Alberta Health Services

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On April 1, 2009, AHS brought together 12 formerly separate health entities in the province: nine geographically based health authorities (Chinook Health, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Region) and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addiction (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).

LITERATURE REVIEW:
MEN AT RISK SUICIDE PREVENTION PROGRAM EVALUATION

PREPARED FOR: **ALBERTA MENTAL HEALTH BOARD**

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INTRODUCTION

The Alberta Mental Health board is a provincial health board involved in numerous initiatives to advocate, advise and collaborate with provincial, national and international partners. Their mission is to "provide strategic, fiscally responsible leadership in advancing mental health with [their] partners in advocacy and support, research, service and policy framework development, and evaluation"[1].

Meyers Norris Penny LLP has been engaged by the Alberta Mental Health Board to carry out a formative evaluation of the Men at Risk program, a suicide prevention program aimed at helping men. This program was developed in the Peace Country geographic region, and is now being duplicated within the East Central Health Region (Camrose and Lloydminster).

In addition to stakeholder consultation, a literature review was completed to summarize up-to-date research regarding workplace stress, suicide prevention programs, and the mental health provision challenges related specifically to men (i.e. social marketing). A summary of the key literature findings is presented herein.

[1] http://www.amhb.ab.ca

RISK FACTORS FOR SUICIDE

Every year in Alberta, more than 450 people die by suicide, claiming more lives than motor vehicle collisions, AIDS or homicide[2]. However, the rates of death by suicide are not universal across genders. While women attempt suicide three times more than men, men are four times more likely to die by suicide[3]. In 2001/2002, the suicide rate of men in Alberta aged 35-59 years was 33 per 100,000, substantially greater than the overall provincial rate of 15.2 per 100,000[4].

The difference in suicide rates among men and women likely has underlying causes rooted in traditional masculine and feminine experiences. For example, men can be more prone to certain risk factors such as a history of drug and alcohol abuse, and not having children in the home. When these male risk factors are removed from the analysis, the gender differences in suicide risk disappear[5]. This illustrates the strong interaction between mental health issues and cultural factors, such as traditional masculinity and family life.

The reasons why people attempt suicide are complex and variable. Individuals contemplating or dying by suicide are generally experiencing a narrowing of the range of options available to them[6], and see no other way out. Mood disorders, including major depression and stress both appear to play an important role in the instance of suicide[7]. Proper primary health provider screening, diagnosis, and treatment of mood disorders and stress is a key factor in preventing suicidal behaviour amongst Canadians. In addition to increasing the capacity of primary health care providers to prevent suicidal behaviour, it is also important to increase the awareness and education of the general public, including knowing what resources are available to help.

Risk factors for suicide present an interaction of many factors, including age, sex and race. The typical profile of an individual who dies by suicide is “an older, white male who is depressed and possibly alcoholic; lives alone or is socially isolated; uses a highly lethal irreversible method … dies after his first suicide attempt; has grown increasingly hopeless; has recurring work, sexual

[2] Alberta Mental Health Board, 2006.
[3] Gelman, 1994.
[4] Alberta Mental Health Board, 2006.
[5] Young et. al. 1994.
[6] Rotheram-Borus et. al. 1990
[7] Ibid.

and marital problems; has experienced a series of stressful negative life events; and often sees suicide as the only permanent resolution to persistent life problems"[8].

Protective factors against suicide are generally the opposite of the risk factors discussed here. Some protective factors involve an individual's physical characteristics such as being young, female, and non-white. However some protective factors involve lifestyle choices and ways of coping, and include the individual having:

- Healthy and extensive social contacts,
- An intact marriage with children,
- Access to effective treatment, including antidepressants,
- Proper sleep, exercise and diet,
- Coping skills, and
- Cognitive flexibility, or the ability to adapt cognitive processes to deal with unexpected life situations[9].

[8] Maris et. al. 2000
[9] Maris, 2002.

MENTAL HEALTH AND MEN

The interaction between psychological risk factors and the incidence of suicide in men points to the importance of understanding the mental health service provision available to men, and the particular mental health risk factors prevalent in men.

Providing mental health counseling to men presents some challenges, including:

- Men tend to be more comfortable with feelings of anger, aggression, and competitiveness rather than self-disclosure and intimacy,
- Men can become ostracized for expressing traditionally feminine feelings, and can be torn between acting as a strong man and a sensitive man,
- Men can be made to feel inadequate if they are unable to take control of a situation,
- Men are typically socialized to become more aggressive and can be prone to suicide and other acts of violence,
- Men are typically aware of, and place importance on the social stigma associated with seeking help for mental health issues, and
- Men are prone to particular biological problems, including particular stress-related diseases which can also increase their risk of suicidal behaviours[10].

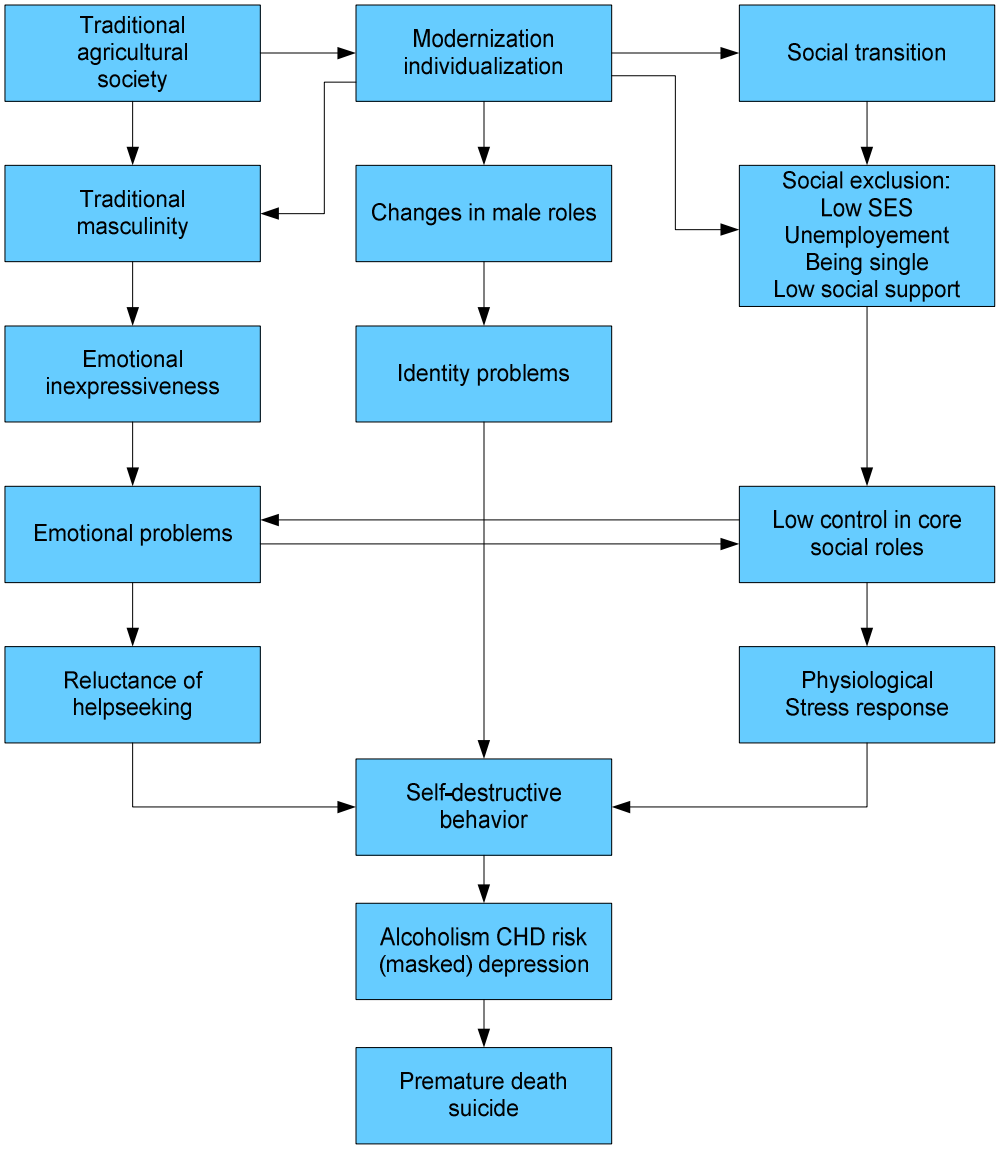
Depression and Major Depressive Disorder are risk factors for suicidal behaviour. While women are approximately twice as likely to develop depression as men, men are more likely to distract themselves from depressive feelings, including turning to alcohol and other methods of avoidance[11]. The unwillingness to seek out mental health provision further compounds the issues caused by depression in many men, and makes them more likely to attempt suicide.

It has further been determined that men experience depression differently than women[12], which can make diagnosis difficult even if the individual does seek help and treatment. For example, men may not present with depressive symptoms congruent with the DSM-IV (i.e. depressed mood and sadness), but instead present symptoms including irritability, increased stress, body pain, and cognitive difficulties[13]. Additional symptoms displayed may include reduced ability to

[10] Neukrug, 2003.
[11] Nevid, Rathus & Greene, 1997, Gunnell, Rasul et. al. 2002.
[12] Kuehn, 2006.
[13] Ibid.

cope with stress, anti-social behaviour, low impulse control, abuse, and anger[14]. Greater physician understanding of and sensitivity to men's concerns about mental illness, including social stigma regarding traditional masculinity, is essential to developing treatments with which men will feel comfortable[15]. Social education of the differences between men's and women's depressive symptoms is also essential, as it will provide men with a critical understanding of their own mental health.

The diversity of male risk factors and symptoms is depicted by Moller-Leimkuhler (2003):



[14] Wilkins & De-Ville Almond, 2003.
[15] Keuhn, 2006, Skogman, Alsen & Ojehagen, 2004.

HELP-SEEKING BEHAVIOUR IN MEN

Contact with primary care providers in the time leading up to suicide has been found to be common, with approximately 20% of those who die by suicide seeking contact with a mental health professional, and 45% seeking contact with their personal physician within a month of their death by suicide[16]. Eighteen percent of men included in the Luoma et. al. (2002) study group had contact with a mental health service professional within a month of their suicide, and 35% had contact within a year of their suicide. These rates are approximately twice as high for women included in the study group.

Men tend to seek counseling less frequently and attend fewer counseling sessions than women. Further, men tend to wait until they are experiencing a crisis before seeking counseling, which compounds the urgency of their situation[17]. Men generally place a great emphasis on controlling their own situation, and as a result may not want to seek help, even if they are aware of their unhealthy situation[18]. Feelings of traditional masculinity are also compounded by misconceptions about mental illness and a lack of awareness of the available treatments for mental health issues[19].

Not only does the frequency and duration of help-seeking behaviour differ for men, but so does the method. Men tend to seek help mainly for physical symptoms, and are less likely to report psychosocial problems or distress during their consultation[20]. Men can also ignore physical symptoms until they have worsened through feelings of invincibility[21], another indicator of images of traditional masculinity greatly interfering with mental health provision for men. Men are also more likely to seek help for specific health problems more than general health concerns with varied symptoms[22]. This presents a particular problem for those men experiencing depressive symptoms, as the symptoms can be varied and difficult to describe and/or diagnose.

[16] Luoma et. al. 2002.
[17] Neukrug, 2003
[18] Keuhn, 2006.
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Tudiver & Talbot, 1999.

While it has been made clear that men generally seek help less than women do, it does not appear that gender is the only significant difference in determining help-seeking behaviours. Occupational and socioeconomic status is equally important, factors that have been determined through the widespread differences in study design and demographic samples[23]. Such samples have not been homogeneous, as there is truly no typical 'male' and no typical 'female', resulting in conclusions made being based on generalizations not accounting for within-group variability.

It is essential that men who decide to seek help for mental health issues feel supported, and it has been found that men receive most support for health concerns from their female partners, and little from their male friends[24]. This may be due to some men being unfamiliar with the mental health diagnosis and treatment process, and being uncomfortable with discussing issues surrounding suicidal behaviour. It is most likely that these men receive mental health support from females as a default, rather than specifically seeking them out for help.

The difficulties faced by men in seeking help and overcoming barriers to receiving mental health care can be lessened by the use of mentors or gatekeepers. In studies of adolescent groups, it has been found that those individuals who participated in suicide intervention and education programs were more knowledgeable about suicide risk factors, and were more able to intervene when peers displayed parasuicidal behaviour[25].

While physicians and occupational health providers represent an important role in suicide prevention, it appears that men would also benefit from having a peer mentor or support group available to them[26]. The use of peers in a work environment, where men may be experiencing a great deal of stress that may lead to parasuicidal behaviour, may lessen the social stigma, unwillingness, and intimidation to seek help and discuss their problems.

[23] Keuhn, 2006, Ostamo et. al. 2002.
[24] Tudiver & Talbot, 1999.
[25] Stuart, Waalen & Haelstromm, 2003.
[26] Ramsey, et. al., 1994.

WORKPLACE WELLNESS

Providing sufficient mental health care through the workplace can be increasingly expensive for Canadian companies, however anxiety and depressive disorders can also have large economic and workplace performance costs. As discussed earlier, anxiety and depression have been found to be significant risk factors for suicide.

Research into providing workplace mental health programs has focused on the following:

- The prevalence of anxiety and depressive disorders in the workplace,
- The social and economic costs resulting from these disorders, and
- How quality mental health care can help reduce the burdens resulting from these conditions[27].

Langlieb & Kahn (2005) discuss the co-occurrence of anxiety and depressive disorders, which further compounds the issues in the workplace. It estimates that the annual cost associated with anxiety and depressive disorders in the United States is $146.2 billion, including direct and indirect health care costs. The annual cost associated with mental disorder in Canada is estimated at $7.87 billion, also including direct and indirect health care costs[28]. The vast difference between these two spends is likely caused by a number of factors, including population level, cost of health care, and cost of health care administration[29]. Average rates of depression are similar in Canada and the United States, found to be 8.2% and 8.7% respectively[30].

A study by the Health Enhancement Research Organization estimated that each employee with depressive symptoms generated $3,189 USD in annual health costs compared with $1,679 USD generated by an employee not experiencing depression. If the employee experiencing depression was also under high stress, the cost increased by 147%.

There is a large disparity between absenteeism rates of Canadians according to their mental health status. Canadian men aged 35-49 with mental illness exhibited an average of 73.65

[27] Langlieb & Kahn, 2005.
[28] Alberta Mental Health Board & Institute of Health Economics, 2006.
[29] New York Times, 2003.
[30] Vasiliadis et. al., 2007.

absent days per year, contrasted with 27.13 days per year exhibited by men without mental illness[31].

In addition to lost work days, 'presenteeism' is cited as a source of major concern, defined as when an employee goes to work but cannot work at full capacity. It was found that workers with depressive symptoms lost 5.6 hours per week of productive time versus 1.5 hours per week by individuals not experiencing depression.

Langlieb & Kahn (2005) explain that presenteeism affects employers in three ways: low productivity by the employee at work, when the worker leaves, and when other workers begin to compensate for the affected worker's low productivity. Mental health issues in the workplace can also affect other employees, including the lowering of morale, higher turnover, and general discontent.

Reasons why employers may not have sufficient mental health care options in place include:

- Depression and other mental disorders may escape detection,
- Benefit programs may exclude mental health care,
- Human Resource managers may not be trained to deal with mental health issues, and
- Concern surrounding the value of mental health care to be commonly utilized.

Langlieb & Kahn (2005) also research the outcomes of successful employer mental health care programs, and found improvements in work productivity and reduction in utilization and costs for medical services.

While Langlieb & Kahn (2005) focused on the need for employers to be aware of mental health issues and their impact on the workplace, Nakayama & Amagasa (2004) focused on the employee's personal understanding of his/her own mental health status and its effect on mental health care provision at work. It found that employees had generally poor knowledge of risk factors for suicide, and had unfavorable attitudes toward depressive colleagues. They concluded that a program providing employees with appropriate information surrounding mental health was needed in order to properly capitalize on mental health options.

[31] Alberta Mental Health Board & Institute of Health Economics, 2006.

While it has been established that offering mental health care support to employees is an important issue for companies, it is also important to note possible obstacles to the successful implementation of such a program. Often, the roots of stress that can contribute to anxiety and depressive symptoms, making the employee more susceptible to experiencing parasuicidal behaviour, can be rooted in the organizational culture of the company[32]. Overcoming the stigma of viewing self-disclosure of mental issues as weakness is also critical to the success of any workplace wellness program[33].

Implementing a successful workplace wellness program will assist in:

- Maximizing the well-being and productivity of people working for the organization,
- Minimizing people getting injured, ill, or killed during work activities,
- Improving the organization's reputation in the eyes of its stakeholders, and
- Avoiding damaging financial effects of turnover[34].

[32] Ramon, 2005.
[33] Ibid.
[34] Hillier et. al. 2005.

MARKETING MENTAL HEALTH PROGRAMS TO MEN

The social stigma surrounding men accessing mental health services resulting from ideals of traditional masculinity can make it difficult to successfully promote and market a suicide prevention program to men. Social marketing techniques can be employed to better inform and encourage men to seek help if they are experiencing mental health problems[35].

Social marketing of mental health programs can be defined as "the process of understanding the wants and needs of the target market. Its purpose is to provide a viewpoint from which to integrate the analysis, planning, implementation, and control of the health care delivery system"[36].

Essential components of a social marketing approach include:

- A program management process,
- The ability to influence human behavior on a large scale,
- The ability to create benefits and reduce barriers that matter to specific audiences,
- The ability to generate consumer-oriented decision making, and
- Resulting increased societal benefit[37].

Rochlen & Hoyer (2005) undertook a thorough evaluation of current practices of marketing mental health to men, and found that men's reluctance to seek help for mental problems could be reduced by marketing services in a way congruent to traditional male gender roles. Men with greater belief in traditional male roles have been found to be more interested in seeking help through structured interventions (i.e. classes, videotapes), rather than traditional one-on-one or group counseling.

Guard (2006) outlines several possible methods of developing a social marketing program for suicide prevention, including utilizing focus groups, interviews with the target audience, surveys, and polls regarding the attitudes and behaviors of the target population.

[35] Leff et. al. 2006.
[36] Rochlen & Hoyer, 2005.
[37] Smith, 2006.

Special considerations to include when developing marketing suicide prevention services include:

- Emphasize help-seeking and prevention including protective factors,
- Provide specific information on finding help,
- List the warning signs, risk factors, and protective factors, and
- Highlight effective treatment for mental health problems.

It is equally important to exclude certain messaging from your social marketing strategy, including:

- Do not normalize suicide,
- Do not glamorize or sensationalize suicide,
- Do not present suicide as inexplicable, as this will only contribute to the person's feelings of helplessness, and
- Do not present suicide as a result of stress only.

In creating messages for social marketing of suicide prevention, Guard (2006) recommends:

- Simple messages containing analogies,
- Unexpected messages,
- Concrete messages with specific language and details,
- Credentialed messages from authorities in the mental health profession,
- Emotional messages, and
- Testimonials from people of a similar demographic.

The ability to reach suicidal individuals through media campaigns has come under scrutiny. Daigle et. al. (2006) researched the effectiveness of Quebec's Suicide Prevention Weeks through a telephone survey. It was discovered that this program did not influence attitudes or intentions to seek help for suicidal behaviours, which contributed to the low intensity of the educational campaign. Daigle et. al.(2006) recommend that any media campaign designed to prevent suicide through education be intensive and demographically specific.

Presenting suicide as a rare phenomenon to a population at particular risk may be a successful method of marketing treatment, rather than presenting suicide as a common solution chosen by members of this group's demographics. For example, instead of noting that 5% of people

experiencing depression may attempt suicide, it would be more helpful and proactive to point out that 95% of these individuals[38] experiencing depression seek out treatment and support. Demographics at particular risk for suicide may require alternative approaches and positive messages regarding their options[39]. This tactic also relates to the importance of educating at-risk individuals of protective factors, including cognitive flexibility and coping skills.

Social contagion is a term used by psychologists or mental health professionals to describe a type of copycat effect, whereby imitative behaviour is produced by suggestion and word of mouth influence[40]. The issue of suicide contagion is a crucial consideration during the development of a social marketing strategy, as increasing the recognition of individual cases of suicide may lead to reinforcement of an individual's intentions of suicide[41]. It is essential to incorporate alternative approaches, accessible treatment options, and positive messaging into any social marketing program.

[38] These values have been used for example, and do not relate to any particular study
[39] Chambers et. al. 2005.
[40] Marsden, 1998.
[41] Chambers et. al. 2005

SUICIDE PREVENTION PROGRAMS: CURRENT STATE AND RECOMMENDATIONS FOR FURTHER DEVELOPMENT

The literature reviewed throughout this process provided several areas for further study or evaluation, including additional cohort studies of help-seeking behaviour in men. The existence of gatekeeper programs has proven to be effective in providing mental health support for men at risk for suicide, and these programs could be presented in a peer setting to further reduce intimidation and hesitation.

The current effectiveness of suicide prevention through formal programs, legislation and policies is largely unclear. Burgess et. al. (2004) examined current preventative measures in place throughout one hundred countries and the resulting changes in suicide rates. Contrary to their hypothesis, they found that the adoption of formal policies and measures was correlated with an increase in suicide rates, even when income status and time were normalized. This relationship was particularly evident for suicide rates in males. This inverse relationship could be the result of suicide contagion, as mentioned earlier regarding sensationalizing instances of suicidal behaviour.

The ability to effectively evaluate suicide prevention programs is essential to inform policy, although this process is difficult to carry out. The methodological difficulties inherent in evaluating such programs include problems of randomization, heterogeneity in treatment implementation, the need for large sample sizes and longitudinal studies[42].

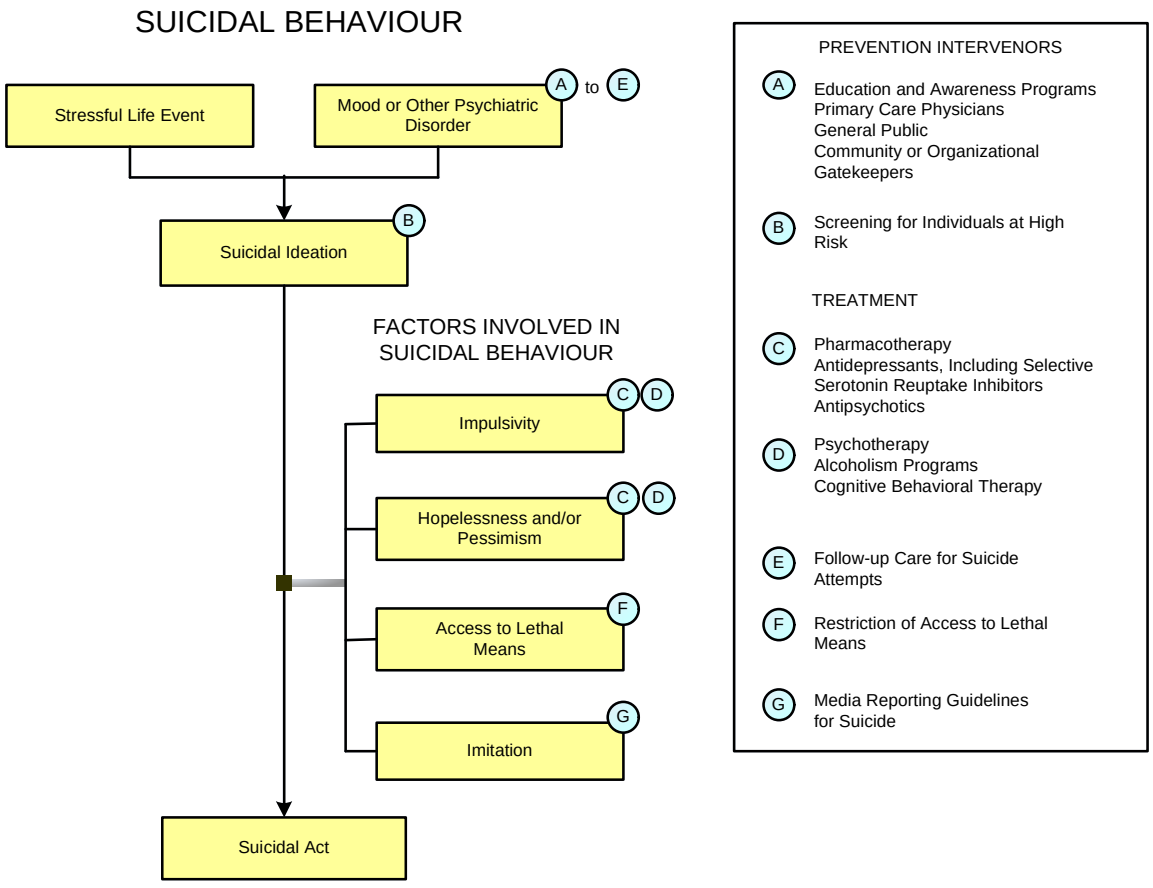
Cavanagh et. al. (2003) carried out a review of psychological autopsy studies of suicide, and determined that strategies aimed at reducing suicide face significant issues. Strategies that are population-based and focus on the reduction of accessibility to means of self-harm are supported by recent reports of lower suicide rates. However, suicide rates among men remain higher today than previously, and one method of death by suicide is often simply replaced by another after access is restricted[43].

[42] Jenkins & Kovess, 2002.
[43] Gunnell & Frankel, 1994.

Another strategy of suicide reduction is focusing on those of increased risk. Due to the lack of risk factor specificity and public sensitivity to those risk factors, Cavanagh et. al. (2003) found that some researchers argue the usefulness of mental disorder as a risk factor. Further, the significant overlap in risk factors for suicide throughout the general public can make it difficult to interpret data and decide which demographic groups to target.

There is currently a range of suicide prevention programs utilized throughout Canada, aimed at assisting such groups as men, women, youth, Aboriginal peoples, and specific occupational groups. The importance of public education and the ability to recognize and treat individuals experiencing mental disorder is essential to the development and sustainment of a suicide prevention program, no matter what the demographic.

Mann et. al. (2005) carried out a systematic review of current suicide prevention strategies worldwide, including determining the multiple factors involved in suicidal behaviour and where specific preventive strategies are targeting. The summary of their findings is depicted below:



Mann et. al. (2005) affirm that suicide prevention is possible, due to the majority of suicidal individuals seeking help from their primary care providers. They assert that a key strategy to be employed by prevention programs is that of improved screening of individuals experiencing depressive symptoms and more effective treatment of prolonged depression.

In terms of developing a national strategy for suicide prevention, Anderson & Jenkins (2005) explore the implementation of the United Nation guidelines. Finland was the first country to implement these guidelines, and addressed the need of helping people in four stages:

1. Prevent suicide from occurring,
2. Prevent problems from worsening and becoming insurmountable, through support of resources,
3. Prevent those circumstances that lead to mental health problems, and
4. Teach individuals coping mechanisms to manage their own lives while providing alternatives and support.

The Finnish strategy has experienced a fair amount of success and outlines six recommendations specific to preventing suicide:

1. Focus on the requirement that life circumstances of a parasuicidal individual should be investigated and treatment should be implemented,
2. Focus on developing awareness of the link between life events, stressors, and intoxication with substances,
3. Focus on the increased risk of people who may be experiencing mental health issues,
4. Focus on building awareness of the predisposing factors to depression, including physical illness and disability,
5. Focus on crisis situations that have developed over a period of time, and
6. Ensuring health care professionals are perceptive of the possible socioeconomic risk factors for suicide[44].

While Finland's strategy is well-known as being the initial national suicide prevention effort, Anderson & Jenkins (2005) note the range of national strategies currently in use share themes,

[44] Wilson, 2004.

and build upon others' success. Countries utilizing national suicide prevention strategies include the United States, England, Ireland, Scotland, Australia and Japan.

Shared themes incorporated by comprehensive national suicide prevention strategies include:

- Public education,
- Responsible media reporting,
- School-based programs,
- Postvention,
- Crisis intervention, and
- Training of health professionals[45].

Suicide prevention programs currently being utilized across Canada differ in a number of respects, including the source of funding, target demographic, delivery method, and degree of evaluation performed[46]. While studies have yielded different results regarding the effectiveness of programs, specific suicide risk factors faced by particular demographics, and the optimal delivery method, the majority opinion is the existence of suicide prevention programs is positive for the general public[47].

[45] Anderson & Jenkins, 2005.
[46] Interior Health, 2005.
[47] Success Works, 2003, Washington State Youth Suicide Prevention Program, 2006.

RELATIVITY TO THE MEN AT RISK PROGRAM

There is a diversity of opinion present in the literature surrounding mental health, gender issues in health care, suicide prevention strategies, and social marketing to men. Understanding which research can best be applied to developing, expanding, and/or evaluating the Men at Risk program in Alberta is therefore challenging.

However, the literature has illuminated several areas in which the Men at Risk program seems to be following leading practices in suicide prevention, mental health care support, and gender counseling models. For example:

- The structure of the Men at Risk program is congruent with the structured intervention techniques found to be most favorable for reducing men's reluctance to seek help for mental problems by those who hold beliefs in traditional gender roles,
- The Men at Risk program emphasizes help-seeking and prevention, contributing to the vital screening and education aspects of suicide prevention,
- The program seeks to access men in the workplace, providing appropriate information surrounding mental health issues. This has been identified as needed to properly capitalize on mental health options. The program provides participants with specific information on finding help, eliminating the barrier of feeling uninformed or alone,
- Overcoming the stigma of viewing self-disclosure of mental issues as weakness has been identified as being key to the success of any workplace wellness program – and the Men at Risk presentations seek to do just that,
- The program lists the warning signs, risk factors, and protective factors associated with suicidal behaviour,
- The Men at Risk program utilizes emotional messages, storytelling and testimonials from survivors of suicide, and also delivers messages through mental health professionals,
- The Men at Risk program is intensive and demographically specific,
- The facilitators and developers of the program have a good understanding of the risk factors and issues surrounding suicide, and are not normalizing, glamorizing, or presenting suicide as inexplicable,
- The Men at Risk program understand the unique pressures and challenges facing mental health provision to men, and have responded appropriately, and
- The program provides a further tool to Albertans by offering education, information and resources in the workplace.

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