capital and mental well-being are determinants of their engagement in the student experience process” (The heads of the Irish Association of University and College Counsellors - www.hea.ie). One initiative has been the introduction of a Mental Health Guidelines/ Strategies at a number of third level colleges, however there is currently only 2 (UCC and TCD) that have policies in place. The policies include clear guidelines for staff dealing with students in both acute and non-acute situations and support services available to the students and their opening times. (See, for example, Trinity College Dublin: Student Mental Health Policy and Guidelines and U.C.C. Student Health Policy. 2010). “Third level institutions have the opportunity to influence attitudes to mental health and help seeking among all students” (National Office for Suicide Prevention, 2005:25). While all universities and colleges have some form of mental health response in place it can, of course, be questioned just how adequate and effective they are.

Responses vary between third level institutes in terms of the degree of development, formality and cohesiveness of response. As mentioned above Trinity College Dublin was the first third level college to introduce a mental health policy in 2008, soon followed by University College Cork in 2010. Both policies are quite short consisting of between 15-19 pages. Both Mental health policies address the following and can be seen as equivalent:

- Admissions, disciplinary policy and procedure:

In relation to admissions, mental health is viewed as a disability by both colleges, and expectations of disclosure on such a disability are expected of the student to primarily benefit the student. “Students with mental health difficulties may qualify for a CAO Supplementary Admission Offer if, because of their disability, they cannot compete equally” (University College Cork, 2010: 13). “Disclosure of a disability, including a mental health condition, is designed to enable College to prepare” (Trinity College Dublin, 2008: 9). Both colleges refer students to the disability services prior to admission or during their first academic year. Alternative arrangements for examinations can be provided once the student has registered with the disability services. This appears as


though it would work quite well for students that have been diagnosed with mental health issues/ illness, however it does not detail the requirements needed to be eligible or considered disabled due to mental health.

All students are subject to their particular college’s student rules, however allowances are provided by both colleges in such cases whereby the student is a danger to him/herself (Trinity College Dublin, 2008) or his/her mental health difficulties are preventing understanding or are in fact the cause of the actions (University College Cork, 2013).

Guidance on dealing with students experiencing mental health difficulties; support services available in the college to be used in both acute and non-acute situations: Advice given by both colleges is where possible, do not act alone; seek help from a colleague. Depending on the severity of the situation different services are contacted. Services within both colleges include the Chaplaincy, University Counselling, College Student Health Services, Security, Senior Tutor. External services included SouthDoc (UCC)/DubDoc (TCD), ambulance, Gardaí, A&E in various hospitals. External services are only to be contacted in the event of an emergency case. Guidelines are provided in both instances on what constitutes urgent/non-urgent cases. UCC Mental Health Policy 2010 details such cases:

- Non urgent: If the student is or appears to be:
  - Withdrawn, low in mood, tearful or unduly anxious, has a sudden deterioration in academic performance
  - Does not display features considered as urgent.
- Urgent: If the student is or appears to be:
  - Very aggressive/ threatening
  - Suicidal/ wishing they were dead
  - Threatening self-harm
  - Expressing bizarre thoughts or ideas
  - Unduly agitated or behaving in a bizarre manner (University College Cork, 2010: 10)

However, one area of weakness was noted in the Mental Health Policies (both UCC and TCD). Periodic evaluation of services is not included as required in either Policy and periodic evaluation is not something that must be done as part of the implementation of the Policy.
Dundalk Institute of Technology was the first IT to follow similarly with the introduction of Mental Health Guidelines for Students in 2012, but there is still no Institute of Technology that has taken the plunge and put a mental health policy in place.

4.3.1 Mental Health Promotion at CIT

Cork Institute of Technology has all the services noted in both the UCC and TCD Mental Health Policies: Chaplaincy, Student Counselling, Security, Year coordinator and Medical Health Service. However one service that was not mentioned as part of the Mental Health Policies are the Students Union and particularly the Student Welfare Officer, which is a recognised student support service in CIT. As the CIT college campus is not a relatively large third level institute, it is also recognised by many as having a pastoral approach by its lecturers. Lecturers are recognised as approachable and a source of support for students. This pastoral role is not only reserved for those specialised in that role i.e. Student Counselling. In 2012 CIT issued ‘CIT Student at Risk Guidelines’, an A4 sheet that was distributed to all staff in college. It described what to do when a student appears distressed, “he/she should be advised and supported to attend the Student Counselling Service” (Cork Institute of Technology 2012), similar to that of non-acute cases in both Mental Health Policies. At the Cork Institute of Technology, lists of support services available can be found on the website (www.cit.ie), they are also advertised for students through various literature such as posters, student handbook, ExpliCIT magazine and other CIT publications.

Cork Institute of Technology appears to equally have the means and services similar to Trinity College Dublin and UCC but the Institute lacks a single mental health policy for all. However an absence of a published strategy does not mean there isn’t anything is in place and conversely a published strategy/policy does not mean effective services are available for use on the ground.
4.4 Youth Mental Health Initiatives

A factor contributing to poor youth mental health in Ireland is the current design of our mental healthcare system, which is currently unfulfilling for the unique developmental needs of Ireland youths. If Ireland is to reduce the impact of mental disorders, self-harm and potentially the suicide of Ireland’s vulnerable people, transformational change and service redesign is necessary. Presented here are two recently adopted rapidly evolving support services in place for youth mental health in Australia and the UK.

4.4.1 Australia Initiative

_Headspace_ is the National Youth Mental Health Foundation (hereafter Headspace NYMHF) in Australia for youths aged 12-25. It was established in 2006 and it is “a company limited by guarantee, established for the public charitable purpose of promoting the improved health and mental health outcomes for young people in Australia, including through early intervention and prevention programs” (Headspace NYMHF, 2012: 2). Jess Phillips from the Headspace Youth National Reference Group states one of the aims that headspace hopes to achieve, “decrease a lot of the stigma that comes along with seeking help” (http://www.headspace.org.au/about-headspace/who-we-are/board). Headspace has attempted to do this by becoming involved with youths at an early stage and it addresses youth mental health from various routes such as online support, secondary schools and drop in centres. Headspace currently provides school support to 405 secondary schools and has 55 centres across Australia, 10 have opened in the last year and 15 more are due to open in the near future. (www.headspace.org). ‘eheadspace’ provides online support for youths and has only recently been introduced in the last year. (www.headspace.org). Wendy McCarthy AO, Headspace Chair stated in the 2012 annual report that headspace is “beginning to get to a place where we will fulfil our strategy, which is to reach as many young people who need the service in Australia as we can” (http://www.headspace.org.au/about-headspace/who-we-are/board). Headspace appears to have identified itself as one of the main sources of support for youths in Australia with various methods of service provided. There is an argument here for the advantage or disadvantage of this, in Ireland there is currently a plethora of services for mental health, in an attempt to identify these a list has been compiled consisting of the majority of known services in the Cork region of Ireland (see appendix VII). This creates competitiveness, variation and choice for those seeking help, however when one main
organisation is recognised as the leading source of support, people have security in the fact that they are going to a service which has been recognised and identified as the best.

One area that was admirably addressed in the 2011-2012 annual report was need for further training and evaluation of the service. To boost skills 21 live online training sessions were held for the centres and each centre was provided with a $2,500 training grant. (http://www.headspace.org.au/about-headspace/who-we-are/board). Centres were assisted to better record and evaluate their success rate and this is evident through their annual reports. In this same year headspace claims to have helped 33,897 people, of which 60% were visiting a headspace centre for the first time (http://www.headspace.org.au/about-headspace/who-we-are/board). However “As of June 30 2012, headspace centres had helped 67,751 young people since headspace was established in 2006” (Headspace NYMHF, 2012: 1). In one year alone headspace progressed to helping just under half of the total number previously helped over 5 years. This blatantly identifies that effort and resources have gone into this strategy and its implementation in an attempt to preserve the mental wellbeing of youths in Australia. This is reiterated in the fact that “in the past year headspace has grown in stature as a world leader in early intervention mental health and general health services to young people” (Headspace NYMHF, 2012: 1). Headspace appears to be integrating into the lives of youths and they are involved in its development. This creates multiple opportunities for youths; a sense of belonging; safe environment; a place to express concerns. Headspace appears to be at a place where Ireland strives to be in relation to mental health, the implementation and positive evaluation of a strategies success.

4.4.2 United Kingdom Initiative

A somewhat similar mental health initiative to headspace, in the United Kingdom, is Mind. Mind is a charitable organisation which was established over 65 years ago. It provides advice and support to empower anyone experiencing a mental health problem. “Each local Mind is an independent charity, run by local people for local people but all are affiliated to Mind, this ensures that each one meets Minds quality standards of governance and service delivery” (http://www.mind.org.uk/about-us/what-we-do/ ). This type of service may appeal to many individuals, however even though confidentiality would play a pivotal role here, the fact that the service is run by local people in their own local community, may deter people from availing of the service for fear of gossip. Services provided by Mind include:

- Supported housing
• Crisis helplines
• Drop in centres
• Employment and training schemes
• Counselling
• Website information on mental health and Mind

Here again we see a different approach taken with various methods of service provided by the one organisation. There are currently 160 local Mind drop in centres set up. “In 2011 local Minds worked with over 250,000 people across England and Wales” (http://www.mind.org.uk/about-us/what-we-do/). This is a much larger number than that of Headspace, however it must be noted that Headspace specifically targets those aged 12-25, Mind does not currently appear to have a target age group and is working with people of all ages.

One area that Mind has focused on to reduce the stigma associated with mental health is the media. This is the 20th year Mind have celebrated the Mind Media Awards. “The awards acknowledge the best and most accurate portrayals of mental health across all media platforms, combating the stigma and stereotypes surrounding mental health problems” (http://www.thenationalstudent.com/Features/2013-09-23/The_Mind_Media_Awards_2013.html). The awards are made up of TV, radio and print campaigns as well as digital media, current affairs coverage and individual professional and student journalists for their work and contribution. This could perhaps be an initiative that is adopted for a third level setting. Amongst the nominations are a high presence of celebrity fronted programmes. This aids in reducing stigma associated with mental health. When those in the eye of the public come forth, taboo’s begin their journey of acceptance.

4.4.3 Ireland Initiative

Headstrong was briefly touched on earlier in this Literature Review (see Section 4.1.3 Jigsaw), however as it is the National Centre for Youth Mental Health, it is dutifully identified here as a leading Irish initiative. Headstrong is “a charitable organisation supporting young people’s mental health in Ireland, its goals include that every young person will have at least “one good adult” in their life, and that when they need support, they will be able to seek and obtain it” (http://headstrong.ie/headstrong-support-advocacy/what-is-headstrong/). The benefit of ‘one good adult’ on youths’ mental health was established through research conducted by Headstrong (see My World Survey, 2012). Headstrong’s
services are research based which ensures that a current, up to date, focused service is provided. “Headstrong is involved in leading edge evaluation research in youth mental health to determine young people’s mental health needs, assure quality programming, and assess outcomes of its work” (http://headstrong.ie/research/).

Some of the services provided by Headstrong include:

- The Jigsaw programme which is an innovative early intervention prevention programme that is community based. There are currently 10 Jigsaw projects in Ireland.
- Online support for youths – access to Mental Health information and support services available
- Online resources for parents/teachers/others – offers signs that a student may be struggling, support packs.
- Easy online access to current research linked to youth mental health
- Access to online blogs

The Jigsaw programme is similar to that of Mind and Headspace adopting a community based low threshold support to youths. Outside of the Jigsaw programme, the initial point of support offered by Headstrong is online, this can be viewed in a positive light as online support seeking is becoming increasingly popular (as previously discussed in Section 4.2.1 Support Seeking in Young Adults)
4.5 Literature Review Conclusion

Any list of topics to be discussed in relation to suicide, will most likely fail to be exhaustive, as this literature review is. However, by looking at previously identified causes and various aspects associated with suicide, a further understanding of ‘suicide’ and the ‘suicide bereaved’ is gained.

There is currently a focus on mental health in young people and the need for young people to be supported and educated by both their school and communities has been identified, however service provision and evaluation has received scant attention. The My World Survey identified 43% of the 8,221 participants (aged 17-25) reported that they had thought their life was not worth living at some point, further 51% experienced suicidal ideation. These high numbers of potentially suicidal students reflects findings in the Challenging Times Two study which found that among 19-24 year olds almost 1 in 5 had experienced suicidal ideation over the course of their lifetime (Cannon et al., 2013). It is evident that suicidal ideation is a prominent issue for youths, and it must be noted that suicidal ideation can sometimes be consequential of experiencing suicide bereavement (Young et al., 2012). Survivors of suicide/suicide bereaved face unique challenges, among which suicidal ideation is one. This influenced the emergent focus the ‘suicide bereaved’ (within the community of 18-25 year old students) in this study and gave precedent for further research to be conducted.

As the statistics indicate a higher incidence of male suicides than that of female suicides in this country over several years (www.cso.ie), it is now possible to state that a pattern exists that one sex is more inclined to take their own life than the other. Therefore, the challenge presents that comparisons must be made between the two genders in attempt to establish why that is the case. Throughout this thesis, gender is used as a type of lens or looking glass, the ‘gender lens’ attempts to bring dimensions of suicide and suicide bereavement into view.

Some prominent up-and-coming developments particularly related to Third Level were identified from this secondary research: Online Support; Mental Health Policy; Aspects of Pro-Active facilitation of Support.

By conducting the primary research of this study, an opportunity is created to firstly promote the services that are available within CIT and then establish students’ attitudes to and usage of them. What services are the ‘suicide bereaved’ students most likely to use/ not use? Has the support service worked well? Has suicidal ideation been a presenting issue for the suicide
bereaved students? This research also hopes to highlight opportunities for change, development and identifying (if any) areas in need of improvement in college supports to better respond to this complex phenomenon.
5. Methodology

5.1 Introduction

“We feel that even when all possible scientific questions have been answered the problems of life remain completely untouched” (Wittgenstein, 1922: 6.52)

The scientific method offers investigative approaches to both ‘agreement reality’ and ‘experiential reality’. Agreement reality is the process of learning to accept what everybody around you ‘knows’ e.g. we all ‘know’ and accept that the world is round even though there is few who have seen the world in its entirety. It is a matter of agreed-on knowledge that others provide us (Rubin & Babbie, 2014). Experiential reality is the process of learning through direct experience and observation. (Rubin & Babbie, 2014). Each technique of learning is invaluable in guiding our personal and professional behaviour, however relying on them exclusively can be risky, e.g. at one time everybody ‘knew’ the world was flat. One key feature of the scientific method is that everything is open to question, “we should consider the things we call ‘knowledge’ to be tentative and subject to refutation” (Rubin & Babbie, 2010: 6). We can question any belief, no matter how cherished it may be.

This research questions if there are gender differences when processing a death by suicide; in attitudes and responses, in seeking usage of supports. Furthermore, how effective is the current support provision, and is there room for development?

Across disciplines (and within) there are varying views of what research is and how it relates to the kind of knowledge being sought. Paradigms guide how we make decisions and carry out research. Kuhn defined paradigms as “universally recognised scientific achievements that for a time provide model problems and solutions to a community of practitioners” (1970: viii). Simply put, a paradigm is a pattern derived from a belief system (or theory) that guides the way we do things, or more formally establishes a set of practices for a period of time. Mouton and Marais (1988) contentiously argue that disciplines in the domain of Social Sciences remain at a phase of relative ‘immaturity’ due to the fact that there is no discipline in which there is a single dominant paradigm. “Goals such as an in-depth understanding, explanation, analysis, and interpretation” are posited as more common in the social sciences, it is therefore notable that the social sciences do not compare favourably (in some people’s eyes) with the natural sciences “as long as a typically natural science standard is used as a yardstick for such comparisons” (Mouton & Marais, 1988: 150).
However, when one considers the work of Konrad Lorenz and Niko Tinbergen, Nobel prize winners in ethology (the science of animal behaviour), correspondence can be drawn from their work, to that of grounded theory in the social sciences as noted by Burton (2000). Ethologists emphasised the importance of getting rid of preconceptions when studying a species of animal. “Ethologists would acknowledge that prior hypothesis bias our perceptions, as Popper does, but unlike Popper they would see this as a hindrance rather than an advantage” (Burton, 2000: 13). They would argue that theories should emerge later, from immersion in the data.

5.2 Research Paradigm/ Framework

The origins of Mixed Methods research can be traced among fieldwork sociologists and cultural anthropologists from the early 20th century (Creswell, 1999: 458; Johnson et al., 2007: 113) Mixed methods, as a research paradigm, is seen as emerging from the 1990s onwards, establishing itself alongside the previous paradigms so that, “we currently are in a three methodological or research paradigm world, with quantitative, qualitative, and mixed methods research all thriving and coexisting” (Johnson, Onwuegbuzie & Turner, 2007: 117). The mixed methods approach has emerged as a ‘third paradigm’ for social research. It has advanced to the point where it is “increasingly articulated, attached to research practice, and recognised as the third major research approach or research paradigm” (Johnson, Onwuegbuzie & Turner, 2007: 112). However, there is evidence to suggest that for a long time the use of mixed methods has been going on in the background without being celebrated or heralded as part of a new paradigm (see for example Mayo, 1933; Roethlisburger & Dickson, 1939).

The distinctive nature of the mixed methods approach, the core ideas and practices on which the paradigm stands have been captured in the works of those such as Creswell, 2003; Creswell and Plano Clark, 2007; Tashakkori and Teddlie, 1998. These writers have argued that the defining characteristics of the mixed methods approach involve the use of:

- Quantitative and qualitative methods within the same research study.
- A research design that identifies the sequencing and priority that is given to the quantitative and qualitative elements of the data collection and analysis.

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1 Karl Popper (1902-1994) philosopher and professor is known for his rejection of the classical inductivist views on the scientific method, whilst in favour of empirical falsification.
- An account of the manner in which the quantitative and qualitative aspects of the research relate to each other.
- Pragmatism as the philosophical underpinning for the research

By using both quantitative and qualitative methods to address the cultural complexity and diverse needs of community members within CIT, some clarity on issues in this area (suicide/suicide bereavement) can be sought. Most mixed-methods research do not use a grounded theory framework as it is predominantly associated with qualitative methods. However, Oktay (2012) argues that Glaser (1978) later incorporated quantitative research for grounded theory studies to verify the logical argument being developed. It is hoped that by using mixed methodologies as part of this research a platform for future development in relation to mental health promotion will be created within CIT.

Creswell describes grounded theory as “a qualitative strategy of inquiry in which the researcher derives a general abstract theory of process, action, or interaction grounded in the views of participants in a study” (2009: 13). In this sense, the research aimed to draw on the views and opinions of students and professionals to help identify how best to improve college supports services to address the students’ needs arising from suicide in those known to them and others. Grounded theory in the social sciences involves the discovery of theory through the analysis of data. This research was of an investigative and interpretative nature and in this way, the framework of grounded theory is reflected in the study which is further detailed in the next section.

5.3 Research Design

A research design is a blueprint or framework for conducting a research project. It identifies the procedures needed to gather the relevant or required information. “The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible” (deVaus, 2001: 9). All researchers set particular boundaries or restrictions around what their research study will address. “These boundaries define terms used in the study, delimit the scope of the inquiry, limit the practices used, and target the significance of the proposed study for different audiences” (Creswell, 2003: xxiv). These boundaries are identified by the main research questions. As with considerations in research design, the research question and the constructs of the study usually bring about the choice or type of strategy used. (Marczyk, DeMatteo & Festinger, 2005).
This research is of an investigative and interpretive nature, and sets out to discover if there are gender differences when processing a death by suicide and the attitudes amongst third level students aged 18-25 attending Cork Institute of Technology towards suicide bereavement and appropriate supports. The use of the word *processing* here represents how a death by suicide has affected the student’s life from various aspects: emotionally; physically; academically and what they have done in response to it, i.e. coping mechanisms used including usage of various supports (professional or otherwise). This research also aims to establish the views of professional stakeholders in relation to this topic to identify any agreement as to future and incremental developments to improve supports to and strengthen the resilience of the suicide bereaved student.

The research questions of this study are primarily descriptive as the research aims explore the trends in CIT. However there is also an element of explanatory research as the research aims to find out why certain trends exist e.g. why would CIT students prefer to seek support within or external to CIT in relation to personal problems.

In response to research question one:

<table>
<thead>
<tr>
<th>‘What are CIT student attitudes and responses to suicide? Are there gender differences in these?’</th>
</tr>
</thead>
<tbody>
<tr>
<td>A quantitative approach using a questionnaire with CIT students was undertaken. Quantitative research evidence provides an indication of the scale of an issue, it provides a study with impact and grabs the reader’s attention, according to Burton, Bundrett and Jones (2008).</td>
</tr>
</tbody>
</table>

In response to research question two:

<table>
<thead>
<tr>
<th>‘How aware are students of the supports available to them in dealing with mental health problems (of self and others) and what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?’</th>
</tr>
</thead>
</table>
| A quantitative approach was adopted for both parts of the question through the same questionnaire as afore mentioned. A qualitative approach was also adopted for the second part of the question through interviews conducted with professionals both within CIT and externally, primarily involved in student supports. Qualitative research may be defined as the “study of things in their natural settings, attempting to make sense of or interpret phenomena
in terms of the meaning people bring to them” (Denzin & Lincoln, 1994: 2, cited in Needgaard & Ulhøi, 2007: 5). Qualitative research is often seen as more flexible and fluid in its approach. Combining both quantitative and qualitative can add profound insight into the area of research. Burton, Bundrett & Jones state that “combining evidence from these forms can significantly add to the strength and depth of an argument” (2008: 146). Interviewees were decided upon due to their expertise in the area and their involvement with students in relation to the research topic.

In response to research question three:

<table>
<thead>
<tr>
<th><strong>‘What changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (self and others)?’</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Both a qualitative and quantitative approach was adopted through the afore mentioned interviews and questionnaire. However, the phrasing of this question in the questionnaire was of a qualitative nature, it was open ended thus allowing for detailed viewpoints from participants. It was imperative to gain viewpoints from both parties of this research so see if there was a viewed need for improvement and to make comparisons (if any) on developments identified.</td>
</tr>
</tbody>
</table>

5.3.1 Revoked Research Method

In addition, it was initially planned that two focus groups would be held, see Appendix X for detailed plan. The focus groups were to consist of approximately 6 students each to capture a greater depth of qualitative material and to discuss issues raised from the student survey in greater detail. It has been suggested by Curtis and Curtis that 6-9 participants would be the typical number in a focus group (2011). However, in the application of the ethical protocol, matters were raised whilst in communication with the CIT Counselling Services and it was identified, there was concern that student’s well-being could be put at risk. It was decided not to hold the focus groups of volunteers arising from the student survey, despite a successful pilot focus group being held (see Appendix X for further detail) and a sufficient number of students volunteering to take part post survey administration.
5.4 Participants – Sampling Strategy

5.4.1 Questionnaire Sample

The questionnaires were distributed amongst eight separate purposively sampled groups, which consisted of a total of 325 participants $m = 200$ (61.5%), $f = 99$ (30.5%), excluded = 26 (8%). Cohen and Manion describe stratified and purposive sampling as “selecting subjects from a population list in a systematic fashion/build up a sample that is satisfactory to their specific needs” (1994: 87/89).

In relation to the student sample selected, the questionnaire was only distributed to students attending college at the main campus of Cork Institute of Technology as it is the most populated campus. There were chosen from two faculties: Business and Humanities, Engineering and Science. The other three faculties (CIT Cork School of Music, CIT Crawford of Art and Design and National Maritime College of Ireland) were excluded as there were not based on CIT main campus. The list of departments in each faculty, from which the sample were chosen can be seen in Table 5.1.

Table 5.1 - Departments in CIT

<table>
<thead>
<tr>
<th>Business and Humanities</th>
<th>Engineering and Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounting and Information Systems</td>
<td>Mechanical, Biomedical and Manufacturing Engineering</td>
</tr>
<tr>
<td>Management and Marketing</td>
<td>Civil, Structural and Environmental Engineering</td>
</tr>
<tr>
<td>Tourism and Hospitality Studies</td>
<td>Process, Energy and Transport Engineering</td>
</tr>
<tr>
<td>Social and General Studies</td>
<td>Construction</td>
</tr>
<tr>
<td>Continuing Education</td>
<td>Electrical and Electronic Engineering</td>
</tr>
<tr>
<td>Education Development</td>
<td>Architecture</td>
</tr>
<tr>
<td></td>
<td>Centre of Craft Studies</td>
</tr>
<tr>
<td></td>
<td>Chemical and Process Engineering</td>
</tr>
</tbody>
</table>

It was then decided that an even number of departments should be chosen from each faculty to ensure that the research was balanced across these.
Business and Humanities
There were three Departments Social and General Studies, Continuing Education and the Department of Education Development that were excluded from the survey as students attending these courses have training and experience in the area of mental health. Honours Social Care students volunteered to pilot the focus group format, but, as detailed earlier, ethical concerns resulted in a decision not to proceed with the planned focus groups.

This left three departments (half the number in the faculty) from which classes could be chosen:

- Accounting and Information Systems
- Management and Marketing
- Tourism and Hospitality Studies

Engineering and Science
There are eight departments in this faculty, as none of these courses would be based around mental health and they were all predominantly male, departments were chosen at random by means of drawing them from a hat.

As there were 3 out of 6 departments chosen from the other faculty, half of the overall number were also chosen here:

- Mechanical, Biomedical and Manufacturing Engineering
- Civil Structural and Environmental Engineering
- Process, Energy and Transport Engineering
- Construction

As the research is based on those whose age ranges between 18-25, it was decided that classes would be chosen from 2nd and 3rd year students, firstly in an attempt to ensure that everyone would be over the age of 18 but also student’s age would average between 18-25 in those class groups.

The percentage gender ratio for 2nd and 3rd years of the different departments was sought from CIT administration office. The average gender ratio of each of the departments for 2nd and 3rd years was established. This was achieved by adding up the percentage gender ratio and then dividing it by the number of departments in the faculty. On this basis the classes were chosen, so that there would be a balanced representation of each faculty.
Table 5.2 - Average gender percentage ratio in CIT

<table>
<thead>
<tr>
<th></th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business and Humanities (2\textsuperscript{nd} &amp; 3\textsuperscript{rd} yrs) 2012-2013</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Engineering and Science (2\textsuperscript{nd} &amp; 3\textsuperscript{rd} yrs) 2012-2013</td>
<td>90.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

*Source: CIT Admissions Office

Table 5.3 - Departments reflecting average gender percentage ratio in CIT

<table>
<thead>
<tr>
<th>Business and Humanities</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Management and Marketing</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Year 3 Accounting and Information Systems</td>
<td>59%</td>
<td>41%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Engineering and Science</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Mechanical, Biomedical and Manufacturing Engineering</td>
<td>91%</td>
<td>9%</td>
</tr>
<tr>
<td>Year 3 Civil, Structural and Environmental Engineering</td>
<td>91%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Two classes from each Department (8 class groups in total) were chosen by the Head of that Department. One Head of Department identified a recent death by suicide in one of her initial proposed class cohorts, following the ethical protocol, it was decided that the questionnaire be distributed to a different class chosen by the Head of Department. The questionnaire was then distributed to the chosen class groups. The following chart depicts the actual gender percentage ratio of questionnaire respondents:

Fig. 5.1 – Departmental gender percentage ratio of respondents’
The following chart depicts the respondents’ ages, the average age of male participants was 20 years, the average age of female participants was also 20 years. Respondents that exceeded 25 years of age were excluded from this research (m=18), (f=6).

Fig. 5.2 – Respondents’ Age

5.4.2 Interviewee Sample

In order to obtain a professional perspective seven semi-structured interviews were also conducted with key informants. Four interviews were conducted internally in CIT, with CIT professional support providers, two further external interviews were also conducted with the UCC Student Welfare Officer and the TCD Student Union Welfare Officer. Finally a recognised, national expert in suicide prevention research was recruited for her comparative and contextual insight, the Director of Research at the National Suicide Research Foundation. Professionals were chosen from separate colleges for comparative purposes. UCC and TCD were deliberately chosen as they both were the only colleges in Ireland (at the time) to have a Mental Health Policy in place. It must however be acknowledged other colleges did have guidelines/ strategies in place such as Dundalk IT and NUIG but these two chosen colleges (UCC and TCD) had policies that had been in place over 3 years. Interviewees were chosen due to their expertise in student services and their role in working with and supporting the student population on campus. All interviewees have experience working with third level students in a professional supportive manner. Where there were two or more professionals providing the same service (e.g. 3 college nurses), the decision was left with them as to which individual would participate in the interview.

The primary purpose of these interviews was to establish the interviewees views on supports within CIT/UCC/TCD; if they have had experience with those processing a death by suicide,
could they see a gender difference in accessing supports, the purpose of their role, and additional points/views. It was also decided that an interview would be held with an external expert, who has a wide range of professional experience and knowledge in this area so that further insight could be gained as to how student services could provide adequate support to the suicide bereaved student and those connected. The external expert chosen was Dr Ella Arensman – Director of Research with the National Suicide Research Foundation due to her extensive expertise in the area. She also has strong links within a third level setting (UCC). The primary purpose of this interview was to gain further insight and professional viewpoint into recent initiatives in relation to suicide and the advantages/disadvantages certain third level supports hold in relation to suicide. Dr Arensman was approached in order to provide an overarching perspective on initiatives in the field and as she also has published in the area of student mental health promotion.

Each interviewee was given the option of anonymity as part of the research; it is evident in the table below those that opted for it.

### Table 5.4 – Professional Interviewees

<table>
<thead>
<tr>
<th>Workplace</th>
<th>Occupation</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cork Institute of Technology</td>
<td>Nurse</td>
<td>Anonymous</td>
</tr>
<tr>
<td>Cork Institute of Technology</td>
<td>Student’s Union Welfare Officer</td>
<td>Ms Niamh Hayes</td>
</tr>
<tr>
<td>Cork Institute of Technology</td>
<td>Counsellor</td>
<td>Anonymous</td>
</tr>
<tr>
<td>Cork Institute of Technology</td>
<td>Chaplain</td>
<td>Fr. David McAuliffe</td>
</tr>
<tr>
<td>Trinity College Dublin</td>
<td>Student’s Union Welfare Officer</td>
<td>Ms Aisling Ni Chonaire</td>
</tr>
<tr>
<td>University College Cork</td>
<td>Student’s Union Welfare Officer</td>
<td>Mr David Carey</td>
</tr>
<tr>
<td>National Suicide Research</td>
<td>Director of Research</td>
<td>Dr Ella Arensman</td>
</tr>
</tbody>
</table>

#### 5.5 Procedure

##### 5.5.1 Questionnaire Procedure

The researcher was acutely aware of the sensitivity of the topic and how imperative it was to ensure that all necessary precautions were taken to anticipate and cater for students at risk and to ensure that voluntariness and anonymity of participation was secured at all stages. Further, and in line with the CIT Code of Good Practice in Research (2005), for all research involving human participants, harm minimisation in participation was a priority. Steps were
taken to ensure filling out the questionnaire would not have a negative effect/impact and that advice for further support was included in the distributed survey. During the researcher’s undergraduate research a questionnaire with similar purpose was developed. That questionnaire was developed further to be used as part of this research. When a second draft was passed on to the researcher’s supervisors, it was advised that the questionnaire become more directed from previous research and more focused.

A third draft of the questionnaire was then piloted amongst students known to the researcher which revealed that further changes were required. Two questions were to be re-structured so as to simplify the question being asked (Q9 and Q12 of questionnaire). It was also suggested that the use of the phrase ‘psychological problem’ be re-phrased to ‘mentally distressing problem’. This was later further changed to ‘personal problem’ with the advice of the researcher’s supervisor.

A fourth draft of the questionnaire was then sent to the CIT Ethics Committee and it was decided that further changes were needed, primarily to the layout. It was decided to re-sequence sections of the questionnaire, ‘personal experiences’ would now be placed as the second section instead of the first. In addition, questions were re-phrased, format and presentation was developed; colours were introduced and font sizes were changed.

A fifth draft was developed and was distributed amongst professional supports in CIT for comment and feedback: the Students’ Union Welfare Officer and the Student Affairs Manager. Their comments were as follows and were actioned:

The Students’ Union Welfare Officer suggested that page numbers be introduced to the questionnaire and that Q9 and Q17 were too similar. Furthermore, it was noted that the ‘Head of Department’ as a source of support had been omitted from Q17, and the SUWO suggested that it was introduced. After feedback was received and addressed from the SUWO, a letter of support (see Appendix IV) was provided to the researcher in relation to the distribution of the questionnaire.

The Student Affairs Manager suggested minimal changing to phrasing of questions. He also suggested that the questionnaire be printed in black and white as it has proven to be easier for students with some learning difficulties to read. After feedback was received and addressed from the Student Affairs Manager, a letter of support (see Appendix IV) was provided to the researcher in relation the distribution of the questionnaire.
After all the feedback from the professional supports in CIT had been taken on board and approval was provided by the CIT Ethics Committee, a sixth and final draft of the questionnaire (Appendix I) was developed and this was the one which was distributed amongst the sample of CIT students as outlined above. The grounded theory influence of gaining views of participants in the study, further determined the high level of ethical approval that was needed to conduct this research with all participants, students and professionals alike. The questionnaire was evidentially rigorously and scrupulously examined to ensure that all necessary precautions were taken so that the research could be community centred and voice those within it i.e. the student population.

On the front of each of the questionnaires was a cover letter (Appendix I) with the aim of explaining the research, the voluntariness of participation and the safeguards for anonymity. Attached to each of the questionnaires were two information sheets (Appendix II) with the aim of detailing current supports available should anyone feel negatively impacted by participation in the survey. These information sheets originated during the researcher’s undergraduate research and were further developed by means of: discussions with both supervisors and professional support staff within the college; part of the ethics protocol; piloting amongst some students to ensure information was clear and presented in the most user friendly format. A separate sheet was also attached to the questionnaire to target some students for the focus groups (Appendix III).

Once the questionnaire (incorporating the information sheets) was finalized, contact was made with the chosen Heads of Department to request permission to distribute the survey to some of their students. It was considered important to seek Head of Department approval for a number of reasons including the likelihood that they would be aware of any particular sensitivities to the topic in any given class group. In an attempt to gain permission, Heads of Departments were provided with the letters of support by CIT professional supports, the questionnaire itself and a consent form (Appendix IV). However, it was approaching exam period (summer) when the questionnaire was finalized and in an attempt to ensure harm minimisation was upheld, it was decided not to distribute the questionnaire until early in the following academic year. This was decided following the ethical protocol.

At the beginning of the following academic year, initial contact was again made with the chosen Heads of Departments. Contact was then made with individual lecturers and arrangements were made to distribute the questionnaire at the outset of scheduled lectures.
The survey was distributed between October and November 2013. In distributing the surveys the researcher addressed the class and explained the purpose of the research. She also pointed out the cover sheet (Appendix I) on the front of the questionnaire which explains the aims and nature of the study in further detail. She emphasized that participation was voluntary. She also pointed out the attachments with the questionnaire and advised that participants take the information sheets away with them. Participants were also invited to fill out the additional attachment regarding the focus group, if they were interested in further participation in the research.

The day after the first branch of surveys were distributed (to two class groups) the Counselling Service at CIT contacted one of the two supervisors to alert the researcher to a concern expressed by a student, who was attending the counselling service, about the manner in which the survey had been distributed. Despite voluntariness being stated the student reported she felt compelled to participate and further felt unable to leave before collection of the completed surveys by the researcher. This complaint was taken very seriously. The researcher met with one supervisor (Ms. Moira Jenkins) to ‘role play’ and thereafter refine how she introduced and explained the voluntary nature of participation before any further application/distribution of the survey. The counselling service was contacted by email to confirm the steps that had been taken in response to the student’s expressed concerns and to indicate avenues for a formal complaint if dissatisfied with the researcher’s response. The Head of the CIT Ethics Committee was informed of the complaint by Dr Áine de Róiste.

In improving the introduction to the survey and emphasis on the voluntariness of participation, the researcher refined and developed the opening speech. The key areas that were agreed and addressed were as follows:

- **Further emphasis on voluntary participation**, a clear statement to the students ‘you do not have to do this’. Also further emphasis on their freedom to withdraw, if they felt that this was not for them, they could leave whenever they wished, and they did not have to stay in the room.

- **Placed further emphasis on the fact that they did not have to complete the whole questionnaire** if they decided to participate. If the student decided to only answer one question that was fine, if they decided to answer half of the questions that would be fine and if they decided to answer it all, that would be great too. They were in no way obliged to complete the questionnaire.
Reiterated anonymity will be upheld at all times.

No further action was taken by the concerned student and the counselling service reported that the email as to action taken in regard to the concerns raised was well received by the student concerned. At no stage during this complaint process was the student raising the concerns, nor indeed her counsellor, identified. Copies of the emails sent and received in this matter have been retained.

The rest of the distribution and collection of surveys went well and no further problems emerged at this stage. A total of 299 surveys were collected and used as part of this research from 325 surveys that were distributed.

5.5.2 Interview Procedure

Initially the researcher visited each of the professional support providers in CIT sampled for the study and verbally explained what the research study was about. Each potential interviewee was also provided with an informative letter to explain further about the research. This was done at the outset to establish rapport and to identify whether they would be interested in participating. A follow-up email along with a consent form (Appendix IV) and an interview schedule (Appendix V) and stamped envelope was then sent on to CIT interviewees. Once the consent form was received, signed by the interviewee, a time and date was arranged for the interview.

The targeting of two external interviewees was premised on the student literature on established welfare supports, while the third external expert was chosen due to her pivotal role in suicide research. The researcher phoned and emailed the other three external professionals (TDC SUWO, UCC SUWO and Director of Research at the National Suicide Research Foundation) detailing who the researcher is and what the research consists of. When there was interest in participation shown, interviewees were emailed further detailing what the research is about, the interview schedule and a consent form. Dates and times for interviews were then confirmed. In line with the ethos of grounded theory whereby researchers are prompted to begin early analytic thinking and interact with data (Hesse-Biber & Leavy, 2008), it was initially intended to conduct the interviews after the results from the questionnaire had been acquired. However, as the time for the distribution of the questionnaire had to be changed (see section 5.5 Procedure: Questionnaire) so too did the interviews due to time constraints of this research study. The interviews took place between May and July 2013 before the survey. As a result of this, specific questions could not be
asked deriving from results of the questionnaire, however, questions in particular areas could
still be asked which allowed for comparisons to be made from data analysis. The order in
which the interviews took place was as follows:

Table 5.5 – Interview Schedule

<table>
<thead>
<tr>
<th></th>
<th>Interview Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>CIT SUWO</td>
</tr>
<tr>
<td>(b)</td>
<td>CIT Counsellor</td>
</tr>
<tr>
<td>(c)</td>
<td>CIT Nurse</td>
</tr>
<tr>
<td>(d)</td>
<td>CIT Chaplain</td>
</tr>
<tr>
<td>(e)</td>
<td>UCC SUWO</td>
</tr>
<tr>
<td>(f)</td>
<td>TCD SUWO</td>
</tr>
<tr>
<td>(g)</td>
<td>Director of the National Suicide Research Foundation</td>
</tr>
<tr>
<td></td>
<td>16\textsuperscript{th} May ’13 @ 2pm</td>
</tr>
<tr>
<td></td>
<td>28\textsuperscript{th} May ’13 @ 9am</td>
</tr>
<tr>
<td></td>
<td>28\textsuperscript{th} May ’13 @ 2pm</td>
</tr>
<tr>
<td></td>
<td>11\textsuperscript{th} June ’13 @ 11am</td>
</tr>
<tr>
<td></td>
<td>13\textsuperscript{th} June ’13 @ 5pm</td>
</tr>
<tr>
<td></td>
<td>17\textsuperscript{th} June ’13 @ 4pm</td>
</tr>
<tr>
<td></td>
<td>29\textsuperscript{th} July ’13 @ 12.15pm</td>
</tr>
</tbody>
</table>

Six interviews were recorded, with consent by use of a Walkman and mobile phone and were
later transferred into text format. One interviewee did not consent for the interview to be
recorded, notes were taken throughout the interview instead. This was not viewed as
complication by the researcher as notes were taken during all interviews. Transcripts of these
interviews were sent to each interviewee for approval (within 2 weeks after the interview was
conducted) as a fair and accurate account of the discussion. Interviewees were advised to
make any changes they saw fit, four out of seven of the interviewees made changes to the
transcripts, of which, three were minor changes and one had major changes. In the events
where changes were made, a finalised version was written up and sent back to the interviewee
for confirmation (within 10 days). Interviewees were also sent a brief synopsis of the research
study and the recommendations that arose from it in debriefing (see Appendix XX), as well
as a thank you card for their participation.

5.6 Materials

5.6.1 Questionnaire Materials

The questionnaire entitled ‘Suicide Awareness’ consisted of 18 questions, and was divided
into two sections: Section A: Support Services in CIT; Section B: Personal Experiences. The
format of questions varied throughout and consisted of: open ended questions; closed ended questions; sequenced answers; ticking where appropriate; grading/rating; tabular.

**Section A** consisted of 11 questions, which were focused on CIT support services and the student’s opinions and usage of them. The first two questions addressed students age and gender. In response to Research Question 1, ‘What are CIT student attitudes and responses to suicide? Are there gender differences in these?’ - Three questions focused on students views on suicidal gestures, appropriate responses and the student as a source of fellow student support. In response to Research Question 2, ‘How aware are students of the supports available to them in dealing with mental health problems (of self and others), what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?’ - Two questions sought to distinguish students awareness of student services on campus and identify how that student came about the existence of the service/s. In response to Research Question 3 ‘What changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (of self and others)?’ - Four questions addressed the services available within CIT, how helpful they are to students and any suggestions for improvements. It also addressed their opinion on Online Counselling.

Only those that had experienced a death by suicide were invited to continue the questionnaire, the questionnaire was complete after Section A for those that had not experienced a death by suicide.

**Section B** consisted of 7 questions. The questions were focused on the student’s experience and exposure to suicide and what they did/didn’t do to help deal with the process of acceptance of it. The first question addressed the participant’s history of suicide bereavement. This was tabular (yes/no boxes) in format. In response to Research Question 2, three questions explored professional support and non-professional support seeking and use of student support services at CIT. In response to Research Question 1, two questions explored students response and coping mechanisms to suicide bereavement. In response to Research Question 3, one question asked what was found to be particularly helpful in CIT in a response to a death by suicide.
Table 5.6 - Summary of Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Sought Through Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are CIT student attitudes and responses to suicide? Are there gender differences in these?</td>
<td>Response sought through questions 3. 4. 10. 15. 16. of the questionnaire</td>
</tr>
<tr>
<td>How aware are students of the supports available to them in dealing with mental health problems (of self and others), what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?</td>
<td>Response sought through questions 5. 6. 13. 14. 17. of the questionnaire</td>
</tr>
<tr>
<td>What changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (of self and others)?</td>
<td>Response sought through questions 7. 8. 9. 11. 18. of the questionnaire</td>
</tr>
</tbody>
</table>

It took on average 12 minutes to complete the questionnaire over all class groups. As the form for the focus group was also attached to the questionnaire and extra 2 minutes of time was allocated for this purpose.

5.6.2 Interview Schedule Materials

All seven of the interviews consisted of 4 main sections in the schedule; Role; Policy/Guidelines; Gender and responses; Future developments. However each interview was slightly different as follow up questions sometimes originated on the spot as a result of what was said by the interviewee.

**Role:** This section (3 questions) explored the primary purpose of having professional student supports at third level. It also questioned how the various supports constitute co-ordinate responses, and asked what do student support professionals see as their role with regard to supporting students.

**Policy/Guidelines:** This section (4 questions) investigated what, if any, mental health policy/guidelines were in place in the college and if there were evaluation procedures relating to these in place. It also questioned what guidance is provided to staff when dealing with a student who is suicide bereaved, if there is a need for training staff in a pastoral role and if so, what training is needed.
Gender and Responses: This section (4 questions) explored interviewees’ experience of suicide bereaved students and probed whether there is a gender difference in the issues raised by male and female students. It also questioned what the interviewee thought would assist male students in engaging with support services and also if there were any recent initiatives that were impressive that could be adapted to a third level setting.

Future Developments: This section (5/7 questions) investigated the introduction and implementation of a mental health policy, the current student services seen to best support suicide bereaved students and the introduction of videos on the home page of college websites, detailing different areas of mental health and services within the college. A vignette was also included to gain further in-depth detail of how suicide bereavement is addressed.

The interview schedule remained extremely similar for six of the interviewees (Appendix V). [Four professional support providers at CIT, Students’ Union Welfare Officer at UCC and TCD] so as comparisons (if any) could be made. The interview questions for the external expert varied slightly but the schedule still consisted of the four main sections (Appendix VI).

Interviewees were informed that the interview should take approximately 30 minutes, though as the interviews were semi-structured this time span was not guaranteed.

5.7 Ethical Considerations

Ethics is “a branch of philosophy which addresses issues of human conduct related to a sense of what is right and what is wrong and as such it may be regarded as a society’s code of moral conduct” (Remenyi et al., 2011: 1). The researcher recognized the paramount need in any research with human participants to ensure respect is accorded to them in terms of their rights, dignity and worth. The sensitive nature of the topic and the potential vulnerability of the research participants is hard to overstate. For this reason, the research ethics protocol may be held to a higher standard than studies of more innocuous issues. However to avoid the topic due to its sensitivity would be to ignore an issue of great concern and discussion amongst third level students: “In Ireland, the rate of suicide peaks among young men and in this way trends in Irish suicide are fairly unique.” (NSPO, 2006:8). The phenomenon of suicide in Ireland is distinctive on a number of grounds. Male suicides occur with a ratio of almost 4 males: 1 female, including the 18-25 age group and this statistic gave cause for the research to be gender based. One of the researcher’s main concerns was that potentially some
of the young people surveyed may recently have experienced the loss of someone to suicide, also that they may currently have thoughts of suicide and therefore the provision of cogent and accessible information as to sources of further support and advice was seen as crucial to harm minimisation in the work.

Early in the research an ethical protocol was discussed and developed from key ethical considerations (see below) and at all times participant well-being was seen as the paramount concern. Approval was sought for the research study by the CIT Ethics Committee and the CIT Student Affairs Manager before research and field work began. Approval by the CIT Ethics Committee pending amendments to the questionnaire and the focus group schedule was obtained via one of the supervisors. In addition to an exacting refinement of the student survey in line with the ethical protocol over a number of drafts at two stages the over-arching ethical parameters of the research were invoked – firstly to refine the explanation and introduction of the student survey and secondly in determining that planned focus groups should not proceed (determined 21st November 2013).

5.7.1 Key Considerations

5.7.2 Age

All participants were required to be over the age of 18. This was safeguarded by distributing the questionnaire to 2nd and 3rd year classes only as students would very rarely be under the age of 18 at that stage of their college career. That being said, no policing of the age of questionnaire respondents took place and no mechanism to ensure students were over 18 was established.

5.7.3 Informed Voluntary Participation

The students took part in the surveys on a voluntary basis after being provided with information about the study. They were not in any way or at any stage obliged to fill out the questionnaire. They did so of their own free will and without constraint or expectation of reward. This was noted on the survey itself and reiterated verbally by the researcher at distribution.

5.7.4 Freedom to withdraw

Participants had the freedom to withdraw at any stage, i.e. to remove from active participation in the research. This was stated in text format in the cover letter of the
questionnaire and further highlighted verbally on distribution of the questionnaire. This was also stated in text format in the cover letter of the interview schedule provided to each of the interviewees.

5.7.5 Confidentiality

Participants were informed that confidentiality would be maintained throughout the research process. Where a student’s name was revealed, at no stage was a student’s name ever used nor was any identifying information published in any document connected with this study. Documents were stored in a locked unit and will be destroyed when the research has been marked to ensure that confidentiality is upheld, in line with Cork Institute of Technology Code of Good Practice (2005). Interviewees were provided with the opportunity to be identified or remain anonymous and only have their role detailed in the research, those who chose to have their identity concealed are only known to the researcher and her supervisors.

5.7.6 Informed consent

All participants were informed by means of a cover letter of the nature and purpose of the research (see Appendix I, V and VI for cover letters). This information as to the nature and purpose of the study was reiterated verbally at distribution of the questionnaire and also more informally whilst acquainting with interviewees.

5.7.7 Information sheets

Information sheets (Appendix II) were attached to each questionnaire. The purpose of these were to inform the students in a user friendly format, of the supports that are available within CIT and outside for any student anxious or adversely impacted as a result of participation.

5.7.8 Precautions taken for potential distress

Curtis and Curtis state that “explicitly discussing the potential for distress with possible participants” (2011: 17) is extremely important. Due to the sensitivity of the topic the utmost care was necessary so as not to place students at risk. Precaution was taken in the phrasing and wording of questions but it was also decided that two information sheets be attached to each questionnaire. The participants were able to take the information sheets away with them which detailed support services available to them within CIT and useful websites for further relevant information. Furthermore the information sheets aimed to ensure that awareness was fostered as to help and support being found through friends and family as well as through
professionals. In the event that a student did become distressed during filing out the questionnaire a volunteer known to the researcher was provided and would be waiting to accompany the student once he/she had left the class room. The volunteer’s role was to accompany the individual until he/she received further support, be it from a support provider at CIT or a friend/family member. It was decided that it would be vital that the volunteer did not leave the individual on their own during their period of distress.

5.7.9 Records

“Data generated in the course of the research/must be held for a sufficient period of time/must be kept securely” (CIT Code of Good Practice, 2005:5). To adhere to the CIT Code of Good Practice necessary precautions needed to be taken. The completed questionnaires and interview recordings and transcripts were stored and locked in a unit until the research was complete and after graduation they will be destroyed.

5.7.10 After care

In the event that any participant did become distressed, a follow up email was to be sent to them to ensure that they were ok and to offer further support if necessary. Students and Interviewees were thanked for their participation. Lecturers which co-operated in relation to the distribution of the questionnaires were provided with a thank you card.

5.7.11 Harm Minimisation

Time of Distribution

It was decided that it would not be in the students best interest to distribute the questionnaire so close to their final summer exams, some 3rd year groups would be in their degree year. It was determined by the researcher, both supervisors and Head of Department that students would be under pressure and placing such a sensitive questionnaire on them at this particular point may put their well-being at risk. It was decided to defer the distribution until the beginning of the following academic year as students would be ‘fresh’ and they would be less inclined to be feeling the pressure of college life at that particular time.

Questionnaire Sample

As previously noted, one Head of Department identified a death by suicide had recently occurred in one particular class. On discussion with both supervisors it was decided that it
was in the best interest of the students not to distribute the questionnaire at that particular time. A different class group was chosen by the Head of Department.

**Questionnaire Distribution**

As previously detailed extensively, concern was expressed by one student attending the counselling service at CIT regarding the manner in which the questionnaire was distributed; despite voluntariness being stated, the student felt compelled to participate and further felt unable to leave before collection of the completed surveys. In improving the introduction to the questionnaire in emphasising the voluntariness of participation, the researcher improved the realisation of the ethical protocol in this regard.

**Focus Group Cancellation**

In the student survey, students were asked if they would be interested in participating in a focus group to allow more extensive discussion, primarily on future initiatives to assist suicide bereaved students. Twenty seven students indicated they would be interested in the focus group whilst completing the survey in Oct/Nov 2013 and provided an email address so they could be contacted by the researcher as to the time and location of the focus group sessions.

A student who had indicated that s/he wished to participate in the focus group, requested to meet the researcher. The student will not be identified and the details of the conversation will be kept to a minimum in order to maintain confidentiality. The student was evidently going through a difficult time, the researcher expressed concern for the student’s well-being and queried if participation in the focus group would be the best thing for them right now. The student was unsure and stated that they would discuss the matter with those that were supporting them at this time. The researcher informed the student that confidentiality could not be fully upheld and that she would have to tell her supervisor what had happened, although she would not reveal his/her identity.

The researcher informed her supervisor of what had happened and then informed a Counsellor at CIT on the advice of her supervisor. The Counsellor was very appreciative of this but identified something that the researcher had not acknowledged. Some of the students that have put their names forward might be doing so in the hope that this would help them; directly and individually. This was not and never had been the purpose of these focus groups.
The student subsequently informed the researcher s/he had reconsidered participation in the focus group and had decided not to participate.

Whilst the concern about the individual student that came forward had been addressed satisfactorily, not least as the student’s contact with professional supports was confirmed, the question remained, how to identify and recruit students that would be willing to participate, whilst ensuring that such volunteers are mentally ‘fit and healthy’ at the moment and not at risk of stress or anxiety from participation?

After discussions with the supervisors, it was decided that the focus groups would not be conducted as potential for distress remained among potential participants and no prevention or mitigation of such a risk could be secured in the time frame for the research. Students who had expressed an interest were emailed to inform them that the focus groups would not be going ahead.

It is noteworthy that a pilot focus group was held before this event with six student volunteers from the Social Care year four group, who self-identified as having a professional interest in the area (see Appendix X for the schedule of the pilot focus group).

5.8 Data Analysis

According to Burton, Brundrett and Jones “Qualitative data, by its very nature requires the identification of emergent key themes for it to be organized and collated and interpreted (2008: 147). Data analysis in qualitative research consists of reducing the overall data collected into themes through a process of coding. Boyatzis describes four stages in developing the ability to use thematic analysis:

1. Sensing Themes – recognizing the codable moment.
2. Doing it reliably – recognizing the codable moment and encoding it consistently.
3. Developing Codes
4. Interpreting the information and themes in the context of a theory or conceptual framework – contributing to the development of knowledge.

This approach was adopted herein by theming the interview from those previously identified in the interview schedule. This was a reliable format, consistent and could be followed by any other researcher. One strength that qualitative data holds is that it is able to offer insight and humanity into the analysis. Qualitative data is concerned with “meanings and the way people understand things” (Denscombe, 2003: 267). Once the interviews were completed and
transcribed, the researcher set about analyzing the data. The data collection instruments and procedures were verified for precision and accuracy, prior to any detailed analysis. The data was then analyzed for relevant themes. Themes were identified from those previously established in the interview schedule. This was a reliable format and could be followed by any other researcher. Categories/themes were exhaustive; everything that was to be coded fit into one or another category/theme – again, resulting from those previously identified in the interview schedule. Each category/theme had a clear operational definition i.e. Role; Policy/Guidelines; Gender and Responses; Future Developments. This aided in ensuring that the categories/themes were internally homogenous i.e. within a category/theme every answer relates to another and the category definition.

As previously mentioned, combining data from both qualitative and quantitative research can significantly add strength and depth to the research study. As described by Creswell (1994) the link between qualitative and quantitative research is desirable by researchers as it allows the combination of the richness and uniqueness of qualitative information and the precision and discipline of quantitative methods. Boyatzis suggests that “the computation or articulation of interrater reliability, or convergence of perception of multiple judges, must occur aswell” (1998: x). A link between qualitative and quantitative methods is not simply converting themes into codes and then counting presence or frequency.

Quantitative research is primarily collated and organized though the use of diagrams or tabulation. Quantitative data provides ones research study with impact and comparisons are primarily self-evident. However, Burton, Brundrett and Jones suggest “the data does need to be explained and interpreted and contextualized, do not expect the numbers alone to be sufficient” (2008: 149). Once all the questionnaires were completed and collected, the researcher set about analyzing the data though the use of IBM SPSS Statistics. Further analysis was then conducted by creating linkage between the themes from the qualitative data analysis and the statistics from the quantitative data analysis. For example, in relation to online counselling, four out of six student support providers reluctantly acknowledge value in such an initiative, in contrast an overwhelming majority of questionnaire respondents stated that they would be more inclined to seek support for personal problems were counsellors available online with 87.5% of males and 87% of females stating such.
5.9 Presentation of Results and Findings

The final and remaining stage of any social research process is to communicate the findings and recommendations to potentially improve or solve the problem/issue. This generally involves the researcher preparing and presenting a written report to the client, which in this case is the Cork Institute of Technology. The final chapters of this thesis will present the results of this research, as well as a discussion of the main themes/ key findings. The standard technique used to present the qualitative data gathered in the interviews is the use of direct quotes from participants. This is primarily the way in which the interview results are presented, however there were particular themes that were easier detailed in tabular format. The standard technique used to present the quantitative data gathered by the questionnaires are charts and tables which arise from information input to IBM SPSS. Cross tabulations were conducted to seek out and extract patterns (if any) that could be found.

‘Key Findings’ that have been identified by the researcher as relevant or important will be visible throughout the Results Chapter, these key findings may include a combination of both quantitative and qualitative results to easily identify comparisons (if any) for the reader.
6. Results

The results have been divided into two sections and are presented in the format by which they were conducted: interview results; questionnaire results. The researcher purposefully decided on this format of presentation to allow the reader to see this topic from a ‘professional’ perspective and thereafter from the student perspective.

In relation to the first section, interviews were held with seven identified professionals. Each interviewee was given the option of anonymity as part of the research. Abbreviations are introduced for the reader to easier identify with the interviewee.

6.1 Interview results - Professional Role (Part A)

6.1.1 Role of Student Support Providers

All interviewees were asked what they believe their professional role was with regard to supporting students, options were not provided as part of the question and interviewees could identify as many roles as they wished. The various answers were categorised and the following two Tables (6.1.1 and 6.1.2) indicate the most popular/ re-occurring answers that were provided.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Provide Support (General)</th>
<th>Provide Short term support</th>
<th>Act as a Referral Service</th>
<th>Provide Information and Guidance</th>
<th>Promote physical, mental and social health</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO – CIT</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>SUWO – UCC</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is evident that the SUWO’s of the three sampled colleges concur that the main purpose of their role is to act as a referral service and to promote student well-being within the college.

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2 The term ‘professional’ is used loosely in this research, as noted previously (see 1.2 Thesis Overview) it was decided for the purpose of this study such terminology was permissible as SUWO’s are viewed as a ‘professional student support’ within third level settings, in which this research is based.

3 Student Union Welfare Officer CIT: Ms Niamh Hayes, Chaplain CIT: Fr David McAuliffe, Counsellor CIT: Anonymous, Nurse CIT: Anonymous, Student Union Welfare Officer TCD: Ms Aisling Ni Chonaire, Student Union Welfare Officer UCC: Mr Dave Carey, Director of Research at the National Suicide Research Foundation: Dr Ella Arensman.

4 Student Union Welfare Officer hereafter SUWO, Director of Research at the National Suicide Research Foundation: Dr Ella Arensman hereafter DNSRF.
is surprising that the UCC SUWO did not acknowledge providing support to students as part of the role for a person in such a position, however both TCD and CIT SUWO’s did. The level of support provided is discussed further below including the other interviewees.

Table 6.1.2 – Role in Supporting Students (CIT)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Provide Support (General)</th>
<th>Provide Short term support</th>
<th>Act as a Referral Service</th>
<th>Provide Information and Guidance</th>
<th>Promote physical, mental and social health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaplain – CIT</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse – CIT</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Counsellor – CIT</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Overall these two tables show that 5 out of 6 student support professionals believe part of their role is to act as a referral service. This was the common view held by all and suggests that the majority of student support services view their role as an immediate response support service. *We know what's outside of our remit, we know the things we can’t help the student with any more. We are here to settle them down, find out what’s causing their upset and then refer them onto an agency that helps them better*” – CIT Counsellor. The use of the word ‘remit’ here suggests the task or activity officially assigned to the counselling sector in CIT and when further support is needed by a student, they are referred on.

This table also indicates that 4 out of 6 student support professionals believe part of their role is to provide support, and the CIT Counsellor put a clause on this stating that the support is ‘short term’. Table 6.1.3 below identifies the number of sessions provided in short term support. The other support professionals indicated general support, which in turn effectively suggests initial point of contact for general issues. *“We do have a lot of skills that can support students but if we feel like we are not skilled enough then we usually would refer them on to the counselling service or the health centre”* – SUWO, TCD.

DNSRF has been excluded from these tables as she does not work directly with the student population, however, her viewpoint on what college support professionals should be is as follows: *“Step by step it (mental health) is becoming more and more accepted. I think it is a major part in policy and intervention and prevention, it should be part of the college*
structure as well”. If supports are to be part of the college structure, should services become more applicable to longer term support needs of students?

She also noted her view of what mental health supports in third level should consist of, “I would say low threshold access to counselling. I think UCC from my perspective has a very accessible counselling support service”. The use of the word ‘accessible’ here may cover a wide variety of conditions, however what may be meant here and would be considered advantageous are: it is on campus, it is free, students can self-refer. She commented on the need for continually sourcing new information by research to be utilised to the best of its ability. “New information coming from intervention research, prevention as well creates a possibility to do some monitoring amongst the students to see if there are any specific mental health issues”.

6.1.2 Services provided by Counselling in third level colleges

Professionals from the three different participating colleges were asked what their counselling service provides (Table 6.1.3), (note options were not provided as part of the discussion, categories were established afterwards from re-occurring responses). This data was collated from internet research⁵ on the sampled colleges counselling services and from discussions with interviewees⁶ on the service provided in their particular college (note options were not provided as part of the discussion, categories were established afterwards from re-occurring responses).

Table 6.1.3 - Counselling Supports in Third Level

<table>
<thead>
<tr>
<th>College</th>
<th>Cost of counselling service for the student</th>
<th>Number of Sessions Provided</th>
<th>Reasons for short term support</th>
<th>When the student requires further support:</th>
<th>Emergency Slot Provided</th>
<th>Mental Health Policy in Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIT</td>
<td>Free</td>
<td>6</td>
<td>Budgetary requirements</td>
<td>Referred to an external service</td>
<td>Yes</td>
<td>Not Currently</td>
</tr>
<tr>
<td>TCD</td>
<td>Free</td>
<td>6-8</td>
<td>None provided</td>
<td>Referred to an external service</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>UCC</td>
<td>Free</td>
<td>4-6</td>
<td>Budgetary requirements</td>
<td>Referred to an external service</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

⁵ Information on sampled colleges counselling services was sought through internet research via the college website [www.ucc.ie; www.tcd.ie; www.mycit.ie].
⁶ UCC SUWO, TCD SUWO, CIT Counsellor.
The findings revealed that 2 out of the 3 colleges have introduced a Mental Health Policy. Substantial similarities are evident in the nature and duration of services provided and there is no evidence to suggest CIT is providing a different level of support due to a lack of a Mental Health Policy.

Two out of the three colleges sampled stated that students only receive ‘short term’ support due to budgetary requirements. The ‘short term’ support consists of a limited number of counselling sessions with all three sampled colleges, ranging closely around the 6 sessions mark (the reason for this particular number was not sought). The length of time of the sessions held was not identified. When students require further support (i.e. more than 6 sessions) all three colleges refer students to an external service. Budgetary issues resounded as the reason for this in two of the three colleges and somewhat mirrors the Government’s diverting of funds from mental health to the rest of the health service, for example, the Capital Development Scheme whereby “€50m per annum is to be made available from the sale of old psychiatric hospitals and lands”, has not been possible due to our changed economic environment, this has therefore had a further impact on the implementation of *A Vision For Change* (http://www.dohc.ie/publications/vision_for_change_5th/hse_nat_reg/final_5th_annual_report). This further highlights the difference between the introduction of and implementation of a Mental Health Policy and the difficulties that can be faced. Extending the student counselling provision is an obvious and direct way of reaching students in distress.

All three colleges refer students to external services which may require payment and certainly entail travel costs for the student. It is worth in this regard looking also at Section 6.6 of these results where Table 6.6.1 indicates that student respondents would choose CIT support services due to convenience and they were also viewed as being more student orientated. It is unknown to what degree students pursue referred supports once free, on campus, counselling ceases.

However, it must also be noted here that in Section 6.6 of these results, Figure 6.6.4 indicates a need for both internal and external services to be made known to students as the margin between internal and external support seeking is minimal.
6.1.3 Conclusion – Professional Role (Part A)

Five out of six student support professionals believe part of their role is to act as a referral service; this was one of the highest common views held by all interviewees. This suggests that the majority of professional student support providers view their role as an immediate source of support in response to student issues. If the student requires further support they are referred to either an internal or external service, depending on the situation. For example, if a student presented to the SUWO, he/she might refer the student to the College Counselling Service, if the student has attended the Counselling Service for the set number of sessions provided by the college, but still requires further support, he/she might refer the student to an external counselling service. This is consistent throughout the three sampled colleges, regardless of whether there is a Mental Health Policy in place or not.

One reason professional student supports are providing short term/ immediate response support, arouse in some of the interviews held. Both CIT and UCC support providers acknowledge the reason for short term counselling support was due to budgetary requirements. It was noted by the researcher that the budget played a pivotal focus in the discussion with some of the interviewees, in particular CIT Counselling “I think it’s excellent, but you provide the budget for it… Unfortunately, it costs a fortune, we just don’t have the money for it”. Development of services was somewhat dismissed as there was the impression given by some interviewees they were barely able to cope with the number of students presenting currently, particularly at Counselling. UCC SUWO states “the pressure on services, like counselling, has increased because of financial concerns etc.” This was starkly evident in all three colleges – services are under pressure. It is unavoidable and unsurprising that it is evidentially in the sampled college’s financial best interest to cap support for any individual student and refer on so that an immediate support response can be provided to a larger number of students.

This suggests that there should be a strong, working link between external services and the individual College - to ensure the students well-being and to aid the student in the transition between support providers. However, the reality of this transition for students was not sought and the degree which students pursue referred supports once free, on campus, counselling ceases, would require further research. However the CIT Counsellor did identify “I have a list of different agencies, some specialise in eating disorders, some might be around sexual identity, some deal with bereavement or loss. We have quite an extensive list and it’s all up
on our website, the ‘My CIT’ website’. This research study has also identified a need for both internal and external services to be offered to students as, to re-iterate a point made above, the margin between internal and external support seeking is minimal (as seen if Fig. 6.6.4), where by 41.5% of male and 32% of female respondents indicated they would seek support within CIT and 39.5% of male and 52% of female respondents indicated they would seek support external to CIT.

It appears that a lack of a Mental Health Policy does not ensure a different (or lesser) level of counselling service provided to students. This is noteworthy considering there is great value seen by CIT student support professionals and DNSRF in the implementation of a Mental Health Policy – an issue which is explored during the next section.

6.2 Interview results – Policy/ Guidelines/ Training within 3rd level (Part B)

6.2.1 Introduction of a Mental Health Policy

As noted above two out of three colleges sampled have introduced a Mental Health Policy. Trinity College Dublin was the first college in Ireland to do so, in 2008, soon followed by University College Cork, in 2010. As indicated in the literature review, the Mental Health Policy in TCD has the following aims:

“By articulating a written policy and providing guidelines on student mental health, College aims to promote student well-being, provide a safe and healthy work environment for all students and staff, ensure that appropriate intervention is taken where needed and encourage students with mental health difficulties to disclose them so that appropriate arrangements can be made to support them” (Trinity College Dublin, 2008: 5).

Parallel to TCD, the Mental Health Policy in UCC has similar aims:

“UCC acknowledges the pressure students are under and in developing this policy is clearly stating its support for all students by ensuring that support services are in place, including clear guidelines for staff involved in supporting students during periods of distress. This policy, in particular, seeks to ensure that University administrative and disciplinary procedures are consistent with a positive approach to promoting mental well-being” (University College Cork, 2010: 3).

To view both Mental Health Policies in full see Appendix IX. In summary these Mental Health Policies are short and concise (35-37 pages including appendices). Both Mental
Health Policies address the topic of Mental Health and the legislation relating to it. Both policies address all of the following, however the order in which they are presented varies slightly:

- Administrative policies and procedures including such topics as admission, fitness to practice, examination arrangements.
- Mental Health and disciplinary policy and procedures.
- Services available to help students in distress.
- Guidance for staff and students is provided in acute and non-acute situations.
- Confidentiality.

Student support professionals were asked if they had noticed any benefits or difficulties posed since the implementation of the Mental Health Policy:

SUWO – TCD: “To be honest, I know we have one but I wouldn’t be au fait with it, I know we have a very strong one from our reputation”.

SUWO – UCC: “I am going to say no. I haven't noticed any difference because I wouldn’t have been in office before the policy was in place so I couldn’t comment on any difference. But no, I haven’t seen any difficulties either”.

It is evident that professionals from both colleges are unfamiliar with the effects (if any) of the introduction of a Mental Health Policy in their college, further insight is gained into this in the next section: evaluation of services. However interviewees responses coincide with findings shown table 6.1.3, which suggests that support services provided may not directly alter as a result of a Mental Health Policy. DNSRF provided her viewpoint on the introduction of a Mental Health Policy to colleges: “I think it's crucial. It is crucial for both parties, so to have programmes and evidenced informed projects for the students but equally so for staff. Particularly because of a relatively high rate of suicide and self-harm amongst young people”. The ‘relatively high rate of suicide’ that DNSRF notes has been addressed in the Literature Review which details that Ireland’s rate of youth suicide still remains the 5th highest in Europe (HSE, 2008). In addition in 2007 nearly 11,000 people presented self-harm injuries in emergency departments according to the National Office for Suicide Prevention. The high level of necessity that the DNSRF indicates in relation to Mental Health Policies at Third Level are clearly evident to ensure the well-being of staff and students.
However, she also aptly acknowledges that “It is one thing to have wonderful guidelines on the shelf but if they are not being implemented then there is no point in evaluation”. It can also therefore be questioned whether the afore mentioned interviewees are unfamiliar with the effects of the introduction of a Mental Health Policy due to a possible lack of implementation?

**Key Finding 1:** Whilst there is great value seen in a Mental Health Policy (further detailed in Table 6.2.3), there is no evidence to suggest the introduction of a Mental Health Policy ensures a better service provision for students; there appears to be a lack of evaluation on existing Mental Health Policies at TCD and UCC to establish the effectiveness of a Mental Health Policy in a third level college (this is further detailed in the next Section 6.2.2). Overall this shows that in order to fully see the effectiveness of a Mental Health Policy, there needs to be facilitated evaluation.

### 6.2.2 Evaluation of Services

SUWOs from TCD and UCC were also asked if the effectiveness of the implementation of the Mental Health Policy on services has been evaluated in any way (CIT SUWO was not included as there was no such Policy in place at the time).

SUWO – TCD: “That would be evaluated on a frequent basis, at the very least from year to year. All the stakeholders would work together to go through what happens in the year, whether it is actually reflective of the service provision and what happens, as well as legislation etc. Recommendations would then be made”.

SUWO – UCC: “To the best of my knowledge, so far, no”.

These findings suggest that periodic evaluation of services is not included in the Policy in either college, and no such evaluation is required. However, evaluation is being conducted at some level (even if not to the SUWO’s knowledge and not as a requirement of the Mental Health Policy itself). For example the Counselling Service at UCC has a level of evaluation through student feedback “We would appreciate frank feedback on your experience as a user of SCD, so that we may evaluate and develop the service delivered to students” (http://www.ucc.ie/en/studentcounselling/about/conditions/).
Table 6.2.1 – Evaluation of Student Support Services at CIT

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Union Welfare Officer</td>
<td>“A lot of the time the college brings in consultancy firms to do reviews and evaluations of specific services”.</td>
</tr>
<tr>
<td>Chaplain</td>
<td>“Support services within CIT are responsible to particular individuals to present for their work and reports are presented. Reports usually consist of what you did throughout the year, an assessment of your outcome and future planning, Reports are presented to either the President, Vice-President or the Student Affairs Manager”.</td>
</tr>
<tr>
<td>Nurse</td>
<td>“I don’t know of any way the services are being evaluated at the moment”.</td>
</tr>
<tr>
<td>Counselling</td>
<td>“From a counselling perspective, we have a review at the end of every year, the review is there for two reasons; to look at what went well and what didn’t go well and to address those needs. We constantly re-train and upgrade ourselves. The students also fill out questionnaires before they finish up with us so we are gaining feedback from them also on what we are doing well or where improvement is needed”.</td>
</tr>
</tbody>
</table>

It is remarkable that the student service providers submitted such varied responses. Each service appears to be individual and distinct in its evaluation. However, there are some similarities between the Counselling and Chaplain services at CIT with regard to reporting/reviewing the work done throughout the year and aiming to identify areas in need of improvement.

It must be acknowledged that the more in depth response from CIT may be directly as a result of the greater number of service provider interviewees in comparison to other colleges, however comparing only the SUWOs of the three sampled colleges, CIT is evidenced as the only college to bring in external independent firms for evaluation purposes, which is unusual considering that the two other sampled colleges have a Mental Health Policy in place. UCC SUWO even admitted that, to his knowledge, there has been no evaluation of services. However, it is also notable that the CIT Nurse also admits no knowledge of services being evaluated so this suggests that while there is some evaluation being conducted in the colleges sampled, not all support providers are either participating/aware it is on-going.

DNSRF was asked how the effectiveness of the implementation of a Mental Health Policy at third level is best evaluated: “It would be important to have independent evaluation because if implementation and evaluation happens by the same stakeholders I think there could be bias or people could even overlook certain important outcomes. It is also important that
when people implement a certain policy, that they monitor how they actively and proactively can do that”.

Thus it appears that CIT conducts both external and internal evaluation on services as suggested by DNSRF. The importance of independent evaluation is obvious, it is to ensure that evaluation is done openly, honestly and with fresh outside views. TCD and UCC appear to conduct only internal evaluation which can lead to biased outcomes in terms of areas of new development and aspects considered to have worked well.

6.2.3 - Training for staff

(i) The Student Union Welfare Officers from TCD, UCC and CIT were asked if a student had recently experienced a death by suicide, what (if any) guidance or training is provided to staff on appropriate responses. Each interviewee simply identified those that have been trained in the area as a source of response:

Table 6.2.2 - Appropriate Responses to a Death by Suicide

<table>
<thead>
<tr>
<th>TCD</th>
<th>CIT</th>
<th>UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Chaplaincy</td>
<td>- Counselling</td>
<td>- Counselling</td>
</tr>
<tr>
<td>- Senior Tutors Office/7</td>
<td>- Chaplaincy</td>
<td>- Health Service</td>
</tr>
<tr>
<td>- Counselling</td>
<td>- Head of Dept.</td>
<td>- Chaplaincy</td>
</tr>
<tr>
<td>- Student’s Union Welfare Officer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

However the SUWO from CIT also identified guidelines provided for all CIT staff:

“There is the student at risk guidelines, it’s basically when students present themselves maybe with suicidal thoughts, showing risk of self-harm or causing harm to others, following a traumatic event where the student could be at risk, if a student is in a crisis situation or someone who appears distressed, they are just guidelines” (For a copy of these guidelines, see Appendix VII). The importance of guidelines such as these for lecturers can been seen in Section 6.6, table 6.6.3 which identifies that questionnaire respondents overwhelmingly viewed lecturers as the most helpful source of support (by both genders) in CIT with 72% of female and 64% of male respondents indicating such.

7A member of the academic staff is appointed ‘Tutor’, to look after the general welfare and development of students appointed to him/her. Senior Tutor in Senior Tutor’s Office of TCD – Dr Claire Laudet (2014).
Whilst the SUWO - TCD identified that academic staff were not advocated for pastoral roles, “The pastoral role is supposed to be there for their tutors”, a level of training is still detailed by them: “Some staff members are safeTALK trained. So that would be more referral, but not all of them would be trained to do that”. Similarly CIT staff and students have been offered safeTALK training for the last three years during ‘Mental Health Week’, which is conducted in November. The SUWO - UCC agreed that lecturers were not advocated to take on a pastoral/ gatekeepers role, “It is actually talking about people that are in specific pastoral roles that would be receiving training in terms of their job. Essentially you would be talking about Counselling, Health Service and to some degree the Chaplain” – SUWO, UCC. The reason for this was unclear but both colleges (TCD and UCC) acknowledge that only recognised supports are to provide support to students. Lecturers are not expected to take the position of a pastoral role when potentially lecturing to class groups of 200 students or more.

However, this does not coincide with DNSRF views. DNSRF recommends further development in this area: “One of my main recommendations in terms of staff would be that any lecturer working with students should at least be offered the opportunity to do what I refer to as a gatekeeper session. The lecturers would be more aware of important signs of depression or potential suicide risk. That doesn’t mean that I would advocate that every lecturer needs to be transformed into a counsellor, that is not the case. However, if they are good gatekeepers then it will be easier for them to refer, to pick up warning signs”.

Key Finding 2: Lecturers at CIT are overwhelmingly viewed as the most helpful source of support by students with 64% of male and 72% of female respondents indicating such (see Table 6.6.3). The opportunity of ‘gatekeeper’ training for frontline college staff has limitless potential positive outcomes such as, earlier detection of a distressed student and essential referral skills, as detailed by the DNSRF.

Note: Key quantitative results are referenced here before the quantitative data has been examined to easily identify comparisons or similarities for the reader, see page 128 for detailed findings.
(ii) Professional student support providers at CIT were asked if they believed there was need for greater institute guidance when supporting a CIT student suffering from suicide bereavement, options were not provided as part of the question. Interviewee’s responses were categorised afterwards, whereby the value seen in the Introduction of a Mental Health Policy emerged:

Table 6.2.3 – Need for Further Institute Guidance

<table>
<thead>
<tr>
<th>Profession</th>
<th>Need for Further Institute Guidance</th>
<th>Value in the Introduction of a Mental Health Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Union Welfare Officer</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chaplain</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nurse</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Counselling</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

All student support professionals at CIT were unanimous that there needs to be further institute guidance for both professional student support services at CIT in relation to supporting suicide bereaved students and for other staff. “I think there is always a need to develop and make things better. Certainly I know, a lot of other colleges at the moment are doing a lot of policies and guidelines around mental health and I think certainly we can all learn from them” – CIT Nurse. The strong positive value seen in the introduction of a Mental Health Policy was held by all interviewees, “I am very passionate about the fact that there needs to be a proper Mental Health Policy in this college (CIT) to support students from lots of different areas, from disability as well as mental health” - CIT Counsellor. The emerging value seen in the development and introduction of a Mental Health Policy may be perhaps as the development of institute guidance on suicide could fall under this umbrella as detailed by the CIT Chaplain: “A Mental Health Policy would support the institute in guidance. Yes I do see a need and that’s how we could do it as an institute” – CIT Chaplain.

6.2.4 Peer Support for Third Level Students

(i) Peer Support has not yet become established in CIT, however a pilot form has been introduced in certain areas of the College in the last year (2013-2014) whereby volunteers
were sought to provide support/information to new access students. TCD and UCC however have established peer support services for 1st years and they described the training that takes place:

SUWO – UCC: There is an initial 2 day (changed to 3 days: 2014) training course⁸, “It’s basic training really around the information about the college, all the services available and then a little bit around dealing with students in distress and all that but, very much geared towards referring them to the appropriate supports”.

SUWO – TCD: There is an initial full week training⁹, “A number of regular students would be trained in peer support skills. The Counselling service provides the training. The coordinator would get previously trained peer supporters to come in as well and help facilitate it. Every few months they would have different training, recently there was an LGTB training day.”

Students that provide peer support acquire the necessary training needed to fulfil their role in a positive way for both themselves and the students they are supporting according to both interviewees. However, the training they receive reflects their role. Their role appears to vary somewhat from UCC to TCD, UCC peer supports appear to be that of a point of contact and referral service for students whereas TCD peer supports appear to take a more conventional approach with the support aspect of student support in mind i.e. LGBT training.

(ii) The interviewees were also asked their viewpoint on Peer Support Services:

SUWO – UCC: “I am a huge advocate for it. A class of roughly 400 people, you go into a class sit next to somebody, you will probably never sit next to them again for the year. It can be difficult to cultivate relationships, friendships, anything like that. It is essentially cost-neutral, besides the payment for the people that run it. It is kind of self-fulfilling in a way because it has worked so well that a lot of the first years that go through it, then want to become part of it themselves, which is why the number has increased year on year. We have now got 300 volunteers for this coming September (2013)”.

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⁸ UCC initial peer support training covers topics such as: effective listening, communication skills, leadership skills, referral skills, roles, boundaries and confidentiality, being an effective peer support leader in various situations, presentation skills, social skills.

⁹ TCD initial peer support training covers topics such as: advanced active listening skills, empathy, recognising and accepting personal bias, procedures and policies, facilitating social interaction, mediation and conflict resolution, responding to a student in distress, self-care.
SUWO – TCD: “I think they can be really affective, it can be a great stepping stone. Some students might be more comfortable talking to someone who is at the same age and the same wavelength. Some don’t feel that it is such a big deal if they go and talk to peer supports – this is a casual thing, I’ll go over for a chat”.

DNSRF provides arguments from both sides on Peer Support Services: “I would have great confidence in peer support services when there is professional coaching involved in it and behind it. I would have concerns about peer support services where that type of coaching or support is not available. Consistently our outcomes from youth based services indicate that indeed young people, if they have mental health issues, it is very likely that they will speak to other young people. If it is only young people who receive the negative information from a peer and there is no overall coaching or support, I think it may even have adverse effects. Particularly in relation to issues such as copycat suicide or copycat self-harm”.

It is evident that peer support in both of the colleges mentioned above is admired by the SUWOs. Both suggest it is a positive way of integrating students into the college that may be struggling a little. It assists in cultivating relationships with other peers and can act as a stepping stone in seeking professional support where necessary.

DNSRF similarly acknowledges the positive features of peer supports, but she also identifies the detrimental results that can arise from poorly trained/coached/supported peer supports. It is remarkable that the potential detrimental effects from poorly trained peer supports are acknowledged yet, what about those that can been seen to be in a support role but have not received any training (i.e. lecturers) and a student presents to them with a personal problem, perhaps suicidal ideation?

6.2.5 Conclusion – Policy/ Guidelines/ Training (Part B)

The real value of a Mental Health Policy can only be seen when there is evidence of implementation and evaluation. Once a Mental Health Policy has been implemented, it is vital that there is both independent evaluation and internal evaluation to ensure the level of its effectiveness is distinguished. It has been established that there is no evidence to suggest CIT is providing a different level of support due to a lack of a Mental Health Policy. However, it was unanimous amongst the professional student support providers at CIT that the introduction and implementation of a Mental Health Policy (including further institute
guidance on suicide bereavement) is strongly supported and is evidently viewed as a necessity by professional support providers at the college.

With regard to staff training, views varied. The two universities sampled (TCD and UCC) identified that lecturers were not advocated nor required to take on a pastoral/gatekeepers role. However, TCD did indicate that some lecturers have undergone ‘safeTALK’ training, whether this training was provided by the college or not was not identified. DNSRF and CIT differed on academic staff training, noting the importance of gatekeepers and acknowledging those, within the college community, including lecturers, that have the potential to be good gatekeepers. ‘Peer Support’ also appears to fall under the umbrella of gatekeepers. Roles of peer supporters vary slightly between TCD and UCC as UCC is more geared more towards academic support whereas TCD aims to offer a more holistic peer support service, however, both are primarily a point of contact for students and there to support students integrating into the college. A further development of the CIT peer support initiative post-dated the field work on this point, whereby a similar scheme is due to be piloted across the campus, amongst all first year students in the following academic year (2014-2015).

DNSRF aptly notes a cause for concern should the peer supports be poorly trained or the initiative poorly conducted. There may be cause for serious concern should a student present with an issue where the peer support is ill equipped to address it in the appropriate manner. This re-iterates the upmost importance of training student support providers.

6.3 Interview results – Gender and Responses (Part C)

6.3.1 Students looking for support in relation to suicide bereavement

Student support professionals were asked if they have had much experience with suicide bereaved students, this was their response:

Table 6.3.1 – Experience with Suicide Bereaved Students

<table>
<thead>
<tr>
<th>Profession</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO – CIT</td>
<td>“In my two years here in the role, I have only come across it three times”.</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>“Luckily, I haven’t had any experience this year”</td>
</tr>
<tr>
<td>SUWO – UCC</td>
<td>“I would have had three over the last two years”</td>
</tr>
</tbody>
</table>
Counsellor – CIT  “We have noted an increase in the last two years in the number of students who are presenting with issues around friends who have dies by suicide, although, it wouldn’t be a huge percentage of the number of students that come here”

Chaplain – CIT  “I haven’t had many students that would be here for that reason”

Nurse – CIT  “I haven’t had a huge amount, I have had some”

From the table above it is clear that the number of students presenting with this issue of suicide bereavement appears small. This is quite surprising considering the high rate of recorded suicide deaths in Ireland and reported research studies such as the My World Survey showing a peak in levels of depression in young adults. The Central Statistics Office for suicide deaths in Ireland recorded 486 suicide deaths in 2010, 525 suicide deaths in 2011 and 507 suicide deaths in 2012 (www.cso.ie). In the second section of this chapter it becomes clearer the high level of students’ that have experienced a death by suicide. Of the 200 males that completed the questionnaire, 99 of them were suicide bereaved, and of the 99 females that completed the questionnaire 40 of them were suicide bereaved, for more detail see Section 6.7, Figure 6.7.1. However, it is unsurprising and congruent that the CIT support professionals are experiencing a low number of students presenting with the issue of suicide bereavement as questionnaire findings revealed that of the 137 respondents sampled that reported experiencing a death by suicide, a mere total of 11 (m=6, f=5) students identified seeking professional support in relation to this issue (see Table 6.7.8 for further detail).

The following table indicates a potential cause of why such a low number of students present with the issue of suicide bereavement to college support services:

Table 6.3.2 – Seeking Support for Suicide Bereavement

<table>
<thead>
<tr>
<th>College</th>
<th>“Sometimes if a student has experienced a death by suicide, staff won’t be aware of it, the onus is on the student to come forward”</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO – CIT</td>
<td>“If it’s someone external (that has died by suicide) it’s down to the individual unfortunately to notify the support service of the supports they need”</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>“It was actually somebody outside of the university who had died, so the university wasn’t aware of it. There was no action taken towards those students or anything like that, they had to go and seek the support themselves”</td>
</tr>
</tbody>
</table>

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The Student’s Union Welfare Officer from each of the three colleges noted that unless it is a student in their college that has died by suicide, a lot of the time it is up to the bereaved student to come forward for support. As detailed in the literature review, one of the key outcomes noted in the second report of the Suicide Support and Information System (SSIS) was “Proactive facilitation of bereavement support resulted in a significantly higher uptake of support by families/friends bereaved by suicide compared to a non-proactive approach” (Arensman et al., 2013: 5). This suggests where a pro-active approach is provided, there is an increase in support uptake.

Key Finding 3: Although it is reported that very few students are presenting to student support professionals with the issue of suicide bereavement, it is not due to a lack of students experiencing loss by suicide, with just under half of questionnaire respondents detailing such. However, it is reported by student support providers that the onus is on the student to present with the issue – findings from secondary research (such as the SSIS report, 2013) and perspectives held by interviewees (see Section 6.4.3) suggest that aspects of pro-active facilitation of support is a potential area of development, examples of which can be seen in Section 6.4.2.

Note: Key quantitative results are referenced here before the quantitative data has been examined to easily identify comparisons or similarities for the reader, see page 132 for detailed findings.

Another causation for the low number of students presenting to CIT support services may be that 57.5% of female student respondents 38% of male student respondents (over all a total of 37%) that had experienced a death by suicide stated that they would be more inclined to seek support for personal problems outside of CIT (see Section 6.7.7). This may account for some students affected by suicide deaths nottaking up support services available to them.
6.3.2 Gender Differences

(i) Student Union Welfare Officers were asked if they had identified a gender difference in the students attending their service:

Table 6.3.3 – Student Service Attendance

<table>
<thead>
<tr>
<th>College</th>
<th>Comment on gender differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO – CIT</td>
<td>“It was surprising predominantly male students that came in”.</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>“There would have been a greater number of guys than girls”.</td>
</tr>
<tr>
<td>SUWO – UCC</td>
<td>“There was two males to one female”.</td>
</tr>
</tbody>
</table>

SUWOs from all three sampled colleges identified a gender difference in the students attending their service, surprisingly males predominate by far the largest cohort in this instance. According to student support professionals, males are more inclined to seek support from student based supports than females, this is re-iterated from survey findings in Table 6.6.3 in Section 6.6 which suggests that males prefer seeking support in an informal, familiar setting.

However this gender difference conflicts with findings from the student survey which indicates that females detailed a higher awareness and usage of student supports. This reveals an apparent flaw in the research method as there should have been greater clarification in the breakdown of support sought i.e. was it for financial, accommodation or health/ mental health support was sought. This is discussed further in the discussion chapter and limitations.

(ii) Student support professionals were asked if they had noticed any gender differences in issues raised by suicide bereaved students:

Table 6.3.4 – Issues Raised by Students

<table>
<thead>
<tr>
<th>Profession</th>
<th>Comment on gender differences RE: issues raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO - CIT</td>
<td>None stated.</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>“Generally speaking the girls were more likely to open up to me or specifically come to me or a reason”.</td>
</tr>
<tr>
<td>SUWO - UCC</td>
<td>“The female was a lot more open about the situation, a lot more emotional about it. [With males] it was very much more a matter of coaxing it out of them, through general conversation first, trying to read into the incident that occurred”.</td>
</tr>
</tbody>
</table>
It is starkly evident from the interviewees that males are less inclined to be open/direct with what is bothering them. There is a commonality between interviewees’ responses: females essentially talk more, they are more open and direct about their issues at hand whereas males are more reluctant to discuss their issues, however, male’s unwillingness of verbal exploration in response to suicide does not necessarily imply a weaker or less complete processing of the situation. However the experience’s detailed by support providers are re-enforced by DNSRF’s comment on gender differences of issues presented to support providers: “There is definitely some evidence and this is also coming from GP’s for example who do have experience with men or young men whether it’s bereavement or other issues in their lives that quite often they present initially with physical symptoms, although that is reducing”. This suggests that men may present with a very different issue than that which ails them, and as previously noted, according to the SUWOs young men predominantly seek support, which is perhaps the most surprising finding (although the purpose of the support is not known).

| Counsellor – CIT | “Yes indeed, males will present in a very different way… or won’t follow up… but may put in a request for a group of them coming together. Females want to talk, males don’t. That is one of our greatest worries here, that there are probably a lot of young men out there who process this stuff on their own and who don’t come to us”. |
| Chaplain - CIT | “Males I found to be more covert, less straight forward, more angular”. |
| Nurse – CIT | “Males are less inclined to meet you face to face. Males usually present quieter. I find they are not as talkative so it takes longer to work out. Females, they are more up front with you straight away and more trusting”. |
6.3.3 Male students engaging with support services

Professional student supports were asked what they would suggest to further assist/ facilitate male students in engaging with support services when affected by a death by suicide. Options were not provided as part of the question and interviewees could provide as many suggestions as they wished. The following Table (6.3.5) indicates the most popular/ re—occurring answers after they were categorised:

Table 6.3.5 – Increase Male Usage of Student Supports

<table>
<thead>
<tr>
<th>Profession</th>
<th>Sports</th>
<th>Increase Students Knowledge of Services</th>
<th>Increased Advertising + Gender Specific</th>
<th>More role models speaking out</th>
<th>Change views on engaging with services</th>
<th>Programmes or workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling – CIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chaplain – CIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse – CIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUWO – CIT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUWO – UCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggestions that were put forward by professional support providers without any probing by the researcher, varied. Two, was the highest number of interviewees that agreed on any of the top suggestions put forward to assist/ facilitate male students in engaging with supports. Some similar points reoccurred from questionnaire respondents when asked to provide suggestions (if any) for improvements in CIT supports. The ideas that reoccurred included: more advertising; have more interaction with students, for more detail see table 6.6.4 Section 6.6.

6.3.4 Conclusion – Gender and Responses (Part C)

Part C of these results concludes that while there are a low number of students seeking support for the issue of suicide bereavement, it is not due to a lack of students experiencing it. Two potential causations for this are noted: a total of 37% of the students sampled would rather seek support external to CIT; the onus is on the student to seek support, which may be quite daunting.
Interviewees identified a strong gender difference in the issues presented from the students that have sought support. According to the interviewees, females acknowledge such issues, males divert from them. Professional student support providers attempted to identify what could potentially assist/ facilitate males in engaging with student supports which resulted in varied responses. However comparisons were made from both interviewees suggestions and questionnaire respondents suggestions to narrow down those recommended as most likely to have an impact:

- Increased Advertising
- Programmes or Workshops

6.4 Interview results – Future Developments (Part D)

6.4.1 Online Counselling

Student Support professionals were asked their views on online counselling/ therapy as a support service for students:

Table 6.4.1 – Introduction of Online Counselling

<table>
<thead>
<tr>
<th>Profession</th>
<th>Viewpoint</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUWO - CIT</td>
<td>“I’m not for it to be honest. I believe it should be done face to face because you need to be able to read the person, so I don’t think it would be as effective online”</td>
</tr>
<tr>
<td>SUWO – TCD</td>
<td>“I think it’s a great stepping stone, ideally this will progress and help them to go and see an actual counsellor face to face you know. I definitely do see it [online counselling] as a positive”</td>
</tr>
<tr>
<td>SUWO – UCC</td>
<td>“I initially wouldn’t have been greatly in favour of it because I think there is something in trying to develop that on a one to one basis. But as time has gone on and the pressure on services, like counselling, has increased because of financial concerns etc. Their waiting list has grown to a certain extent, their budget is getting cut back and stuff like that so if it can help ease that on a lower level basis, then I would be in favour of it”</td>
</tr>
<tr>
<td>Counsellor – CIT</td>
<td>“I wouldn’t be an advocate for it, I’m not going to knock it in anyway but personally I can’t see us doing it in here. I would much prefer to see us doing person to person relationship”</td>
</tr>
<tr>
<td>Chaplain – CIT</td>
<td>“We live in an age of ‘onlineism’ as it were and no doubt it has its value. However, I think it’s difficult to beat the intimacy of face to face encounters”</td>
</tr>
<tr>
<td>Nurse – CIT</td>
<td>“If it’s the only thing that they will access but I really think that there is nothing as good as face to face”</td>
</tr>
</tbody>
</table>
In relation to the SUWOs from the three sampled colleges, CIT and UCC are particularly reluctant to show support for online counselling, TCD does express some positivity towards it but again just as a helping hand towards what really needs to happen (person to person support). It is the general consensus by all three SUWO’s that face to face counselling is the appropriate and necessary support service however, there is some room for online support almost as a last resort.

Professional student supports at CIT agree that it is hard to beat face to face contact for the purpose of counselling, however overall 4 out of 6 of the professional interviewees do see some value in such an initiative. The professional student supports at CIT did not appear as negative towards online counselling, rather they were ‘unsure’ of its potential.

**Key Finding 4: This research reports an overwhelming majority of CIT students (87.5% of male, 87% of female respondents) stated they would be more inclined to seek support were counselling services available online. In contrast, support provider interviewees proved reluctant to embrace such a suggested development. Concerns were expressed by some, detailing that ‘face to face’ counselling is a necessity in effective counselling.**

**Note:** Key quantitative results are referenced here before the quantitative data has been examined to easily identify comparisons or similarities for the reader, see page 125 for detailed findings.

It is surprising that support providers only reluctantly acknowledge some value in such an initiative when, in contrast, such an overwhelming majority of questionnaire respondents stated that they would be more inclined to seek support for personal problems were counsellors available online, with 87.5% of males and 87% females stating such (see Fig. 6.6.3). This remarkable disjunction is explored further in the following discussion chapter.

DNSRF shares her views on ‘online counselling’ as a source of support for students: “I definitely think this is a whole area that is promising but I think at the same time we still have to be very careful”. As noted by the professional support providers, for the purpose of counselling, this initiative (were it to be introduced) must be approached with caution.
6.4.2 Videos on Mental Health and Support Services at Third Level

Student support professionals at CIT were asked their views on the introduction of videos on the MyCIT website\(^\text{10}\), which would be similar to that on the ‘My Mind Matters’ website. The videos would consist of:

- Students/ young people explaining different areas of mental health and their experiences
- Identified heroes i.e. Dónal Óg Cusack speaking on mental health/ sexual orientation
- Student Support Professionals detailing what their service provides and the area in which it is situated

Table 6.4.2 – Videos on Mental Health and Student Supports

<table>
<thead>
<tr>
<th>CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Union</td>
</tr>
<tr>
<td>Welfare Officer</td>
</tr>
<tr>
<td>Chaplain</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Counselling</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

It is evident that these videos were seen to have exceptional potential added value and all providers thought that they would be effective in creating awareness both of mental health and services available both within CIT and externally. However, the Nurse and the Counsellor were the only two professionals that expressed any knowledge in the area, whilst the other two remaining interviewees potentially agreed as the idea sounded promising when initially explained. This was noted by the researcher during the interviews.

DNSRF provides her viewpoint on the introduction of such videos: “I think that there would be added value in doing that. One of the suggestions that I would give and this is in line with positive mental health promotion, the counsellor in the video, it is important that they

\(^{10}\) MyCIT is the college website and access point to student emails which would be accessed by students on a frequent (almost daily) basis.
explain what exactly is going to happen, what the steps are to deal with what a person is going through. It would be in line with the evidence to highlight the positives, the benefits of going to counselling. On the one hand they have to give an explanation of what depression means, what does it mean when you are addicted to alcohol or things like that but on the other hand also highlight how can we improve. It should be balanced information that is presented in the video between the negatives and the positives. I think it would be encouraging for people to get a better understanding of what is involved”.

DNSRF suggests an open honest approach to the videos, not just to present the positives but to acknowledge what it is that is going to happen when/if they choose to seek support from a college support service and identify what to expect. This would potentially re-assure students and also put students as ease as they will be more aware of what they are about to experience.

6.4.3 Conclusion – Future Developments (Part D)

It is a general consensus by all three SUWOs that there is some value in developing online supports, however they also all asserted it is not to be viewed as a primary source of support. It was felt by all SUWOs that face to face counselling is the most appropriate and necessary support for students.

Similarly professional student supports at CIT see value in such an initiative and acknowledge changing times, “We live in an age of ‘onlineism’ as it were and no doubt it has its value” – CIT Chaplain. The viewpoint held by CIT interviewees was similar to that of the SUWOs: it’s hard to beat face to face contact for the purpose of counselling. In balance, the professionals’ view on the development for online counselling were cautious rather than negative. “If it’s the only thing that they will access” – CIT Nurse. It was more of unease at its scope and potential, maybe as a concern it would be seen as an alternative rather than complementary to face to face counselling.

It is surprising to see online counselling being only reluctantly embraced by support providers when, as noted previously, an overwhelming majority of both males and females welcomed the idea.

The introduction of videos on Mental Health and Student Support Services was viewed by interviewees as effective in creating awareness both of mental health and services available within CIT and externally but a holistic picture must be portrayed in the videos. These videos were seen to have exceptional potential added value and was met with overwhelming support
by interviewees. “Being able to visualise something takes the fear out of it” – CIT Nurse. In relation to the development of student services in CIT, further advertising of available supports was one of the most popular ideas among a varied number of responses that arose from interviewees (see Section 6.4.3). Were such videos to be introduced and emailed to each student at the beginning of each semester, the influence it would have on students uptake of services in response to issues (such as suicide bereavement) can only be estimated, however focusing on the recent TCD initiative (SilverCloud Online Support), there is evidence to suggest that it would increase students uptake of services. During evaluation of the initiative (SilverCloud Online Support), one of the main reasons why students chose to utilise the new initiative as a source of support was because it was suggested to them (Trinity College Dublin, 2013). This is discussed further in the following discussion chapter.
6.5 Questionnaire Results

A questionnaire was distributed to 325 CIT students\textsuperscript{11}, targeted as a stratified purposive sample. Student responses that fell outside the targeted age range or where gender had not been specified were excluded on collation\textsuperscript{12}, resulting in a total of 299 respondents. As previously noted the average age of both male and female respondents was 20 years. Students were advised that participation was voluntary and that they were in no way obliged to fill out the questionnaire.

Following the layout of the questionnaire, this section of the results has been further sub-divided into two sections. All participants (both suicide and non-suicide bereaved) were invited to answer section A, which is the first section addressed here. The second section (section B) is more focused, and only addresses the section of the questionnaire where respondents had expressed experience of a death by suicide. Please note that for the benefit of the reader, results are rounded to the nearest percentage where appropriate.

6.6 Section A: Including All Categories (suicide bereaved & non-suicide bereaved)

6.6.1 Suicidal Thoughts

Respondents were asked their opinion of the following statement: \textit{If you suspect someone may be at risk of suicide, it is important to ask them directly about suicidal thoughts}, the following chart details their response:

Fig 6.6.1- Approaching the Topic of Suicide

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{fig6.6.1.png}
\end{figure}

\textsuperscript{11} Male participants =218, female participants = 105.
\textsuperscript{12} Participants whose age fell outside the target group (m=18), (f=6). Two participants also failed to state their gender.
The figures above indicate an overwhelming majority of both genders agree with this statement. Out of the 200 male respondents, 158 (79%) strongly agreed/ agreed with this statement. Similarly, out of the 99 female respondents, 85 (86%) strongly agreed/ agreed with this statement. A minority of males 21% with fewer females 13% strongly disagreed/ disagreed with the statement. However it should be noted that acknowledging that the individual should be asked about their suicidal thoughts and actually asking the individual are two different things.

6.6.2 Awareness of Support Services on Campus

(i) Participants were asked to identify any current CIT support services they were aware of for suicide bereaved students. There was a significant number of males respondents (110) that did not indicate any awareness of potential supports at CIT, a percentage total of (55%), over half of the respondents, which is stark. This was significantly lower in females respondents (16) did not indicate any awareness of potential supports at CIT, a percentage total of (16%).

To further test for gender differences in students awareness of support services, statistical analysis was conducted:

Table 6.6 (a) – Chi-Square Test\textsuperscript{13} (Gender & Awareness of Support Services)

<table>
<thead>
<tr>
<th>Gender * Student Awareness of Support Services</th>
<th>Cases</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Valid</td>
<td>Missing</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>110</td>
<td>55.0%</td>
<td>0</td>
<td>0.0%</td>
<td>110</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>16.0%</td>
<td>0</td>
<td>0.0%</td>
<td>16</td>
</tr>
</tbody>
</table>

\textsuperscript{13}A Post Hoc Test was conducted on aforementioned Chi Square Test (see Appendix XXI for further detail) where the standardised residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.
<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Count</th>
<th>Yes</th>
<th>Unanswered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% within Gender</td>
<td>45.0%</td>
<td>55.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>52.0%</td>
<td>87.3%</td>
<td>66.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of Total</td>
<td>30.1%</td>
<td>36.8%</td>
<td>66.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Count</th>
<th>Yes</th>
<th>Unanswered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% within Gender</td>
<td>83.8%</td>
<td>16.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>48.0%</td>
<td>12.7%</td>
<td>33.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of Total</td>
<td>27.8%</td>
<td>5.4%</td>
<td>33.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
<th>Count</th>
<th>Yes</th>
<th>Unanswered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% within Gender</td>
<td>57.9%</td>
<td>42.1%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of Total</td>
<td>57.9%</td>
<td>42.1%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>40.968a</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correctionb</td>
<td>39.390</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>44.244</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>44.244</td>
<td>1</td>
<td>.000</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>40.831</td>
<td>1</td>
<td>.000</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 41.72.
b. Computed only for a 2x2 table

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal Phi</td>
<td>-.370</td>
<td>.000</td>
</tr>
<tr>
<td>Cramer’s V</td>
<td>.370</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
</tr>
</tbody>
</table>

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between gender and awareness of services, \( x^2 (1, n = 299) = 3.70, p = .000, \phi = \)
Therefore, the level of CIT students’ awareness of support services available is linked to whether they are male or female.

The following chart depicts respondents’ (male = 90, female = 83) awareness of various supports. Respondents could include up to 7 different support services, therefore the percentages represent each service individually i.e. the % total for each service was calculated as the % out of a total number of respondents by gender and overall total (male: 200, Female: 99, Total: 299). For example, 70% of female respondents (n = 69 out of 99) expressed awareness of the counselling service, a marginally lower percentage (33%) of male respondents (n = 66 out of 200) expressed awareness of the counselling service. The total percentage of student awareness of the counselling service was 45% (n = 135 out of 299).

Fig. 6.6.2 - Student Awareness of Support Services

It is evident that the female population have greater awareness of all services currently available at CIT for suicide bereaved students. One surprising finding is that a mere 2% of males and 3% of females identified lecturers as a source of support for suicide bereaved students, however table 6.6.3 indicates that 64% of males and 72% of females found lecturers to be most helpful/ extremely helpful for personal problems. It is visually evident from the chart above that identified professional student supports, such as counselling are viewed as the most appropriate source of supports for suicide bereaved students. Note, the question did not provide a presentation of services, they were self-chosen by respondents.

To further test for gender differences in students expressed awareness of the counselling services, statistical analysis was conducted:
Table 6.6 (b) – Chi-Square Test (Gender & Expressed Awareness of Counselling Service)

<table>
<thead>
<tr>
<th>Cases</th>
<th>Valid N</th>
<th>Percent</th>
<th>Missing N</th>
<th>Percent</th>
<th>Total N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender * Counselling</td>
<td>299</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>299</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Counselling</th>
<th>Count</th>
<th>% within Gender</th>
<th>% within Counselling</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Yes</td>
<td>66</td>
<td>33.0%</td>
<td>48.9%</td>
<td>22.1%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>134</td>
<td>67.0%</td>
<td>81.7%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Female</td>
<td>Yes</td>
<td>69</td>
<td>69.7%</td>
<td>51.1%</td>
<td>23.1%</td>
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<td>30</td>
<td>30.3%</td>
<td>18.3%</td>
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<tr>
<td>Total</td>
<td>Yes</td>
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<td>45.2%</td>
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<tr>
<td></td>
<td>No</td>
<td>164</td>
<td>54.8%</td>
<td>100.0%</td>
<td>54.8%</td>
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<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
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</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
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<td>.000</td>
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<tr>
<td>Continuity Correctionb</td>
<td>34.543</td>
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<tr>
<td>Likelihood Ratio</td>
<td>36.558</td>
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<td>.000</td>
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<tr>
<td>Fisher's Exact Test</td>
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<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>35.889</td>
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<td>.000</td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 44.70.
b. Computed only for a 2x2 table

<table>
<thead>
<tr>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
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<tbody>
<tr>
<td>Nominal by Nominal Phi</td>
<td>-.347</td>
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<tr>
<td>Cramer's V</td>
<td>.347</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
</tr>
</tbody>
</table>
A Chi-square test\textsuperscript{14} for independence (with Yates Continuity Correction) indicated a significant association between \textit{gender} and \textit{awareness of the counselling service}, $x^2 (1, n = 299) = 3.47$, $p = .000$, $\phi = -.347$. Therefore, the level of CIT students’ awareness of the counselling services is linked to whether they are male or female.

\textbf{Key Finding 5:} A gender difference in students’ awareness of supports is reported; female respondents depicted a much greater awareness of student support services on campus at CIT than males. However Table 6.7.1 reveals that almost the exact percentage of suicide bereaved males that expressed knowledge of the services (37%) also stated usage of the services (34%).

The significant percentage of male respondents (55%) that did not indicate any awareness of any potential supports raises the question whether male students’ lack of use of support services is due to a comparative lack of awareness of supports available? This is also explored further focusing on suicide bereaved male respondents (see table 6.7.1) and it is explored in the discussion chapter. However, as noted earlier SUWOs interviewees reported a higher instance on males presenting for support than females, this details a confusing clash of findings which is addressed in strengths and limitations.

\textbf{(ii)} When participants were asked to identify how they were aware of these services, eight possible answers were provided in which respondents acknowledged their source(s) of information. It is unsurprising to see a similar pattern of males (55%) and females (16%) not answer this question; if the students were unable to identify services (as evidenced in the previous section) they will be unable to identify any source of information (as they expressed no knowledge of services).

Induction evidently plays a pivotal role in creating awareness of student support services for the student population at CIT, as it was stated to be the best source of information for 44 male respondents (22%) and 44 female respondents (44%). Induction only takes place once, at the beginning of students first academic year at CIT. However, table 6.7.1 of these results

\textsuperscript{14} A Post Hoc Test was conducted on aforementioned Chi Square Test (see Appendix XXII for further detail) where the standardised residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.
indicates that almost the same percentage of suicide bereaved males that expressed awareness of student support services, detailed usage of those services. This would suggest a need for easy access to information on student services as all times as males appear to seek out information when there is intent to use them. This is further addressed in the next section (Section B). The next most popular sources of information were viewing posters on campus and through word of mouth. To view a chart further detailing students response (see Appendix XII).

6.6.3 Seeking Online Support for Personal Problems (Reflective of Key Finding 4 as indicated earlier)

Respondents, having been informed that some counsellors were now providing counselling support online to the public, were asked ‘If the CIT counselling service provided services confidentially online, would you be MORE inclined to seek support for personal problems’, the following chart depicts respondents views:

**Fig. 6.6.3 - Online Support**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>17%</td>
<td>40%</td>
<td>24%</td>
</tr>
<tr>
<td>Agree</td>
<td>70.5%</td>
<td>47%</td>
<td>63%</td>
</tr>
<tr>
<td>Disagree</td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Unanswered</td>
<td>1.50%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

It is starkly evident that CIT students would welcome the opportunity of online counselling and a majority of both genders state they would be more likely to engage with counselling online support. The overwhelming majority, 87.5% of males and 87% of females, strongly agree/ agree that they would be more inclined to seek support via the internet. This finding is
notable also for the similarity of response from both male and female students. As indicated above, this was an area of suggested development that a majority of interviewees proved reluctant to embrace and cautious of its development, for further detail see Section 6.4 of the results - *Future Developments*. This finding is discussed further against other published research such as the *My World Survey*, 2012; *Turn2Me*, 2009; *SilverCloud-TCD*, 2013 including recent developments in the following chapter.

### 6.6.4 Where Students Seek Support for Personal Problems

(i) Participants were asked if they would be more inclined to seek support for a personal problem within CIT or external to CIT, the following chart indicates respondents’ views:

**Fig. 6.6.4 - Support Seeking**

<table>
<thead>
<tr>
<th></th>
<th>Within CIT</th>
<th>External to CIT</th>
<th>Unanswered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>41.50%</td>
<td>39.50%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>32%</td>
<td>52.00%</td>
<td>16%</td>
</tr>
</tbody>
</table>

The chart above indicates that males would be slightly more inclined to seek support within CIT and females would be slightly more inclined to seek support externally to CIT, it must be noted that the margin between internal and external support seeking is minimal, it remains almost 50/50, this indicates a need for both internal and external services to be made known to students. There is a low percentage of both males and females that did not answer this question, this could be due to various reasons however some examples are: they might never have thought about where to seek support; they would not seek support; they were unsure.

(ii) Students’ views varied with several different reasons for their choice of preferred support. The following Tables depict the most popular causations produced by respondents as to why they would seek support either within CIT/ external to CIT:
Table 6.6.1 – Within CIT

<table>
<thead>
<tr>
<th></th>
<th>Convenience</th>
<th>More Student Orientated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>46%</td>
<td>31%</td>
</tr>
<tr>
<td>Females</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

The most popular reason provided by both male and female respondents for choosing CIT support services was due to its convenience and it was regarded as being more student orientated. These causations were closely followed by CIT services being: cheaper/ free; having experience with student issues. For further detail of students responses, please see Appendix XIII.

Table 6.6.2 – External to CIT

<table>
<thead>
<tr>
<th></th>
<th>Keep the two separate</th>
<th>More Confidential</th>
<th>Don’t want people to know (they are getting support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>23%</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>29%</td>
<td>22%</td>
<td>24%</td>
</tr>
</tbody>
</table>

It is evident that keeping up appearances is vital to the above respondents (both male and female), as well as self-preservation, as the top three causations for seeking support external to CIT was to ensure privacy of their support seeking. The most important causation for seeking support externally for male respondents was because they didn’t want people to know they were seeking help, with 25% stating such. This raises the issue of stigma attaching to any evidence that support is being sought and suggests that stigma is still associated with mental distress. “When it comes to talking about feeling it is viewed as something that would ′dent′ their masculinity” Male 20 yrs. This is further re-iterated by the second most important reason provided: confidentiality, by both male respondents (25%) and female respondents (24%).

A link can be drawn from students’ responses here and their views of online counselling detailed above at Figure 6.6.3. Online counselling further creates a sense of confidentiality and non-disclosure of identity as they will be dealing with the support service through the computer and do not have to physically be addressed. The most important causation for the
female respondents to seek external support was to keep the two separate, with 29% stating such, although no further detail was sought as to why. For further detail of students responses, please see Appendix XIV.

6.6.5 Approval Ratings for Current Student Supports (Reflective of Key Finding 2 as indicated earlier).

Students were asked comment on the eight different supports currently available in CIT and indicate whether they were found to be: no help at all; slightly helpful; helpful; extremely helpful or not applicable to them. The following table indicates both male and female respondents’ views:

Table 6.6.3 – Student ratings of support services

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td>67%</td>
<td>61%</td>
<td>52%</td>
<td>34%</td>
</tr>
<tr>
<td></td>
<td>(134)</td>
<td>(60)</td>
<td>(104)</td>
<td>(34)</td>
</tr>
<tr>
<td>Medical Centre</td>
<td>68%</td>
<td>61%</td>
<td>60%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>(136)</td>
<td>(60)</td>
<td>(120)</td>
<td>(52)</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>60%</td>
<td>34%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>(120)</td>
<td>(34)</td>
<td>(34)</td>
<td>(33)</td>
</tr>
<tr>
<td>SUWO</td>
<td>34%</td>
<td>33%</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>(68)</td>
<td>(33)</td>
<td>(44)</td>
<td>(15)</td>
</tr>
<tr>
<td>Yr. Co</td>
<td>22%</td>
<td>15%</td>
<td>51%</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td>(44)</td>
<td>(15)</td>
<td>(102)</td>
<td>(58)</td>
</tr>
<tr>
<td>Lecturer</td>
<td>51%</td>
<td>59%</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>(102)</td>
<td>(58)</td>
<td>(74)</td>
<td>(33)</td>
</tr>
<tr>
<td>Sports Trainer</td>
<td>37%</td>
<td>37%</td>
<td>51%</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>(74)</td>
<td>(74)</td>
<td>(74)</td>
<td>(74)</td>
</tr>
<tr>
<td>Head of Dept.</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>(74)</td>
<td>(74)</td>
<td>(74)</td>
<td>(74)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Helpful/Extremely Helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21%</td>
<td>22%</td>
<td>36%</td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>28%</td>
<td>22%</td>
<td>36%</td>
<td>22%</td>
</tr>
<tr>
<td>No Help At All/ Slightly Helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12%</td>
<td>15%</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Female</td>
<td>19%</td>
<td>19%</td>
<td>20%</td>
<td>19%</td>
</tr>
</tbody>
</table>

It is surprising that such a high number of respondents felt that support services were not applicable to them. This, of course, may be as students will not see a service/support as
relevant until they need it. However, it is notable that between 50% and 70% of male respondents felt that the four identified professional support services (counselling; medical centre; chaplaincy; SUWO) were not applicable to them and that this perceived irrelevance was slightly greater than that of female respondents.

It is remarkable that CIT lecturers are seen so overwhelmingly as the most helpful source of support by both genders. This is, however, not shockingly surprising as CIT is noted for lecturers taking on a pastoral role and the Institute has long emphasised the informality and closeness of the staff/student relationship. “I would go to a lecturer that I know and trust about the situation. They can often advise on how to resolve the situation” Male 19yrs. This further underlines the perception of the student support staff interviewed as key informants as to the importance and value of the close lecturer/student communication established at the institute. The key role of lecturers as first points of contact for students and as key referral points could be further utilised to encourage students to seek support from professionals and echoes the point made by DNSRF as to the potential of lecturers as gatekeepers, this is explored further in the following chapter.

It is highly relevant to this study that the male respondents noted the top three sources of most helpful support as those not recognised as a ‘professional’ source of support – lecturers, year coordinator, sports trainer. This suggests that males prefer seeking support in an informal, familiar setting. Whilst female students responses largely echoed those of male students, it is notable that female students indicated that they are more inclined to seek professional support and rate those supports as useful. This response is in line with female responses to awareness of formal supports available as outlined in Figure 6.6.2.
### 6.6.6 Peer Concerns

Students were asked, since they have begun their studies at CIT, had they ever worried about fellow peers being suicidal. The following chart depicts respondents’ experiences:

**Fig. 6.6.5 – Expressed Concerns for Fellow Peers**

The number of male respondents [43 (21.5%)] and female respondents [15 (15%)] that expressed concern for fellow students was a minority.

Evidently the number of male respondents concerned for fellow students is higher than that of female respondents. However, it is startling and alarming the number of students that male respondents were concerned about. Over the cohort of 200 male students surveyed, 43 respondents identified 81 students known to them who were thought to have been suicidal. It must be noted again here that the number of male participants was almost double that of female participants, although that does not eliminate the potential sheer volume of students thought to be in a vulnerable position by male respondents.

The use of the word *potential* is in acknowledgement of possible overlapping of students expressed concern for fellow peers; respondents could be talking about the same people. For example, Student X expressed concern for Student Y, Student X1 also expressed concern for Student Y, and Student X2 also expressed concern for Student Y. However, understandably, for ethical reasons, students’ responses could not be personalised so as to establish whether this was evident, but it must be noted as a possibility.
6.6.7 Suggestions for Student Services on Campus

Participants were asked to provide any advice they would offer to improve CIT support services. It must be noted that there was a large number of participants chose to not answer this question, males [95 (45%)], females [36 (36%)]. There could be several different reasons for this, however, a high number of respondents indicated that the student support services were not applicable to them (see Table 6.6.3) therefore they would not provide any suggestions/advice on them.

However, from the 105 males and 63 females that did provide a response, the following top (most re-occurring) two suggestions were provided:

Table 6.6.4 – Suggestions for services

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More advertising [27 (13.5%)]</td>
<td>• More advertising [14 (14%)]</td>
</tr>
<tr>
<td>• More interaction with students [21 (10.5%)]</td>
<td>• Listen [9 (9%)]</td>
</tr>
</tbody>
</table>

Whilst again it must be noted the percentages are small, it is evident that more advertising is visibly the most prominent advice/suggestion provided by both male and female respondents. Support service providers having more interaction with students is evidently the second most common piece of advice provided by male respondents. This concurs with section 6.6.5, Table 6.6.3 which suggests that males prefer to seek support in a familiar setting. For further detail on other suggestion put forward by respondents (see Appendix XV).

Key Finding 6: 58 of the 299 respondents expressed suicidal ideation concerns for 104 fellow peers; this is a key finding as it reveals the volume of students thought to be in a vulnerable position by fellow peers. Male respondents detailed a much higher level of concern for fellow peers than females.
6.7 Section B: Suicide Bereaved\(^{15}\) (A Closer Look)

The second section of the questionnaire focused on student’s personal experiences of suicide deaths. Only those that had experienced such an instance were invited to participate in Section B of the questionnaire\(^16\).

6.7.1 Experience of Suicide Deaths

Respondents were asked if they had experienced the suicide of someone they knew in their lives, and if so to indicate the number of people and their gender. Please note that ‘other’ has been detailed by respondents on this occasion, as: work colleague; family friend; classmate; friend of a friend; family member belonging to a friend. The following charts visually depicts student respondents’ experiences:

Fig. 6.7.1 - Respondents’ Death by Suicide Experiences

The highest number of suicide deaths experienced by both genders is that of friends with males reporting a higher percentage in 3 out of the 5 categories.

As regards the individuals that died by suicide and their gender, it comes as no surprise to see that male suicides are largely the majority reported as experienced by both male and female

\(^{15}\) ‘Suicide Bereaved’ is a convenient term used by the researcher, respondents did not label themselves as such: the research explored whether or not respondents had experienced a death by suicide, not the level of ‘bereavement’ per se.

\(^{16}\) Total respondents of Section B = 139 (m=99), (f=40).
respondents. The suicide gender rate in this country is almost 4:1 male to female (www.cso.ie). The number of male friend suicide deaths experienced is stark - 49 male respondents reported 70 male friend suicides. This is an overwhelming number, with profound implications such as complicated grief, concurrent depression, PTSD and suicidal ideation as detailed by Young et al. (2012). The number of female suicide deaths experienced by respondents is slight in comparison. For further detail on the number of suicide deaths (including their gender) experienced by respondents (see Appendix XVI).

6.7.2 Awareness and Usage of Student Support Services (Reflective of Key Finding 5).

The following Table indicates suicide bereaved respondents’ awareness of support services on campus in line with their usage of them. As noted earlier, in the attempt of seeking students awareness of services, the question allowed for the student to identify the supports on their own merit and they were not prompted by the services being presented on the questionnaire, thus, for example, of the 37 suicide bereaved male respondents that detailed awareness of services – 29 expressed awareness of the counselling service and of that 29 that expressed awareness, 4 of them sought support by usage of the counselling service. The ‘access service’ is not included in the usage of services, as the supports were listed and presented as part of the question, where by the participant could rank their level of usage as indicated in Table 6.7.6.

Table 6.7.1 – Students Awareness of Support Services and Usage of Them

<table>
<thead>
<tr>
<th></th>
<th>Counselling Service</th>
<th>Chaplaincy</th>
<th>Medical Centre</th>
<th>Students Union</th>
<th>Access</th>
<th>Lecturers</th>
<th>Head of Dept.</th>
<th>Total Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicide Bereaved Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Awareness of Services</strong></td>
<td>29 (29%)</td>
<td>16 (16%)</td>
<td>8 (8%)</td>
<td>10 (10%)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
<td>37 (37%)</td>
</tr>
<tr>
<td><strong>Usage of Services</strong></td>
<td>4 (4%)</td>
<td>1 (1%)</td>
<td>9 (9%)</td>
<td>2 (2%)</td>
<td>--</td>
<td>25 (25%)</td>
<td>8 (8%)</td>
<td>34 (34%)</td>
</tr>
<tr>
<td><strong>Suicide Bereaved Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Awareness of Services</strong></td>
<td>31 (77.5%)</td>
<td>16 (40%)</td>
<td>7 (17.5%)</td>
<td>11 (27.5%)</td>
<td>0 (0%)</td>
<td>1 (2.5%)</td>
<td>0 (0%)</td>
<td>36 (90%)</td>
</tr>
<tr>
<td><strong>Usage of Services</strong></td>
<td>3 (7.5%)</td>
<td>1 (2.5%)</td>
<td>15 (37.5%)</td>
<td>1 (2.5%)</td>
<td>--</td>
<td>10 (25%)</td>
<td>2 (5%)</td>
<td>21 (52.5%)</td>
</tr>
</tbody>
</table>
It is evident that suicide bereaved females depict a greater knowledge of student services available than that of males (as previously established amongst all respondents in Figure 6.6.2) however, this does not reflect their usage of services which is marginally lower (37.5%). In contrast, almost the exact number of males that expressed knowledge of the services (37%) also stated usage of the student services (34%). This is striking as it leads one to question do males only seek out knowledge of services when there is intent to use them? Or the more hopeful question of if males became more aware of the services available on campus, would they be more inclined to use them? This is addressed in greater depth in the next chapter.

### 6.7.3 Chi-Square Test – Gender & Awareness of supports (Suicide Bereaved)

A Chi-Square Test for independence was conducted to establish whether there was a significant difference in the number of suicide bereaved males and females that expressed awareness of student services (Table 6.7.3)

<table>
<thead>
<tr>
<th>Cases</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Valid</td>
<td>Missing</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>Gender * Student Awareness of Support Services</td>
<td>139</td>
<td>100.0%</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>139</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

A Post Hoc Test was conducted on aforementioned Chi Square Test (see Appendix XXIII for further detail) where the standardised residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.
Table 6.7.3 - Gender * Student Awareness of Support Services Crosstabulation

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Yes</th>
<th>Unanswered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td>37</td>
<td>62</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>37.4%</td>
<td>62.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>50.7%</td>
<td>93.9%</td>
<td>71.2%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>26.6%</td>
<td>44.6%</td>
<td>71.2%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>36</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>90.0%</td>
<td>10.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>49.3%</td>
<td>6.1%</td>
<td>28.8%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>25.9%</td>
<td>2.9%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>73</td>
<td>66</td>
<td>139</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>52.5%</td>
<td>47.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Student Awareness of Support Services</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>52.5%</td>
<td>47.5%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 6.7.4 - Chi-Square Tests

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>31.641a</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correctionb</td>
<td>29.566</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>35.474</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>31.413</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td></td>
<td>139</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 18.99.
b. Computed only for a 2x2 table

Table 6.7.5 - Symmetric Measures

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal</td>
<td>Phi</td>
<td>-.477</td>
</tr>
<tr>
<td></td>
<td>Cramer's V</td>
<td>.477</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td></td>
<td>139</td>
</tr>
</tbody>
</table>

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between gender and awareness of services, $x^2 (1, n = 139) = 4.77, p = .000, \phi =$
Therefore, the level of CIT student’s awareness of support services available is linked to whether they are male or female.

**6.7.4 Usage of Student Services; views on support provided.**

The following table indicates suicide bereaved students usage of particular identified supports in CIT in the first row with the corresponding level of support they felt was provided underneath.

Table 6.7.6 – Suicide Bereaved Students’: usage of student services, with views on support provided.

<table>
<thead>
<tr>
<th>Use of Services</th>
<th>Counselling Service</th>
<th>Medical Centre</th>
<th>Chaplaincy</th>
<th>SUWO</th>
<th>Year Coordinator</th>
<th>Lecturers</th>
<th>Sports Trainer</th>
<th>Head Of Dept.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Bereaved Males Total = 99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Services</td>
<td>4 (4%)</td>
<td>9 (9%)</td>
<td>1 (1%)</td>
<td>2 (2%)</td>
<td>8 (8%)</td>
<td>25 (25%)</td>
<td>8 (8%)</td>
<td>8 (8%)</td>
</tr>
<tr>
<td>Helpful/ Extremely Helpful</td>
<td>4 (4%)</td>
<td>8 (8.1%)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
<td>6 (6%)</td>
<td>23 (23%)</td>
<td>8 (8%)</td>
<td>7 (7%)</td>
</tr>
<tr>
<td>No Help/ Slightly Helpful</td>
<td>--</td>
<td>1 (1%)</td>
<td>--</td>
<td>1 (1%)</td>
<td>2 (2%)</td>
<td>2 (2%)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Level of Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Stated</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1 (1%)</td>
<td></td>
</tr>
</tbody>
</table>

| Suicide Bereaved Females Total = 40 |                    |                |            |      |                  |           |                |               |
|use of Services       | 3 (7.5%)          | 15 (37.5%)     | 1 (2.5%)   | 1 (2.5%)| 2 (5%)           | 10 (25%)  | 2 (5%)         | 2 (5%)        |
| Helpful/ Extremely Helpful | 3 (7.5%)          | 11 (27.5%)     | 1 (2.5%)   | 1 (2.5%)| 2 (5%)           | 9 (22.5%) | 1 (2.5%)       | 2 (5%)        |
| No Help/ Slightly Helpful | --                | 3 (7.5%)       | --         | --    | --               | 1 (2.5%)  | --             | --            |
| Level of Support      |                    |                |            |      |                  |           |                |               |
| Not Stated            | --                 | 1 (2.5%)       | --         | --    | --               | 1 (2.5%)  | --             | --            |

Of those that experienced a death by suicide, females detailed a higher percentage of usage of CIT supports, this gender difference in the take up of services was also noted in the previous section 6.7.2. The top two services used by suicide bereaved students are the Medical Centre and Lecturers, Lecturers being the most chosen source of support for the males as 25% stated usage and 23% stating they found the service to be helpful/ extremely helpful. The Medical Centre was the most chose source of support for the females as 37.5% stated usage and
27.5% stating they found the service to be helpful/ extremely helpful. The Chaplaincy and the SUWO are the least used service by both genders. It was decided to cross-tabulate these results to establish some indication of what services suicide bereaved students were more inclined to use, further to identify if those services were thought to have proved helpful.

Overall what is notable from the table above is that of the males that detailed usage a mere 6% stated they found them to be no help/ slightly helpful, similarly a low percentage of females (10%) found the services to be of no help/ slightly helpful. The number of respondents that found the services helpful is obvious. Therefore this suggests that the low number of usage of some of the particular services is not as a result of the service being inadequate as evidenced from respondents’ experiences but rather some other deterrent, perhaps stigma as detailed after table 6.6.2.

6.7.5 Support Seeking for Personal Problems

The following table indicates the breakdown of support seeking views held by questionnaire respondents:

Table 6.7.7 - Support Seeking Breakdown

<table>
<thead>
<tr>
<th></th>
<th>Within CIT</th>
<th>External to CIT</th>
<th>Unanswered</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Questionnaire Respondents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>83 (41.5%)</td>
<td>79 (39.5%)</td>
<td>38 (19%)</td>
<td>200 Males</td>
</tr>
<tr>
<td>Females</td>
<td>32 (32.3%)</td>
<td>51 (51.5%)</td>
<td>16 (16.2%)</td>
<td>99 Females</td>
</tr>
<tr>
<td><strong>Total Students</strong></td>
<td>115 (38.5%)</td>
<td>130 (43.5%)</td>
<td>54 (18%)</td>
<td>299</td>
</tr>
<tr>
<td><strong>Suicide Bereaved Respondents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>41 (41.4%)</td>
<td>38 (38.4%)</td>
<td>20 (20.2%)</td>
<td>99 Males</td>
</tr>
<tr>
<td>Females</td>
<td>14 (35%)</td>
<td>23 (57.5%)</td>
<td>3 (7.5%)</td>
<td>40 Females</td>
</tr>
<tr>
<td><strong>Total Students</strong></td>
<td>55 (40%)</td>
<td>61 (44%)</td>
<td>23 (16%)</td>
<td>139</td>
</tr>
<tr>
<td><strong>Non-Suicide Bereaved Students</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>42 (41.6%)</td>
<td>41 (40.6%)</td>
<td>18 (17.8%)</td>
<td>101 Males</td>
</tr>
<tr>
<td>Females</td>
<td>18 (30.5%)</td>
<td>28 (47.5%)</td>
<td>13 (22%)</td>
<td>59 Females</td>
</tr>
<tr>
<td><strong>Total Students</strong></td>
<td>60 (37.5%)</td>
<td>69 (43%)</td>
<td>31 (19.5%)</td>
<td>160</td>
</tr>
</tbody>
</table>
The table above indicates no difference in support seeking between suicide bereaved and non-suicide bereaved respondents. Interestingly, males are more inclined to seek support within CIT and females are more inclined to seek support external to CIT for personal problems. Whether the individual has experienced a death by suicide or not does not appear to influence their response. The percentage difference in both groups varies slightly but its impact is minimal, the overall result remains the same.

6.7.6 Seeking Professional Support in Connection to Suicide Bereavement

Respondents were asked if they had ever sought professional support when trying to come to terms with a death by suicide, a high percentage of both male (95%) and female (87.5%) respondents indicated that they never sought professional support either within CIT or externally to CIT.

The following table indicates the number of respondents that stated they had experienced a death by suicide, the number that sought support and where they sought it:

Table 6.7.8 - Professional Support Seeking in Relation to Suicide Bereavement

<table>
<thead>
<tr>
<th></th>
<th>Experienced Suicide Bereavement</th>
<th>Sought Professional Support</th>
<th>Within CIT</th>
<th>External to CIT</th>
<th>Not Stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>99</td>
<td>6 (6%)</td>
<td>1 (1%)</td>
<td>5 (5%)</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>40</td>
<td>5 (12.5%)</td>
<td>1 (2.5%)</td>
<td>2 (5%)</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Total</td>
<td>139</td>
<td>11 (8%)</td>
<td>2 (1.5%)</td>
<td>7 (5%)</td>
<td>2 (1.5%)</td>
</tr>
</tbody>
</table>

The low number of respondents that stated they sought support (8%) is stark. In the previous table 83% of suicide bereaved respondents acknowledged where they would seek support for a personal problem. Yet despite having experienced a death by suicide, a mere 8% actually sought support. This raises various questions, such as, is experiencing a death by suicide not viewed as a personal problem? Or if it is, what is stopping the respondents from availing of support?

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One thing that is also notable from this table is that there are a higher percentage of females that sought professional support than males. Males sought support external to CIT, this is not reflective of what was evidenced in section 6.7.5 which identified that males were more inclined to seek support within CIT for personal problems. It must also be noted here the extremely low number of respondents in this instance, however, it still raises the question if the results in 6.7.5 would have changed were the question phrased differently i.e. replace ‘personal problem’ with ‘dealing with a death by suicide’.

**6.7.7 Seeking Support Online or In Person.**

The following table details suicide bereaved respondents’ views of online support seeking i.e. if they agree/ disagree they would be MORE inclined to seek support online, and the relationship to seeking support within or external to CIT. For example, 86 suicide bereaved male respondents reported they agree/ strongly agree that they would be more inclined to seek support online, of that 86; 36 indicated they would seek support within CIT, 34 indicated they would seek support external to CIT and 16 did not indicate where they would seek support.

**Table 6.7.9 - Seeking support Within/ External to CIT and Online Support**

<table>
<thead>
<tr>
<th></th>
<th>Suicide Bereaved Males Total = 99</th>
<th></th>
<th>Suicide Bereaved Females Total = 40</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Online Counselling</td>
<td>Seek Support Within CIT</td>
<td>Seek Support External to CIT</td>
</tr>
<tr>
<td>Agree/ Strongly Agree</td>
<td>86 (87%)</td>
<td>36 (36.4%)</td>
<td>34 (34.3%)</td>
</tr>
<tr>
<td>Disagree/ Strongly Disagree</td>
<td>11 (11%)</td>
<td>5 (5.1%)</td>
<td>4 (4%)</td>
</tr>
<tr>
<td>Unanswered</td>
<td>2 (2%)</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Online Counselling</th>
<th>Seek Support Within CIT</th>
<th>Seek Support External to CIT</th>
<th>Support Seeking Not Stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree/ Strongly Agree</td>
<td>36 (90%)</td>
<td>11 (27.5%)</td>
<td>22 (55%)</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Disagree/ Strongly Disagree</td>
<td>4 (10%)</td>
<td>3 (7.5%)</td>
<td>1 (2.5%)</td>
<td>--</td>
</tr>
<tr>
<td>Unanswered</td>
<td>0 (0%)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
The high percentage of both male and female suicide bereaved respondents that would be more inclined to seek support online is reflective of all participants views as detailed in Figure 6.6.3.

This table shows that there is no striking relationship between views on online counselling seeking and support seeking within or external to CIT. However, females who agreed with online counselling were also more likely to seek support external to CIT. This is not surprising because, as noted earlier online support reflects some of the reasons why students chose to seek support externally e.g. non-disclosure of identity therefore ensuring confidentiality.

**Table 6.7.10 – Correlation: Seeking Online Support and Support Within/ External to CIT**

<table>
<thead>
<tr>
<th></th>
<th>Online Support</th>
<th>Support Seeking Within/External to CIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman’s rho</td>
<td>1.000</td>
<td>-.062</td>
</tr>
<tr>
<td>Online Support</td>
<td>Correlation Coefficient</td>
<td>Sig. (2-tailed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.475</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>137</td>
</tr>
<tr>
<td>Support Seeking</td>
<td>-.062</td>
<td>1.000</td>
</tr>
<tr>
<td>Within/External to CIT</td>
<td>Correlation Coefficient</td>
<td>Sig. (2-tailed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.475</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>137</td>
</tr>
<tr>
<td></td>
<td></td>
<td>139</td>
</tr>
</tbody>
</table>

The relationship between seeking support within/external to CIT and seeking online support was investigated using Spearman rho (the non-parametric alternative) correlation coefficient. Cohen (1988:79-81) suggests the following guidelines when determining the strength of the relationship: Small r (rho) =.10 to .29 (+or-); Medium r (rho) =.30 to .49 (+or-); Large r (rho) =.50 to 1 (+or-). A correlation of 0 indicates no relationship at all.

Preliminary analysis was performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. From the table above it is evident that there is no significant correlation between the two variables (-.062), indicating a weak relationship between seeking support within/ external to CIT and seeking online support. Seeking support either within or external to CIT helps to explain a mere .3844% of the variance in respondents’ views in their take up of online support.
6.7.8 Non Professional Supports in Connection with Suicide Bereavement

Participants were asked ‘Outside of professional services, please indicate what other supports helped you when trying to come to terms with the suicide of someone you knew’, the following charts illustrate respondents’ views. Please note that ‘other’ in this instance covers a variety of supports.

Fig. 6.7.2 - Non Professional Supports (Male)

It is evident with females that family and friends play a pivotal role when coming to terms with a death by suicide; friends are viewed as the most helpful/ extremely helpful with a whopping 62.5% of respondents stating such. Similarly, friends are evidentially viewed as the

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18 ‘Other’ has been detailed by respondents in this instance as; school/college; sport; alcohol; work.
most helpful by male respondents with a startling 52% of respondents’ stating that they found them to be helpful/ extremely helpful. This indicates a gender similarity in respondents uptake of non-professional supports. College peers appear to play more of role with females also, with 25% of respondents stating that they found them to be helpful, however, males respondents perceive college peers and Church the least helpful with a total of 40% stating they were no help at all. Over all it is visible from the two figures above that females perceive fewer non-professional supports to be of no help at all. However, it must be noted that on reflection the researcher identified that the scale could be contended to be biased in favour of ‘helpful’ as it should have included two prompts indicating a level of help and two prompts indicating a level of no help i.e. ‘slightly helpful’ could have been replaced with ‘not helpful’.

6.7.9 Coping Mechanisms

(i) Participants were informed of what some people do i.e. exercise, pray, eat or drink more, when attempting to come to terms with a death by suicide, in an attempt to identify coping skills/ mechanisms in response to a death by suicide there was a low response rate with 44% of male respondents and 30% of female respondents failing to disclose what they did that helped them during the bereavement period. Females detailed a higher response rate, however of those that did respond (55 males (56%), 28 females (70%)), a gender similarity was visible.

Focusing on the most frequently identified, both genders expressed avoidant coping strategies such as: ‘trying to continue as normal’; ‘playing sport/ exercising more’; ‘spending time alone’, however ‘talking to friends and family’ proved to be the most popular with female respondents (37.5%), this was also presenting as the second highest coping strategy detailed by male respondents (14%) (see Appendix XIX for further detail).

(ii) Particularly Helpful at CIT: coping with a death by suicide.

Participants were asked to identify if anything particularly in CIT helped them to cope with suicide bereavement. The high number of participants that opted not to answer this question was stark, (males = 83, females = 20). The number of male respondents that answered the question are an extreme small minority (16), however half the number of female respondents answered (20). However, despite the low response rate, college peers, lecturers and the GYM were identified to have particularly helped male respondents. It is notable that the medical
centre was rated most helpful by female respondents together with college peers. For further
detail, (see Appendix XVII).

6.7.10 Concerns for Fellow Peers and approaching the topic of Suicide (Reflective of Key
Finding 6 as indicated earlier)

Of those that have indicated experiencing a death by suicide, the following tables detail the
number of respondents that reported they were worried about fellow peers being suicidal
since they have begun their studies at CIT, it also details their viewpoint on approaching the
topic of suicidal thoughts directly:

Table 6.7.11 - Peer Concern, Approaching the Topic of Suicide

<table>
<thead>
<tr>
<th></th>
<th>Suicide Bereaved Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approach Suicidal Thoughts</td>
</tr>
<tr>
<td></td>
<td>Directly</td>
</tr>
<tr>
<td>Males = 99</td>
<td></td>
</tr>
<tr>
<td>Agree/ Strongly Agree</td>
<td>78 (79%)</td>
</tr>
<tr>
<td>Disagree/ Strongly Disagree</td>
<td>21 (21%)</td>
</tr>
<tr>
<td>Total</td>
<td>99 (100%)</td>
</tr>
<tr>
<td>Females = 40</td>
<td></td>
</tr>
<tr>
<td>Agree/ Strongly Agree</td>
<td>35 (87.5%)</td>
</tr>
<tr>
<td>Disagree/ Strongly Disagree</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>40 (100%)</td>
</tr>
</tbody>
</table>

Table 6.7.12 - Expressed Peer Concern RE: Suicidal ideation

<table>
<thead>
<tr>
<th></th>
<th>All Questionnaire Respondents</th>
<th>Suicide Bereaved Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expressed Peer Concern</td>
<td>Number of fellow peers thought to be suicidal</td>
</tr>
<tr>
<td>Males = 200</td>
<td>43 (21.5%)</td>
<td>81 people</td>
</tr>
<tr>
<td>Females = 99</td>
<td>15 (15%)</td>
<td>23 people</td>
</tr>
<tr>
<td>Males = 99</td>
<td>29 (29%)</td>
<td>61 people</td>
</tr>
<tr>
<td>Females = 40</td>
<td>7 (17.5%)</td>
<td>9 people</td>
</tr>
</tbody>
</table>

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Of the 43 male respondents that expressed concern for their peers, 29 males were suicide bereaved, from which concern was expressed for 61 fellow peers, three quarters of the total number concerned. This suggests that males who have lost someone to suicide become more concerned about those around them. Out of those 29 male respondents 25 agreed/ strongly agreed that if you suspect someone may be at risk of suicide, it is important to ask them directly about suicidal thoughts. This coincides with the ‘safeTALK’ guidelines and results here show the importance and necessity for gatekeeping training such as ‘safeTALK’ so that earlier detection of risk factors can be identified in a further attempt to ensure students wellbeing.

Overall there was a lower number of females concerned for fellow peers. Of the 15 female respondents that expressed concern for their peers, 7 females were suicide bereaved, from which concern was expressed for 7 fellow peers, less than half of the total number concerned. This might suggest that females are not as exposed to suicidal ideation as males. Similarly out of the 7 female respondents 6 agreed/ strongly agreed that if you suspect someone may be at risk of suicide, it is important to ask them directly about suicidal thoughts.

**6.7.11 Academic Studies in Connection with Suicide Bereavement**

Participants were asked if they had ever struggled with their academic studies while trying to come to terms with a death by suicide. The following chart details respondents’ views:

*Fig. 6.7.4 - Academic Effects (N = 139)*

- **Yes (academically affected)**
  - M = 14% (n: 14)
  - F = 22.5% (n: 9)

- **No (not affected academically)**
  - M = 31% (n: 31)
  - F = 17.5% (n: 7)

- **Not aware of any academic affects**
  - M = 14% (n: 14)
  - F = 10% (n: 4)

- **Unanswered**
  - M = 41% (n: 41)
  - F = 50% (n: 20)
Majority of respondents, male (41%) and female (50%) alike, stated that coming to terms with a death by suicide has not affected them academically. However, it is evident from the chart above that females are marginally more aware of what is happening for them academically and emotionally alike. There were notably more males that stated they were unaware if experiencing a death by suicide has ever affected them academically. There is also a higher percentage of male participants that opted to not answer this question.

6.8 Focus Groups Not Undertaken

As previously noted in the Methodology section, it was initially hoped that two focus groups would also have been conducted. The groups would have consisted of 6 self-selected questionnaire participants, this would have created further in-depth analysis. The focus groups would have taken place after the questionnaires had been completed, thus allowing for any outstanding questions/areas to be addressed. Due to ethical concerns this research could not be undertaken (see section 5.7.11 Harm Minimisation for further detail).
6.9 Results Conclusion

In response to research question one ‘what are CIT student attitudes and responses to suicide? Are there gender differences in these?’ the main key findings were as follows:

There did not appear to be a significant gender difference (+/- 7%) in CIT student attitudes towards approaching the topic of suicide. An overwhelming majority of both genders (M = 79%, F = 86%) identified that if they suspected someone is at risk of suicide, it is important to ask them directly about suicidal thoughts. Of the 299 respondents 58 indicated ‘suicidal ideation’ concerns for 104 fellow peers.

In response to personal problems, CIT lecturers were overwhelmingly recognised as the most helpful source of support with little gender difference (+/- 5%) as a high percentage of both genders expressed the same viewpoint (M = 67%, F = 72%). They key role of lecturers as first points of contact for students and as key referral points could be further utilised to encourage students to seek support from professionals and echoes the point made by DNSRF as to the potential of lecturers as gatekeepers.

Further, in response to suicide bereavement, the low percentage of total respondents that stated they sought professional support is stark (8%). However, in light of the minimal number of respondents that indicated seeking professional support, findings revealed females were more inclined to seek professional support for personal problems.

In response to research question two ‘how aware are students of the supports available to them in dealing with mental health problems (of self and others) and what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?’ the main key findings were as follows:

There was a significant number of male respondents (110) that did not indicate any awareness of potential supports at CIT, a percentage total of (55%) which is stark. This was significantly lower in female respondents (16), a percentage total of (16%) which indicates a gender difference in student awareness. Looking at awareness and usage of services in further detail by focusing on suicide bereaved students, almost the exact percentage of males that expressed awareness of services (37%) also stated usage of student services (34%). The percentage is still quite low however the finding is striking, as it leads one to query if males only seek out services when there is intent to use them. In contrast, suicide bereaved females detailed an
extremely high awareness of student services with 90% indicating such. However there was a marginal difference in females take up/ usage of services which was much lower (52.5%).

The findings from this study revealed that the phrasing of questions in relation to seeking professional help, will impact on participants responses. When participants (suicide bereaved) were asked if they had ever sought professional support in relation to suicide bereavement, a total of 6 males (6%) and 5 females (12.5%) indicated such. As previously identified the low percentage of students that sought professional help is stark. However, interestingly, when participants (suicide bereaved) were asked about their level of usage of student supports for ‘personal problems’ (excluding physical problems) a total of 34 males (34%) and 21 females (52.5%) stated usage. This is an intriguing finding as it raises the question of stigma, does the stigma associated with suicide bereavement still exist?

In response to research question three ‘what changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (of self and others)?’ the main key findings were as follows:

An overwhelming majority of student participants indicated that they would be more inclined to seek support via the internet. There was an extremely minimal gender difference in this area (+/- .5%), with high percentage of both genders were in agreement (M = 87.5%, F = 87%). However, a majority of interviewees proved reluctant to embrace such a suggested development and were vocally cautious of its development.

One pressing area of development that was acknowledged by both student respondents and CIT interviewees, was that advertisement of student support services needs to be improved. This research study addressed the topic of producing videos on mental health and support services at CIT with the aim of informative promotion and aspects of pro-active facilitation of support. These videos were seen by interviewees to have exceptional, potential, added value and all providers thought that they would be effective in creating further awareness both of mental health and services available both within CIT and externally.

Furthermore the perceived value seen in the introduction of a Mental Health Policy was unanimous by all interviewees. However, this research study also revealed that there are substantial similarities in the nature and duration of services provided at the third level colleges sampled (regardless of whether there is a Mental Health Policy in place).
7. Discussion

7.1 Discussion Introduction

The conceptual framework of this research study was based on the premise that survivors of suicide may experience unique challenges during their grief and queried if there were gender differences in ‘processing’ a death by suicide. In dealing with or ‘processing’ a death by suicide, suicidal thoughts/ suicidal ideation is not uncommon (Wertheimer, 1991; Young et al., 2012). As previously identified the statistics indicate a stubborn sex difference with males representing on average 80% of all suicides over the past nine years in Ireland (www.cso.ie). Thus, one is led to question whether or not gender relates to the ways suicide grief is dealt with. This small scale research study took a ‘crude binary gender approach’ with the assumption that there was harmony/ conformity between student respondents’ sex and gender, otherwise known as Cis-gender (Erickson Cornish et al., 2012). The binary gender approach presented as a typical starting point for this research study however, future research might be well advised to incorporate the perspectives of minority genders such as transgender, genderqueer, gender neutrois and pangender. These were not considered in the current research study.

The research design was a two part process, which drew on the views and opinions of students and ‘professionals’ in dealing with a death by suicide as outlined in the previous chapters. By using both quantitative and qualitative methods exploration was undertaken on issues such as suicide/ suicide bereavement. Students’ consultation and participation is important in developing effective services. However, it was unfortunate that some qualitative research (student focus groups) could not be conducted due to ethical concerns, which is unsurprising given the sensitivity of the issue. The results paint an informative picture of students’ awareness and use of supports; student support service provision and the limits of college supports; gender similarities and differences in relation to support awareness/ use. This research did not substantiate gender difference in support provision, however, there is some evidence to support gender specific advertisement of services in creating awareness among all students. There was also some notable discord between ‘professionals’ views and those of students in relation to future development of appropriate student supports.
The subsequent themes and research questions explored in this chapter relate to the identified ‘key’ findings. A short discussion of the quantitative findings precedes the discussion of the qualitative findings to provide context for the later, although on one reading the qualitative findings may be seen to justify primary examination. There is little Irish research in relation to this topic at third level despite the release of Governmental policies such as *A Vision For Change* (2006) and National Strategies such as *Reach Out* (2005), that each highlighted both the evidence of the mental health vulnerabilities of the third level age cohort and the need for service response. However, this paucity of published and specific inquiry was ameliorated and met by the recent large-scale study which incorporated third level students: *My World Survey* (Dooley & Fitzgerald, 2012). It was the first national study on youth mental health in Ireland from ages 12 – 25 and provided findings of significant value this study built upon. This particular research study appears unique in this country to date as it focused primarily on student support provision at third level and establishing how best to support third level students when they have lost a loved one to suicide. Whilst it is acknowledged that this research study had a limited sample both numerically and geographically, some findings receive amplification by other research such as ‘*My World Survey*’ and accord with the core insights of that pioneering work. For example, in relation to the concordance of the value of the ‘one good adult’ identified in the ‘*My World Survey*’ and the importance attached to contact with individual lecturers at CIT in the present work. This synthesis of existing knowledge and any further insight available from this study is the primary aim of this discussion.

This *Discussion* chapter has been structured into four main sections - the first three reflecting on the three research questions and the extent to which the findings address these; the fourth section considers the contribution this study makes to the field of knowledge on the topic, the recommendations drawn, and also considers the strengths and limitations of the research.

7.2 ‘*What are CIT student attitudes and responses to suicide? Are there gender differences in these?***

7.2.1 *Student Attitudes in Approaching the Topic of Suicide*

In relation to approaching the topic of suicide, four fifths of the entire sample, 85 females (86%) and 158 males (79%) in the student survey reported that if they suspected someone is at risk of suicide it is important to ask them directly about suicidal thoughts. There was a gender similarity in students’ response, with minimal difference of (+/- 7%).
This finding reveals that CIT students have a strong general awareness of good practice that is being promoted at the moment (e.g. Console, safeTALK as detailed below) should one encounter a risk of suicide.

‘Console’ is a National Suicide Charity and provides training programmes in suicide prevention and bereavement. QPR is a ‘suicide prevention’ one day training programme. QPR stands for ‘Question, Persuade and Refer’, these are identified as three simple steps to help save a life from suicide. “Just as people trained in CPR help save thousands of lives each year, people trained in QPR learn how to recognise the warning signs of a suicide crisis and how to question, persuade and refer someone to help” (http://www.console.ie/index.php?contentid=Suicide-Prevention-Projects).

Another similar initiative is ‘safeTALK’, a half day training programme that “prepares participants to identify persons with thoughts of suicide and connect them to suicide first aid resources” (safeTALK, 2013). The National Office for Suicide Prevention coordinates safeTALK and ASSIST training at a national level. This safeTALK training promotes the practice of Tell, Ask, Listen and Keep-safe.

Focusing on ‘Question’ (Console) and ‘Ask’ (safeTALK), these training programmes promote asking the individual directly ‘are you feeling suicidal?’, if there is cause to do so. It is arguable that the thrust of these training courses is having an impact on students’ attitudes and responses to such situations and shows that ‘suicide awareness’ is trickling down the lines and is indeed reaching both young males and young females.

The National Office for Suicide Prevention details that ongoing evaluation of safeTALK revealed participants felt more confident in such a situation and it impacted on knowledge, attitudes and behaviour (www.nosp.ie). Similarly, a 2007 evaluation of safeTALK in Scotland revealed participants felt more likely to recognise the signs of someone at risk (www.chooselife.net). The safeTALK training programme has been offered to students and staff of CIT for the last three years. However, it is not known how many students have participated in the safeTALK training provided through CIT or indeed in other courses outside the college also. Students may acquire such knowledge through other various sources such as word of mouth or online, the details of which were not sought as part of this research.

In any case, the attitudes expressed by CIT students in directly assessing if suicide ideation is a concern for their peers/ friends, shows that a ‘communal’ caring approach is developing in youths responses to mental health issues. It is hopeful that this is reflective of a general
‘cultural shift’ in attitudes towards mental health in Irish society. Despite the funding pressures facing the mental health sector and the piecemeal implementation of *A Vision For Change*, it has contributed to positive changes in attitudes to mental health and is reflected here. Further findings from this study (section 6.6.6 *Peer Concerns*) reveal the importance of students having a pro-active attitude towards suicide ideation, which is discussed below.

One of the most chilling findings from this research was that, over the cohort of students surveyed (M=200), (F=99), male respondents (21.5%) identified 81 students known to them who were thought to have been suicidal, whilst female respondents (15%) identified 23 students known to them were thought to have been suicidal/ still struggling with suicidal ideation, a total of 104. There appears to be a heightened awareness amongst males about their peers’ mental health. However, it must be acknowledged that the number of male survey respondents was over double that of female respondents suggesting there will be a higher number of students that males are concerned about, however, that does not eliminate the sheer volume of students thought to be in a vulnerable position by male respondents. It must also be noted that participants were purposively chosen to be representative of the student population in CIT (see *Section 5.4.1 Questionnaire Sample* for further detail).

These high numbers of potentially suicidal students accords with findings in the *Challenging Times Two* study (Cannon et al., 2013) which found that among 19-24 year olds almost 1 in 5 had experienced suicidal ideation over the course of their lifetime. This is further reflected in the *My World Survey* (Dooley & Fitzgerald, 2012) which reported that of the 8,221 Irish participants aged 17-25, 43% indicated that they had thought that their life was not worth living at some point, and just over half of the sample 51% had expressed suicidal ideation. Young male respondents appear to be acutely conscious of mental health issues and of the vulnerability of some of those around them, in this regard, however, there is an identifiable disjunct as males respondents displayed a significantly lower awareness of support services on campus than that of female respondents (+/-39%). Is it not arguable that if young men were more aware of the student support services available then they may be less anxious for their peers? The questionnaire alone does not suffice in understanding such an outcome and further qualitative research would have been of benefit to further explore this striking finding. If the focus groups were conducted, this could have been a point of discussion to establish why more males express such peer concern compared to females, and attempt to identify what it is that concerns them (i.e. what they perceive as ‘warning signs’). As outlined before and discussed below in relation to strengths and limitations of this study, it would not have
been ethically sound to conduct the focus groups but it does provide some priority for future exploration.

It must be acknowledged here also that these numbers might not be true and that there is potential of possible overlapping of concerned students; respondents could be talking about the same people. As detailed earlier in the Results Section, for example, Student X expressed concern for Student Y, Student X1 also expressed concern for Student Y, and Student X2 also expressed concern for Student Y. However, understandably, for ethical reasons, students’ responses could not be personalised so as to establish whether this was indeed the case could not be established, but it must be noted as a possibility.

In all, these findings show the potential high number of CIT students, a total of 104, that are currently perceived (by the student sample) to be experiencing mental health issues or struggling with suicidal ideation. As such, it can be hypothesised to reflect the wider picture of students in third level colleges nationally and is congruent with recent, relevant reports such as the My World Survey detailed above. This shows the need for initiatives, similar to that of Jigsaw, “bringing mental health services to where the children and teenagers were, rather than wait, probably in vain, for the most vulnerable to access help themselves” to be influential within a third level community (McDonagh, 2013: 5). There are promising signs that the recent emphasis on reducing stigma and targeting male mental health (YMSP, 2013) may be beginning to pay off. Jigsaw Galway details an increase in males take up of services. It was reported that “one of the most heartening things about Jigsaw to date is the level to which young males have engaged with the service – 53%” (Fitzmaurice, 2012: 27). There is further evidence mental health is being increasingly addressed valiantly within third level education by the provision of student services on campus e.g. medical care; counselling; chaplaincy support. However, as this study shows, many young people today are still somewhat intimidated by the thought of accessing professional mental health services, and further restricted by the idea that things ‘aren’t that bad’ to make use of them yet (this is discussed further in Section 7.3).

7.2.2 Assenting ‘informal’ Support Service Provision

In CIT, the student survey revealed that a majority of students primarily seek support from individual lecturers already known to them (on campus) and known family/friends (off campus) for personal problems, this also resonates with findings from the My World Survey. This is presented in Table 6.6.3 of the results chapter whereby lecturers presented as the most
helpful/ extremely helpful source of support (professional and non-professional alike) for student participants. “I would go to a lecturer that I know and trust about the situation. They can often advise on how to resolve the situation.” (Male 19yrs). There was little gender difference on this viewpoint (+/- 5%), with 72% of females and 67% of males stating such. This suggests that there is a gender neutrality in CIT students preferred chosen source of support and, similarly, the positive level of support the student receives (regardless of their gender) is also apparent.

The My World Survey (Dooley & Fitzgerald, 2012) suggests that if vulnerable students had ‘one good adult’ in their lives, known, trusted, accessible and non-judgemental, to support them, the benefits would be of great value. It contends that access to ‘one good adult’ affects life satisfaction; builds self-esteem and promotes a sense of belonging, similarly the absence of ‘one good adult’ is related to increased likelihood of self-harm and suicide.

The idea of this ‘one good adult’ can be adopted and actioned in many ways, for some students at a third level college such as CIT, their ‘one good adult’ may be the sports trainer, a particular year head, a particular lecturer. However, in this research study student support interviewees from TCD (SUWO) and UCC (SUWO) indicated that lecturers were not advocated to take on a pastoral/ gatekeepers role (however it must be noted - both Mental Health Policies provide direction for lecturers on how best to respond to a distressed student, should they present) . The reason for lack of avocation of lecturers support was unclear but it appears the viewpoint held was that those colleges have a higher student - lecturer ratio than CIT. “A class of roughly 400 people, you go into a class and sit next to somebody, you will probably never sit next to them again for the year” – UCC SUWO. Lecturers are not expected to take the position of a pastoral role when potentially lecturing to class groups of 200 students or more. However, TCD and UCC have a full-time student population of 16,000 whereas CIT surprisingly has a higher number of full-time students 17,000 (http://www.coursehub.ie/index.php/compare/controller-collage.html). Each student support system (within TCD & UCC) varies slightly but SUWOs from each of these two colleges acknowledge that only recognised supports (e.g. counselling/ medical) are to provide aspects of mental health support to students. However, it must be noted that students at TCD and UCC were not surveyed and may also have returned similar results to that of CIT students (given the opportunity), indicating a known lecturer being a preference for support when distressed.
Despite the large student population (17,000 as detailed above) CIT has a reputation as having a notably personable and ‘pastoral’ relationship between lecturers and students and the Institute has long emphasised the informality and closeness of the staff/student relationship. Lecturers were recognised by students in the survey as approachable and a source of support and hence it appears, the student perception of the ‘pastoral’ role is not confined to those specialised in providing support i.e. Student Counselling. As there is such a high proportion of students that report turning to their chosen lecturer for support, there thus needs to be training offered to lecturers so as to ensure they are competent in supporting any given student on aspects mental health support. The key role of lecturers as first points of contact for students and as key referral points could be further utilised to encourage students to seek support from professionals.

In 2012 CIT issued ‘CIT Student at Risk Guidelines’, an A4 sheet that was distributed to all staff in college. It described what to do when a student appears distressed, “he/she should be advised and supported to attend the Student Counselling Service” (Cork Institute of Technology, 2012). While these guidelines are a stepping stone towards advancement in this area, DNSRF recommends further development: “One of my main recommendations in terms of staff would be that any lecturer working with students should at least be offered the opportunity to do what I refer to as a gatekeeper session. The lecturers would be more aware of important signs of depression or potential suicide risk. That doesn’t mean that I would advocate that every lecturer needs to be transformed into a counsellor, that is not the case. However, if they are good gatekeepers then it will be easier for them to refer, to pick up warning signs”. The DNSRF conceptualises the ‘gatekeeper’; an initial point of contact for the student in distress and if utilised to its full potential, the potential positive outcomes appear valuable.

As noted above the ‘safeTALK’ suicide prevention programme has been offered to both staff and students in CIT for the last three years, which is a half day training programme. As the counselling service in CIT has extensive experience with current presenting student issues, it would appear to be economically sound if the counselling service could provide another day/half day training course on, for example the ‘gatekeepers role’ in line with the safeTALK programme. This added training programme would further inform lecturers of presenting issues of students at CIT, and what the main warning signs for students at risk are. It could detail guidelines to follow should a student present with various issues and what precautions to take. This training, ideally, would be for the benefit of all the frontline staff - lecturers/
tutors/ secretaries, so that they may feel more confident and better able to support students should they present with stressful issues. Staff could also then be reminded to take care of their own well-being and the availability of employee assistance from the college in the form of counselling or otherwise if required. This proposed staff training programme detailed herein similar to that of peer support training at TCD (disclosed during interview held with SUWO – TCD, 2013) as there, the trainees are seen as acting gatekeepers and the training is provided by student counselling service on campus.

However, interestingly another informative finding from the survey was the need for both internal and external support provision. Almost half of respondents from the student survey indicated that they would rather seek support externally to CIT (M = 39.5%, F = 52%), the majority of whom would seek support from a family member or friend. In this instance, the idea of this ‘one good adult’ can be adopted and actioned by an individual external to the college community, i.e. friend/ relative. However, it must be noted that there is a need for further links and communication with external supports for two identified reasons: some students prefer to seek support externally; as a student is only to receive 6 counselling sessions within CIT, they then will be referred on to an external service. The question remains, at what stage does the institutes ‘Duty of Care’ end? Should there be a follow up procedure, how far can you follow a student? The college community is not obliged to advance the skills of individuals external to the college setting in an attempt to ensure student’s well-being, however there is an opportunity here to develop the skills of those within it. The ‘one good adult’ concept could be included in the training for lecturers/ frontline staff to encourage the student to either identify an on campus support or an accessible and immediate support source off campus to confide in. The first point of contact for a struggling student is crucial and important ensuring the safety of the student.

7.2.3 Is professional support deemed necessary by the suicide bereaved student?

Whist many respondents deemed family and friends as an important source of support (and indeed their support might have been sufficient for some), one of the most prominent findings from the survey was the low number of respondents that indicated they had sought professional support in relation to a suicide death. In response to suicide bereavement 5 (12.5%) female respondents indicated they had sought professional support and 6 (6%) male respondents indicated they had sought professional support for this purpose. The overall low number 11 (8%) of respondents that stated they had sought professional support is stark.
However, this finding is somewhat challenged as the same suicide bereaved respondents indicated a higher use of support services for ‘personal problems’. An increase of 16 females (total 21 (52.5%) and an increase of 28 males (total 34 (34%)) expressed usage of college support services for personal problems. This raises some questions such as: did the phrasing of the question affect students’ response? Is there reluctance for students to disclose seeking help in response to suicide? Did the students not need professional support? As detailed earlier, family and friends play a pivotal role in supporting students and perhaps this is deemed sufficient by students?

The Chaplain and Nurse from CIT similarly revealed that they would not have many students presenting with the issue of suicide bereavement, “I haven’t had many students that would be here for that reason” – CIT Chaplain. However, notably the CIT Counsellor expresses concern as there has been “an increase in the last two years in the number of students presenting with issues around friends who have died by suicide”. The low number of students presenting with the issue to formal student support services is notable considering the number of participants in this particular research alone that reported they have experienced a death by suicide (139), just under half of the total student survey respondents (299).

In the case of suicide, the bereaved (otherwise known as the survivor) has to live with the thought that the death was self-inflicted and may have been self-chosen. “It is estimated that as many as three quarters of all suicide victims will have announced their intention to commit suicide, either directly or indirectly” (Litman, 1970a; Stengel 1972; Keir 1986 cited in Wertheimer, 1991:53). Unfortunately, it is because of this that survivors of suicide often face unique challenges during grief, potentially experiencing added feelings of anger, guilt and suicidal ideation (Lucas & Seiden, 1987; Young et al., 2012).

The pain of processing the loss of a loved one by suicide coupled with rejection, anger and perceived responsibility may sometimes become overbearing. Some students might feel that they are unable to disclose the reason why they are seeking support as they feel undeserving and that it is almost inappropriate for them to do so, however, that does not mean they are not in need of support. Wertheimer (1991) argues that it can help survivors when they talk things over with someone, a professional or a close family/ friend or both. Whilst it must be acknowledged that not every death by suicide experienced requires formal professional support and that sometimes family and community support will suffice, as detailed by Provini
(2000), the need for both options to be available, is apparent (this is further addressed in Section 7.3).

It is noteworthy that the percentage of females (12.5%, n:5) that reported seeking professional support in response to suicide is over double that of males (6%, n:6) indicating a slight gender difference, albeit resulting from an extremely low percentage of relevant respondents overall. This is reflective of the work of Chrisler and McCreary, 2010; YMSP, 2013; Cleary, 2005; Martin and Doka, 1996, suggesting that men are less likely than women to seek help for both mental and physical health concerns. However, contrary to these gender findings, the three SUWOs that participated in this study, stated that in their experience, suicide bereaved students consisted of a male majority. Again it must be noted that the number of students that presented to the SUWOs was small with a total of 6 suicide bereaved students seeking support from 2 of the SUWOs (CIT and UCC) over a 2 year period. Yet it does raise the question – are male students more inclined to seek support from a personal contact/ someone they are familiar with rather than seek out identified professional support? This is further explored in Section 7.3.

The SUWOs from each of the three colleges noted that unless it is a student in their college that has died by suicide, a lot of the time it is up to the bereaved student to come forward for support, which might help to explain the low number of students presenting. Arguably there is a need and added value to shift some of the onus and responsibility from those seeking support to those providing it, to ensure that support is offered in an accessible manner to those in need of it. One of the key outcomes noted in the second report of the Suicide Support and Information System (SSIS) was “Proactive facilitation of bereavement support resulted in a significantly higher uptake of support by families/ friends bereaved by suicide compared to a non-proactive approach” (Arensman et al., 2013: 5). The second report of the SSIS (2013) presents results of investigations into subgroups and cluster suicides on 307 cases of suicide in Cork City and County between September 2008 and June 2012.

The key finding of the SSIS (2013) cannot be ignored with a proven uptake of bereavement support by a staggering 39.5% of participants occurring where proactive bereavement support was offered and by a mere 3.8% of the participants where a non-proactive approach was adopted (Arensman et al., 2013). Another aligned example outlined in Section 7.4.1 of this chapter is an aspect of pro-active support at Third Level (TCD), whereby an email is sent to students informing them of the development of a new mental health initiative ‘SilverCloud’
During evaluation of the initiative students acknowledged one of the main reasons why they chose to utilise the new initiative as a source of support was because it was suggested to them, it was offered, the students did not have to seek out this new mental health initiative of their own accord.

“The importance of promoting positive mental health among this large third-level student population cannot be underestimated, with recent research showing a high percentage of students experiencing mental health difficulties including depression, anxiety, loneliness, substance misuse and suicidal behaviour” (A Vision For Change, 2006:95). It is recognised thus in government policy and student services development that third level institutions have the opportunity to influence attitudes to mental health and help seeking among their students. Similarly, the Union of Students in Ireland acknowledge that colleges could actively address a healthy approach to students’ issues/concerns, “all third level institutes should be encouraged to adopt the concept that they should be a ‘health promoting college’ (http://usi.ie/policy/usi-physical-health-strategy/). As it has been established that there is a high number of CIT students that have been affected by a suicide death/s, it is argued that students’ response in dealing with the effects can be aided by action within the college community itself. This undeniably has been attempted in CIT through various meetings (tea/coffee mornings and guest speakers) and activities (releasing balloons into sky in memory of those lost) which are held predominantly during mental health week every November, however pro-active support focuses on attempting to encourage the individual to seek professional support (when necessary), in a more inviting, informative, approachable manner.

One pressing area of development that was acknowledged by both student respondents and CIT interviewees was that advertising of student support services needs to be improved. Advertising was the most prominent student advice/suggestion for improvement provided by both male (13.5%) and female (14%) student respondents, and that this could be done in line with pro-active support being offered. A feature that is extremely catching on the ‘My Mind Matters’ website and worthy of consideration by CIT, is videos detailing various aspects of mental health and support such as, ‘how does counselling work’; ‘does counselling help?’; ‘is counselling for me?’ . This research study addressed the topic of producing similar videos on mental health and support services available specifically at CIT and asked community participants for their views on the idea. The video/s would potentially consist of:
- Students/ young people explaining different areas of mental health (such as suicide bereavement) and detail their experiences;
- Identified speakers i.e. Donal Óg Cusack (who has spoken in CIT in the past and received a great audience and response) discussing sexual orientation and mental health;
- Student Support Professionals (such as a CIT Counsellor) detailing what their service provides, what counselling is and the area in which it is situated.

When this suggestion of advertisement was presented to the professional student support providers at CIT, the positive views expressed were overwhelming. These videos were seen to have exceptional potential added value and all interviewees thought that they would be effective in creating awareness both of mental health and services available both within CIT and externally. Were these videos to be introduced and emailed to each CIT student at the beginning of each semester, the influence it would have on students uptake of services in response to issues (such as suicide bereavement) can only be estimated, however focusing back on the TCD initiative (SilverCloud), there is evidence to suggest that it would increase students uptake of services.

However, were such videos to be developed, the CIT Counsellor detailed the financial difficulties that may be faced, “I think it’s excellent, but you provide the budget for it... Unfortunately it costs a fortune, we just don’t have the money for it (mental health promotion videos). I would love to see it. I would love to see this extended, I would love to see more money being put into it”. It is evident that this area of development in combining further advertisement with aspects of pro-active support would be challenging but it is also evident that there needs to be development in this area. CIT has potential to call on internal student resources for such development with multi-media degrees in place. Such resources could and arguably should be utilised, building on student feedback with the advice and supervision from the counselling service and other interested parties such as the CIT SUWO and the Office of the Registrar. However, it must be noted that if CIT is to advise students to take up professional student support, the service/facility must be accessible and available for them. The ease with which survivors are able to find and utilise the support they need to deal with a death by suicide can depend on a number of different factors such as “the availability of appropriate services, how well those services are publicised, and whether there is a key referral system” (Wertheimer, 1991:152). It would indeed create a negative effect were
suicide bereaved students to accept the invitation of college support services but then be refused the support on arrival due to limited availability.

7.2.4 Academic performance concerns posed in response to suicide bereavement

Findings from this research study indicate that 22.5% of females and 13% of males acknowledged that they had struggled with their academic studies whilst trying to cope with a death by suicide. Females expressed a greater awareness of how the experience of suicide death/s affected them academically. Nearly one third of the sample, (31.5%) of males expressed they were unaware if their academic studies had been affected whereas a notably lower percentage of females (17.5%) expressed lack of awareness. It is evident from this study that suicide bereavement is affecting some students at CIT academically. There are academic guidelines in place in CIT should a student experience ‘exceptional circumstances’ including bereavement and these same guidelines are apparently followed should the ‘exceptional circumstances’ be suicide bereavement, whilst not expressed in the Regulations (Cork Institute of Technology, 2010). However, in light of the low number of students presenting with the issue of suicide bereavement, it appears some students may not disclose their loss and may be unaware of the academic allowances available. They may not be aware that being suicide bereaved by the death of someone other than a close relative could be considered as an ‘exceptional circumstance’ and within discretion of a Progression Examination Board for deferral or other action (Cork Institute of Technology, 2010).

Balk suggests that “many college students faced with the death of someone they care for are thrown into a maelstrom of emotional and cognitive confusion that challenges core assumptions on what life is about and what it means to live in a moral world” (2011: 3). Cognitive impacts of bereavement can threaten student’s grades and as a result the vision of their career should their grades drop. “Difficulty concentrating or remembering are common cognitive impacts of bereavement” (Balk, 2011: 33). Some students may feel incapable of accomplishing things that matter to them. This further re-iterates the need for aspects of pro-active facilitation of support to be introduced for students at third level (as detailed above) to ensure students do not suffer academically, and indeed the importance of the role of the front line lecturer in advising the student as to their options and advocating for that best option on behalf of the student in formal assessment fora.
7.2.5 Coping mechanisms disclosed in response to suicide bereavement (other than use of professional and non-professional/ informal supports)

When participants were questioned on what they did (if anything) that helped them cope in their response to experiencing a death by suicide, the high level of participants that did not provide a response was startling. 44% of males and 30% of females refrained from answering this question. This could be due to students’ lack of acknowledgement of what they did at that time, the phrasing of the question may have impacted on students low response rate or students may not have felt comfortable to disclose what it was that helped them cope. It is none the less concerning that students did not depict their coping skills and presented as unsure/ unaware of how they cope.

There are no ‘quick-fix’ techniques to help a survivor cope with a traumatic loss such as suicide. Doka (1996) suggests sensitivity, compassion and enduring support from immediate family and large groups i.e. church/ sports team/s, will help survivors develop a new life strategy and heal. The idea that social integration can support survivors coping or indeed those struggling with suicidal ideation resulting from grief has been argued for many years. Durkheim found religion had a moderating influence on suicide, primarily because it is a force for social cohesion (Durkheim, 1952 [1897]). However, Kushner and Sterk (2005) argue that with high levels of social integration, the incidence of self-destructive behaviours, such as suicide are often at the greatest. “The quality of relationships is always paramount, and participation alone does not necessarily translate into acceptance, trust, or reciprocity” (Kushner & Sterk, 2005: 4). What is being said here by Kushner and Sterk is very interesting in so far as, participating and going through the motions is not adequate although many of us would like to believe it is. For example, if a student is involved in a sports team, part of a society, participates well in college, one might assume that he/she is well integrated and coping well with suicide bereavement but in fact he/she might not be and might actually feel very isolated and alone. There if a fear that if a student feels isolated and alone, he/she may turn to substance misuse as a form of coping.

Students who drink alcohol for coping reasons tend to be frequent users, often drink alone and are more likely to binge drink (Cooper, 1994; Cooper et al., 1995; Williams and Clark, 1998). Using alcohol to control negative emotions or drinking to suppress depression or anxiety is an example of using alcohol to cope (Cooper et al., 1995). Students who are unable to cope may turn to negative strategies when faced with a crisis such as suicide.
bereavement. Where there is a lack of developmental learning/ change in this area (coping), potential outcomes could be detrimental, “alcohol often transformed an unhappy state into a potential death” (Cleary, 2005: 8). Strong links were found between excessive drinking and suicidal behaviours in the My World Survey, “young adults classified as possibly alcohol-dependent were significantly more likely to have thought their life was not worth living, and to have reported self-harm and having made an attempt on their life” (Dooley & Fitzgerald, 2012: 99).

There appears to be a need to inform and educate students on different ways of coping when one is struggling/ experiencing crises. Coping mechanisms are in fact used frequently and if we were to make a count of the number of times daily that we are called upon to cope, we would be surprise at the sheer prevalence and complexity of these activities (no matter how large or small the situation being dealt with). For survivors of suicide, who may be experiencing extreme shock and horror, writing may be a means of exercising a measure of control over potential overwhelming emotions. Anthony Storr in his book Solitude, suggests that the creative act of writing “is one of the ways of overcoming the state of helplessness… a coping mechanism, a way of exercising control as well as a way of expressing emotion” (1989: 129). Similarly, Balk and Corr (2009) suggest that keeping a journal may be helpful for those bereaved by the suicidal death of a loved young person.

Findings from those that did respond indicated that talking to family and friends is extremely valuable to females with (37.5%) stating such. Female grief reactions have been viewed as more appropriate and more beneficial for processing grief, with the grief reactions that are often found in males (e.g. inexpression of emotion) being considered inappropriate and unhealthy responses to loss (Martin & Doka, 1996). “Women typically seek vocal expression of their grief, whereas men seem much less inclined to talk about their feelings. Men seem much more inclined to become introspective and do things rather than talk about what they are experiencing” (Balk, 2011: 33). However, there have been changes in gender roles throughout the ages which is primarily due to the fact that “gender is arbitrary, flexible and based in culture” (Goldstein, 2001: 2). It can be questioned if perhaps this gender differential is diminishing in light of cultural and social changes regarding mental health as males begin to take a step towards change. The contribution of high profile male role models in reducing stigma around mental ill health is important, for example, Conor Cusack has done so, with the release of ‘Depression is a friend, not my enemy’ (2013), as detailed in the Literature Review.
That being said, these established generalisations on recognised gender response are arguably still reflected and evident in this study’s findings as the male respondents expressed what may be classed as ‘avoidant’ coping strategies with 16% (the highest percentage) stating that they tried to continue as normal and 13% stated they played sport and/exercised more. ‘Self-reliance’ is contended to be valued by the traditional male gender role, therefore some males may be inclined to be reluctant to share their grief with others and instead take active roles, or involve themselves in activities in the aftermath of a loss (Martin & Doka, 1996).

However, it is striking and unusual that these results indicate the second and third most common expressed form coping mechanisms by female respondents closely reflects that of males with 10% stating that they tried to ‘continue as normal’ and a further 10% stating that they spent ‘time alone’. Another similarly striking result is that the second highest coping mechanism indicated by males was ‘talking to family and friends’ with 14% stating such. This closely reflects female respondents’ views. Whilst the numbers indicating this gender similarity in coping strategies are small, it is impossible to ignore the trend for males and females to respond somewhat similarly to suicide as: a high percentage of both male and females are aware of current practice (safeTALK as detailed above) being promoted (+/- 7% gender difference) in relation to suicide ideation; an extremely low percentage of both males and females indicated they sought professional support in response to suicide bereavement (+/- 6.5% gender difference), this is discussed further in the next section.

7.3 ‘How aware are students of the supports available to them in dealing with mental health problems (of self and others) and what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?’

7.3.1 How aware are CIT students of the services on campus?

This small scale study showed a significant gender difference in students’ awareness/knowledge of existing support services in CIT. Whilst throughout the research study, minor variations between genders could be seen, this was the primary section of the study where major differences were identified. A majority of male respondents (110) did not indicate any awareness of supports, (55%) i.e. over half of the male respondents. This is a startling finding as there was such a high number of males that had experienced suicide bereavement and it seems unimaginable that they would not at the very least have some awareness of students supports (even if they were never to be used). However, looking at awareness of services in further detail by focusing on suicide bereaved respondents, revealed a further insight; from
the number of males [37, (37%)] that expressed awareness of services, [34, (34%)] of the same sample stated usage of the student services. This is depicted in Table 6.7.1 of the Results Chapter. The overall number is still low, however this is a striking finding as it leads one to query if males only seek out services when there is immediate intent to use them? Again, had the focus groups been permitted to go ahead, further insight may have been gained on some of the causations as to why men appear oblivious to support services unless they are needed. Support services that are available did not appear to be ‘common knowledge’ amongst males but it did however appear to be amongst females.

This reported lack of awareness of services was significantly lower in female respondents as only 16% indicated no awareness of supports. Whilst a greater knowledge of services is expressed there is a difference in females take up/ usage of services. Focusing on female suicide bereaved respondents: of the high percentage of females (90%) that expressed awareness of services, only (52.5%) of the same sample stated usage of services. Whilst females may not use student services, they are still aware that they exist. The query thus exists, whether or not there is a need for gender specific advertisement of services? A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between gender and awareness of services.

There is some evidence from this research study that shows students’ participation may well result in more effective/ more constructive service supports. Some of the primary insights of this study were not on gender differences but in fact it creates an informative picture of what services students use and if they were found to be useful (both formal and informal). Jigsaw Galway reports that some of the causations for the high uptake of males use in the service (53%) is due to a number of factors:

- Young people’s direct involvement in the planning
- Design and delivery of the service
- The quality environment and supports on offer
- Ease of access
- Word of mouth (Fitzmaurice, 2012: 27).

The gender difference found in awareness of student services is reflective of what has been identified as the traditional male gender role. The issue of ‘help seeking’ amongst males can broadly be considered to be associated with how individuals become aware of, and respond to health concerns against the background of social norms. One male respondent also
commented on this trend “When it comes to talking about feeling it is viewed as something that would ‘dent’ their masculinity” (Male, 20Yrs). Balk argues that college support programmes/services “need to appreciate the press for young college males to conform to visions of masculinity that abhor appearing out of control or vulnerable; create places males see as safe and yet that offer challenges for growth and development” (2011: 25). A recent report on young men and suicide in Ireland suggests that “Young men need to see emotional expression as a skill that improves with practice” (YMSP, 2013: 9). Using a phrase such as ‘mental fitness’ instead of ‘mental health’ has potential to make a difference, as detailed by the GAA. The GAA in partnership with St Patricks Mental Health Foundation recently (April 2014) launched an innovative resource ‘Play in My Boots’ (www.gaa.ie). The initiative has two primary aims:

- De-stigmatise mental health by speaking to players in a sporting language familiar to them, i.e. using the term ‘mental fitness’ to emphasise the positive nature of mental health.
- Reminding individuals that maintaining ‘mental fitness’ requires work and skill development in the same way as maintaining physical fitness does.

However, this initiative/resource has only been introduced in April 2014, so as of yet, the benefits of it cannot be fully measured.

This was further reflected by student support providers as part of this research study as they identified gender differences in both the issues presented by both male and female students and how they are presented. “Males will present in a very different way… or won’t follow up… but may put in a request for a group of them coming together. Females want to talk, males don’t. There are probably a lot of young men out there who process this stuff (suicide bereavement) on their own and who don’t come to us” – CIT Counsellor. This viewpoint was mirrored throughout the interviewees; females are more inclined to be up front and straight with the issue, men take a more angular approach to the issue (whatever emotional issue that may be). However, DNSRF details that there is some evidence of a shift in males approach, “There is definitely some evidence and this is also coming from GP’s for example who do have experience with young men whether it’s bereavement or other issues in their lives that quite often they present initially with physical symptoms although that is reducing”.

Some of the causations that can boost male’s engagement with services (as detailed earlier by Jigsaw Galway) are evident in CIT college support services i.e. ‘ease of access – support services are on campus which ensures an ease of access for students. However there is
evidently room for further development in creating awareness of services particularly amongst the male cohort. This study is feeding into a Mental Health Policy which is currently under development in CIT, more excitingly the team are willing to speak to the students and incorporate their views and suggestions. It is hoped that this will further aid in creating a ‘general knowledge’ of support services available to students on campus.

7.3.2 Usage of professional student supports

The suicide bereaved students (both male and female) detailed the same top two services (Lecturers, Medical Centre) that are used for personal problems. The order in which they are preferred however is insightful: of the 34 suicide bereaved males (34%) that expressed use of student services 25 (25%) stated accessing support from Lecturers resulting in them being the most used source of support, this is followed by 9 (9%) of males detailing use of the Medical Centre. Further, of the 21 suicide bereaved females (52.5%) that expressed use of student services, 15 (37.5%) stated accessing support from the Medical Centre resulting in this being the most used source of support. This is followed by 10 (25%) of females detailing used of lecturers as a source of support. The results on females usage of professional services reflects previous published research (i.e. women are more inclined to seek help than males as detailed in YMSP, 2013), and remains higher than males (+/- 18.5%). This is further reflected in the fact that when participants were asked to identify services found to be helpful/ extremely helpful, female respondents indicated that they were slightly more inclined to seek professional support and rate those supports as useful. As one questions whether or not male students are more inclined to seek support from someone who they are familiar with rather than seek out identified professional support, this small scale study suggests that male students preferred supports appear to be informal ones i.e. lecturers, SUWO’s, Sports Trainers.

‘Self-reliance’ is something which is valued by the traditional male gender role, therefore some males are inclined to be reluctant to share their grief with others and instead take active roles, or involve themselves in activities in the aftermath of a loss (Martin & Doka, 1996). Where males may immerse themselves in sports training/ college work, it is vital for the front line staff (trainer/ lecturer) to be equipped in identifying a struggling student, however males reluctance to discuss their concerns could potentially make it harder for the front line lecturer/’gatekeeper’ to determine whether or not the student is in need of additional support. Other hurdles, including lack of suitable privacy for such personal conversations and time
restraints (e.g. lecturer has a class to get to) must be acknowledged. This further re-iterates the need for training front line staff as detailed earlier in Section 7.2.2.

A notable finding in relation to students’ usage of support services was that SUWOs from all three sampled colleges (UCC, TCD & CIT) identified a gender difference in the students attending their service, however, surprisingly, males predominate by far the largest cohort in this instance. However, this gender difference conflicts with findings from the student survey which indicates that females reported a higher awareness (+39%) and usage of student support services. This reveals an apparent flaw in the research method as there should have been greater clarification in the breakdown of support sought i.e. was it for financial, accommodation or health/ mental health support was sought? The higher percentage of males that sought support from the SUWOs, may have been in relation to practical support, for example, ‘how do I get to building X?’ With hind sight this identifies a weakness in the research/ interview schedule for the SUWOs and suggests that further research would need to be conducted to identify the number of students that present to SUWO supports for mental health support specifically. This is further addressed in Section 7.5 Strengths and Limitations.

In relation to students seeking support within or external to CIT, students saw benefits of both {within CIT: M = 41.5%, F = 32%}, {External CIT: M = 39.5%, F = 52%}, with little gender difference, indicating a need for both internal and external services to be made known to students. However, regardless of students views, even if a student would preferably seek support within CIT, the majority of student support professionals from all three sampled colleges believe part of their role is to act as a referral service: referring students to external services due to (in some cases) budgetary requirements which further re-iterates the need for a strong working link between the college and external referral services (as noted earlier).

Students’ views varied with several different reasons for their choice of preferred place of support. The most popular reason provided by both male and female students for choosing CIT support services was due to its convenience. It emerged that ‘keeping up appearances’ was vital to those that chose support services external to CIT (both male and female) as the top three causal factors for seeking support externally was to ensure privacy of their support seeking: ‘keep the two separate’; ‘more confidential’; ‘don’t want people to know’. This suggests that image is important to these respondents and raises the issue of stigma still attaching to any evidence that support is being sought. It must be noted that is stigma does not present itself as gender specific as both genders provided the aforementioned responses.
As previously noted, the GAA in partnership with St Patricks Mental Health Foundation recently (April 2014) launched an innovative resource ‘Play in My Boots’ (www.gaa.ie). One primary source of the initiative is to de-stigmatise mental health. This is sought through communication with players in a sporting language that they are familiar with, e.g. using the term ‘mental fitness’ to emphasise the positive nature of mental health. If we are to reduce the impact of mental disorders, self-harm and potentially the suicides of Ireland’s young people, transformational change and service redesign is necessary.

It must be acknowledged that Ireland has taken valiant strides in relation to relevant support services available to the public, whilst criticisms have been levied as to national co-ordination. In fact it is almost impossible to keep track of all the different agencies, services and governmental bodies that are constantly developing new initiatives to tackle the alarming rate of suicide deaths in Ireland. This plethora of response has been commented on: “It is estimated there are several hundred support groups or counselling organisations offering services in different parts of the state” (O’ Brien, 2013: 5). Arguably, this creates competition, variety and choice for those seeking help, however when one main organisation is recognised as the leading source of support, people have security in the fact that they are going to a service which has been recognised and identified as the best.

However, in any event, in 2010, the World Health Organisation (WHO) stated that relatively few suicide prevention programmes have been rigorously evaluated for their effectiveness in reducing suicide and related risk factors. This is not to suggest that available services are ineffective but rather, there is a lack of published evaluation of these initiatives. The following table indicates suicide prevention efforts that have been classified into three levels: Universal; Selective; Indicated, (US Department of Health and Cuman Services, 2001; Cited in World Health Organisation, 2010: 6).

Table 7.1 Suicide Prevention

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<tr>
<th>Level</th>
<th>Definition</th>
<th>Examples</th>
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<tr>
<td>Universal</td>
<td>Affects everyone in a defined population regardless of the risk of suicide</td>
<td>Public education programmes about the dangers of substance abuse; public awareness of depression; limiting access to pesticide; building barriers on hotspots of suicide by jumping; and promoting responsible media reporting on suicide stories</td>
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Selective Targets subgroups at particular suicide risk; there are a number of risk factors found related to suicide, such as mental illnesses, substance abuse, financial debts, unemployment, chronic pain for the elderly, study stress, and access to suicide means.

Programmes for women in rural areas; people who are unemployed and with financial debts; young people with depressive symptoms or substance abuse problems; elderly with chronic physical illness and/or living alone; school kids with a high level of study stress; or victims of physical or sexual abuse; gatekeepers training for police, teachers, general practitioners, and community stakeholders who may identify and provide early intervention to people with possible suicide risks during their daily work.

Indicated For specific individuals who, on examination, have a risk factor or condition that puts them at very high risk, e.g. recent suicidal attempts.

Crisis management or follow-up care; programmes for patients with recent suicidal attempts or deliberate self-harm behaviours who have been admitted and discharged; and close monitoring measures on patients with prior suicide attempts.

This table details a broad mix of intervention strategies that are believed to have a greater likelihood of reducing suicide rates. However, evaluation on the prevention of something that someone may or may not do i.e. choose to die by suicide, can understandably be argued as a difficult task. This research study alone encountered numerous road blocks by ensuring that a grounded theory approach was adopted (this is further addressed in strengths and limitations in Section 7.5). Whilst the value in terms of authenticity in participatory research is widely acknowledged, the difficulties in vital ethical safeguards and approvals raises the question - if the challenges that researchers face in suicide research deters others from conducting the independent evaluative appraisal that the WHO have called for?

The benefits of having a unified, well recognised national source is under explored. One non-Irish national initiative that has undergone independent evaluation as to its effectiveness is ‘Headspace’, (see file:///C:/Users/Sandy_2.Tosh/Downloads/final_independent_evaluation_of_headspace_report.pdf for the Headspace evaluation report 2009). Headspace is the National Youth Mental Health Foundation in Australia for youths aged 12-25. It appears to have established itself as one of the main sources of support for youths in Australia with various methods of service.
provided. Headspace appears to be integrated into young peoples’ lives, similar to that of attending school or going to the doctor and it arguably has become a universally known resource for students. In establishing such a reach and normalised position, this has endeavoured to eliminate the stigma that is associated with availing of mental support. This is an initiative that needs to be introduced at an early age for it to become the norm and considered socially acceptable, an adaptation of such an initiative for third level colleges would be ambitious. However there are aspects that could be drawn from it. It appears to be a source of support that is integrated into the student life, and is a source of support that is accessible both within and external to the education setting.

If a ‘drop in’ centre was to be introduced for college students (one per county) within an established support service such as Pieta House where all students with a college ID card could access at low or no cost, it may make the transition for students from internal college counselling easier and it may encourage students to seek support after it is no longer available within the college (i.e. 6 counselling sessions are up). These ‘drop in’ centres/ student focussed services could be equally funded by all colleges within the particular county and subsidised by the HSE from the mental health budget allocation. The support offered could consist of counselling and medical advice. As noted earlier, the service provided could be at a lower cost i.e. €10 per visit in line with similar costs for the college service on campus.

7.4 ‘What changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (of self and others)?’

7.4.1 Online Counselling Development

Student respondents of this research were asked whether the CIT counselling service provided support confidentially online, would they be more inclined to seek support online for personal problems? Whilst this study has a limited sample both numerically and geographically, there is a strong indication that online support is a welcoming development as a majority of males (87.5%) and females (87%) strongly agreed/ agreed that they would be more inclined to seek support via the internet. It is evident that there is an extremely minimal gender difference (+/- .5%) in students’ response. The emerging call for online support is also recorded by participants in the My World Survey which indicated that “over three-quarters (77%) participants reported they would be likely to use the internet as a source of help” (Dooley, B. & Fitzgerald, A., 2012: 61). It is remarkable that CIT students welcome online support, and interestingly also place strong value in personal relationships with lecturers (as
identified earlier). This is a surprising finding as on the one had a majority of students express the need for online support (distance, not personal, no relationship building) yet, on the other hand express the need for personal informal support (speaking with a known entity i.e. lecturer, face to face contact, relationship exists). Perhaps the focus groups (were they permitted) could have added further depth to this finding and aided in establishing the main causations that would entice students to seek support either online or face to face with a lecturer.

Through the development of technology and the use of the internet, it seems understandable that people search the web for support and answers to their problems. There is a significant body of evidence developing which suggests that young people will access and are using online counselling services. ‘Kooth.com’ an award winning online counselling service for 11-25 year olds based in the UK reports that “82% of users rate the service as either good or excellent” (http://www.xenzone.com/pdf/kooth_info.pdf). Similarly, ‘Kids Helpline’ is Australia’s only 24/7, private and confidential counselling service for youths aged 5-25. In the Kids Helpline 2011 overview, it was noted that a total of “8,941 real time web counselling sessions were provided and all of the 19, 121 email contacts received a reply” (Kids Helpline, 2011: 9).

In contrast to the positive view of the online prospect by students, a majority of interviewees proved reluctant to embrace such a suggested development and were vocally cautious of its development. The SUWOs from the three sampled colleges were hesitant to show support for online counselling, it was the general consensus by all three SUWOs that face to face counselling is the appropriate and necessary support service, however they saw there is some room for online support, almost as a last resort, “I initially wouldn’t have been greatly in favour of it because I think there is something in trying to develop that on a one to one basis. But as time has gone on and the pressure on services, like counselling has increased because of financial concerns etc. Their waiting list has grown to a certain extent, their budget is getting cut back and stuff like that so if it can help ease that on a lower level basis, then I would be in favour of it” – SUWO UCC.

Professional student supports at CIT agree that it is hard to beat face to face contact for the purpose of counselling, however overall 4 out of 6 of the professional interviewees did see some value in such an online counselling initiative. The professional student supports at CIT did not appear negative towards online counselling, rather they were unsure of its potential.
However, since this study was undertaken, a recent report has been published *Bridging the Digital Connect: exploring youth, education and health professionals’ view on using technology to promote young people mental health* (2014) which depicts the views of 900 professionals having completed a survey (Clarke et al., 2014). The results from the report detail that there is a desire amongst professionals to utilise online mental health resources and there is recognition in the role of online technologies in the promotion of positive mental health. Therefore the welcoming gap of online supports identified between CIT support professionals and CIT students appears smaller on a broader scale. Further, in Ireland there are online supports available at Turn2me.org. The ‘Engage Programme’ at Turn2me offers weekly 1 to 1 online counselling sessions with a professional counsellor or therapist which are held over an 8 week period for persons aged 18+.

Concern was expressed by some of the professional interviewees in this context that ‘face to face’ counselling is needed in certain areas. Indeed the ‘Engage Programme’ acknowledges similar concerns as to scope and that it is not thought to be suitable for all types of problems in a persons’ life and that people experiencing any of the following should seek professional face-to-face support elsewhere:

- At risk of seriously harming yourself.
- Experience severe and/or long-term anxiety/ depression.
- Experience personality disorder, bi-polar disorder or psychosis e.g. schizophrenia.
- Suffer from substance abuse.
- Experienced childhood abuse/ neglect or severe adult trauma.
- Not comfortable/ familiar using the internet.
- Under 18 years of age (https://www.turn2me.org/engage-over-ride).

It must be noted that whilst these guidelines exist and strive to be adhered to, due to the nature of online programmes, anonymity can be upheld and therefore the individual may not identify themselves as a sufferer, for example, of childhood neglect and continue to use the programme. This is a potential issue with all online support services.

Bereavement; coping with traumatic events; coping/adjusting with change; depression; general personal development are some of the common issues that have been identified/ addressed in one to one online therapy thus far (Turn2me, 2009). These are issues that are common for third level students to experience and it is acknowledged widely further
emphasis needs to be placed on supporting students in such distress. An evaluation strategy is in place where by those taking part “complete various questionnaires and outcome measures to ensure that we can evaluate progress over the course of therapy (as well as being able to evaluate our service over time)” (https://www.turn2me.org/engage-over-ride). However, while it is acknowledged that evaluation is being sought, there is no evidence of what the evaluation on the site is detailing, for example, is there positive or negative feedback from programme users.

Focusing more closely on third level colleges, Freja Petersen and Amy Colla presented ‘The integration and experience of structured online supported programmes in Student Counselling at Trinity College Dublin’ at the Technology for Well-Being International Conference, Dublin 2013 (http://ie.reachout.com/wp-content/uploads/2013/09/Integration-and-experience-of-structured-online-support.pdf). SilverCloud originated from a TCD project on technology and mental health and the TCD student counselling service were also involved in designing the platform and writing programmes so that confidential, interactive online programmes with weekly support and feedback from counsellors would be available to TCD students.

Like the ‘Engage Programme’ SilverCloud in TCD is concerned about use of the platform by students at risk (http://ie.reachout.com/wp-content/uploads/2013/09/Integration-and-experience-of-structured-online-support.pdf) and has taken measures to address these recurring concerns. When a student would sign up for one of the three available programmes: ‘Mind Balance’; ‘Mind Balance Anxiety’; ‘See Myself’ - students would fill out a preliminary form/ questionnaire, and where there are risk indications the counsellor calls the client to further assess and offer face to face screening if it was deemed necessary.

Some of the reasons why students stated they chose to utilise SilverCloud as a support service (detailed at the technology for well-being conference, 2013) was because:

- They saw obstacles in attending face to face counselling,
- It was more flexible,
- General preference for online (felt more comfortable),
- Suggested to them (students were informed of the service via email),
- Embarrassed seeking help face to face (didn’t feel that there problem was that bad)
These reasons from the TCD students resonate precisely with the findings from the CIT student survey herein. Some students detailed that the reason why they chose to utilise the ‘SilverCloud’ support service was because it was suggested to them, this is reflective of the second SSIS report (as detailed in Section 7.2) that students were more inclined to take up the support service when it was pro-actively offered to them. Again, there appears to be lessons for development of online counselling at CIT in this regard also.

It is important to note that formal support providers at TCD also reported benefits to online counselling provision and these comments may assuage some concerns expressed by CIT support provider interviewees. Some of the reasons that TCD Counsellors gave as to why they like to utilise ‘SilverCloud’ (detailed at the technology for well-being conference, 2013) were because:

- It is a break from face to face work,
- They have time to think before responding,
- It is easy to use for therapists,
- Time per review (6-8 reviews can be done in under an hour)

Some challenges that the counsellors faced:

- The feeling of sending into a void,
- Not working in depth

One TCD Counsellor stated “I don’t think it’s a substitute for one to one therapy, but I do see it as an extremely valuable resource for the students who will not attend one to one therapy for whatever reason” (http://ie.reachout.com/wp-content/uploads/2013/09/Integration-and-experience-of-structured-online-support.pdf). It is evident that the positives of this online support initiative far out-weigh that of the negatives, in terms of reach - whilst it is hard to over-state the importance of face to face counselling and building a relationship between a therapist and the client, it is imperative, as noted by the TCD counsellor, that there is another form of support for students that will not attend one to one therapy and are struggling with certain types of issues.
Examples of three different case study successes in the ‘SilverCloud’ service (detailed at the technology for well-being conference, 2013) where the online support was triumphant in:

(1) Its initial purpose, i.e. provide student support online;

(2) Bridging a student from online support to face to face counselling;

(3) The integration of both face to face and online support for during the summer months.

It has been noted that TCD was the first college in Ireland to introduce a Mental Health Policy, this has been followed by several colleges in the introduction of Mental Health Policies/ Guidelines/ Strategies in some cases. Similarly, they are the first college to implement an online support strategy for third level students. As such TCD has emerged as an innovator in the development of mental health initiatives for third level students in Ireland and must be admired for this.

There is no evidence to suggest why a similar initiative of online counselling could not be developed and introduced in CIT. There is a demand for it with a high majority, over four-fifths of the total student participants (M = 175 (87.5%)), (F = 86 (87%)) sampled stating such. Society is constantly developing, changing and evolving, especially through technology. It is imperative that support services for youths also develop, change and evolve to ensure that an adequate appropriate level of support is provided to ensure students well-being.

7.4.2 Introduction of a Mental Health Policy

The impact of the introduction of a college wide Mental Health Policy at TCD and UCC is yet to be independently assessed. Certainly the absence of such a college wide policy does not appear to effect the availability of counselling services, nor the duration of the service provided. When the counselling service that was provided to students was addressed between TCD and CIT, substantial similarities were indicated in the nature and duration of the service provided. There was no evidence that suggested CIT provided a different level of support due to a lack of a Mental Health Policy in place (see Section 6.1.2).

However, when professional student supports at CIT were asked if they believed there was need for greater institute guidance when supporting a suicide bereaved student and if they
saw value in the introduction of a Mental Health Policy - the unanimous response was astounding.

All of the CIT student support interviewees identified that there needs to be further institute guidance for both professional support staff and for academic staff, in relation to supporting suicide bereaved students. It is unsurprising that interviewees included academic staff in this need assessment for an Institute wide policy; due to the nature of the established pastoral role lecturers play in CIT (see Section 7.2.1). Furthermore the perceived positive value seen in the introduction of a Mental Health Policy was also unanimously shared. This may be as the development of institute guidance on suicide could fall under this umbrella. DNSRF similarly indicated a high level of necessity for shared staff/student Mental Health Policies in third level settings, “I think it’s crucial. It is crucial for both parties, so to have programmes and evidenced informed projects for the students but equally so for staff. Particularly because of a relatively high rate of suicide and self-harm amongst young people”.

Reach Out mandates that third level education organisations should, “Review, adapt if appropriate, and disseminate mental health promotion, suicide prevention and critical incident management materials and resources for third level colleges (such as The Mental Health Initiative, 2003, Trinity College Dublin and the Northern Area Health Board)” (National Office for Suicide Prevention, 2005:24). Therefore there is an obligation on higher education institutions to establish what students’ perceptions and experiences are of suicide, so that they can take appropriate actions to support them in a positive manner and an established precedent to do so in a single Mental Health Policy for the college. The National Office for Suicide Prevention introduced ‘Reach Out’ – A National Strategy for Action on Suicide Prevention in 2005, setting out a range of actions for governmental and non-State bodies in this regard until 2014 and support initiatives at third level should be viewed as part of that larger drive.

As indicated in the literature review, mental health and the development of allied community supports have received greater focus at policy level in recent years. Third level education providers have begun to further address mental well-being of the student community in recent years. The logic of this goes far beyond crisis management - “Students’ mental capital and mental well-being are determinants in their engagement in the student experience process” (The heads of the Irish Association of University and College Counsellors - www.hea.ie). One initiative, as noted, has been the introduction of a Mental Health Policy or Guidelines or
Strategies at a number of third level colleges. The existing policies developed to date share the characteristics of clear guidelines for staff dealing with students in both acute and non-acute situations and support services available to the students and their opening times. (See, for example, *Trinity College Dublin: Student Mental Health Policy and Guidelines* and *U.C.C. Student Health Policy. 2010*). “Third level institutions have the opportunity to influence attitudes to mental health and help seeking among all students” (National Office for Suicide Prevention, 2005:25). While all universities and colleges now have some form of mental health response in place it should, of course, be questioned just how adequate and effective they are.

As mentioned above Trinity College Dublin was the first third level college to introduce a Mental Health Policy in 2008, soon followed by University College Cork in 2010. Both policies are quite short consisting of 15 and 19 pages respectively. Commonalities are found in both policies in the following aspects:

a. **Admissions, disciplinary policy and procedure:**
   In relation to admissions, mental ill health is viewed as a disability by both colleges, and expectations of disclosure on such a disability are expected of the student to primarily benefit the student. Alternative arrangements for examinations can be provided once the student has registered with the disability services (University College Cork, 2010; Trinity College Dublin, 2008). This appears as though it would work quite well for students that have been diagnosed with mental health issues/ illness, however it does not detail the requirements needed to be eligible or considered disabled due to mental health.

   All students are subject to their particular college’s student rules, however allowances are provided by both colleges in such cases whereby the student is a danger to him/herself (Trinity College Dublin, 2008) or his/her mental health difficulties are preventing understanding or are in fact the cause of the actions (University College Cork, 2013).

b. **Guidance on dealing with students experiencing mental health difficulties; support services available in the college to be used in both acute and non-acute situations:**
   Depending on the severity of the situation different services are contacted: the Chaplaincy, University Counselling, College Student Health Services, Security, Senior Tutor. External services included SouthDoc/DubDoc, ambulance, Gardaí, A&E in various hospitals. External services are only to be contacted in the event of an emergency case.
Guidelines are provided in both instances on what constitutes urgent (e.g. very aggressive or suicidal) /non-urgent (e.g. tearful, unduly anxious) situations.

When student support professionals from TCD and UCC were asked if they had noticed any benefits or difficulties posed since the introduction of the Mental Health Policy, the response was surprising. Professionals from both colleges were unfamiliar with the effects (if any) of the introduction of a Mental Health Policy in their college. This coincides with other findings from this study which reveal that student support services provided may not directly differ as a result of a Mental Health Policy or lack of. Substantial similarities were found in the nature and duration of the counselling services provided from all three sampled colleges (UCC, TCD and CIT).

Cork Institute of Technology appears to have the means and services equal to TCD and UCC albeit on a relatively smaller scale, but the Institute lacks a single Mental Health Policy for all. Whilst a published strategy/policy does not mean effective services are available for use on the ground the value of a single policy for all students and staff in the academic community was explored. Professional student supports from TCD and UCC were asked if the effectiveness of the implementation of the Mental Health Policy on services had been evaluated in any way. The findings revealed that periodic evaluation of services is not included in either Policy and periodic evaluation is not something that is required by the Policy. However, it must be noted that evaluation was reported as being conducted on some level in both TCD and UCC on the service being provided but not specifically as to the effects of the Mental Health Policy.

CIT is currently in the process of developing a Mental Health Policy, of which this research study is assisting in. One area that evidentially should be included in this policy is guidelines for its implementation and guidelines for its evaluation. A recommendation arising from this study will be directed specifically to the committee drawing up the inaugural policy for consideration. DNSRF details how a Mental Health Policy at Third Level is best evaluated, "It would be important to have independent evaluation because if implementation and evaluation happens by the same stakeholders I think there could be bias or people could even overlook certain important outcomes. It is also important that when people implement a certain policy, that they monitor how they actively and pro-actively can do that". It is evident that CIT already conducts both external and internal evaluation on certain services. The Mental Health Policy (were it to be introduced) would ensure that all services are evaluated
both internally and externally in line with the impact/effects that the Mental Health Policy has (if any).
7.5 Strengths and Limitations

This research study entailed roadblocks in ensuring that a mixed method grounded theory approach was adopted; delays and some curtailment presented, however the participatory ethos was achieved through interviews held and student surveys secured. “Grounded theory strategies prompt early analytic thinking and keep researchers interacting with their data” (Hesse-Biber & Leavy, 2008: 156). This was endeavoured with intent of conducting the interviews after the questionnaire had been distributed, collected and analysed. It was planned that findings from the questionnaire would then be interpreted into the interview schedule(s) where appropriate. However, the grounded theory approach also further determined the high level of ethical approval that was needed to conduct this research with all relevant community participants. In an effort to ensure students well-being, the time of distribution of the questionnaire had to be changed following consultation with of relevant parties: Heads of Departments; Supervisors; the Researcher. It was decided that it would not be in the students best interest to distribute the questionnaire so close to their final summer exams (the time ethical approval was received).

Due to time restraints of this research study the interviews had to be conducted prior to questionnaire distribution. However, Hesse-Biber and Leavy suggest that “grounded theorists choose or create specific methodological strategies to handle puzzles and problems that arise” (2008: 156). In this regard, the researcher faced a problem of research format. It can be observed that the research was governed by the identified approaches. Whilst the inability to redraft interview schedules to reflect student survey responses was a limitation on the original research plan, the extensive consultation and multiple drafts of the survey did include the input of many other key stakeholders in the CIT community. The time and co-ordination required in such consultation is not to be underestimated, particularly in light of the limitations of a set period for post graduate degree and the academic calendar and availability of students.

The researcher was acutely aware of the sensitivity of the topic and how imperative it was to ensure that all necessary precautions were taken to anticipate and cater for students at risk and to ensure that voluntariness and anonymity of participation was secured at all stages. Also, in line with the CIT Code of Good Practice in Research (2005), for all research involving human participants, harm minimisation in participation was a priority. The high
level of ethical approval that was needed to conduct this research was amplified by the adoption of the mixed method, grounded theory paradigm.

However, having sought and designed an ethical protocol that reflected views of a range of community participants, it was adhered to, and as a result, an aspect of the original research design had to be abandoned. One particular attempt was to gain a qualitative, in depth voice from the students of CIT by planned focus groups, but due to the effective ethical protocol in place, a CIT Counsellor identified that some of the students that have put their names forward to participate in the focus group, might be doing so in the hope that this would help them; this was not and never had been the purpose of the focus groups. This point (identified by the CIT Counsellor), in conjunction with a meeting held between the researcher and one participant (see Section 5.7.11 Harm Minimisation), led to it being determined that the focus groups would not be conducted. Potential for distress remained among potential participants and no prevention or mitigation of such risk could be secured in the time frame for the research. In this regard, the ethical protocol that was developed and approved by the CIT Ethics Committee and the CIT Student Affairs Manager was effective in its application and secured its purpose of safe-guarding and ensuring students well-being. On the other hand, the loss of the discourse between students on the topic, in the form of focus groups was regretted, particularly as the pilot focus group had been fruitful (details of which have not been disclosed as part of this research study due to confidentiality, see Appendix X for pilot focus group method).

Due to the voluntary nature of this research, all participants were merely encouraged to answer truthfully when expressing their views or sharing personal experiences, however, no guarantee can be given that all information provided was truthful and honest. Similarly, as the questionnaires were completed in a classroom setting and many students were sitting next to peers, this may have influenced the participants’ responses and therefore this may have impacted on the accuracy of their answers. With hindsight, there is a growth in public use of internet and it must be noted that ‘online surveys’ might have been another form of beneficial survey distribution. Rubin and Babbie (2010) suggest that the anonymity of online can facilitate responses in what are recognized as ‘sensitive’ areas. This may have resulted in a different response rate. It must also be noted that online surveys are less expensive and less
time consuming. Students would have had the opportunity to fill out the questionnaire in their own time and also perhaps in the comfort of their own home.

However, Rubin and Babbie (2010) also suggest that distributing the surveys ‘face to face’ creates further opportunities: students would have the opportunity to clarify confusing items and the researcher/ distributer has the opportunity to observe participants responses. It was decided imperative that the questionnaire be administered in a physical format rather than online to ensure students well-being and address any queries they may have. This was another of the many steps taken to ensure filling out the questionnaire would not have a negative effect/impact, in line with the CIT Code of Good Practice in Research (2005) ensuring that all research involving human participants prioritizes harm minimization. As indicated in the Methodology Chapter a support person was also available where the survey was distributed and information sheets were provided to all survey participants.

Barnes (1996) suggests that it would be helpful for the grounded theory researcher to have experience of the culture of the respondents, either by working or living in their culture prior to investigation. As the researcher was a student and member of the CIT community for 4 years at the onset of this research study, one could assume that understanding and knowledge of injustices was acquired and a strong sense of responsibility is carried to ensure injustices do not persist.

However, whilst the reality of the researcher being a student of the CIT community is seen as a strength (as noted above), it could also be recognised as a possible limitation. The ‘interviewer effect’ can be defined as “the change in a respondent’s behaviour or answers that is the result of being interviewed by a specific interviewer”. As the interviewer/ researcher was a postgraduate student, it may have had an effect on the interviewees responses (particularly the CIT interviewees). Respondents may have viewed the research of less importance and only for academic purposes rather than an attempt to create change. Yet on the other hand, the respondents may have engaged more in the interviews as the research was being conducted by a community member that is knowledgeable of the college’s position regarding the provision of student services. The researcher noted a transition in two of the CIT interviews. At the onset of the interview, respondents were quite distant and formal in their response, however on conclusion of the interview, respondents became more engaged
and enthusiastic. Perhaps this was because the ‘interviewer effect’ provided them with pre-conceived ideas, however these appeared to change during participation of the research.

One area of weakness that emerged from this research was an apparent flaw in the research method regarding a question from the interview schedules. SUWOs from all three sampled colleges identified a gender difference in the students attending their service and, perhaps surprisingly, males predominated in this instance. According to the SUWOs, males are more inclined to seek support from SUWOs than females, this is also reflected in Table 6.6.3 of the results chapter which does suggest that males prefer seeking support in an informal familiar setting.

However this gender difference conflicts with findings from the student survey which indicates that females detailed a higher awareness and usage of student supports. This reveals a flaw in the research method; there should have been greater clarification in the breakdown of support sought from Student Union Welfare Officers i.e. was it for financial support, accommodation support or health/ mental health support that males were presenting predominantly for at the SUWOs’ office.

Future research in this area could include a focus on Student Welfare Officers alone: record the number of male and female students that present to them on an annual basis, identify the presenting issues that the student discloses (for example: first year student states there are issues with current student accommodation and they are looking to move elsewhere) and if this changed or other issues emerged throughout their meeting (for example: the student reveals that s/he is struggling living so far away from home, s/he feels isolated and excluded, s/he hasn’t been feeling like themselves and feels very low a lot of the time). This has potential to establish if students are presenting to student union based supports i.e. SUWOs for mental health difficulties/ issues and could give rise to the development of evolving student based supports for students with mental health difficulties at third level.

The combinations of qualitative and quantitative research methods added strength and depth to the research because it allowed the combination of the richness and uniqueness of qualitative data and the precision and discipline of quantitative data and therefore can be seen as a strength. Further, the grounded theory emphasis on inclusive research methods reinforces
the validity of the research, as views were obtained by both the students and the support providers.

Despite the losses identified above in the capture of data as a result of the application of the transformative paradigm, the advantages were foundational to the ethos of the study. This research was community centred and ensured authenticity by voicing those within it. An audit trail documents the research steps taken from the start of a research project, tracing the procedure. An audit trail (see Appendix XVIII) was conducted as part of this research, which is a useful strategy for determining the trustworthiness of qualitative inquiry and re-in forces where validity is evident. Convergent validity is also evident as this research study’s findings are in agreement and reflective of recognized, established studies such as the My World Survey.

Surveys are particularly useful when we describe the characteristics of a large population (such as a third level college). Rubin and Babbie (2010) suggest that because surveys make large sample research feasible, the findings are generalizable. As this research was primarily specific to CIT, and the sample was representative of CIT, the research findings can be generalized for the main college campus of CIT. However, the research findings cannot be generalized to all colleges in Ireland. It could be worthwhile to do similar research, with replicated methods in other third level Universities and Institutes of Technology and Colleges of Further Education. It would be interesting to highlight differences in facilities, funding, and support given by a range of Irish colleges to students with regard to mental health. Similar research could also help to outline further barriers and determinants influencing third level students engagement in mental health support services. Such a research approach could also provide students with mental health difficulties a voice, a voice to help further develop facilities and environments that may help alleviate barriers that may exist in support seeking.

“Inter rater reliability measures are being increasingly suggested, it seems, by reviews as part of grounded theory or interpretative methodologies” (Symon & Cassell, 2012: 193). Whilst the coding scheme was identified as part of this research, and appeared a reliable format as it could be followed by any other researcher, inter rater reliability was not conducted as part of this study. This is a limitation of the study as the strength/ reliability of the coding scheme
was not tested. However, whilst some qualitative researchers argue that assessing inter rater reliability is an important method for ensuring rigor, others do however argue that it is not so important.

This research identified that a majority of CIT students would be more inclined to seek support online. Future research could determine, the level of support that could be offered and the level of support that students are looking for (i.e. is it for general queries regarding mental health or is it for those struggling with moderate/ severe mental health difficulties). What are frequent queries for students in relation to mental health that could be covered? Evaluation of the effectiveness of online counselling/ support could be conducted.
7.6 Discussion Conclusion

Through the researcher’s investigation of the research statement an insight was gained into gender differences when processing death by suicide and attitudes amongst third level students aged 18-25 attending CIT and professional stakeholders.

7.6.1 – Do Gender Differences Exist?

Students’ awareness/knowledge of existing support services in CIT showed a significant gender difference. Whilst throughout the research study, minor variations between genders could be seen, this was the primary section of the study where major differences were identified. There was a high majority of male respondents (110) that did not indicate any awareness of supports, a percentage total of (55%), over half of the respondents, which is stark. A significantly lower number of female respondents (16) did not indicate any awareness of supports, a percentage total of (16%).

Published research suggests that many men still view any ‘feminine’ characteristics as weak including calling for emotional support, expressing feelings that are not masculine; crying, displaying fear. It can be speculated that this, in turn, contributes to the young male’s lack of initiative to seek support when going through the loss of someone by suicide, this argument is further supported by findings in this research; from the 99 males that indicated they had experienced the loss of a loved by suicide, a mere 6 sought professional support. “Being tied to rigid forms of masculinity which prevent disclosure of fears as well as discussion of emotional needs places some young men in an unhealthy environment both socially and psychologically” (Cleary, 2005:50). It appears that men do not want to be seen in a vulnerable position of ‘help seeking’ as it seems that is ‘displaying weakness’ on their part.

However, one striking finding that contradicts this was the SUWOs from all three sampled colleges identified an opposing gender difference in the students attending their service, surprisingly males predominate by far the largest cohort in this instance. According to student support professionals, males are more inclined to seek support from student based supports than females, this is further reflected in table 6.6.3 of the results chapter which does suggest that males prefer seeking support in an informal familiar setting. However it has proven to be one area of weakness that emerged from this research. A flaw is revealed in the research method; there should have been greater clarification in the breakdown of support sought i.e. was it for financial support, accommodation support or health/mental health support that males were presenting predominantly for at the SUWOs’ office. Put plainly, whilst there
might have been more males attending the student based support service, it may have been for more innocuous issues than that of mental health, for example: free condoms are provided by the welfare officer which may draw men into the office but it can be questioned if they’re there for support in relation to safe sex or is it the free condoms?

Reflecting back at awareness of services in further detail by focusing on suicide bereaved students revealed a further insight; almost the exact number of males [37, (37%)] that expressed awareness of services also stated usage of the student services [34, (34%)]. The overall number is still low, however this is striking as it leads one to query if males only seek out services when there is intent to use them. If this is so, this would also suggest a need for easy access to information on student services at all times.

In contrast to this, female respondents (suicide bereaved) detailed a high level of awareness of services with 90% detailing such. Whilst a greater knowledge of services is expressed there is only a marginal difference (37.5%) in females take up/ usage of services with 52.5% stating usage of services. However, the results on females usage of professional services reflects previous published research (i.e. women are more inclined to seek help than males as detailed in YMSP, 2013), and remains higher than males (+/- 18.5%). This is further reflected in the fact that when participants were asked to detail services found to be helpful/ extremely helpful, female respondents indicated that they were slightly more inclined to seek professional support and rate those supports as useful. This implies that women are more inclined to acknowledge that there is an issue and seek help in relation to the issue. This was further reflected by student support providers as part of this research study as they identified gender differences in how the issues were presented by both male and female students, “Males are less inclined to meet you face to face. Males usually present quieter. I find they are not as talkative so it takes longer to work out. Females, they are more up front with you straight away and more trusting” – CIT Nurse.

7.6.2 – Is there a need for new initiatives?

Some third level students are evidentially going through a difficult period in their lives and services are looking for ways to reach them. Identified above is a gender specific issue of support awareness and how issues are raised in support settings. However, this study identified that this was predominantly the only area of significant gender difference in relation processing a death by suicide. There are other areas of Mental Health Promotion that
can be addressed for development that are gender neutral (as evidenced throughout the study).

In relation to support seeking, there is a significant body of evidence developing which suggests that young people will access and are using online support services, as previously detailed in the Literature Review (‘kooth.com’ in the UK; ‘Kind Helpline’ in Australia). No noticeable gender difference was recorded in this regard.

An online counselling initiative has been implemented in TCD and the evaluation proved positive outcomes for students and staff. Some of the reasons why students stated they chose to utilise SilverCloud as a support service was because: they saw obstacles in attending face to face counselling; it was more flexible; general preference for online (felt more comfortable); suggested to them (students were informed of the service via email); embarrassed seeking help face to face (didn’t feel that there problem was that bad). Some students detailed that the reason why they chose to utilise the SilverCloud support service was because it was suggested to them, this is reflective of the second SSIS report (2013), as students were more inclined to take up the support service when it was pro-actively offered to them.

The introduction of online support/ counselling is an area of exciting new development and the reasons CIT students gave for not accessing current formal supports on campus are neatly answered by the TCD student’s reasons for embracing the ‘SilverCloud’ initiative. There was an overwhelming supportive response provided by student respondents to the idea of online counselling with minimal gender difference (+/- .5%) 

Aspects of pro-active facilitation of support services have potential to be achieved through emailing students informing them of services available and inviting them to avail of them. Further to a written email, a video which could cover carious aspects of mental health and visually detail what the service is, where it is and what you can expect a session to be like, was met with overwhelming approval by interviewees and needs to be constantly available, e.g. on the ‘mycit’ webpage, rather than limited to first year induction. However, if aspects of pro-active facilitation are to be conducted, the service must be in a position to uphold what is being offered, for example, availability.

As previously indicated, CIT has a reputation for lecturers taking on a ‘pastoral role’ and the Institute has emphasised the informality and closeness of the staff/ student relationship. The
key role of lecturers as first points of contact for students and as key referral points could be further utilised to encourage students to seek support from professionals and echoes the point made by DNSRF as to the potential of lecturers as ‘gate keepers’. The informative training of front line staff: lecturers, tutors and secretaries so they may act as ‘gatekeepers’ is an area of development that is inviting as it is partially already being undertaken by individuals. The purpose of the training would be to further ensure both student and staff safety when/ if they are dealing with delicate situations. The ‘gate keeper’ training has been evidenced by the WHO, 2010 as a preventative (suicide) effort for particular sub groups such as: substance abuse; financial debts; study stress, all of which are arguably evident in Third Level Settings.

In relation to the introduction of Mental Health Policies, it has emerged that the existing policies at third level in TCD and UCC do not require that periodic evaluation be conducted to establish the effectiveness of its implementation. Whilst evaluation was reported as being conducted on some level on the individual service being provided i.e. counselling service, there was none specifically as to the effects of the Mental Health Policy. It appears that this is an area of needed development, otherwise the effectiveness of the Mental Health Policy remains unknown, similar to the extent to which it has been implemented.
7.7 Recommendations

1.) Training Opportunity - This research revealed that lecturers are an important source of support for CIT students. In line with the safeTALK programme that is already available to students and staff at CIT, the potential positive outcome of introducing a further safekeeping programme such as one entitled ‘gatekeepers role’ is a necessity. This programme could be facilitated by the counselling service (similar programmes have been presented by the counselling service in other colleges), to ensure that it is cost effective and immediately relevant to CIT. The student counselling service would have extenuating experience with current presenting student issues and would be in an excellent position to provide direction on what it is to be a ‘gatekeeper’ for academic/ front line staff at CIT, and inform them that indeed, many have already been fulfilling this role. The value of developing in house training returns to the positionality and authenticity of the community voice and has strengths over bought in programmes (the safeTALK programme being purchased by the HSE from the US).

The purpose of offering further training would be to further ensure both student and staff safety when/if they are dealing with delicate situations. The training could be offered to staff at the beginning of each semester, whereby it would be either a half day/ day programme. The priority for roll out would be to Heads of Departments and Course Co-ordinators and thereafter to all active teaching academic staff in line with the My World Survey principle and the findings of this study.

2.) Aspects of Pro-Active Support – Findings from secondary research and perspectives held by interviewees suggest that aspects of pro-active facilitation of support is an area of development in third level colleges that should be addressed. This research study aligns itself with other Irish research such as the My World Survey revealing that many third level students (in CIT in this instance) are evidentially going through a difficult period in their lives and services are always looking for ways to reach them, having a pro-active approach is one.

Two aspects of pro-active support have been identified during this research as potentially useful in CIT: to send an email to students informing them of a particular service and inviting them to try it (as seen in TCD, and further to a written email, attach a video which would cover various aspects of mental health and visually detail: what the service is; where it is; who you would expect to meet. This can take some of the fear away as they are aware of
what they will be greeted with, should they choose to attend the service. However, if a pro-active approach is to be taken with a service, the service must be in a position to uphold what is being offered, i.e. availability.

Further research could evaluate the effectiveness of using aspects of pro-active facilitation by recording the number of students presenting (are they increasing/ decreasing) but also by means of recording how the student came about using a particular service (word of mouth or by means of an email which prompted them to go and seek help).

3.) Online Support – This research reports that an overwhelming majority of CIT students identified that they would be more inclined to seek support were counselling services available online. The introduction of online support/ counselling presents as an area of exciting new development and it should be addressed by more third level colleges. There is a significant body of evidence developing internationally which suggests that young people will access and are using online counselling service. Such an initiative has been implemented in TCD and the evaluation proved a positive outcome by both staff and students at TCD. There is no reason why other third level colleges (such as CIT) could not develop a similar initiative.

Further research in this area could establish what the main areas of concern are for students that would motivate them to seek support online. A descriptor of the service could be established i.e. the level of support online counselling could provide (this is evidenced in TCD whereby students’ progress to ‘face to face’ counselling where further support is deemed necessary. Evaluation should also be conducted as part of the development of this new initiative whereby both students and staff provide feedback on their experiences and identify issues (if any).

4.) Mental Health Policy Introduction – This research study identified that all CIT interviewees concurred that there needs to be further institute guidance in relation to supporting suicide bereaved students. There is also strong value seen in the development and introduction of a Mental Health Policy (particularly as the development of institute guidance on suicide could fall under this umbrella). CIT are currently developing a Mental Health Policy, the first draft of which was due to be submitted 12th May 2014. This draft will be assessed by a number of selected committee members (consisting of those involved in student services). A further draft is then due to be drawn up. One area that has been excluded from previous Mental Health Policies is its evaluation. The Mental Health Policy (for CIT) should
consist of guidelines of its implementation and its evaluation. Evaluation should be conducted internally and externally and it should be done on an annual basis.

The evaluation on the implementation of a Mental Health Policy at CIT will further determine its purpose and the level of its effectiveness as this could not be identified by the interviewee participants of this study (TCD SUWO, UCC SUWO) where Mental Health Policies had been in place for over 3 years.


Bunreacht na hÉireann (Constitution of Ireland, enacted in 1937), Articles 41 & 42.


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Appendix I

Includes:

- Questionnaire Cover Letter

- ‘Suicide Awareness’ Questionnaire
Suicide Awareness

My name is Sandra Conroy, I am a Social Care graduate and currently an MA postgraduate student of CIT. The purpose of this questionnaire is to research how young people respond to emotional problems, including dealing with a death by suicide.

The research aims to find out what professional college supports CIT students are aware of, their use/potential use of such services and if there is a gender difference in relation to both their attitudes and usage of them. In addition, the research aims to look at what further initiatives/support services could be developed and introduced to further help the mental health of CIT students.

I appreciate that this is a very sensitive subject. If there are questions that you find too difficult to answer, then just skip it and please note the sources of help and support listed on the information sheets attached.

You are in no way obliged to fill out the questionnaire. It is completely voluntary and you have the freedom to withdraw from participation at any stage. The only personal facts that are required in the questionnaire are your gender and age. Everything that is answered will still be kept strictly confidential. I would be very grateful if you could answer as honest as possible as to establish where more work is needed to better support those in such circumstances.

*If you are affected by filling out this questionnaire please find attached an information sheet with a list of support services that can help.*

If you would like to participate further in this research, focus groups will also be held. Please find attached a form detailing in general what these will consist of.

Kind Regards,

Sandra Conroy
Postgraduate Research Student
Email: sandra.conroy@mycit.ie
Section A: Support Services in CIT

1. Please tick one: Male ☐ Female ☐

2. Age _________

3. Any suicidal gesture, no matter how "harmless" it seems, demands immediate attention. Please tick one:
   Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐

4. If you suspect someone may be at risk of suicide, it is important to ask them directly about suicidal thoughts. Please tick one:
   Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐

5. What professional support services in CIT are you currently aware of for students who have experienced the suicide of someone they know? Please name these.

   * ____________________________   * ____________________________

   * ____________________________   * ____________________________

   * ____________________________   * ____________________________

6. How are you aware of the services that you mentioned in the previous question?

   Please tick as many as relevant:
   - Orientation/Induction ☐
   - Notices/Posters ☐
   - Student handbook ☐
   - ExpliCIT & other CIT publications ☐
   - What's On ☐
   - Word of mouth ☐
   - CIT website ☐
   - Other (please specify) ☐
7. The Counsellor is now ONLINE!! Some counsellors are now providing counselling support online to the public. Any problems or questions that people have can now be addressed over the computer.

“If CIT counselling service provided services confidentially online, I would be more inclined to seek support for personal problems.”

Please tick one:

- Strongly Agree ☐  - Agree ☐  - Disagree ☐  - Strongly Disagree ☐

8. Please complete either A or B, whichever one best reflects your opinion:

A. If I had a personal problem I would seek support from the professional student support services at CIT because...

B. If I had a personal problem I would seek support from the professional support services outside of CIT because...
9. **Please tick where appropriate:**

Since I have begun my studies at CIT, for **personal problems (excluding physical)**, I have found the following supports to be:

<table>
<thead>
<tr>
<th></th>
<th>No help at all</th>
<th>Slightly helpful</th>
<th>Helpful</th>
<th>Extremely helpful</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Service</td>
<td></td>
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<tr>
<td>Medical Centre</td>
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<tr>
<td>Chaplaincy</td>
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<td>Students' Union Welfare Officer</td>
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<tr>
<td>Year coordinator</td>
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<tr>
<td>Lecturers</td>
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<tr>
<td>Sports/ Hobbies trainer</td>
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<tr>
<td>Head of Department</td>
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</table>

10. (i) Since you have begun your studies at CIT, have you ever worried about some of your college friends/peers being suicidal?

   No ☐  Yes ☐ → **If yes, how many?_____**

(ii) If you **have** ever worried about some of your college friends/peers being suicidal, what did you do?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Talk to them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to other friends/peers</td>
<td></td>
<td></td>
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<tr>
<td>Talk to professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to my own family</td>
<td></td>
<td></td>
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<tr>
<td>Other (please specify)</td>
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</tbody>
</table>
11. **Please complete the following statement:**

The advice I would give to CIT support services with respect to helping students with personal problems, including dealing with a death by suicide is...

*If you have ever experienced the suicide of someone you knew, please continue. If not, the questionnaire is now complete, thank you for your participation.*
Section B: Personal Experiences

12. If you have experienced death by suicide of any of the following please tick the yes box & indicate the gender. If not, please tick the no box.

*Note:* If you have experienced the suicide of *more* than one of the following please indicate the number in the gender box.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>✓</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Friend</td>
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<tr>
<td>Family member</td>
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<tr>
<td>Relative</td>
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<td>Neighbour</td>
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<tr>
<td>Other</td>
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13. Did you ever seek professional support when trying to come to terms with the suicide of someone you knew? *Please tick:*

No □ Yes □ → If yes, where? CIT □ External to CIT □

14. *Please tick where appropriate:*

*Outside of* professional services, please indicate what *other* supports helped you when trying to come to terms with the suicide of someone you knew?

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<thead>
<tr>
<th></th>
<th>No help at all</th>
<th>Slightly helpful</th>
<th>Helpful</th>
<th>Extremely helpful</th>
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<tr>
<td>Family</td>
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<tr>
<td>Friends</td>
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<tr>
<td>College peers</td>
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<tr>
<td>Church</td>
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<tr>
<td>Other (please specify)</td>
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</table>
15. In response to the suicide of someone they knew, some people drink or eat more, others pray or exercise more and some stop doing anything. What did YOU DO that helped you cope with suicide bereavement?

Please complete the following statement:

I...

...this helped me cope.

16. Have you ever struggled with your academic studies while trying to come to terms with a death by suicide? Please tick one:

Yes ☐ No ☐ Not that I am aware of ☐

17. Please indicate your usage of the following supports in CIT for any personal problem:

<table>
<thead>
<tr>
<th>Support</th>
<th>Never used</th>
<th>Infrequent use (once/twice)</th>
<th>Moderate use (a few times)</th>
<th>Frequent use (several times a year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Service</td>
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<td>Medical Centre</td>
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<td>Chaplaincy</td>
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<td>Students’ Union Welfare Officer</td>
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<td>Year coordinator</td>
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<td>Lecturer</td>
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<td>Sports trainer</td>
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<td>Head of Department</td>
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18. Please complete the following statement:

I found the ___________________________ in CIT particularly helped me in coping with the suicide of someone I knew because...

The questionnaire is now complete, thank you for your participation. Please note the list of support services on the information sheets attached.
Appendix II

Includes:

- Information Sheets
Information Sheet

We All Need To Look After Our Health

Student life can be stressful and it's easy at times to become isolated. There is a lot of support available within the college community, if things are tough at the moment.

If completing this questionnaire has raised any anxieties or concerns, for you or others the following are available and happy to help you:

Within C.I.T.:

- Counselling Service – Located on the 2nd floor of the C.I.T. Student Center (over the Medical Center). The Counseling Center is open between 8.30am and 5.00pm, Mon-Fri. It's CONFIDENTIAL!

Appointments of 40 minute duration can be arranged by dropping in or phoning Shirley on (021) 4335775

- Chaplaincy – Offices are located on D-Corridor (D151) and on the 1st Floor of Student Centre. They are open Mon-Fri, 8.30am to 5.00pm.

Chaplain: Fr. David McAuliffe. Tel 021-4335754. It's CONFIDENTIAL!

Student Support Team Email: chaplaincy@cit.ie Tel 021-4326362

- CIT Students’ Union Welfare Officer – Office located on first floor of Student Centre. Call 021 4335273 or email suwelfare@cit.ie

Here are some useful links also:

http://www.headsup.ie/

www.suicideaware.ie/

http://ie.reachout.com/
A Problem Shared is a Problem

Halved

Some of us find it difficult to talk when we are feeling a little blue or down about something. Sometimes we don’t even know what that something is that’s causing us to feel this way...

You would be surprised how much it really can help by simply spending time with someone you trust; a friend, a relation that you can talk to. How much lighter and more relieved do you think you would feel? Try it and find out! They sometimes know you better than you know yourself...

It’s also a good excuse for drinking plenty

Tea/Coffee
Appendix III

Includes:

- Focus Group Attachment
Would you be interested in further participation of this research?

There will be focus groups held to further discuss some of the following:

- How would you cope in general with the loss of someone by suicide?
- What ranges of supports are in place in CIT to help cope, how could these be improved?
- For what kind of mental health problems would you seek help?
- What kind of services in CIT could be developed that young men would use?

The session will take approximately 1 hour of your time.

If you would be interested, please fill out your details and I will be in contact with you to discuss what will happen and to answer any questions or queries you may have.

Name __________________________

Email address ______________________ or Mobile ______________________
Appendix IV

Includes:

- Consent Form (Head of Department)
- Consent Form (Focus Group Participants)
- Consent Form (Interviewees)
- Letter of Support Provided by CIT Student Affairs Manager
- Letter of Support Provided by CIT Student Union Welfare Officer
Head of Dept. (Consent Form)

I ______________ give permission for two classes of third year students (chosen by me) in the Department of Civil, Structural & Environmental Engineering participate in Sandra Conroy’s research study entitled “Gender differences when processing death by suicide: attitudes amongst third level students aged between 18-25 attending CIT and professional stakeholders”, if they so wish.

The purpose and nature of the study has been explained to me in writing. In particular I note that all participation is voluntary and anonymous. Students in the indicated class cohorts are to be given the opportunity not to participate without comment. I also note that all participants will be alerted to current support services within CIT to promote the well-being of the student.

The name/s of the courses I give permission to be approached in order to secure involvement are as follows:

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<thead>
<tr>
<th>Course</th>
<th>Lecturer</th>
<th>Contact details</th>
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Focus Group (Consent Form)

I ___________________ consent to voluntary participation in Sandra Conroy’s research study entitled “Gender differences when processing death by suicide: attitudes amongst third level students aged between 18-25 attending CIT and professional stakeholders”.

The purpose and nature of the focus group has been explained to me in writing. In particular I note that all participation is voluntary and I have the freedom to withdraw from participation at any stage of the session. Confidentiality is paramount in this research study and I agree to keep all information revealed in the focus group session confidential. I agree to address other participants by the cartoon name tags provided.

I also note that all participants will be alerted to current support services within CIT to promote the well-being of the students involved.

Signature_________________________ Date Signed____________
Interviewees (Consent Form)

I ________________ agree to participate in Sandra Conroy’s research study entitled “Gender differences when processing death by suicide: attitudes amongst third level students aged between 18-25 attending CIT and professional stakeholders.”

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily and realise that I can withdraw at any time without any repercussions and can decline permission for my data to be used.

I understand that a transcript of the interview will be sent to me which I can amend where I see fit.

I understand that extracts from my interview may be quoted in the thesis.

Please tick one box:

I give permission for my interview to be recorded by use of a Walkman and mobile phone □

I do not give permission for my interview to be recorded □

Please tick one box:

I wish to be named as part of this research □

I do not wished to be named or identifiable as part of this research □

Please note that if you do not wish to be named or identified, you will be addressed as a ‘professional expert’ from the service which you provide.

Signature ___________________________ Date Signed ____________
16th April 2013

Sandra,

I am aware, as part of your MA in Social Care, you are planning to conduct research on how young people respond to emotional problems, including dealing with a death by suicide.

My understanding is that a key part of this study is to ascertain the supports available to those who are dealing with emotional problems, including dealing with a death by suicide.

I feel that any study which enhances the quality of Services offered to students is to be welcomed and supported.

I am also cognisant that a study, such as this, can be very sensitive and welcome the fact that students can decide if they wish, to participate or not in this study. I also welcome the fact that you have indicated where students can get assistance and support in a caring, non-judgemental and confidential way, either within the structures currently available at the Institute or external to the Institute.

I would advocate that anyone who is exposed to this study, and does feel the need to talk or seek assistance to trust themselves and take that first step in asking for help and support either for themselves or for another who is experiencing difficulty.

My best wishes with this study.

Dr Dan Collins

(Academic Administration and Student Affairs Manager)
To whom it may concern,

I have reviewed the questionnaire submitted by Ms Sandra Conroy, MA postgraduate student Department of Social and General Studies CIT, for her thesis, and I would like to lend my support to it.

I examined Sandra’s questionnaire and submitted feedback to her which she took on board willingly. I am therefore approving the questionnaire to be distributed to CIT students.

If you would like any further information about my contribution, please do not hesitate to contact me on the phone number above.

Kind Regards,

[Signature]

Niamh Hayes

VP Welfare

CIT Students’ Union
Appendix V

Includes:

- Interview Schedule for CIT Support Professionals (including cover letter)

- Interview Schedule for UCC and TCD (SUWO)
To whom it may concern,

My name is Sandra Conroy. I am a Social Care graduate and currently an MA postgraduate student of CIT. As part of my MA degree I am undertaking supervised research entitled: "Gender differences when processing death by suicide: attitudes amongst third level students aged between 18-25 attending CIT and professional stakeholders." The aim of this research is to gain an understanding of what it is like for CIT students processing a death by suicide, and to find out if there are gender differences in their response to this. The research also aims to find out what professional college supports CIT students are aware of, and if there is a gender difference in attitudes to and usage of them.

As part of this research I hope to interview third level institution support professionals who have experience of working with young students. The general areas that will be discussed during the interviews will be as follows:

- The professional’s view of their role as a support for CIT students;
- The professional’s opinion on policies/ guidelines (if any) in place;
- The professional’s experience of gender differences in students take up of support services;
- The interviewee will also be asked their opinion on what initiatives/additional services could be developed at CIT to better support students faced with suicide bereavement.

Participation is voluntary and the interviewee has the right to stop the interview at any time and also has the right to refuse to answer any question. A transcript will be sent to the interviewee to ensure a fair reflection of the discussion is agreed. Confidentiality will be maintained and matters in relation to the interviewee being named in the research were addressed in the consent form previously provided.

The interview should take approximately 40-60 minutes. Please find attached the interview schedule. Please do not hesitate to contact me if any aspect of the proposed interview needs clarification or further detail.

Thank you in advance for your participation,

Sandra Conroy
Postgraduate Research Student
Email: sandra.conroy@mycit.ie
Phone: 086-2064810
Interview Schedule for CIT Student Support Professionals

A. Role
1. What do you see as your role with regard to supporting students?
   1.1 In the event of a student presenting with a mental health emergency at CIT, what do you see as the available supports within the institute?
   1.2 How do the various support professionals at CIT co-ordinate a response?

B. Policy/Guidelines
2. What, if any, mental health policy/guidelines exist to assist staff in supporting the mental well-being of current and prospective students?
   2.1 If a student has recently experienced a death by suicide, what (if any) guidance is provided to staff on appropriate responses?
   2.2 What provision is there for acknowledging extenuating circumstances for academic purposes for a suicide bereaved student?
   2.3 What happens after a student has sought support from you, who would you inform either formally or informally?

C. Gender and responses
3. What is your experience of the incidence of students looking for support in relation to suicide bereavement?
   3.1 In your experience is there a gender difference in the issues raised by male and female students struggling with suicide bereavement – in type or presentation?
   3.2 Have you had many encounters of male or female students inquiring about support in relation to a friend struggling with suicide bereavement?
   3.3 What do you suggest would assist male students in engaging with support services when affected by a death by suicide?

D. Future Developments
4. Do you see a need for greater institute guidance when supporting a CIT student suffering from suicide bereavement?
   4.1 UCC and TCD have introduced mental health policies for staff and students, do you see value in such an initiative at CIT? How should consultation on any such initiative occur?
   4.2 In your opinion what services do you think best support students suffering from suicide bereavement?
   4.3 How should the institute evaluate the effectiveness and efficiency of student support services provided in such situations? What do you think we do well now?
4.4 Some counsellors are now providing counselling support online to the public. Any problems or questions that people have can be answered over the computer. What are your views of online counselling/therapy as a support service for students?

4.5 A 'peer mentoring service' was implemented here at CIT in the second semester of this academic year for students registered with the access service, what are your views on it? Is there potential for it to be introduced across the student body as a whole?

4.6 How do you think CIT can further foster a culture of mental health awareness generally and, specifically, support young men experiencing loss through suicide?

4.7 Finally, How would you respond to the following scenario?

Mary, a student has approached you regarding her worries about her friend Jack. Both of them lost another friend, Ian, to suicide. Mary finds Jack has withdrawn into himself and he doesn't like talking about Ian and what happened. Mary is unaware what to do and has come to this service to ask for help.

- What advice would you give Mary?

E. Additional comments or suggestions
Interview Schedule for UCC and TCD (SUWO)

A. Role
1. What do you see as your role with regard to supporting students?
   1.1 In the event of a student presenting with a mental health emergency at college, what do you see as the available supports within the institute?
   1.2 How do the various support professionals co-ordinate a response?

B. Policy/Guidelines
2. Since the introduction of a Mental Health Policy/ Guidelines to assist staff and students in supporting the mental well-being of all current students, have you noticed any benefits or difficulties posed by these set policies/ set procedures?
   - Is there anything that stands out as working particularly well?
   2.1 Has the effectiveness of the introduction of the Mental Health Policy/ Guidelines been evaluated? If so, how?
   2.2 If a student has recently experienced a death by suicide, what (if any) guidance or training is provided to staff on appropriate responses?
   2.3 What provision is there for acknowledging extenuating circumstances for academic purposes for a suicide bereaved student?

C. Gender and responses
3. What is your experience of the incidence of students looking for support in relation to suicide bereavement?
   3.1 In your experience is there a gender difference in the issues raised by male and female students struggling with suicide bereavement – in type or presentation?
   3.2 Have you had many encounters of male or female students inquiring about support in relation to a friend struggling with suicide bereavement?
   3.3 What do you suggest would assist male students in engaging with support services when affected by a death by suicide?

D. Future Developments
4. In your opinion what services do you think best support students suffering from suicide bereavement?
   4.1 As part of the 'My Mind Matters' programme, online counselling is offered to the students. What are your views of online counselling/ therapy as a support service for students?
   4.2 Has there been a positive response to 'My Mind Matters'? Why is this the case, in your opinion?
4.5 What are your views on a holistic 'peer mentoring service', not just academic?

4.6 How do you think third level institutes can further foster a culture of mental health awareness generally and, specifically, support young men experiencing loss through suicide?

4.7 Finally, How would you respond to the following scenario?

Mary, a student has approached you regarding her worries about her friend Jack. Both of them lost another friend, Ian, to suicide. Mary finds Jack has withdrawn into himself and he doesn't like talking about Ian and what happened. Mary is unaware what to do and has come to this service to ask for help.

- What advice would you give Mary?

E. Additional comments or suggestions
Appendix VI

Includes:

- Interview Schedule for External Professional
To whom it may concern,

My name is Sandra Conroy. I am a Social Care graduate and currently an MA postgraduate student of CIT. As part of my MA degree I am undertaking supervised research entitled: "Gender differences when processing death by suicide: attitudes amongst third level students aged between 18-25 attending CIT and professional stakeholders." The aim of this research is to gain an understanding of what it is like for CIT students processing a death by suicide, and to find out if there are gender differences in their response to this. The research also aims to find out what professional college supports CIT students are aware of, and if there is a gender difference in attitudes to and usage of them.

As part of this research I hope to interview some external professional experts who have a wide range of professional experience and knowledge in this area. The general topics that will be discussed during the interview will be as follows:

- The professional’s view of the role of third level education supports for students;
- The professional’s opinion on policies/guidelines/training within third level education;
- The professional’s perspective on gender differences in students take up of support services;
- The interviewee will also be asked their opinion on what current and future initiatives/additional services could be developed to better support students faced with suicide bereavement.

Participation is voluntary and the interviewee has the right to stop the interview at any time and also has the right to refuse to answer any question. A transcript will be sent to the interviewee to ensure a fair reflection of the discussion is agreed. Confidentiality will be maintained and matters in relation to the interviewee being named in the research will be addressed in the consent form provided.

The interview should take approximately 40-60 minutes. Please find attached the interview schedule. Please do not hesitate to contact me if any aspect of the proposed interview needs clarification or further detail. I would be very much obliged if you would consider taking part in my research.

Thank you in advance for your participation,

Sandra Conroy
Postgraduate Research Student
Email: sandra.conroy@mycit.ie
Phone: 086-2064810
Interview Schedule for External Professionals

The following is a list of topics to be canvassed during the interview.

A. Role
1. What do you think is the primary purpose of having professional student mental health supports on campus at third level?
   1.1 In your view, what should Mental Health supports in third level education consist of?
   1.2 In the event of a student presenting with an urgent mental health matter at college, what in your opinion, would be the essential/best evidenced college supports to coordinate a response?

B. Policy/Guidelines/Training within 3rd Level
2. What are your views on the introduction of a Mental Health Policy/Guidelines in some colleges around Ireland to assist staff and students in supporting the mental well-being of all current students?
   - Are you aware of any evidence of benefits or difficulties posed by these set policies/set procedures?
   2.1 How do you think the effectiveness of the implementation of a Mental Health Policy/Guidelines at third level, is best evaluated?
   2.2 Do you see a need for training staff in a Pastoral role, particularly, when dealing with events such as a student who has been suicide bereaved?
      - If yes, why? What benefits might accrue?
      - If no, why not?
   2.3 Are you aware of any evidence of appropriate training for staff positioned in a Pastoral role?
      - Examples: ASSIST, Console QPR, Listening skills.

C. Gender and responses
3. The incidence of men committing suicide is notably higher than women in this country, with an average ratio of 4:1 deaths by suicide, since 2003. Are there any recent initiatives, in an attempt to tackle this, that have impressed you, either nationally or internationally?
   - In your view, which of these initiatives is most promising to piloting in a third level setting?
3.1 Would you agree that there is a gender difference in the issues raised (in type or presentation) by male and female students bereaved by suicide?
- If yes, how do you suggest this could be addressed in a third level setting? i.e. do you see a need for gender specific services?

D. Current and future developments

4. Within third level settings, what recent mental health initiatives have been previously evaluated or evidenced as very effective that you are aware of?

4.1 As part of the ‘My Mind Matters’ programme, online counselling is offered to the students. What are your views of online counselling/therapy as a support service for third level students?

4.2 What are your views on the introduction of videos on the home page of third level college’s websites across the board, similar to those on ‘My Mind Matters’ which explain different areas of Mental Health and services provided within the college?

4.3 What are your views on ‘peer support services’?

- What should peer support training consist of?

4.4 ‘My World Survey’ suggests that having ‘one good adult’ is important in the mental well-being of young people. Do you agree with this statement?

- How do you think the concept of ‘one good adult’ could be introduced/further developed in supports for third level students?

4.5 How do you think third level institutes can further foster a culture of mental health?

E. Additional comments or suggestions
Appendix VII

Includes:

- List of Mental Health Supports (Cork Region Primarily)
List of (some) Mental Health Supports – Cork Region & Online

- Pieta House
- Console
- Samaritans
- 3t’s: Turn The Tide of Suicide
- Aware
- Suicide Aware
- NightLine
- Save Our Sons and Daughters :SOSAD
- See Change
- Headstrong
- HeadsUp
- Turn2Me
- Grow
- www.1life.ie
- www.hse.ie
- ie.reachout.com
- pleasetalk.org
- www.letsomeoneknow.ie
- www.spunout.ie
- www.mentalhealthireland.ie
- yourmentalhealth.ie
- www.yspi.eu (youth suicide prevention Ireland)
Appendix VIII

Includes:

- CIT ‘Student at Risk’ Guidelines
For the attention of CIT staff

CIT Student at Risk Guidelines.

If a student presents in class or on campus appearing distressed, he/she should be advised and supported to attend the Student Counselling Service located in the Student Services Building. The student will be offered an appointment with the Co-ordinator of Counselling or the “on duty” Counsellor as soon as possible.

The following are some examples of emergency situations which may need immediate attention.

- Student expressing suicidal thoughts or feelings
- Student at risk of self-harm, or of causing harm to others
- Immediately following a traumatic event, a student whose overall level of functioning may be impaired
- Student in a crisis situation
- Student who appears distressed, especially if he/she indicates no support from family or friends.
Appendix IX

Includes:

- UCC Mental Health Policy (2010). NOTE: the Mental Health Policy
  Appendices have been omitted here, they are available at:

- TCD Mental Health Policy (2008). NOTE: the Mental Health Policy
  Appendices have been omitted here, they are available at:
  http://www.tcd.ie/about/content/pdf/policy_mentalhealth.pdf
Student Mental Health Policy

January 2010
Foreword

I am pleased to introduce this Student Mental Health Policy on behalf of University College Cork. The policy has been developed to help students fulfil their academic and personal potential and thrive in a supportive and caring environment.

Many people experience a period of mental distress or mental illness at some stage in their lives. University life is a time of considerable change and challenge which some students find stressful and potentially threatening to their mental well-being. UCC acknowledges the pressure students are under and in developing this Policy is clearly stating its support for all students by ensuring that support services are in place, including clear guidelines for staff involved in supporting students during periods of distress. The policy, in particular, seeks to ensure that University administrative and disciplinary procedures are consistent with a positive approach to promoting mental well-being.

This Policy is a significant step forward in promoting better mental health among our students. I would like to express my gratitude to all those involved in developing the UCC Student Mental Health Policy.

Con O'Brien
Vice President for the Student Experience
University College Cork
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1. Introduction

1.1 Aim and Objectives of this Mental Health Policy
This Mental Health Policy seeks to establish a coherent framework and a set of procedures to assist the promotion of mental well-being in University College Cork. An effective mental health policy recognises the need for ongoing behaviour modification and attitude revision at all levels of the University, including organisational practice, lifestyle, service provision, guidance and training, support and communication networks. The policy is primarily intended for the benefit of students attending University College Cork and provides support to staff in supporting the mental well-being of all students in the University.

1.2 University College Cork's Role and Responsibility
University College recognises the need to develop services and provide a supportive environment for students in mental distress or suffering from a mental illness. The primary responsibility for the provision of community mental health services lies with the Health Service Executive. UCC therefore aims to

- Provide a range of support services, including the Student Health Service, Student Counselling and Development Disability Support Service, Student's Union, and Chaplaincy
- Provide referral to relevant external agencies where appropriate
- Maintain appropriate contact between the University and relevant external agencies that support individuals with mental health difficulties
- Provide ongoing support for Staff who support students with mental health difficulties
- Encourage students with mental health difficulties to actively seek support
- Provide unambiguous and widely accessible information about the availability of resources and support to both current students and those intending to study at UCC
- Promote an environment in which mental health difficulties are openly acknowledged and not stigmatised
- Challenge any discrimination directed at those who may be experiencing mental health difficulties
- Promote a healthy lifestyle and raise awareness of the adverse effects of drug and alcohol abuse and misuse
- Ensure the Confidentiality of personal information provided by students with mental health difficulties, excepting grave circumstances. See Section 4.

1.3 Responsibility for implementation of this Mental Health Policy
The Vice-President for the Student Experience is ultimately responsible for the implementation of the aims and objectives, as outlined above, on behalf of UCC.

1.4 Legislative issues
The primary pieces of legislation that underpin this policy include the

- Mental Health Act, 2001
- Disability Act, 2005

The Mental Health Act 2001 has particular implication for individuals with significant mental health difficulties, including involuntary admission to psychiatric facilities.
1.5 Mental Health and Wellbeing

The concept of ‘Mental Health’ as it is used in this policy document is broader than the mere absence of mental disorder. Mental Health encompasses a broad spectrum of experiences including mental (psychological-emotional) well-being, mental health difficulties and mental disorder/illness. Mental well-being, mental health difficulties and mental disorder/illness are each a complex manifestation of a range of biological, psychological, social, cultural and historical variables that affect the thoughts, emotions and behaviour of an individual when faced with life’s situations.

In its 2006 report “A Vision for Change” commissioned by the HSE, the Expert Group on Mental Health emphasised the following:

- A model for understanding mental health needs to be formulated because the way mental health is viewed (i.e. the model used) determines society’s approach to emotional distress and mental health problems. If there is no understanding of what factors influence mental health, we cannot hope to promote better mental health, to prevent mental health problems, or to deal effectively with mental health problems

- The bio psychosocial model incorporates key influences on the mental health of the individual and highlights the interconnection and interdependence of people’s biological, psychological and social functioning Mental well-being is associated with an individual’s ability to live in a productive and self-fulfilling manner, having the resilience to cope effectively, when faced with the challenges and stressors that are a part of everyday student life and workload/study.

1.6 Mental Health Distress

Mental health distress is associated with a wide range of experiences that affect how we think, feel and behave and results in a less than effective ability to cope with and manage our lives, particularly when we are faced with a change in lifestyle and a new environment. Evidence of mental health distress may include, among other factors, low-level anxiety or depression, poor concentration and performance, difficulty with eating (or eating to excess), withdrawal from peer group, alcohol and narcotic abuse, changed behaviour and appearance, suicidal ideation, obsessive attitude towards work/pre-occupation with failure. It should be noted that mental health distress may be experienced by anyone at any time and the World Health Organisation maintains that one in four individuals will experience mental health distress at some point in their lives. The experience will not necessarily warrant specialist mental health care or admission to a specialist facility. Common presentations of Mental Health Distress are included in Appendix 1.

1.7 Mental Illness

Mental illness describes the experience of severe mental health difficulties. A more seriously affected student, in addition to needing appropriate professional support, may also cause concern and anxiety among his/her fellow students, and members of staff. Descriptions of common Mental Illnesses are included in Appendix 2.
2. Help available for Students in Distress

Many students experience periods of varying degrees of mental distress during their time at University. Life events such as bereavement, parental separation, unplanned pregnancy, relationship breakdown, and addictions can be traumatic and distressing for students. In addition, transition to university and academic anxiety are common sources of stress. Such issues and stresses have a direct impact on the student experience, academic performance and student retention.

In addition some students will enter University with an established mental illness whilst others will develop a mental illness whilst there. The support networks available to a student vary from individual to individual, and according to whether they are still residing at home with family, or living away from home for the first time, and whether or not they have previously had access to, or been supported by the Mental Health Services. It is important to help students build on existing supports, whilst providing access to additional sources of help when necessary.

2.1 Non-acute situation

In a non-acute situation, where a student is considered to be in some distress and in need of extra support resources may be of assistance to them as follows:

- Family
- Class mates and friends
- University Academic Departments
- University Services
  - Student Counselling and Development Department
  - Student Health Department
  - uLink
  - Student’s Union/Student’s Union Welfare Officer
  - Niteline
  - Chaplaincy
  - Disability Support Service
  - International Education Office
  - First Year Experience Co-ordinator
- Community Services
  - Family Doctor/General Practitioner
  - Mental Health Services; Public Sector or Private Sector
  - Voluntary Agencies including Mental Health Charities.

See Appendix 5 and 6 for contact details of the above University and Community Services respectively.

2.2 Acute situation

In an acute situation, where a student is distressed to the point of needing urgent same-day or next-day support or help out with their usual support network of family and friends, each of the University services listed above, as well as the Student’s own family doctor or other mental health professional involved in their care, should be considered as possible sources of help. Individual University services who feel that expert help is needed should consider referring on to the Student Counselling and Development or Student Health Departments.

2.3 Emergency situation

See Section 3 Guidelines for staff on responding to students in distress.
Actions Advised in Helping a Student in Distress or Crisis

Staff member concerned about mental health of student

Life Threatening Emergency
- Overdose Possible or Definite
  - Request Ambulance - 999 or 112
  - Inform UCC Security - 3111
  - Inform Student Health - 3111
- Student Violent / Armed
  - Contact Garda - 999 or 112
  - Inform Security - 3111

Non Urgent / Non Emergency
If the student is or appears...
- Withdrawn, low in mood, fearful or unduly anxious; has a sudden deterioration in academic performance AND
- Does not display features considered as Urgent/Emergency

Urgent / Emergency
If the student is or appears...
- Very aggressive / Threatening (seek help from Security 3111 and/or Garda on 999)
- Suicide / wishing they were dead
- Threatening self harm
- Expressing bizarre thoughts or ideas
- Unduly agitated or behaving in a bizarre manner

- Explain your concerns to student
- Assure confidentiality
- Advise student to contact Student Counselling, Student Health Department, or their own GP.
- Arrange follow up appointment
- If a student does not or does not wish to follow your advice, his/her wishes should be respected. No further action is appropriate at this stage, unless their condition deteriorates to become Urgent or Emergency as over.

- If possible consult colleague, try not to act alone
- Explain concern to student (unless you believe this will inflation the situation)
- Seek consent to contact Student Counselling and Development, Student Health Department, or Student’s own GP or Psychiatrist
- If consent withheld consider contacting anyway.
- Arrange an urgent appointment with one of the professional services listed above
- Consider accompanying student to appointment.
- Consider A+D SouthDoc if other services unavailable or closed.
- If off-campus contact local health services and request advice or assistance.

Contact Details
Student Counselling and Development
Hours 9:15-1pm, 2:15-5pm M-F
(021) 4903565

Student Health Department
Hours 9:15-1pm, 2:15-5pm M-F
(021) 4902311

UCC General Services Security
24 Hours
(021) 4903111

Anglesea Street Garda HQ
24 hours
(021) 4313031

A+E Cork University Hospital
24 hours
(021) 4920230

South Doc
Evenings week ends
1850 335 999
3. Guidance for Staff on Responding to a Student in Distress

In responding to a student who is causing concern, Staff should only act to the limit of their competency, should always consider involving a colleague and should avoid taking on a pastoral role unless properly trained. The appropriate course of action to be undertaken by a staff member who has become concerned about the mental well being of a student depends on the urgency of the situation. The course of action may also need to be reviewed if the situation alters. The situations can be described or classified as non-urgent/non-emergency, or urgent/emergency. See Flow Diagram on previous page.

See Appendix 4 Advice for Staff on Responding to a Student in Distress.

3.1 Non-urgent/Non-emergency situations
Members of staff who become concerned about a student who appears withdrawn, low in mood, tearful or unduly anxious, or who has deterioration in academic performance or failure to meet deadlines for submission of assignments should consider one or more of the following courses of actions

- Make the student aware of your concern and the basis for that concern
- Advise the student to consider obtaining help/support as per section 2 of this policy
- Assure the student that discussions are confidential and remain so unless you judge them to be a danger to themselves or to other students, or it is a criminal matter
- Offer to communicate your concern to their family, GP, Student Counselling and Development (ext. 3565) or the Student Health Department (ext. 2311)
- Arrange to meet the student at a later date to review the outcome
- If a student does not wish to avail of support services, or does not wish to follow your advice, his/her wishes should be respected. Unless and until their situation or condition deteriorates to become Urgent/Emergency as below, no further action is appropriate at this stage.

3.2 Urgent/ Emergency situations
In circumstances where staff have become concerned about a student and believe the student to be an immediate risk of harm to self or others, one or more of the courses of actions listed below should be undertaken.
Such circumstances could include some or all of the following:

- If a student is expressing suicidal thoughts or other thoughts such as that they wished they were dead
- If a student is threatening self harm
- If a student appears unduly agitated or aggressive, or is exhibiting bizarre behaviour
- If a student is expressing bizarre thoughts or ideas
- If a student appears to be not in touch with reality
Actions advised in Urgent/Emergency situations

• Try not to act alone, if possible seek the help/advice from another colleague.

• If the Student has taken an Overdose telephone 999 or 112 for an emergency ambulance and inform the University Security (ext. 3111). If the incident occurs between 9:15-1pm or 2:15-5 pm contact the Student Health Department (ext. 2311) to seek advice/help until the ambulance arrives.

• If the student is very aggressive/threatening, seek help from Security (ext. 3111) and/or Gardaí on 999 or 112.

• Otherwise, if none of the above applies, make the student aware of your concern and the basis for that concern.

• Ask the student if they are already attending University Counselling/Student Health Departments /GP/Psychiatrist. Get details and with the student's consent contact one of these services (UCC Student Counselling and Development ext. 3565 Student Health Ext. 2311) explain your concerns, requesting their immediate help/intervention and confirm an appointment.

• Accompany the student to the appointment if possible.

• If the student refuses consent to disclose information or refuses to avail of an appointment with any of these agencies, and you believe the student or others to be in danger, you should still consider informing one of the agencies above. It may be best to explain to the student that you are doing this, unless you judge doing so will inflame the situation by making the student more agitated.

• If the incident occurs out with the operating hours of any of the above services, consider contacting the emergency department of either CUH (24-Hrs) or the Mercy Hospital or SouthDoc Evenings/Nights and Weekends.

• If the incident occurs whilst off-campus on a field trip for instance, contact local health services for advice or assistance. Ensure you have the contact details of nearest A+E service and Out of Hour's emergency GP service before departure.

• In exceptional circumstances the provisions of the Mental Health Act may need to apply. See Section 7.
4. Administrative Policies and Procedures

University College Cork is committed to a policy of equal opportunity and welcomes applications from students with disabilities including those with mental health difficulties. The University makes every effort, where possible, to facilitate access and participation of students with mental health difficulties in all aspects of university life. Furthermore, UCC is dedicated to the creation of an environment in which the stigma surrounding mental health can be reduced. In this environment, students experiencing mental health difficulties will be enabled to access the appropriate supports at the earliest juncture.

The University uses the definition of disability as defined in the Disability Act 2005: “disability”, in relation to a person, means a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment”.

4.1 Admissions to UCC

Students with mental health difficulties may gain entry to UCC through the Standard CAO Process or through the CAO Supplementary Admission Process. Most students who register with the Disability Support Service enter UCC via the Standard CAO Process. UCC’s Positive Admissions Policy states that students with mental health difficulties may qualify for a CAO Supplementary Admission Offer if, because of their disability, they cannot compete equally in the Leaving Certificate and, as a result, do not fulfill the necessary admissions criteria to gain a place on merit. For further information on applying through the CAO Supplementary Admission Route please see:

www.ucc.ie/en/dss/ProspectiveStudents/Admissions/CAO/CAOAdmissionsProcedure/

Students who do not enter through the CAO (e.g. postgraduates, evening students, part-time students) are also supported by the Disability Service if the student presents medical evidence of impact of disability from an appropriate consultant. Students with mental health difficulties may register with the Disability Support Service at any time during the academic year to avail of necessary supports.

4.2 Fitness to Practice

Disclosure of mental health difficulties will not adversely affect a person's application to University or legal rights in any way. However, certain physical, sensory, or mental health conditions or illnesses may preclude the safe practice of a chosen profession. In particular students intending to study professional degree programmes should seek appropriate advice from the relevant Head of Department or School in advance of registration.

4.3 Supporting the Educational Impact of Mental Health Difficulties

The Disability Support Service fulfils an important function with respect to the support of students encountering mental health difficulties in the course of their studies. Staff at the DSS recognises that the concept of mental wellbeing is a universally pertinent one and that many people experience some of the symptoms associated with mental health difficulties at some stage in their lives.

Students are met on a one-to-one basis to determine the relevant supports applicable to their needs. These supports include:

- Subject Specific tuition
- Peer Mentoring Programme-Buddy system to enable students with mental health difficulties engage with learning environment
- Loan of laptops so that students experiencing mental health difficulties can work on assignments from home
- Career Support programme enabling the successful transition to the workplace for graduates with mental health difficulties.
4.4 Alternative Examination Arrangements

UCC is committed to ensuring that learners with disabilities will be enabled to demonstrate their knowledge and competency on an equal footing with their peers. A reasonable accommodation might be any action that helps to alleviate a substantial disadvantage.

The granting of reasonable accommodations to learners with mental health difficulties is always consistent with the academic rigor of programmes and also maintains academic standards. The regime of reasonable accommodations also ensures fairness to learners without disabilities in that it will not advantage learners with mental health difficulties over their peers. When a student with mental health difficulties registers with the Disability Support Service, they are assessed for alternative exam arrangements, as part of the initial assessment. The accommodations may include

- Sitting the exam in a room on their own
- Sitting the exam in a smaller venue.

4.5 Deferring or Splitting Exams

Students with mental health difficulties can also be afforded the opportunity to extend one year of their programme over two years or to split the exams over summer and autumn exam schedules without penalty. These arrangements are put in place once medical verification has been supplied to substantiate the rationale for this accommodation.

4.6 Fee Waivers

The University further supports the access and participation of students with mental health difficulties by offering a waiver of fees in the following year where a student has to split their exams on grounds of disability. These arrangements are negotiated on a yearly basis by the Disability Officer in conjunction with the Fees Officer, once the student with mental health difficulties has provided medical certification to verify their need for alternative exam arrangements or fee waiver.
5. Disciplinary Policy and Procedures

5.1 Mental Health and Disciplinary Issues
All students are subject to UCC’s Student Rules, and the rights of an individual with a mental health difficulty must be balanced with the right of all members of the University to study and work in a safe and productive environment.
(See Student rules at www.ucc.ie/en/CurrentStudents/StudentRulesandCharter)

Students with a mental health difficulty may behave inappropriately as a result of that mental health difficulty and care should be taken to ensure that disciplinary procedures do not result in inappropriate action against a student with a mental illness without making all possible efforts to involve specialist psychiatric support.

5.2 Disciplinary Process for Students with Mental Health Difficulties
In the event that a student subject to Disciplinary Proceedings applies for mitigation based on mental health grounds, or if the Disciplinary Committee in dealing with a disciplinary case is of the opinion that a student may have a mental health problem or is patently ill and...

- his/her mental health difficulties may be preventing him/her from understanding the disciplinary process and representing his/her case/situation effectively

and/or

- his/her mental health difficulties may be the cause of the actions which have led to the disciplinary proceedings

...consideration should be given to suspending the disciplinary procedures as per section E points 26-31 of the Student Rules.
(See Appendix 3 Extract from University Student Rules re Discipline and Mental Health)

This provision aims to offer the student an opportunity to receive appropriate treatment and to allow the University obtain a Consultant Psychiatrist’s opinion as to the student’s condition. If a student chooses not to engage in treatment or refuses to attend for psychiatric assessment, the disciplinary process will continue.
6. Confidentiality and Communication

Confidentiality is essential in encouraging students to seek help whenever appropriate. It is important therefore that students feel assured that any personal information they give a staff member will be treated with respect and discretion. In accordance with UCC Data Privacy Policy (available at http://secretary.ucc.ie/Records/privacy.htm), the University has a duty to “Protect personal information from loss, unauthorised access, use, modification or disclosure or other misuse.”

6.1 When to Disclose Information

Information regarding the mental wellbeing of a student is confidential and should only be divulged with the consent of the student.

If consent to disclose information is refused, information may be disclosed if any of the following circumstances apply:

- Where it is considered that there is a danger to the life or safety of the student or other person
- Where a crime is being investigated
- Where it is a requirement of law
- When procedures under the Mental Health Act 2001 are invoked.

6.2 Guidelines for Disclosure and Communication of Information

To ensure appropriate disclosure, the following guidelines should be observed:

- Where a student does agree to personal information being disclosed, ensure if possible, the student is informed:
  - Who will be receiving the information
  - Why the information is being disclosed
  - What information is being disclosed
- Personal information should only be disclosed on a ‘need to know’ basis.
- Issues relating to a student’s mental health should not be discussed in public. Ensure that any discussion, whether in person or by telephone, is done in a discreet, sensitive and private manner.
- Personal identifiable health information should not usually be sent via e-mail.

6.3 Guidelines for Record Keeping

It is good practice to keep brief notes of any interactions with students where there has been guidance or decisions in relation to personal issues, and to inform the student that you are making a record of the encounter.

The record should be dated and written as soon as possible after the interaction with the student. It should state the nature of the interaction and any action taken or advice given. If appropriate, it should also state whether or not the student gave consent for further action.

Records should be kept safely in departments for a minimum period of five years and then destroyed. Confidentiality and security of notes should be maintained in accordance with the principles of the Data Protection Act. (See: www.dataprotection.ie) and the Freedom of Information Act (See: www.foi.gov.ie).
7. Application of the Mental Health Act 2001

Where a student of the University develops a Mental Disorder (as defined in Section 3 of the Mental Health Act 2001), and is deemed to require in-patient treatment, he/she will be encouraged to accept treatment in a Psychiatric Unit/Hospital. The Universities' professional staff involved with the student will facilitate a voluntary admission for such treatment.

Where a student of the University develops a Mental Disorder (as defined in Section 3 of the Mental Health Act 2001) and where the student is deemed by a Registered Medical Practitioner/Doctor to require treatment for this disorder but is unable or unwilling to accept voluntary hospitalisation, the procedures of the Mental Health Act 2001 will be followed: The Act sets out regulations for the involuntary detention of persons to psychiatric hospitals.

Before an adult 18 years and over may be involuntarily detained, the Mental Health Act (2001) requires that:

- (S)He is suffering from a “mental disorder” within the meaning of the Act. For all practical purposes, that means “mental illness” as defined in the University Mental Health Policy
- In addition, one of the following two conditions must also be met, as set out in section 3(1) of the Act, as follows:
  a) because of the illness there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons;

or

b) (i) because of the severity of the illness the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
b) (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

The following are the steps undertaken under the Mental Health Act 2001 to detain a person aged 18 years and over. Any student less than 18 years of age and who is not, and has never been married, is treated as a child under the Mental Health Act 2001, and a different procedure applies- see details of Mental Health Act 2001 on www.mchirl.ie

Step 1: An Application is made on one of the statutory forms 1 or 4 (available from the Student Health Department). The application will be made* either by a spouse/relative, an HSE Authorised Officer, a member of An Garda Síochána, or a member of the Public

Step 2: A Registered Medical Practitioner will assess the person within 24 hours of the receipt of the Application. This may be a Student Health Doctor, a GP or his locum tenens

Step 3: If the Registered Medical Practitioner makes a recommendation that the person should be admitted to a Psychiatric Unit/Hospital under the Mental Health Act, 2001, arrangements will be made to transfer the person to an appropriate Hospital.

*Note the applicant is almost always a member of the student’s family, and involvement of another category of applicant is likely to be needed only in the event of unavailability of a family member.
Trinity College Dublin:

STUDENT MENTAL HEALTH POLICY AND GUIDELINES
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INTRODUCTION

1.1 Policy statement

Trinity College Dublin is committed to an inclusive education for all, which welcomes diversity and promotes equal opportunities for students to develop to their full potential. To this end, the TCD student mental health policy:

- enables College to fulfill its caring, educational and legal responsibilities to students;
- heightens awareness and increases understanding across the college community about mental health issues;
- promotes informed and constructive attitudes to mental health issues;
- encourages a partnership approach, with shared responsibility, between College, its staff, the student body and individual students with respect to dealing with mental health issues;
- follows international best practice guidelines in the area of student mental health, including the provision of appropriate and timely support services for students;
- provides guidance and, where appropriate, promotes training to ensure College staff are aware of the emergency procedures, the support services available and know how to make appropriate referrals and interventions for students they encounter with mental health difficulties;
- facilitates communication and cooperation as appropriate between the relevant College departments and services on matters relating to mental health;
- respects the rights of each individual student and of the student body as a whole;
- defines the right to confidentiality within specified guidelines.

By articulating a written policy and providing guidelines on student mental health, College aims to promote student well-being, provide a safe and healthy work environment for all students and staff, ensure that appropriate intervention is taken where needed and encourage students with mental health difficulties to disclose them so that appropriate arrangements can be made to support them.

It is intended to review and update this policy on a regular basis.

1.2 Relationship to other College policies

Trinity College has a number of other policies, codes and procedures that should be read in conjunction with this policy:

- alcohol policy (www.tcd.ie/info/policies/alcohol.php);
- sexual harassment, racial discrimination and bullying policy (www.tcd.ie/info/harassment.php);
- disciplinary procedures: www.tcd.ie/Secretary/Board/Other_Papers/Statutes-Current.pdf - 2006-03-06

This policy and guidelines should also be read in conjunction with the College Calendar page H18 (II Conduct and College Regulations) (www.tcd.ie/info/calendar); students applying to study or already studying in the Faculty of Health Sciences should take note of Calendar N3 §8.

1.3 Scope of document

Section 2 briefly outlines the meaning of the term ‘mental health’, and explains the distinction between mental health difficulties and mental illness. Relevant legislation is also listed. Section 3 covers College procedures concerning admissions, assessment, disciplinary matters and so forth, where these are relevant to students experiencing mental health problems. Section 4 aims to give guidance to members of College staff and students on how and where to seek help for students experiencing mental health problems. The important issue of confidentiality is also addressed in this section. This short document is supported by a number of appendices giving further information relating to Sections 2 to 4.
MENTAL HEALTH
MENTAL HEALTH

2.1 What is mental health?

Mental health, mental health difficulties and mental illness lie on a continuous spectrum and are not distinct points.

Mental Health

The term 'mental health' refers to how a person thinks, feels and acts when faced with life's situations. It describes a sense of well-being and it implies the capacity to live in a resourceful and fulfilling manner, having the resilience to deal with the challenges and obstacles that life and studying present.

Mental Health Difficulties

Mental health difficulties are problems that affect a person's thoughts, body feelings, behaviour and ability to function. These may occur as a reaction to a painful event or external pressure. They may resolve of their own accord. A student experiencing mental health difficulties that interfere with his/her capacity to function, or which are persistent, may benefit from accessing a staff member attached to one of the College Support Services (Tutor, Counsellor, Chaplain or General Practitioner). If severe, mental health difficulties may signal the onset of mental illness.

Mental Illness

Mental illness is the term used to refer to severe mental health difficulties. Mental illness includes conditions such as schizophrenia, bipolar disorder, depression, anxiety/panic disorders, obsessive compulsive disorders, eating disorders and attention-deficit / hyperactivity disorder (See Appendix A). Students who experience mental illness will require treatment and support from a health professional such as a Psychiatrist, Counselor or General Practitioner.

Further information on common mental health illnesses affecting young people is contained in Appendix A

2.2 Legislation relating to mental health

There are several Acts relevant to mental health, including:

- Mental Health Act 2001
- Equal Status Act 2000 - 2004
- Disability Act 2005

Mental health legislation has little immediate relevance to the vast majority of individuals. College and its staff will always use their best endeavours in dealing with students with mental health difficulties or mental illness.

For further information on the Mental Health Act, 2001, see Appendix E.
03 ACADEMIC AND ADMINISTRATIVE PROCEDURES
ACADEMIC AND ADMINISTRATIVE PROCEDURES

3.1 Admission

Irish and other EU students apply for admission to undergraduate courses in College via the Central Applications Office (CAO). Non-EU students apply to the International Office of College. Postgraduate applicants apply through the Graduate Studies Office.

Trinity has a supplementary application procedure in place for students from non-traditional learning backgrounds, including students with disabilities, from socio-economically disadvantaged backgrounds and mature students (age over 23). Further information is available from the Admissions Office.

www.tcd.ie/Admissions/admissions_info/disability.html

The issue of re-admission to College of a student who is 'off-books' is referred to in Section 3.5.

3.2 Disclosure

Disclosure of a disability, including a mental health condition, is designed to enable College to prepare, in advance, the necessary supports that it may need to put in place to provide the student with full access to education. Duties under the Equal Status Act require the College to make reasonable accommodation for a person with a disability, provided that the cost is within the resources available.

If a student requires particular support or arrangements in College (for example, mental health support or examination support), it is important that the student contacts Disability Services well in advance of his/her application to discuss his/her needs. Applicants will then be in a better position to make an informed decision as to whether or not Trinity College can provide the support and environment they require.

3.3 Fitness to Practice Issues

Disclosure of mental health difficulties or mental illness will not adversely affect a person's application to College or legal rights in any way. However, certain physical and mental conditions may preclude the safe practice of a chosen profession. In particular, students intending to study in the faculty of Health Sciences and other professional courses should seek appropriate medical advice and advice from the head of School or the director of their chosen course before registration (Calendar N3, §8).

Students attending a course in Trinity College should:

- familiarise themselves with the course requirements;
- have the ability to cope with the demands and workloads of a third-level course as special arrangements and accommodations do not remove all difficulties;
- be aware of the demands of the course. They are advised to discuss the demands of each year of their course with the course director or other appropriate member of staff;
- not be a risk to themselves or to other students or staff.

Occasionally an issue may arise as to a student's ability or suitability to participate in a particular course. The college procedures for dealing with such issues are set out at H5, §19 of the Calendar.

3.4 Disciplinary procedures

All students are bound by the College disciplinary procedures as described in Schedule 2 of Chapter XII of the 1986 Consolidated Statutes of Trinity College Dublin as amended in 2006. If it becomes apparent during the procedures for major offences that the student may have a mental health difficulty, then Section 43 of Schedule II of the Statutes will apply, as follows:

43: Cases of student mental ill-health should not normally be dealt with as matters of discipline under the foregoing provisions of this Schedule. Instead, in such cases, where a student constitutes a clear and reasonably imminent danger to himself or herself or to others, the Junior Dean may suspend such a student from the College; provided that:

(a) the Junior Dean has first consulted with and obtained the agreement of the Director either of the College Health Service or of the Student Counselling Service;

(b) the Junior Dean as soon as possible thereafter makes a full report on the matter to the Board; the student shall be given an opportunity to respond to that report; the Board shall decide whether to lift that suspension, and if so, upon what conditions;
(c) If the suspension remains in place, the Board shall, until such time as it concludes that the matter has been satisfactorily resolved, from time to time consider the matter, afford the student the right to comment on it in advance of any such consideration, and decide whether to lift that suspension, and if so, upon what conditions; and

(d) the Junior Dean, the Directors of the College Health and Student Counselling Services, and the Board, as the case may be, shall seek to act at all times in the best interests of the student concerned and of every other member of College.

3.5 Going off-books, withdrawing and re-admission

Students who are unable to continue their studies, or who need to interrupt them on health grounds (including mental health grounds), may be given permission by the Senior Lecturer to go ‘off-books’ or to withdraw from their course (see Calendar H12). Students should discuss their needs with their tutor and their medical advisor before seeking to go off-books. The tutor processes the application to the Senior Lecturer on behalf of the student, and supporting documentation from the health professional will also be required.

Students wishing to return to College after a period off-books on medical grounds need to apply for re-admission before they return (and by the 1st August in the case of JF students), using the re-admission form available from the Senior Lecturer’s office. This re-admission form is a certificate of fitness completed by a medical referee who may be nominated by the Senior Lecturer.

Continuing care may, on occasion, be provided by the relevant Student Support Service whilst a student is ‘off-books’.

Note: Students in good standing may choose to go off books for personal reasons rather than academic or medical reasons. In such cases, they do not need to apply for readmission or present a medical certificate of fitness. If there are mental health concerns, it would be in the student’s interest to encourage him or her to go off books on medical rather than personal grounds, as this procedure will ensure that the student's fitness to resume studies is assessed before s/he is permitted to return to College.

3.6 Examination arrangements

Alternative arrangements for examinations or assessments may be made for students with mental health difficulties that would affect their ability to undertake the examination or assessment as usually conducted. If the student is registered with the Disability Service, then the Service is responsible for making these arrangements in conjunction with the Examinations’ Office. Details can be found on www.tcd.ie/disability. In all other circumstances, students should approach their tutor (if the student is an undergraduate) or their supervisor or course director (if a postgraduate) to discuss special arrangements.

3.7 University Careers Service

Students who have experienced mental health difficulties, particularly where academic achievements have been adversely affected or have led to withdrawal, are advised to consult the Careers Advisory Service staff. Careers advisers have expertise in helping students to be realistic and to market themselves effectively, and in enabling them to decide on positive and constructive disclosure strategies.
04 DEALING WITH STUDENTS EXPERIENCING MENTAL HEALTH DIFFICULTIES
DEALING WITH STUDENTS EXPERIENCING MENTAL HEALTH DIFFICULTIES

The aim of this section is to provide College staff (Section 4.1) and students (Section 4.2) with information and advice on how to deal with students who are experiencing mental health difficulties and, in particular, on how and where to seek professional help. Issues surrounding confidentiality are discussed in Section 4.3.

4.1 Guidelines for staff
Guidance on how to respond to a student experiencing mental health difficulties is given in the flow diagram in Figure 1.

4.1.1 How urgent is the situation?
The first thing to try to establish is how urgent and serious the situation is:

- is the student at risk of hurting her/himself or others?
- is there a risk of suicide?
- is the student out of touch with reality?
- is the student behaving bizarrely?
- is the student confused, drowsy or ill (possibility of overdose)?
- has the student’s behaviour, mood or personality suddenly changed (see Appendix D)?

If you are concerned about any of the above, please follow the emergency guidelines in Section 4.1.2 (daytime) or Section 4.1.3 (out of hours) below.

If the above questions do not apply, then you may be concerned about a student because of his or her:

- lack of interaction, isolation or withdrawal from staff or peers;
- difficulties with daily functioning (eating, sleeping, mood, physical activity, personal appearance);
- attendance problems;
- changed academic performance;
- missed deadlines;
- significant weight loss/gain.

Although these may be an indication of mental health difficulties sufficiently serious to require referral and support, there may not be an urgent crisis. In such cases, please follow guidelines for referral and intervention in Section 4.1.4.

4.1.2 Emergency guidelines (Daytime)
If you think there is potentially an emergency situation, as a staff member you must take immediate action on behalf of the College. Some guidelines on what to do and who to contact are given below - you should not try to deal with the emergency alone. If you are uncertain about what to do, consult with a member of the Student Counselling (01 896 1407) or the College Health Services’ professional staff (01 896 1556). Outside of office hours, contact any of the following:

- the Junior Dean / Registrar of Chambers via ext. 1999;
- The Warden of Trinity Hall 487 1772
- the Chaplains (ext. 1260 & 1901) who may be available;
- another member of staff who may be able to support you

a) Locate and talk to the student yourself or arrange for another member of staff to do so, e.g. a Tutor (the student’s tutor’s name is available on the Student Information System: (www.tcd.ie/isservices/), the Senior Tutor (01 896 2004/2651), the Head of School or the College Chaplains. (You should confirm subsequently that this person has in fact contacted the student)

b) Clarify whether the student is already seeing a professional within College (counsellor, psychiatrist or GP):

- If yes – contact this professional, explain your concerns and the level of the student’s distress and arrange an urgent appointment.
- If no – seek the student’s consent to arrange an emergency appointment for them in the Health Centre (01 896 1556) or in the Counselling Service (01 896 1407). Emergency appointments are available in both services.
on a daily basis. Contact either service and explain the seriousness of your concerns. Accompany the student to the Counselling Service (200 Pearse Street) or the Health Centre (House 47). See College maps: www.tcd.ie/maps. (Note that physical force of any kind must not be used when accompanying a student to the Counselling Service or Health Centre).

- If the student is not prepared to attend the Health Service or the Counselling Service, explain to them gently that, as you have concerns for their welfare, or that of others, you will have to consult with the Counselling Service (ext. 1407) or Health Service (ext.1556) staff and/or talk to their family or next of kin. Give the student a choice as to who they would prefer you to contact in the first instance. For further advice and suggestions, see 'Tips for referring reluctant students' in Appendix C. However, it is a matter for the student to choose whether to accept a referral, and to avail of the supports offered. In exceptional circumstances, the College disciplinary procedures (see Section 3.4 of this document) and/or the provisions of the Mental Health Act 2001 regarding involuntary detentions may need to be implemented (see Appendix E).

- another member of staff who may be able to support you

If the student is distressed but there are no safety concerns, please:

- contact DUBDOC based in St James's Hospital. Call ahead: 454 56 04 (6-10 pm weekdays, 10 am – 6 pm weekends and bank holidays). Outside of these hours, or if advised by DUBDOC, go directly to the Accident and Emergency (A & E) Department, St James Hospital, 01 4162774, 4162775 or 410 3000. If you and the other staff member are happy to do so, you may jointly accompany the student - it is not advisable to do so on your own. Otherwise, ask Security to call an ambulance;

- establish with the student if they wish you to contact their family/next of kin;

- inform the student's tutor, supervisor or course director of the situation at the first available opportunity.

If the student is aggressive or considered to be a risk to him or her self or others:

- seek assistance by contacting the College security staff (ext. 1999). They will contact emergency services (the ambulance and/or the Garda) to arrange transfer of the student to a place of safety. (If the student is unwilling to go to hospital or another place of safety, the College Security will ask the Garda to make an assessment of the situation, in the interest of safety of everybody involved). Take advice from the Garda as to whether it is appropriate to accompany the student;

- establish with the student if he or she wishes you to contact his or her family/next of kin;

- inform the student's tutor, supervisor or course director of the situation at the first available opportunity.

Additional contacts include:

c) Follow up your actions by:

- Liasing with the Service as to the outcome of the assessment.

- Arranging to see the student again if appropriate.

Some general advice on how to talk to, and cope with, students experiencing urgent (or acute) mental health difficulties is included in Appendix C.

4.1.3 Emergency Guidelines (Out of hours)

It is again important to stress here that you should not deal with any emergency alone. You should consult with:

- the Junior Dean / Registrar of Chambers via ext. 1999;

- The Warden of Trinity Hall 487 1772

- the Chaplains (ext. 1260 & 1901) who may be available;

Other useful places to get help outside of College hours include:

Samaritans (24 hours) 1850 609090 e-mail: jo@samaritans.org

AWARE's Depression Line (10am – 10pm) 1080 303 302

Emergency services (fire brigade, Garda, ambulance): 999 or 112.

Remember: if on campus, ring the College emergency number first: ext. 1999.
4.4 Guidelines for intervention and referral for non-urgent concerns

As with an emergency situation, if you are uncertain what to do you should consult with a member of the Student Counselling [01 896 1407] or the College Health Services' professional staff [01 896 1556]. In this situation, you can consult without disclosing the student's name.

The normal steps would be:

- Arrange to talk to the student or for another member of staff known to the student such as his or her Tutor - www.tcd.ie/Senior_Tutor to do so.
- Explain your concerns to the student.
- If s/he agrees with your concerns, check if s/he is attending a professional source of help within College or outside:
  - If s/he is attending a professional, seek his or her permission to liaise with this person.
  - If s/he is not attending a professional, seek his or her permission to arrange an appointment for him or her with either the Student Counselling Service (ext. 1407) or the College Health Service (ext. 1556). Contact either Service and explain your concerns and make an appointment for the student.
- If appropriate, give the student handouts on College support and out of hours support (see Appendix B).
- Arrange a follow-up appointment with the student to keep the lines of communication open.
- If the student is reluctant to accept a referral, see tips for referring reluctant students in Appendix C.

4.2 Guidelines for Students

Students concerned about the wellbeing of a friend should talk to a member of the college staff such as their own tutor or supervisor, their friend’s tutor, a lecturer or a head of discipline or School, any of the Student Services staff (Chaplains [01 896 1260 & 1901], Counsellors [01 896 1407], or Doctors [01 896 1556]). Students may also choose to contact the Students’ Union [normally the Welfare Officer – 01 646 6437] or the Graduate Students’ Union [01 896 1169], who will then contact the appropriate Student Services staff. The Counselling Service provides an emergency slot daily at 5 pm that may be used on such occasions. The College Health Centre also offers emergency appointments, at 9.30am and 2pm.

It is important that students share and discuss their worries and concerns with a staff member (see above) and obtain appropriate professional advice – it is not advisable for students to take on too much responsibility for dealing with such concerns themselves. Liaison with the relevant professional services will also enable the student they are concerned about to get the necessary supports.

4.3 Confidentiality

The purpose of this section is to inform students and staff of the principles guiding the flow of information about a student’s mental health. Confidentiality is considered under the following subheadings:

- General principles regarding confidentiality
- Professional codes of ethics (Doctors, Counsellors, Chaplains, Disability Officers, Occupational Therapists)
- Basic principles on sharing information
- When consent is not given
- Case conferencing
- How to respond to general requests for information from third parties i.e. parents and external bodies
- Freedom of Information Acts.

4.3.1 General principles regarding confidentiality

The important principles are:

- The University is committed to respecting the right to confidentiality of all students and all information disclosed by students relating to a person's mental health will be treated as confidential. Confidential information will only be disclosed with the person's consent. It will only be accessed and/or made available to others on a need-to-know basis for the purpose of the provision of, or access to, services, with the student's consent too.
The principle that no confidential information will be passed on to third parties without the express permission of the student concerned applies unless (a) there is a serious concern that there may be a threat to the safety or life of the student or of others or (b) it involves the investigation of a crime or is otherwise required by operation of law.

Information held by College complies with the requirements of the Data Protection Act and the Freedom of Information Act and relevant College policies.

In obtaining the student’s consent for information to be shared, it is important that staff clarify what the purpose is, and who will be given particular information, so that students can give their informed consent.

4.3.4 Where consent is not given
Students are entitled to refuse consent and such a decision should be respected. In such cases, they should be made aware of the implications of their choice in terms of accessing supports. Students may review their decision at any stage during their time in College.

Once a person is over the age of sixteen, s/he may give an effective consent to surgical, medical or dental treatment and it is not necessary to obtain any consent from her/his parent or guardian.

In some very exceptional circumstances (risk to someone’s life or criminal investigations), information may be given to the appropriate third parties without the student’s consent. In such circumstances, members of staff should consult the Senior Tutor’s Office (ext. 2551,1095 & 2004), the Health Centre (ext. 1556), the Student Counselling Service (ext. 1407), their line manager or their Head of School. Where possible, staff should inform the student of their intended actions; however, protecting the student’s safety or the safety of others takes precedence.

4.3.5 Case Conferencing
When there are concerns for the safety of a student or of others, a Case Conference may be called for all staff involved (a Senior Tutor/Dean of Graduate Studies, College Secretary, Heads of Health, Counselling and Disability, relevant academic staff, tutor, and relevant others) to identify the most appropriate way of assisting all concerned and ensuring their safety.

4.3.6 How to respond to requests for information from third parties
The College does not disclose any information to third parties (including parents) unless explicit permission to do so has been given by the student or there is a serious concern that there may be a threat to the safety or life of the student or of others, or if it involves the investigation of a crime or is otherwise required by operation of law. Occasionally, staff may receive calls from worried and concerned parents, friends or landlords. While it is entirely appropriate to listen to their concerns and to act on them if there is an at-risk issue, it
is not generally appropriate to divulge any information. If unsure of what to do, staff should immediately consult the Senior Tutor’s Office (896 2551/1095/2004), the Health Centre (896 1556), the Student Counselling Service (896 1407), their line manager or their Head of School. Out of hours advice may be sought from the Junior Dean / Registrar of Chambers via ext. 1999, the Warden of Trinity Hall 487 1772, or the Chaplains (ext. 1260 & 1901) who may be available.

4.3.7 Freedom of Information Acts
The College is a prescribed ‘public body’ subject to the terms of the Freedom of Information Acts, which provide: (a) a right for each person to access records held by public bodies; (b) a right for each person to have official information relating to himself or herself amended where it is incomplete, incorrect or misleading; (c) a right to obtain reasons for decisions affecting oneself made by a public body. There are also a number of exemptions from the right of access to information, such as the exemption applying to the personal information of other individuals.

Decisions on the exercise of one’s rights under the FOI Acts are made by appointed decision-makers in the College, with provision for review by more senior College staff. In relation to a record of a medical or psychiatric nature relating to a requester, the FOI decision-maker is permitted to refuse access where disclosure to the requester might be prejudicial to his or her physical or mental health, well-being or emotional condition but in such a case the requester must be advised that, if he or she wishes, access will be offered to a relevant health professional specified by the requester.

It should be noted that College is not the final arbiter regarding access to information and requesters have the right to appeal to the Information Commissioner and to the Courts.
FIGURE 1: HOW TO RESPOND TO A STUDENT EXPERIENCING MENTAL HEALTH DIFFICULTIES

Is the problem serious & urgent?
- Risk of harm to self or others? Risk of suicide? Out of touch with reality? Bizarre behaviour? Sudden behaviour, mood or personality change?

Emergencies
- Either you or other staff locate student and talk. Explain your concerns and worries.

Student unwilling to accept help
- If student not willing to accept help, explain that, due to concerns about their/others safety, you need to consult with Counselling, Health, and/or talk to family or next of kin.
- Give them choice in the first instance.
- See Appendix C for more details.

Non Emergencies Guidelines
- If unsure, ask Counselling, Health, Senior Tutor or Chaplains for advice (without disclosing student’s name).
- Arrange to talk to student.
- Explain concerns and suggest supports.

If student agrees with your concerns
Ask: are they seeing a professional?
- If YES, contact that professional, explain concerns and arrange appointment.
- If NO, suggest and organise appointment with Student Counselling or College Health.

If student not willing to accept help
- Organise a follow up meeting and monitor
- Mention supports again
Appendix X

Includes:

- Focus Group - Method
Focus Group Schedule (Pilot and Planned Cancelled Versions)

Participants

Pilot Focus Group

Participants for the pilot focus group consisted of 6 Social Care Yr. 4 students (2 males and 4 females). The Social Care Yr. 4 group was invited to volunteer in a pilot focus group. The participants were self-selected however the particular group was targeted specifically as the students would have a professional interest in this area, due to the nature of their study. Therefore it was hoped that insightful feedback could be provided.

Focus Group (cancelled)

Participants for the focus group would have consisted of those that had previously filled out the questionnaire. A separate information sheet which described briefly what the focus group would consist of was distributed amongst the questionnaire. Where interest was shown, the student would return the sheet to the researcher with their details (email address/ phone contact) thus focus group participants were self-selected. Questionnaire anonymity was not affected as it was a separate form. The number of self-selected participants (28) exceeded that required, so participants were randomly chosen by pulling 16 names from all those put forward, from a hat.

The participants chosen were contacted via email or mobile phone. However only three students identified that they would be willing to participate. Of these three, one student came forth (see ethics section) to meet with the research as she had concerns. It was decided at this point to cut the focus groups due to a poor student response and also to eliminate potential dis-ease among student participants. The names and contact details of the participants were only known to the researcher. No records of the names were kept on file after the research had been completed.

Procedure

Pilot Focus Group

The researcher presented to the CIT Social Care year 4 group and detailed the nature of the research study. Students were verbally informed of: what the focus group would consist of; re-assured that this was a pilot focus group and information detailed throughout the session
would not be imputed into the research; confidentiality and voluntary participation was explained similar to that detailed at the onset of the questionnaire distribution. The self-selected volunteers provided their email address for the researcher. The researcher then contacted the volunteers for the pilot focus group and detailed the focus group schedule, the date and time that the focus group would be conducted.

The pilot focus group was conducted in G Block in CIT, which was familiar and convenient to the participants. The pilot focus group commenced with the researcher introducing herself, the research and the purpose of the pilot focus group. The researcher reiterated voluntary participation and freedom to withdraw from participation. The researcher stated that full confidentiality would be upheld by her but as there was a group present full confidentiality could not be guaranteed by all. In an attempt to address this, it was stated that by signing the consent form (Appendix IV) students were agreeing to keep all information revealed in the focus group confidential. Name tags of cartoon characters were also provided in an attempt to further uphold confidentiality so that students would not be addressed by their real names. An information sheet (Appendix II) detailing support services was provided to all focus group participants. The researcher held the contact details of each of the participants for a period of time following the pilot focus group in the event that any follow up precautions were needed.

Care was taken to ensure all focus group participants were over the age of 18 and capable to consent as they were Year 4 college students and it would be an extreme rarity that a student in Ireland would be under the age of 18 at such a point in their college career. The facilitator (the researcher) followed the focus group schedule, asking follow up questions and probing throughout (detailed below). Notes were taken by means of a flip chart. There was a limit of allocated time given to each topic from the schedule (detailed below) to ensure that the focus group ran on time and that all topics were covered. Where time began to exceed that of what was allocated the facilitator (the researcher) gently advised the group that the discussion could be re-addressed at the end (if there was time) but that it was time to move onto the next topic. At the end of each section, the researcher re-iterated the main points that were made, back to the group to clarify what had been said, and to ensure that it was interpreted the correct way.

On concluding the pilot focus group a performance comment sheet (Appendix XI) was provided to the participants for feedback on the focus group (see pilot focus group feedback at end). Light refreshments were provided for participants on concluding the session.
Focus Group (Cancelled)

Actual focus groups to be recorded as part of the research did not take place (see section 5.7.11 Harm Minimisation), however they were planned to follow that of the procedure stated above.

Materials

Pilot Focus Group

The focus group concentrated in on some areas that were covered in the questionnaire and interviews, so that more in-depth information could be sought. The focus group schedule consisted of five different sections, including a vignette. The focus group schedule was developed through feedback from both supervisors. This was then intended to be further developed through the feedback provided after the pilot focus group.

The pilot focus group schedule that was provided to the participants, which consisted of the main questions (in **BOLD**), a more detailed one was developed for the facilitator which included potential follow up questions (not in bold), which is detailed below:

1. **Do you think the ‘student experience’ at third level has changed in recent times?**
   If yes, in what ways? Is it for the better or worse? (7mins)

2. **How do you think students cope with the loss of someone by suicide?** (10mins)
   Do you think there is a gender difference in this?
   If yes, in what ways? (5mins)

3. **How would you respond to the following scenario:**

   *Your friend Johnny has lost another friend Ian to suicide. You find Johnny has withdrawn into himself and he doesn’t like talking about Ian and what happened. You are unaware of what to do. Who would you turn to for advice/support?* (15mins)

Sometimes when a student here at CIT loses a friend to suicide, absolutely nobody is aware of it, as it may have happened in their home town in Mayo or Dublin for example. The 2013 Suicide Support and Information System suggests that proactive support increased levels of suicide bereaved availing of support services. Once
services were aware there had been a death by suicide, support services approached the family/individual directly and offered support.

4. **What are your views on proactive support; could this be introduced at third level?** (10mins)

5. **What kind of services in CIT could be developed that young men would use?**

Do you think sport plays an important role here? Why? (7mins)

**Focus Group (Cancelled)**

As previously noted, actual focus groups to be recorded as part of the research did not take place, however the schedule would have been similar to that previously stated with further amendments.

**Pilot Focus Group Feedback**

As a result of the feedback from the mock focus group participants, it was noted that Q1 regarding the ‘student experience’ posed difficulty: it was hard to understand as a time scale was not identified. Some students would find it difficult to compare as they have only been a student in third level for a short period of time. This question would have been developed on if the focus groups were to go ahead.
Appendix XI

Includes:

- Focus Group – Performance Comments Sheet
Performance Comments 😊

Please rate the following from 1 – 5. (Note 5 being of the highest value)

1. Explanation of 'Voluntary Participation', 'Confidentiality' and 'Freedom to Withdraw' from Participation? _____

2. Introduction by facilitator on the research study and purpose of focus group? _____

Please answer the following questions in the space provided.

3. Did you find anything difficult to understand, or that could be easily misinterpreted?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Where you offended by any of the questions asked, have you any suggestions for improvement?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Have you any further advice or suggestions?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix XII

Includes:

- Results: Students Source(s) of Information on Student Supports at CIT
The chart above depicts respondents' (male = 90, female = 83) source of information on student supports at CIT. Please note that respondents could include up to 8 different sources, therefore the percentages represent each service individually and is individually addressed from 100% (100% males = 200, 100% females = 99). For example, 44% of total of female participants (44) identified induction as the primary source of information of student support services, a lower percentage (22%) of male participants (44) identified induction as the primary source of information on student support services at CIT. The total percentage of students that identified induction was 29%.

The top three sources of information for respondents were as follows:

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>Induction</th>
<th>Word of Mouth</th>
<th>Posters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Female</td>
<td>44%</td>
<td>39%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Appendix XIII

Includes:

- Results: Respondents’ Reasons for Seeking Support Within CIT
The chart above depicts respondents' (male = 83, female = 32) reasons for seeking student supports within CIT. Please note that respondents could provide various responses as it was an open ended question, therefore the percentages represent each reason individually and is individually addressed from 100% (taking the number of respondents in this instance as 100% i.e. 83 males = 100%). For example, 50% of female respondents (16) identified convenience as the primary causation for seeking student support services within CIT, a lower percentage (46%) of male respondents (38) identified convenience as the primary causation for seeking student support services within CIT. The total percentage of students that identified 'convenience' was 48%.
Includes:

- Results: Respondents' Reasons for Seeking Support External to CIT
The chart above depicts respondents’ (male = 79, female = 51) reasons for seeking student supports external to CIT. Please note that respondents could provide various responses as it was an open ended question, therefore the percentages represent each reason individually and is individually addressed from 100% (taking the number of respondents in this instance as 100% i.e. 79 males = 100%). For example, 24% of female respondents (12) identified that they ‘didn’t want people to know’ as the primary causation for seeking student support services external to CIT, a slightly higher percentage (25%) of male respondents (20) identified that they ‘didn’t want people to know’ as the primary causation for seeking student support services external to CIT . The total percentage of students that identified ‘they didn’t want people to know’ was 25%.
Appendix XV

Includes:

- Results: Respondents’ Advice/ Suggestions on how to improve CIT Support Services
Advice To Improve CIT Support Services

It must be noted that there was a large number of participants chose not to answer this question, males [95 (45%)], females [36 (36%)]. The chart above depicts respondents’ (male = 105, female = 63) suggestions for student supports at CIT. Please note that respondents could provide several suggestions as the question was open ended, therefore the percentages represent each suggestion individually and is individually addressed from 100% (100% males = 200, 100% females = 99). For example, 14% of total of female participants (14) suggested ‘more advertising’, a lower percentage (13.5%) of male participants (27)suggested ‘more advertising’. The total percentage of students that suggested ‘more advertising’ for CIT support services was 14%. 
Appendix XVI

Includes:

- Results: Respondents experience of Suicide Deaths according to gender
Male Respondents’ Experiences

The charts above detail experiences expressed by suicide bereaved respondents. For example, 50% of male respondents (50) identified that they had lost a friend(s) by suicide. A total of 75 friends of 50 male respondents had died by suicide, of which 70 were male and 5 were female that died.
Appendix XVII

Includes:

- Results: Particularly Helpful in CIT when coping with a death by suicide
The high number of participants that opted not to answer this question was stark (males = 83, females = 20). The number of males respondents that answered the question are an extremely small minority (16), however half the number of female respondents answered (20). Please note that respondents could provide several suggestions as the question was open ended, therefore the percentages represent each suggestion individually and is individually addressed from 100% (100% males = 99, 100% females = 40). For example, 5% of total of female participants (2) identified ‘college peers’, a higher percentage (6%) of male participants (6) identified ‘college peers’ as particularly helpful at CIT in suicide bereavement.
Appendix XVIII

Includes:

- Research Audit Trail
The Research Audit Trail

The physical research audit trail

A physical audit trail documents the stages of a research study and reflects the key research methodology decisions. The physical audit trail for the research undertaken was as follows:

- **Identification of the research problem:** The incidence of young men dying by suicide is notably higher than young women in this country as the Central Statistics Office in Ireland details the trend of males representing on average 80% of all suicide deaths between 2003 – 2011 (www.cso.ie). Recent research such as the *My World Survey* (2012) detailed that there were a high number of young adults in Ireland struggling with mental health difficulties, and it has been noted in the *Reach Out* report (2005) that “Third level institutions have the opportunity to influence attitudes to mental health and help seeking among all students” (National Office for Suicide Prevention, 2005: 25). Ireland’s rate of youth suicide still remains the 5th highest in Europe (HSE, 2008).

In dealing and processing the loss of a loved one by suicide, Wertheimer details that, “suicidal thoughts are not uncommon during the early months of bereavement” (1991: 178). There has been a spate of recent incidents of such clusters in the Cork area. “Research by the National Suicide Research Foundation (NSRF) found a suicide ‘cluster’ involving 18 people – mainly adolescent and young men in a small area in Cork between Sept 2008 and March 2010” (http://www.irishexaminer.com/ireland/study-reveals-suicide-cluster-in-area-of-cork-157678.html).

- **Relevance of Research**

So, the research problem arises: is there a high number of young adults in Ireland exposed to suicide deaths; as there is a gender difference in suicide deaths in Ireland is this gender difference also reflected in individuals responses to suicide; are young adults aware of the effects that have accrued (if any) resulting from dealing with a death by suicide; are the college supports that are in place efficient and effective in supporting vulnerable students? By conducting research in this area, these outstanding questions can be addressed (primarily in the instance of CIT students) and the well-being of students can be further ensured.

- **The Research Proposal:** Based on the research problem, a proposal was developed specific to one Third Level College (CIT) and was submitted to HETAC for approval.
This proposal included an outline of the study, its aims and objectives, and the research questions. The purpose of this study was to gain a better understanding of what it is like for CIT students to respond to a death by suicide, their awareness, use of and attitudes towards support services and to find out if there are gender differences in these. The research aimed to establish a professional perspective also and look at what further initiatives/support services could be developed and introduced to help the mental health of students attending CIT.

- **Reviewing the Literature:** An in-depth review of some of the main causes of suicide was undertaken, however the Literature Review did not offer an exhaustive list of factors as that list may be endless as one individual’s causation may vary to the next in accordance with their own life experiences. The word ‘suicide’ appeared in the English language only in 1635 (Alvarez, 1990, pp.59-93), more 3 centuries later, suicide was decriminalized in Ireland, in 1993. Suicide in this respect is a phenomenon that has only recently been tackled, whilst much research and development has been conducted in this area; when Catholicism dominated the Irish Culture, suicide was regarded as a mortal sin, thus the slow cultural/social shift in society acknowledging that suicide is a problem.

- **Designing a research framework:** The next step involved designing a research framework to support the collection of empirical evidence. Grounded theory in the social sciences involves the discovery of theory through the analysis of data. This research started without preconceptions of outcomes, it was of an investigative and interpretative nature and in this way, the framework of grounded theory is reflected in the study. With a foundation in grounded theory, the research can also be contended with what Mertens (2007/’09/’10/’13) described as the ‘transformative paradigm’, this paradigm can be seen as congruent with the research aims. The transformative approach has a goal of social change and utilises community involvement in creating direction and focus. Transformative research appears to be inclusive, both of research subjects as well as a relatively small group of ‘experts’ in the area (Merten & Ginsberg, 2009). This is reflected in the participants of this research as it included CIT students as well as professionals. This research was community centred and set out to ensure authenticity by voicing those within it.

In response to research question one ‘what are CIT student attitudes and responses to suicide? Are there gender differences in these?’ a quantitative approach using a
questionnaire with CIT students was undertaken. Quantitative research evidence provides an indication of the scale of an issue, it provides a study with impact and grabs the reader’s attention, according to Burton, Bundrett and Jones (2008).

In response to research question two ‘how aware are students of the supports available to them in dealing with mental health problems (of self and others) and what are their attitudes to and usage of these? Do attitudes to accessing/using supports vary according to gender?’ a quantitative approach was adopted for both parts of the question through the same questionnaire as afore mentioned. A qualitative approach was also adopted for the second part of the question through interviews conducted with professionals both within CIT and externally, primarily involved in student supports. Qualitative research may be defined as the “study of things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meaning people bring to them” (Denzin & Lincoln, 1994: 2, cited in Needgaard & Ulhøi, 2007: 5). Combining both quantitative and qualitative can add profound insight into the area of research. Burton, Bundrett & Jones state that “combining evidence from these forms can significantly add to the strength and depth of an argument” (2008: 146).

In response to research question three ‘what changes or further initiatives in CIT support services are needed to best help students respond to and cope with suicide and suicidal ideation (self and others)?’ both a qualitative and quantitative approach was adopted through the afore mentioned interviews and questionnaire. However, the phrasing of this question in the questionnaire was of a qualitative nature, it was open ended thus allowing for detailed viewpoints from participants. It was imperative to gain viewpoints from both parties of this research so see if there was a viewed need for improvement and to make comparisons (if any) on developments identified.

Revoked Research Method

In addition, it was initially planned that two focus groups would be held, see Appendix X for detailed plan. However, in the application of the ethical protocol, it was decided not to hold the focus groups.

- **The Interview Schedule:** The 7 semi-structured interviews were part of the primary source of evidence. Based on issues identified in the literature review and in defining
the research problem, in line with the established research questions, an initial interview schedule was prepared. This was refined through feedback from both supervisors and consisted of four main sections: Role; Policy/Guidelines; Gender and Responses; Future Developments. The interview schedule remained extremely similar for six of the interviewees (see Appendix V). The interview questions for the external expert varied slightly but the schedule still consisted of the four main sections (see Appendix VI). However regardless of the interview schedule, each interview was slightly different as follow up questions sometimes emerged on the spot from what was said by the interviewee.

The interviews with the support providers revealed a flaw in the research method: in the third section ‘Gender and Responses’ there should have been greater clarification in the breakdown of the type of support being sought. As a contradictory gender difference to other research findings was established; detailing that more males seek help from SUWOs at CIT, TCD and UCC than females. However, as the SUWOs role varies greatly in dealing with financial issues, accommodation issues, relationship issues, mental health issues, it would have been worthwhile establishing the main presenting issues that men seek out support from the SUWO for.

- The Questionnaire: The distribution of questionnaire amongst 325 CIT students was part of the primary source of evidence. During the researcher’s latter stages of her undergraduate degree, a questionnaire with similar purpose was developed. Based on issues identified in the literature review and in defining the research problem, the initial questionnaire was rigorously examined, it was subsequently refined through: piloting, feedback from supervisors, feedback from the CIT ethics committee, the CIT SUWO and the CIT Student Affairs Manager. The questionnaire and went through six drafts before it was finalized. The questionnaire provided an indication of the scale of students that were suicide bereaved and provided the study with impact as other research questions were addressed.

- Selection of interviewees and questionnaire respondents: In order to achieve scope of the research problem, the questionnaire was distributed to eight purposively sampled groups attending college at the main campus of Cork Institute of Technology, as it is the most populated campus. As the research is based on those whose age ranges between 18-25, it was decided that classes would be chosen from
2nd and 3rd year students. The percentage gender ratio for 2nd and 3rd years of the different departments was sought from CIT administration office. On this basis the classes were chosen, so that there would be a balanced gender representation of each faculty.

In order to achieve breadth and depth of coverage across the research issues, 7 purposive sampled interviews were conducted with key informants. As the research was based in CIT, for interviewees consisted of support providers at CIT: the Chaplain; the Nurse; the SUWO; the Counsellor. Two further external interviews were conducted with the UCC and TCD SUWOs as they are student support providers in the only colleges (at that time) that had a Mental Health Policy in place for more than 3 years. Finally a recognized, national expert in suicide prevention research was recruited for her comparative and contextual insight: the Director of Research at the National Suicide Research Foundation.

Transformative research appears to be inclusive, both of research subjects as well as a relatively small group of ‘experts’ in the area (Merten & Ginsberg, 2009). This is reflected in the participants of the research as it included CIT students as well as professionals, thus, ensuring an authentic communal voice was established from the research conducted.

- **Evidence collection:** In total 7 semi-structured interviews were conducted. These lasted on average 30 minutes and were recorded and transcribed. These transcriptions were later verified by informants. Over all, a total of 299 surveys were collected and used as part of this research from 325 surveys that were distributed. Student responses that fell outside of the targeted age range or where gender had not been specified were excluded on collation. It took an average of approximately 12 minutes to complete the questionnaire. The interview transcriptions, questionnaires as well as project documentation, independent reports, newspaper articles and website details were used in developing the study’s emerging findings.

- **Managing and analyzing evidence:** A grounded theory approach was used to analyze the questionnaire data. SPSS software was useful in managing the body of evidence and aided the conduction of significant testing of data. Through data comparison several ideas/points emerged from the interview transcripts and these
were coded into key concepts following the four pre-existing from the interview schedule.

- **Distillation of a new theory:** Reflecting on the findings separately and the findings as a whole, relationships between key findings were further explored. Through this process the study's theoretical conjecture was distilled. These contributions added to the ever growing body of knowledge on suicide and various aspects associated with it.

**Conclusion**

The above audit trail is a simple but useful strategy for determining the trustworthiness of research inquiry. From a researcher's perspective, the need to produce an audit of his/her study upon its completion is an important factor in ensuring that significant emphasis is placed on the theoretical, methodological and analytical decisions made throughout the study and that the researcher critically reflects and evaluates the decisions made.
Includes:

- Results: Respondents coping mechanisms when responding to a death by suicide
What Respondents’ Did That Helped them Cope

The following chart details what coping mechanisms respondents used i.e. what they did when attempting to come to terms with a death by suicide:

It must be noted that there was a large number of participants chose not to answer this question, males [44 (44%)], females [12 (30%)]. The chart above depicts respondents’ (male = 55, female = 28) coping mechanisms in responding to a death by suicide. Please note that respondents could provide several suggestions as the question was open ended, therefore the percentages represent each suggestion individually and is individually addressed from 100% (100% males = 99, 100% females = 40). For example, 37.5% of the total of female participants (15) indicated that ‘talking to family and/or friends’ helped them cope, a lower percentage (14%) of male participants (14) indicated this. The total percentage of students that indicated they felt ‘talking to family and/or friends’ helped them cope was 21%.
Appendix XX

Includes:

- Informative letter sent to interviewees on completion of the research study.

Note: A similar version was sent to various Heads of Department also.
Dear

My name is Sandra Conroy. Early last year I was in contact with you regarding research which I hoped to conduct for my MA (by research) in Social Care. The research was carried out over 2 years (2012 – ’14) and has now come to an end. First and foremost I would like to extend my thanks to you for participating in this research, without each of the key informant interviews, this research would not have been possible.

A Brief Synopsis of Research Conducted:

This research study endeavored to understand what it is like for CIT students to respond to a death by suicide by means of their awareness, attitudes and usage of supports and establish if gender tends exist. In order to achieve scope of the research problem, a purposively developed questionnaire entitled ‘Suicide Awareness’ was administered to eight sampled groups consisting of a total of 325 students attending CIT (of which 299 responses were used as part of this research). This research also aimed to look at what further initiatives/support services could be developed and introduced to help the mental health of students attending CIT. For added breadth and depth across the research issues, 7 interviews were conducted with key informants: the professional student support providers at CIT; the Students Union Welfare Officers at UCC and TCD; the Director of the National Suicide Research Foundation.

The research revealed that just under half of questionnaire respondents experienced a death by suicide of which a mere 6% of males and 12.5% of females indicated they sought professional support. Interestingly, in response to personal problems, CIT lecturers were overwhelmingly recognized as the most helpful source of support with little gender difference (+/- 5%). Students are concerned about each other’s mental health and appreciate the accessibility of familiar, semi-formal supports, such as lecturers; sports trainers; Heads of Departments. There is some awareness of formal professional supports but this can be improved and it appears that stigma persists in relation to mental dis-ease and illness.

An overwhelming majority of student respondents indicated that they would be more inclined to seek support via the internet (m = 87.5%, f = 87%). However, a majority of interviewees
proved reluctant to embrace such an initiative and were cautious that it might replace ‘face to face’ counselling which was viewed as a negative outcome.

The following are the recommendations that arose from the research conducted:

1.) Training Opportunity - This research revealed that lecturers are an important source of support for CIT students. In line with the ‘safeTALK’ programme that is already available to students and staff at CIT, the potential positive outcome of introducing a further safekeeping programme such as one entitled ‘gatekeepers role’ is a necessity. This programme could be facilitated by the counselling service (similar programmes have been presented by the counselling service in other colleges), to ensure that it is cost effective and immediately relevant to CIT. The student counselling service would have extenuating experience with current presenting student issues and would be in an excellent position to provide direction on what it is to be a ‘gatekeeper’ for academic/ front line staff at CIT, and inform them that indeed, many have already been fulfilling this role. The value of developing in house training returns to the positionality and authenticity of the community voice and has strengths over bought in programmes (i.e. the safeTALK programme being purchased by the HSE from the US).

The purpose of offering further training would be to further ensure both student and staff safety when/if they are dealing with delicate situations. The training could be offered to staff at the beginning of each semester, whereby it would be either a half day/ day programme. The priority for roll out would be to Heads of Departments and Course Co-ordinators and thereafter to all active teaching academic staff in line with the My World Survey principle and the findings of this study.

2.) Aspects of Pro-Active Support – Findings from secondary research and perspectives held by interviewees suggest that aspects of pro-active facilitation of support is an area of development in third level colleges that should be addressed. This research study aligns itself with other Irish research such as the My World Survey revealing that many third level students (in CIT in this instance) are evidentially going through a difficult period in their lives and services are always looking for ways to reach them, having a pro-active approach is one.

Two aspects of pro-active support have been identified during this research as potentially useful in CIT: to send an email to students informing them of a particular service and inviting
them to try it (as seen in TCD, and further to a written email, attach a video which would cover various aspects of mental health and visually detail: what the service is; where it is; who you would expect to meet. This can take some of the fear away as they are aware of what they will be greeted with, should they choose to attend the service. However, if a pro-active approach is to be taken with a service, the service must be in a position to uphold what is being offered, i.e. availability.

Further research could evaluate the effectiveness of using aspects of pro-active facilitation by recording the number of students presenting (are they increasing/ decreasing) but also by means of recording how the student came about using a particular service (word of mouth or by means of an email which prompted them to go and seek help).

3.) Online Support – This research reports that an overwhelming majority of CIT students identified that they would be more inclined to seek support were counselling services available online. The introduction of online support/ counselling presents as an area of exciting new development and it should be addressed by more third level colleges. There is a significant body of evidence developing internationally which suggests that young people will access and are using online counselling service. Such an initiative has been implemented in TCD and the evaluation proved a positive outcome by both staff and students at TCD. There is no reason why other third level colleges (such as CIT) could not develop a similar initiative.

Further research in this area could establish what the main areas of concern are for students that would motivate them to seek support online. A descriptor of the service could be established i.e. the level of support online counselling could provide (this is evidenced in TCD whereby students’ progress to ‘face to face’ counselling where further support is deemed necessary. Evaluation should also be conducted as part of the development of this new initiative whereby both students and staff provide feedback on their experiences and identify issues (if any).

4.) Mental Health Policy Introduction – This research study identified that all CIT interviewees concurred that there needs to be further institute guidance in relation to supporting suicide bereaved students. There is also strong value seen in the development and introduction of a Mental Health Policy (particularly as the development of institute guidance on suicide could fall under this umbrella). CIT are currently developing a Mental Health Policy, the first draft of which was due to be submitted 12th May 2014. This draft will be
assessed by a number of selected committee members (consisting of those involved in student services). A further draft is then due to be drawn up. One area that has been excluded from previous Mental Health Policies is its evaluation. The Mental Health Policy (for CIT) should consist of guidelines of its implementation and its evaluation. Evaluation should be conducted internally and externally and it should be done on an annual basis.

The evaluation on the implementation of a Mental Health Policy at CIT will further determine its purpose and the level of its effectiveness as this could not be identified by the interviewee participants of this study (TCD SUWO, UCC SUWO) where Mental Health Policies had been in place for over 3 years.

If you wish to find out anything further about the research or you have any questions or queries in relation to this, please do not hesitate to contact me. My supervisors for the duration the research are:

Dr. Áine deRóiste  
Department of Social and General Studies  
Email: aine.deroiste@cit.ie

Ms Moira Jenkins  
Department of Social and General Studies  
Email: moira.jenkins@cit.ie

Yours sincerely,

Sandra Conroy  
Postgraduate Research Student  
Cork Institute of Technology  
Email: sandra.conroy@mycit.ie  
Phone: 0862064810
Appendix XXI

Includes:

- Chi Square Test on Gender and Awareness of Services (all respondents)
- Post Hoc Test on aforementioned Chi Square Test.
Students that completed Section A - (all questionnaire respondents)

Chi Square Test – Gender and Awareness of Supports

To further test for gender differences in students awareness of support services, statistical analysis was conducted:

<table>
<thead>
<tr>
<th>Gender * Student Awareness of Support Services</th>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
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</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Gender</td>
<td>299</td>
</tr>
</tbody>
</table>

Gender * Student Awareness of Support Services Crosstabulation

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Student Awareness of Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Male</td>
<td>90</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>45.0%</td>
<td>55.0%</td>
</tr>
<tr>
<td></td>
<td>52.0%</td>
<td>87.3%</td>
</tr>
<tr>
<td></td>
<td>30.1%</td>
<td>36.8%</td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
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</tr>
<tr>
<td></td>
<td>83.8%</td>
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</tr>
<tr>
<td></td>
<td>48.0%</td>
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<tr>
<td></td>
<td>27.8%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Total</td>
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<tr>
<td></td>
<td>57.9%</td>
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**Chi-Square Tests**

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<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>40.968</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction(^a)</td>
<td>39.390</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
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<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Assoc.</td>
<td>40.831</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 41.72.
b. Computed only for a 2x2 table

**Symmetric Measures**

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<tr>
<th></th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phi</td>
<td>-.370</td>
<td>.000</td>
</tr>
<tr>
<td>Cramer's V</td>
<td>.370</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
</tr>
</tbody>
</table>

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between *gender* and *awareness of services*, \( \chi^2 (1, n = 299) = 3.70, p = .000 \), \( \phi = -.370 \). Therefore, the level of CIT students’ awareness of support services available is linked to whether they are male or female.
Students that completed Section A - (all questionnaire respondents)
Post Hoc Test on Chi Square Test – Gender and Awareness of Supports

<table>
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<tr>
<th>Case Processing Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cases</strong></td>
</tr>
<tr>
<td>Valid N</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Student Awareness of Support Services * Gender</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Awareness of Support Services * Gender Crosstabulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Student Awareness of Support Services</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
<tr>
<td>Residual</td>
</tr>
<tr>
<td>Std. Residual</td>
</tr>
<tr>
<td>Unanswered</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
<tr>
<td>Residual</td>
</tr>
<tr>
<td>Std. Residual</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
</tbody>
</table>

The standardized residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.

<table>
<thead>
<tr>
<th>Chi-Square Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>Pearson Chi-Square</td>
</tr>
<tr>
<td>Continuity Correction&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
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<tr>
<td>Linear-by-Linear Association</td>
</tr>
<tr>
<td>N of Valid Cases</td>
</tr>
</tbody>
</table>

<sup>a</sup> 0 cells (0.0%) have expected count less than 5. The minimum expected count is 41.72.

<sup>b</sup> Computed only for a 2x2 table

The sample size requirement for the chi square test of independence is satisfied as 0 cells have the expected count less than 5 and the minimum expected count is 41.72.
Appendix XXII

Includes:

- Chi Square Test on Gender and Awareness of Counselling Service (all respondents)
- Post Hoc Test on aforementioned Chi Square Test.
Students that completed Section A - (all questionnaire respondents)

Chi Square Test – Gender and Awareness of Counselling Service

To further test for gender differences in students awareness of the counselling service, statistical analysis was conducted:

<table>
<thead>
<tr>
<th>Case Processing Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cases</strong></td>
</tr>
<tr>
<td><strong>Valid</strong></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Gender * Counselling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender * Counselling Crosstabulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counselling</strong></td>
</tr>
<tr>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>% within Gender</td>
</tr>
<tr>
<td>% within Counselling</td>
</tr>
<tr>
<td>% of Total</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>% within Gender</td>
</tr>
<tr>
<td>% within Counselling</td>
</tr>
<tr>
<td>% of Total</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>% within Gender</td>
</tr>
<tr>
<td>% within Counselling</td>
</tr>
<tr>
<td>% of Total</td>
</tr>
</tbody>
</table>
### Chi-Square Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>36.010</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>34.543</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>36.558</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>35.889</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 44.70.
b. Computed only for a 2x2 table

### Symmetric Measures

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phi</td>
<td>-.347</td>
<td>.000</td>
</tr>
<tr>
<td>Cramer's V</td>
<td>.347</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>299</td>
<td></td>
</tr>
</tbody>
</table>

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between gender and awareness of the counselling service, $x^2 (1, n = 299) = 3.47, p = .000$, phi = -.347. Therefore, the level of CIT students’ awareness of the counselling services is linked to whether they are male or female.
Students that completed Section A - (all questionnaire respondents)

Post Hoc Test on Chi Square Test – Gender and Awareness of Counselling Service

<table>
<thead>
<tr>
<th>Case Processing Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
</tr>
<tr>
<td>Valid</td>
</tr>
<tr>
<td>N</td>
</tr>
<tr>
<td>Counselling * Gender</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Counselling * Gender Crosstabulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Count</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
<tr>
<td>Residual</td>
</tr>
<tr>
<td>Std. Residual</td>
</tr>
<tr>
<td>Count</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
<tr>
<td>Residual</td>
</tr>
<tr>
<td>Std. Residual</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Expected Count</td>
</tr>
</tbody>
</table>

The standardized residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.

<table>
<thead>
<tr>
<th>Chi-Square Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
</tr>
<tr>
<td>Pearson Chi-Square</td>
</tr>
<tr>
<td>Continuity Correctionb</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
</tr>
<tr>
<td>N of Valid Cases</td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 44.70.
b. Computed only for a 2x2 table
The sample size requirement for the chi square test of independence is satisfied as 0 cells have the expected count less than 5 and the minimum expected count is 44.70.
Appendix XXIII

Includes:

- Chi Square Test on Gender and Awareness of Services (*Suicide Bereaved respondents*)
- Post Hoc Test on aforementioned Chi Square Test.
Students that completed Section A & B - (Suicide Bereaved questionnaire respondents)  
Chi Square Test – Gender and Awareness of Supports (suicide bereaved).

The following Tables detail a Chi-Square Test for independence which was conducted to establish whether there was a significant difference in the number of suicide bereaved males and females that expressed awareness of student services.

### Case Processing Summary

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>Gender * Student Awareness of Support Services</td>
<td>Valid</td>
<td></td>
<td>Missing</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Gender * Student</td>
<td>139</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>139</td>
</tr>
</tbody>
</table>

### Gender * Student Awareness of Support Services Crosstabulation

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Count</th>
<th>% within Gender</th>
<th>% within Student Awareness of Support Services</th>
<th>% of Total</th>
<th>Female</th>
<th>Count</th>
<th>% within Gender</th>
<th>% within Student Awareness of Support Services</th>
<th>% of Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td>73</td>
<td>52.5%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>66</td>
<td>47.5%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>139</td>
</tr>
</tbody>
</table>

Note: The tables and figures are presented as text due to the limitations of the format. Please refer to the original document for a complete visual representation.
### Chi-Square Tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>31.641*</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction&lt;sup&gt;b&lt;/sup&gt;</td>
<td>29.566</td>
<td>1</td>
<td>.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>35.474</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>31.413</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>139</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 18.99.
b. Computed only for a 2x2 table

### Symmetric Measures

<table>
<thead>
<tr>
<th>Type</th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal Phi</td>
<td>-.477</td>
<td>.000</td>
</tr>
<tr>
<td>Cramer's V</td>
<td>.477</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>139</td>
<td></td>
</tr>
</tbody>
</table>

A Chi-square test for independence (with Yates Continuity Correction) indicated a significant association between gender and awareness of services, \( \chi^2 (1, n = 139) = 4.77, p = .000 \), \( \phi = - .477 \). Therefore, the level of CIT students awareness of support services available is linked to whether they are male or female.
Students that completed Section A & B - (Suicide Bereaved questionnaire respondents)

**Post Hoc Test** on Chi Square Test – Gender and Awareness of Supports (suicide bereaved)

### Case Processing Summary

<table>
<thead>
<tr>
<th></th>
<th>Cases</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>Student Awareness of</td>
<td>139</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>139</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support Services * Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Student Awareness of Support Services * Gender Crosstabulation

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Awareness of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Services</td>
<td>Yes</td>
<td>Count</td>
<td>37</td>
<td>36</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>52.0</td>
<td>21.0</td>
<td>73.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>-15.0</td>
<td>15.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Residual</td>
<td>-2.1</td>
<td>3.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unanswered</td>
<td>Count</td>
<td>62</td>
<td>4</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>47.0</td>
<td>19.0</td>
<td>66.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>15.0</td>
<td>-15.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. Residual</td>
<td>2.2</td>
<td>-3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>99</td>
<td>40</td>
<td>139</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expected Count</td>
<td>99.0</td>
<td>40.0</td>
<td>139.0</td>
<td></td>
</tr>
</tbody>
</table>

The standardized residuals are greater than 2 suggesting a strong difference between the observed and expected frequency cell counts.
### Chi-Square Tests

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>31.641a</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Continuity Correctionb</td>
<td>29.566</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>35.474</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>31.413</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>139</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 18.99.

b. Computed only for a 2x2 table

The sample size requirement for the chi square test of independence is satisfied as 0 cells have the expected count less than 5 and the minimum expected count is 18.99.