

National Guidelines – Suicide Prevention For Males – 2017



Professional Development Training

Appropriate Professional Development (PD) training is vital for effective suicide prevention.

These Guidelines are designed to help management and staff across a range of key sectors and settings to improve their capacity to engage with and support male clients who may be at risk of suicide.

To help improve the effectiveness of prevention efforts, Professional Development training should be evidence based and should be structured to deal with the most important issues and factors relevant to specific at-risk groups.

It is crucial to improving suicide prevention that Professional Development training is conducted in a range of contexts including yet well beyond the health, mental health, and human service fields. These broader contexts include industries with predominantly male workforces, sports clubs, employment and income support agencies, agricultural businesses, legal services dealing with family law, police, judiciary, and prisons.

These Guidelines have been developed in response to strong calls both internationally and within Australia to improve engagement with people who may be at risk of suicide.^{1, 2}

Settings for Professional Development Training

Many people at-risk of suicide, particularly men, are not engaged by health or mental health services.² It is crucial for effective suicide prevention for service providers to develop more appropriate access and outreach strategies to engage men who may otherwise remain isolated. For those men who by choice do not engage with helping services – particularly mental health services, it should be understood that they may not view their distress as a symptom of mental disorder (which may in fact be the case).^{2, 10, 11}

Other settings may offer greater opportunities for effecting suicide prevention. The merit of these settings may for example be that they permit regular contact with male clients or constituents, contain large assemblages of males, or that they afford better opportunities than health or mental health services for identifying males on an experiential and/or behavioural trajectory suggesting cumulative risk factors for suicide.

Useful examples of alternative settings for suicide prevention are those in which there is contact with men who are unemployed and seeking work, or at risk of unemployment. There are strong calls to provide training programs across a range of industries and settings where

staff and management are likely to come in contact with unemployed people. According to Nordt, et al (2015):

Efforts at suicide prevention should be extended to professionals working with individuals at risk of unemployment, such as social workers and human resource management professionals. These professional groups should be informed about the specific risk and trained concerning the practical assessment of suicidality and possible interventions.¹

Reeves et al (2015) have pointed out that:

Greater funding of effective labour market programmes and higher levels of social capital appear to enhance resilience among vulnerable groups.¹⁴

Settings other than health and mental health may include:

- Employment and income support agencies
- Agriculture and fishing industries and allied businesses
- Industries such as mining and construction with major male workforces
- Indigenous communities
- Police, judiciary, prison system, and defense forces
- Family court and mediation services
- Human resources, occupational health, safety and welfare departments
- Tertiary and pre-tertiary training for human service and human resource management roles

Some facts about suicide

Unemployed men and women both have elevated rates of suicide. Unemployment is also a major factor in intentional non-fatal self-harm^{3, 5}

Men account for at least 75% of all suicide deaths in Australia.⁴

Many people who kill themselves have had no contact with mental health services and there is no evidence of a mental disorder for them²

In 2015 there were 3,027 suicide deaths, greater than all road fatalities and murders combined^{4, 6}; this figure is generally agreed to be considerably under-reported⁶

There are large numbers of self-harm incidents in Australia⁸

There are important differences as well as similarities across suicide deaths, incomplete suicide attempts and non-fatal intentional self-harm.⁹ It is vital for effective

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prevention to understand these differences in order to better target particular groups for prevention activity.

Concerns about suicide prevention framed by mental illness and psychiatric diagnoses

Despite strong calls to broaden suicide prevention beyond the mental illness/psychiatric paradigm the majority of activity appears still to be largely characterised by criteria of mental illness and psychiatric diagnoses. This precludes effective engagement with many people who are at-risk but do not have a mental disorder.²

There have also been strong challenges to key aspects of suicide prevention research by international leaders including the estimation of the prevalence of mental disorders in suicide.¹⁰ and the overreliance on categorical measures of psychopathology.¹¹

Even within the health and mental health systems there is growing concern about the effectiveness of policies and programs and the quality of engagement.^{2, 12, 13}

The role of 'raising awareness' of mental health campaigns is being called into question^{2, 14}

Though for over four decades research has revealed the significance of gender differences in the physiology of and behavioural responses to stress, there appears to be little consideration of crucial factors arising from this in suicide prevention activity strategies.^{16, 17, 18, 19, 20, 21}

Data exist suggesting that health, mental health, and welfare services do not deal well with men who may be at risk^{2, 12, 13}

Professional Development Training for Suicide Prevention

At the very least, professional development training in suicide prevention should be informed by:

Reliable data of suicide and incidents of self-harm

- Up-to-date statistics on suicide deaths and self-harm
- A basic understanding of current problems with the way deaths by suicide data are gathered and interpreted
- Data relating to high risk groups, gender, socio-demographic and cultural differences
- Key factors in suicide and self-harm
- Challenges to current approaches to suicide research and prevention reflected in the international literature

Social Determinants affecting male health, mental health, and vulnerability to suicide

- Cultural materialism: the particular expectations of men in Australian society and the emphases of culture that may be associated with psychological distress, male vulnerability to suicide, and mental ill-health
- Health and mental health service responsiveness, appropriateness and track record in outreaching to and

engaging with male constituents

- Culture and Media: The literature of public institutions and mass media, the content and nature of some health and mental health promotion messaging and the language and characterisations of males in popular culture – much of which may be unhelpful or harmful to men
- Gender inequity in social and health policy and funding allocation in relation to evidence based morbidity and mortality data
- Unemployment, underemployment, employment insecurity
- Major cultural shifts in expectations of interpersonal relationships
- Institutional policies and practices that are based on stereotypic characterisations of males

Models for an appropriate approach to working with men

Professorial development training models for suicide prevention should be informed by national and international data, and closely articulated with practical examples of how to engage with men (across a variety of socio-cultural contexts): what works and what doesn't, and why.

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