Talking Points and Data Briefing on Suicide Prevention for Men

Take-Home Points:

- Men, particularly men in the middle years and older, are at disproportionately high risk of suicide compared to other demographic groups.
- Warning signs of acute mental health crisis and suicidality in men may be misinterpreted. But they warrant immediate concern, especially in conjunction with life stressors.
- Most suicidal crises are short-lived; putting time and space between a suicidal person and highly lethal means is crucial. Suicide rates, gun ownership, and proportion of the population that is white and male are all higher in rural areas.
- Whereas women appear to attempt suicide at higher rates than men, men die at much higher rates than women. The choice of more highly lethal means (i.e. firearms) by males appears to account for a significant amount of this disparity. Addressing access to lethal means is an important prevention strategy for this population.
- Health care and work-related settings provide additional opportunities to identify and intervene with men who are potentially suicidal.

Why Focus on This Population?

Although men in the middle years – that is, men 35-64 years of age – represent 19 percent of the population, they account for 40 percent of the suicides in this country.[1] Unless we begin to focus efforts on the population at highest risk of suicide, we will not see the kind of change in suicide rates that we need to see.

Men in middle age and older are dispersed throughout the community, and may often be reluctant to ask for help. A suicide prevention focus on men requires engaging new, non-traditional partners (workplaces, local businesses, gun shops, firing ranges) as well as more traditional ones (primary care, hospitals/emergency departments) to help us reach men and their helpers, with the message that their pain is recognized, and help is available.

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[1] University of Rochester Center for the Study & Prevention of Suicide, Washington, DC: Scientific Consensus Conference, June 11-12, 2003. 12p. (http://www.sprc.org/sites/default/files/resource-program/SPRC_MiMYReportFinal_0.pdf)

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Suicide Among Men

Data

Men are at disproportionately high risk of suicide death compared to women. From 1993-2013, 78% of the 73,705 Californians that died by suicide were male[2]. The majority of those men were White (70%), followed by Hispanic (17%) and Asian/Pacific Islander (8%).

The rate and number of suicides among adults aged 35-64 has been increasing nationally.[3] One-third of men in California who die by suicide are between the ages of 45-64[2].

Men account for 40% of hospitalizations or Emergency Department treatment due to self-inflicted injuries in California[2]. Poisoning was the most prevalent cause of self-injury for both sexes.

Risk and Protective Factors for Men

- Risk factors include:
    - Depression or disrupted mood
    - History of suicidal behavior (ideation and/or attempts)
    - Alcohol use disorders and intoxication
    - Access to firearms
    - Chronic or acute illness or disability
    - Financial stressors both immediate (job loss, lay-offs) and/or ongoing (low income, low status occupation)
    - Intimate partner problems (custody disputes, divorce, breakups, separation, intimate partner violence)
    - Criminal justice involvement (arrest, incarceration, court cases, probation)
- Protective factors include:
    - Access to effective health and behavioral health care
    - Social connectedness and supports
    - Constructive coping and problem-solving skills
    - Reasons for living and sense of purpose

Preventing Suicide Among Men

[2] California Department of Public Health, EpiCenter database (http://epicenter.cdph.ca.gov)
[3] Centers for Disease Control. "Suicide among adults aged 35-64 years—United States, 1999-2010." MMWR, May 3, 2013

- There are challenges with reaching men as a group: they are dispersed throughout communities and no agency or system is dedicated to promoting men's mental health. Signs of distress may be concealed or misinterpreted.
- Approaches need to be designed to reach men where they live, work, and recreate. Specific strategies and partnerships within each community need to be developed to further this goal.
- A multi-faceted and comprehensive approach is needed both during crisis situations, as well as to prevent a crisis from developing, and in the aftermath of a crisis:

   1. If a suicide crisis has developed, put as much separation between the individual and highly lethal means as possible.
   2. Encourage connection with social supports and services that can reduce the burden of life problems that impact risk.
   3. Promote resiliency through behavioral health treatment for substance use issues and to enhance problem solving and coping skills.
   4. In the big picture, encourage boys and young men to feel more comfortable with their feelings, reach out when support is needed. Also encourage men to act as supports for one another and serve as role models for younger men and boys in dealing with life's problems.

Additional Information

Socio-cultural Factors

As a group, men are traditionally socialized to embody values such as strength, toughness, and being a good provider and protector of family and property. It can be difficult to display vulnerability and appear weak, such as by recognizing the need for help and asking for it. Emotional despair in men may be masked by emotions and behaviors more in line with perceived expectations: stoicism, recklessness, increased drug or alcohol use, excessive working, anger and irritability, and resentment. It may also manifest in physical symptoms such as sleep issues, fatigue, and chronic pain.

Men in the middle years tend to experience higher risk of suicide in conjunction with external problems and negative life events, than younger men and women. Financial, employment, and legal problems elevate risk in this group as well as interpersonal relationship problems, such as child custody issues or divorce. Men in lower income brackets are at higher risk than those in higher income brackets.

Research on protective factors for men is also limited. Strategies to specifically boost resilience, especially among boys and younger men, are needed to "inoculate" them in the later years.

A recent qualitative study from Australia[4] used focus groups and screening tools to identify themes common among men who had survived a suicide attempt. Their findings help shed light on risk as well as prevention:

1. Although each man's story was unique, there were common elements of adversity, distress, and poor decision-making producing a "downward spiral" that tended to worsen over time and create barriers in interpersonal relationships and attempts to receive help.

Specific risk factors included:

- a period of depression or disrupted mood (anger, irritability, changes in sleep and appetite, negative perception of life events);
- unhelpful conceptions of masculinity such as stoical beliefs and values;
- social isolation and coping strategies centered around avoidance;
- at least one, and often many, life stressors that added up to a feeling of being overwhelmed and unable to turn things around.

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[4] What Interrupts Suicide Attempts in Men: A Qualitative Study. Player, M.J. et. al. June 19, 2015. PLOS. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128180

2. Men at risk of suicide tended to misinterpret their behavior and thinking and systematically minimize the seriousness and implications of the changes. Family and friends also might miss signs that "didn't look like depression". Agitation, moodiness, irritability, and isolation left others afraid of making things worse or saying the wrong thing.

3. Strategies for reducing risk include recognizing the warning signs as they appear in men, addressing male-specific risk factors, helping men to recognize their own moods and behaviors and develop better strategies for self-care, and willingness to reach out and accept help from their friends, families, and communities (including mental health professionals).

4. Acute risk can be reduced through distraction to other activities and thoughts, practical and emotional supports, and professional intervention. Other considerations include physically limiting their capacity to choose death, through access to lethal means (removing or locking firearms or medications) and possibly hospitalization.

5. Also important are practical help with life problems and focusing on their role and obligations in their family and community. Build positive momentum by setting small and achievable goals to disrupt the sense that things are inexorably spiraling downward. Remind them of how negatively it would impact their family and friends if they died. Have regular contact with a person or people they can discuss problems with and "let off steam" in a positive way.

Access to Lethal Means

Data on means used in suicide deaths demonstrates that firearms are responsible for the majority of suicide deaths. Means used in attempts that do not result in death, but require medical attention, are more likely to be poisoning or cutting/piercing. Most suicide crises or temporary, and the more time and space between an individual considering suicide, and lethal means, the more opportunity for intervention.

Means of Suicide, California, 1993-2013

- Firearms (45,385)
- Hanging/Suffocation (18,286)
- Poisoning (14,202)
- Other
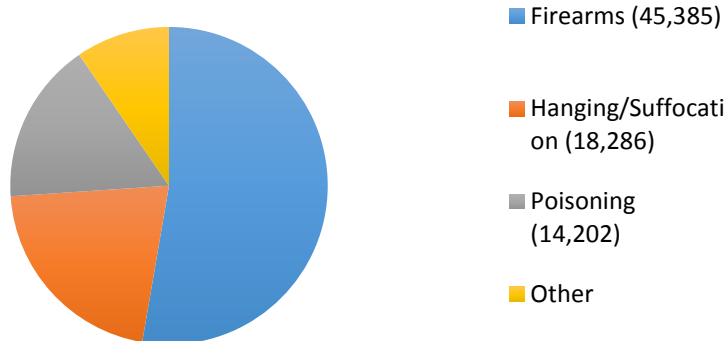
Firearms

Between 1993-2013, slightly more than 60% of suicide deaths occurred by firearms. Men are significantly more likely to use a firearm in their suicide attempt; 40% of the men who died in this decade used a firearm, and about a quarter of the women.
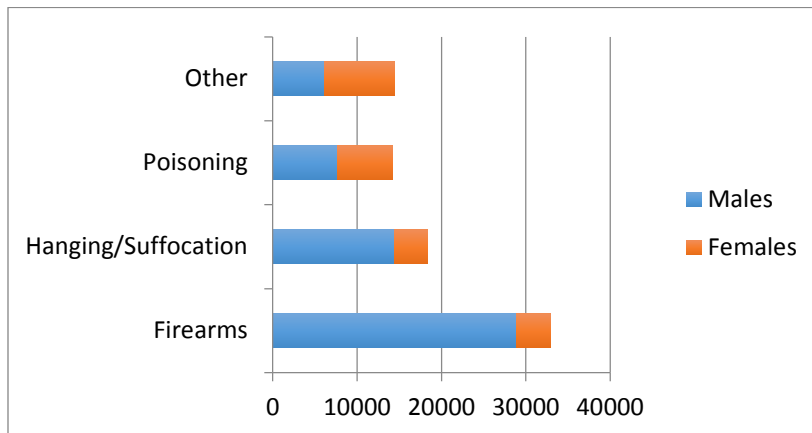
According to a Pew Research Center study[5], three-quarters of gun owners are male, and 82% are white. Men are three times as likely to own guns as women, and middle aged and older men are more likely than younger men. People living in rural areas are twice as likely to own guns as those living in urban areas. So, gun ownership is concentrated in the same population that has the highest rate – and number – of suicides.

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[5]Pew Research Center. Why Own a Gun? 2013. Section 3: Gun ownership trends and demographics. (http://www.people-press.org/2013/03/12/section-3-gun-ownership-trends-and-demographics/)

Around 20% of Californians are registered gun owners. Legal gun ownership is closely tied to social and cultural factors, such as recreational activities (gun clubs, shooting ranges).

Medications

Individuals taking medications that are prescribed to control or treat certain conditions can become dependent on them, leading to substance abuse-related problems that can exacerbate suicide risk. Physical conditions that include chronic pain or other features are themselves risk factors. Side effects of certain medications may include suicidal thinking or behavior, or otherwise contribute to the risk of developing suicidal thoughts or behaviors. Overdose on medications can become the means of suicide. high risk individuals may need particular strategies to help reduce their access to medications to avoid overdoses. Such strategies may include being provided with smaller quantities of medication, use of lock boxes for safe storage, or a temporary change in prescription until the crisis is resolved.

Alcohol Use

The relationship between alcohol use and suicide is complex. At the population level, per capita alcohol consumption is linked to higher rates of suicide, and there is evidence that restrictive alcohol polices, such as increased taxes, decreasing the density of outlets that sell alcohol in a geographic area, zero tolerance laws, and other limits on sales, can help prevent suicide[6].

At the individual level, alcohol's disinhibiting effect can increase impulsivity and suicidal behavior, and alcohol may also be used to self-medicate emotional distress. Risk appears to be higher among people who have an alcohol problem versus those who use alcohol socially or infrequently, and in people who are also experiencing mental health challenges such as depression[7]. Increasing use of substances, including alcohol, is a warning sign of suicide risk.

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[6] Xuan Z, et al. Alcohol policies and suicide: A review of the literature. *Alcoholism Clin & Exp Research*. 2016. (http://onlinelibrary.wiley.com/doi/10.1111/acer.13203/abstract;jsessionid=80DC78899586B156BAD06ECAC8C0D541.f02t03)

[7] Suicidal behavior and alcohol abuse. Pompili et. al. 2010. *Int. J Environ Res Public Health*. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872355/)

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Rurality

Consistently, rural areas have higher rates of suicide than urban areas. There are many potential reasons for this. Rural areas tend to have higher percentages of older white males. As we have seen, white males have very high rates of suicide, especially in middle age and older. Firearm ownership is higher in rural areas, so highly lethal means are often readily accessible to those at risk. In addition, services may be scarcer and more difficult to access.

2008-2014, California
Age-adjusted Death Rates per 100,000 Population
All Injury, Suicide, All Races, All Ethnicities, Both Sexes, Ages 10 thru 85+ Years
Annualized Age-adjusted Rate for California: 11.94

Suppressed/Unstable/Undefined	7.79-12.02	12.03-15.29
15.30-24.23	24.24-47.77	
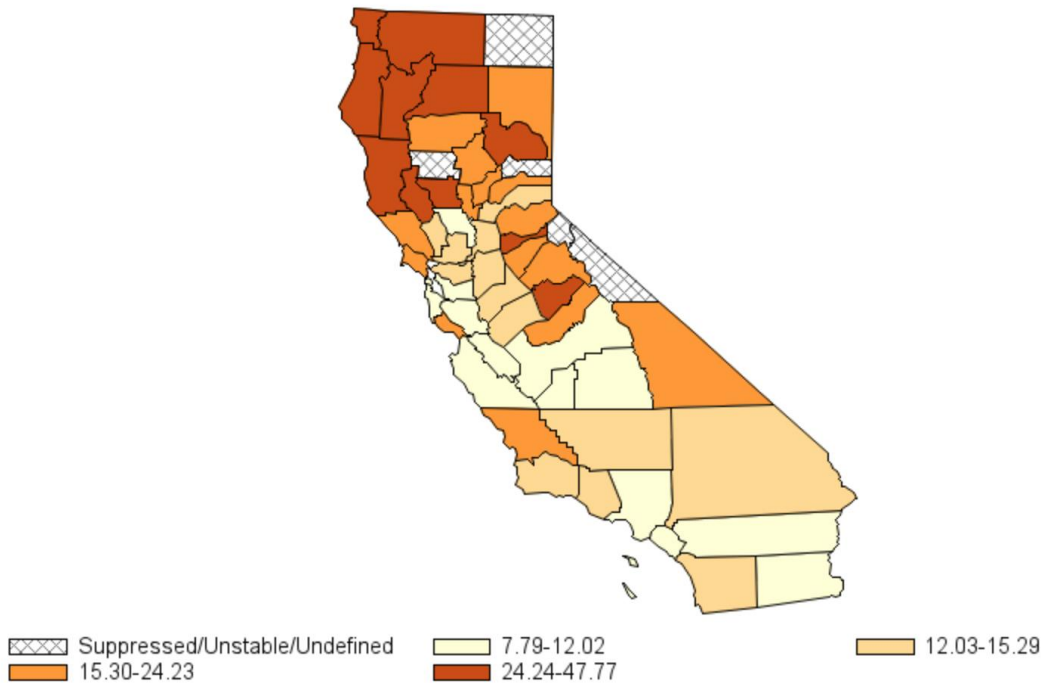
Behavioral Health Treatment: Is the Help Helpful?

Men receive less behavioral health treatment than women, but there are also questions about whether current treatments are as effective for men[8]. Most clinical interventions targeting suicidal behavior and related mental health disorders, as well as the screening tools used to identify them, were developed with primarily female study subjects.

In the absence of robust alternatives, behavioral health treatment is still recommended to assist men with developing and practicing coping and problem-solving skills and ways to manage emotions and distress. Behavioral health providers can better address the needs of men by understanding how men express distress and signs of suicidality, as well as employing treatment modalities them emphasize coping, problem-solving, and self-management skills. Suicide prevention hotlines can be a good resource because they are confidential. Callers reluctant to seek professional mental health treatment, and/or concerned about issues related to mental health stigma may feel more comfortable speaking "anonymously" to someone who does not know them.

Access to mental health treatment

The California Health Information Survey[9] reports on mental health needs and use of mental health services among adults aged 18-64 in California. Unmet need includes either receiving no treatment or treatment that did not rise to a minimally adequate standard.

Several factors were shown to influence the likelihood that mental health needs were met:

- 82% of adult males in California had not had their mental health needs met in the past 12 months; 57% of adult males had not received any treatment, compared to 46.7% of adult women.
- Those with the lowest educational attainment (< 9th grade) had the greatest unmet needs (87%); adults with a postgraduate education had the highest percentage of met needs (34.6%).
- 75% of adults meeting Federal Poverty Level standards had unmet needs, and about half did not receive any treatment at all for mental health needs.

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[8] Suicide Prevention Resource Center. (2016). *Preventing suicide among men in the middle years: Recommendations for suicide prevention programs.* Waltham, MA: Education Development Center, Inc. http://www.sprc.org/sites/default/files/resource-program/SPRC_MiMYReportFinal_0.pdf

[9] D Grant, DI Padilla-Frausto, M Aydin, L Streja, S Aguilar-Gaxiola,J Caldwell. *Adult Mental Health in California: Findings from the 2007 California Health Interview Survey.* Los Angeles: UCLA Center for Health Policy Research, 2011. http://healthpolicy.ucla.edu/publications/Documents/PDF/MentalHealthreportnov2011.pdf

- Uninsured adults had the highest rate of unmet needs (87.4%), with 65.6% not receiving any treatment for their mental health needs.
- Adults who reported having excellent or very good health also reported higher rates of unmet mental health needs than their less healthy counterparts. Those with disability status or chronic conditions were more likely to have received at least minimally adequate mental health treatment. Although the survey report is not conclusive, one possible reason for this is that those who regularly access treatment for their health conditions might also be more likely to receive help for mental health needs.

Addressing access to lethal means

Most suicidal crises are short-lived. Studies of attempt survivors have shown that the decision to end their life was made within hours, or even minutes of their attempt. When a suicidal person has access to a firearm, their attempt is likely to be fatal. The ability to put as much separation between a person who is considering suicide and highly lethal means can save lives.

The Gun Shop Project (GSP) brings together the firearm and public health communities toward the common goal of preventing suicide. The GSP provides materials such as educational tip sheets for firearm dealers and gun range owners to help them know what to look for and how to help a customer, as well as friends and family. Additional resources include the "11 Commandments of Gun Safety" brochure and a poster that help raise awareness among customers.

In 2016 the California Gun Violence Restraining Order (GVRO) law went into effect. It established a process to allow law enforcement and immediate family members to petition the court to obtain a GVRO when a person is at risk of harm to self or others by having a firearm. If granted, the order temporarily prohibits the purchase or possession of firearms and requires the removal of any firearms while in effect. The website www.speakforsafety.org outlines the steps in the GVRO process and links to additional information and resources.

Counseling on Access to Lethal Means is training for mental health, medical health, and other providers who interact with people who may be at risk. This approach provides guidance for asking people questions about whether they have access to medications (among other means, such as firearms) and how to reduce their risk. The 1.5-hour training is available online or in-person.

Some counties in California and in Washington State have worked with pharmacies to educate people about the relationship between suicide and medications. Know the Signs worked with several counties in California to develop pharmacy bags that included messaging around suicide prevention and how to help. Washington State's Forefront program has a Pharmacy Task Force that develops suicide recognition and referral training for pharmacists. They partner with the state pharmacy association. San Diego has a similar program. See also www.pharmacistspreventingsuicides.com.

Primary Care Interventions

Many men will see a primary care provider at least occasionally, especially as they get older. Contact with health care is an opportunity for screening, assessment and treatment. It is important that primary care providers develop an understanding of how warning signs and risk factors appear in men, especially men in the middle years, so opportunities to intervene aren't missed. Work still needs to be done to develop additional tools to identify and treat suicide risk among men. A project at the University of California, Davis is currently underway to develop one tailored male-specific intervention.

Know the Signs developed a Training Resource Guide for Suicide Prevention in Primary Care that can be used to train people in primary care settings to recognize and respond to suicide risk. Within the training guide are resources for clinicians to use in risk assessment.

Counseling on Access to Lethal Means online training also provides guidance for asking patients about their access to lethal means and addressing how to reduce their risk.

Workplace Interventions

> "We have a tough guy mentality – suck it up and get through whatever is thrown at you. The idea to be open to something that is personal, at work, is difficult. Usually there is a perception that you'll be met with indifference. The Operations Staff needs to understand that it is okay to discuss personal issues."[10]

Consider local industries to identify potential partners. Nationally, the Construction Alliance for Suicide Prevention (http://www.cfma.org/news/content.cfm?ItemNumber=4570) has developed initiatives to educate their membership about suicide prevention and mental health. In California, three chapters of the Construction Financial Management Association (CFMA) teamed to hold a suicide prevention summit in April 2017. Find out if there is a chapter of the CFMA near you that might be interested in partnering http://www.cfma.org/content.cfm?ItemNumber=880

Educating co-workers and managers about signs of mental illness and suicide[11], offering Employee Assistance Programs (EAPs), and handling layoffs and terminations carefully are all being explored as ways to reach and support men at risk. Providing a safe space for men to reach out for help, without fear of repercussions at work, is vital.

In addition to the above resources for workplace suicide prevention check out:

- Each Mind Matters resources
- Suicide Prevention Resource Center: Workplaces
- Action Alliance for Suicide Prevention blueprint for workplace suicide prevention
- Construction industry blueprint for suicide prevention
- Society for Human Resource Management Workplace Suicide web page
- Canadian guide for promoting workplace mental health

Other options for reaching working men are through lunchtime gathering places near workplaces or job sites.

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[10] Carson J Spencer Foundation and National Action Alliance for Suicide Prevention. *"A Construction Industry Blueprint: Suicide Prevention in the Workplace."* 2015. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Suicide%20Prevention%20in%20the%20Workplace%20-%20Final.pdf

[11] For instance, MHA California's Wellness Works program http://www.wellnessworksmentalhealth.org/ and the Carson J Spencer Foundation's Working Minds program.

Educational Campaigns and Resources

- San Diego's It'sUp2Us campaign has developed resources to support men's mental health and wellness.
- Man Therapy is a multimedia web site and men's mental health campaign developed by the Colorado Office of Suicide Prevention, the Carson J. Spencer Foundation, and Cactus Communication. Its approach is tailored to working age men and employs specific tools and tactics to reach men.

Each Mind Matters Resources

A wide range of resources can be viewed and downloaded on the Each Mind Matters Resource Center at www.EMMResourceCenter.org

- Know the Signs Radio Spot: customizable to include local resources, these English language radio spots are aimed at the general public with an emphasis on those concerned about a man in their life.

- Restricting Access to Lethal Means: archived 2013 webinar provides an overview of data and strategies to address access to lethal means.

- Suicide Prevention Outreach to Men and Man Therapy: archived 2013 webinar focused on strategies to reach men and highlighted the Man Therapy campaign.

- Skills Building: Messaging for Suicide Prevention: archived 2017 webinar focused on safe and effective messaging for suicide prevention.