GIVING MEN A HAND

The case for a male suicide prevention strategy

AMHF
AUSTRALIAN MEN'S HEALTH FORUM

THINKING DIFFERENTLY ABOUT MALE SUICIDE

Suicide kills 8 people a day, 6 men and 2 women. Closing the gap between male suicide and female suicide would save 1,500 lives a year (ABS 2019).

Yet most work to prevent suicide ignores the differences between men and women and most suicide prevention funding supports services that are better at preventing female suicide (AMHF 2016).

We know that men's and women's experiences of suicide are different. Male suicides are more often associated with relationship problems, money issues, job loss and alcohol abuse, whereas female suicides are more likely to be linked to mental illness and previous suicide attempts (Potts 2106).

The Government currently invests around $5 billion a year in mental health services (DoH 2020) and the majority of money directed at suicide prevention funds services that are known to be more effective at reaching more women than men (AMHF 2020).

We need to think differently.

The Government has set itself a bold and ambitious target of working towards a zero suicide goal. According to Professor Jane Pirkis, Director of the Centre for Mental Health at the University of Melbourne, preventing male suicide would go further than any other approach to achieving this goal (Vallender 2020).

The Prime Minister's National Suicide Prevention Adviser, Christine Morgan, has advised Government that men are one of the groups "known to be more vulnerable to suicide and providing effective approaches to suicide prevention for them is a priority".

Suicide Prevention Australia (SPA), the national peak body for the suicide prevention sector, has called for the development of "a male suicide prevention strategy as a core stream within the national suicide prevention strategy, with funding and accountability attached to measures" (SPA 2020).

There is growing consensus that we need a different approach.

The Australian Men's Health Forum is funded by the Department of Health to provide impartial, well-informed, evidence-based information and advice to Government on men's health policy issues.

There are few more pressing men's health issues than male suicide. Men and boys lose more years of life to suicide than any other health issue, with the exception of cancer (ABS 2019).

Our advice to Government on this matter is simple. We are losing six Australian men to suicide each and every day. The way we do suicide prevention isn't working for men.

We need to do it differently.

Australia needs a plan that directs funding at support services designed with men in mind and gives more men a hand to get involved in preventing male suicide.

Our case for developing a National Plan to Prevent Male Suicide is outlined in this report.

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AMHF receives funding from the Australian Government.

THE FACTS ABOUT MALE SUICIDE

Suicide kills 8 people a day in Australia, six men and two women (ABS 2019).

Being male is one of the leading risk factors for suicide (DoH 2008), with men being three times more likely to take their own lives than women.

The national drive to reduce the number of suicides in Australia isn't working. In recent years we've made good progress in tackling some of the biggest killers of men, but as the Productivity Commission has noted, "there has been no significant and sustained reduction in the death rate from suicide over the past decade, despite ongoing efforts to make suicide prevention more effective" (Productivity Commission 2019).

For example, in the decade between 2009 and 2018 (ABS 2019):

- The number of men dying from coronary heart disease has fallen by 15%
- The number of men dying in transport accidents has fallen by nearly 20%
- The rate of men dying from lung cancer has fallen by over 20%
- The rate of men dying from bowel cancer has fallen by nearly 25%
- The rate of men dying from prostate cancer has fallen by over 25%

In the same decade, the rate of male suicide has travelled in the opposite direction, increasing by 70% in teenage boys aged 15 to 19 and 40% in men aged 20 to 24. Overall, the number of men taking their lives rose by 30% from 1,785 in 2009 to 2,320 in 2018.

Suicide impacts men and boys at every stage of life. From teenage boys, who are nearly two-and-a-half times more likely to kill themselves than teenage girls, to men over 85, who are nearly seven times more likely to take their own lives than women of the same age (ABS 2019).

According to the latest data from the Australian Bureau of Statistics (ABS 2019):

- Every month 12 boys aged 19 years and under die by suicide
- Suicide is the leading cause of death of men under 45
- 40% of deaths in young men aged 15-24 are suicide
- Men of working age (25 to 64 years old) account for 70% of all male suicides
- Men aged 85 over have the highest rate of suicide of any age group
- Men lose more years of life to suicide than any other cause of death except cancer

10 WAYS MALE SUICIDE IS DIFFERENT

Male suicide is different from female suicide in a number of important ways that can help us target suicide prevention initiatives more effectively. For example, men account for:

1. 76% of all suicides
2. 81% of suicides linked to relationship separation
3. 83% of suicides linked to financial issues
4. 85% of suicides linked to pending legal matters
5. 86% of suicides linked to recent or pending unemployment
6. 87% of work-related suicides
7. 87% of health lost to alcohol-related suicide
8. 98% of suicides involving firearms

In contrast, female suicides are:

9. 50% more likely to be linked to a mental illness
10. 40% more likely to be linked to previous suicide attempts

(Sources: ABS 2020, AIHW 2018, Clapperton 2019, Leske 2019, Potts 2016, Routley 2013)

COUNTING THE COST OF THE GENDER DIFFERENCES

In 2018, suicide killed 3,046 people in Australia. A total of 726 people (24%) who took their own lives were women and girls, the remaining 2,320 people (76%) were men and boys (ABS 2019).

According to the Productivity Commission review into mental health, suicide has "enormous social and emotional impacts on individuals, families and the broader Australian community" (Productivity Commission 2019).

The review highlighted the work of ConNetica, which estimated the cost of each suicide to the Australian economy at $6 million (2007 dollars), drawing on the Value of a Statistical Life measure used to evaluate the cost of lives lost in car accidents.

Based on this measure, in 2018 male suicide cost the Australian economy at least $14B. Reducing male suicide to the same level as female suicide would save the economy $9.5B a year.

Research on the impact of suicide also suggests that around six people may be profoundly affected with the impact extending to up to 135 people for each life lost (Productivity Commission 2019).

Based on these figures, closing the gender suicide gap and reducing male suicide to the same level as female suicide would:

- Prevent around 10,000 people a year from being profoundly affected by male suicide
- Prevent as many as 200,000 people a year from being impacted by male suicide
- Save the economy as much as $9.5B a year
- Save the lives of more than 1,500 men and boys a year

THE CASE FOR A NATIONAL PLAN TO PREVENT MALE SUICIDE

The National Men's Health Strategy (DoH 2019) places a strong focus on suicide, with male suicide identified within four of the strategy's five priority health conditions (i.e. mental health, conditions where men are over-represented, injuries and risk-taking behaviour and healthy ageing).

The Strategy calls on "all levels of government" to apply a "gendered lens, engaging with and addressing the unique needs of men and boys to all dimensions of their work" including policy development and the funding and delivery of programs.

In terms of taking action to prevent suicide, the Strategy points to the Fifth Mental Health and Suicide Prevention Plan (DoH 2017) and yet there is no mechanism in place to ensure this Suicide Prevention Plan is aligned with the National Men's Health Strategy and specifically targets men.

One of the key actions the Government committed to under the Fifth Plan was the development of a Suicide Prevention Implementation Strategy 2020–2025. This identified 21 priority actions for health ministers and health services to focus on at Federal, Commonwealth and State level.

AMHF undertook an assessment of these 21 actions and concluded that:

- 2 could be considered to be more male-friendly
- 6 could be considered to be more female friendly
- 13 could be considered to be gender blind/gender neutral

With this in mind, AMHF responded to the consultation on the implementation strategy in May 2019 and called for the development of a "national male suicide prevention action plan".

In July 2019, Prime Minister Scott Morrison announced that his Government would make suicide prevention a key priority and appointed a National Suicide Prevention Adviser to drive a whole-of-government approach to tackling the issue (DPMC 2019).

On making the announcement Mr Morrison said:

"Suicide takes far too many Australians, devastating families and local communities. One life lost to suicide is one too many, which is why my Government is working towards a zero suicide goal."

According to Professor Jane Pirkis, who recently received $5.6million of Government funding to research male suicide:

"Preventing suicide among boys and men would go further than any other approach to achieving the Prime Minister's goal of working towards zero suicides" (Vallender 2020).

In September 2019, Queensland became the first state or territory government to make a significant commitment to tackle male suicide by committing to "making men's suicide prevention a priority" in its suicide prevention plan 2019-2029 (QMHC 2019).

In November 2019, National Suicide Prevention Adviser Christine Morgan advised the Prime Minister that men are one of the groups "known to be more vulnerable to suicide and providing effective approaches to suicide prevention for them is a priority" (Morgan 2019).

There has never been a better time for the Government to commit to developing a National Plan to Prevent Male Suicide.

Federal Health Minister Greg Hunt unveils the National Men's Health Strategy at the Dromana Men's Shed in April, 2019.

5 REASONS WE NEED A PLAN TO PREVENT MALE SUICIDE

1. 3 IN 4 SUICIDES ARE MEN

More than 75% of suicides in Australia are men. Tackling male suicide could have a bigger impact on suicide rates than any other action. For example, while reducing female suicide by a third would lead to an 8% reduction in suicide overall, reducing male suicide by a third would reduce suicide deaths by 25%.

2. IGNORING GENDER ISN'T WORKING

While taking a "gender blind" approach may sound fair and equitable, in practice the mental health system and suicide prevention services reach more women than men. As a result the "gender blind" actions we take to prevent suicide are more effective at helping women and don't respond to the fact that the majority of suicides are men.

3. MEN AND WOMEN ARE DIFFERENT

There are several significant differences between male suicide and female suicide that require different approaches. For example, male suicide is less likely to be associated with a mental health diagnosis or previous suicide attempts (Potts 2016). Yet most suicide prevention work focuses on people with a mental health illness and people who have previously attempted suicide, rather than responding to common risk factors for men such as relationship problems, money issues, job loss and alcohol abuse.

4. WE ARE NOT SPENDING OUR MONEY WISELY

Every year the Government invests more than $5 billion into mental health services and in the 2019-2020 budget nearly $750 million was allocated to "mental health and suicide prevention" (DoH 2020). The majority of the funding for suicide prevention in Australia is directed towards services that are known to be more effective at reaching women than men. We need a plan to direct funding at support services designed with men in mind.

5. THE PLAN IS BACKED BY LEADERS IN SUICIDE PREVENTION

In April 2020, Suicide Prevention Australia (SPA), the national peak body for the suicide prevention sector, stated that it "strongly supports the National Suicide Prevention Adviser's intention to develop targeted strategies to address the rate of male suicide in Australia" (SPA 2020).

SPA has called on the Government to "create a male suicide prevention strategy as a core stream within the national suicide prevention strategy, with funding and accountability attached to measures".

LET'S KEEP PREVENTING FEMALE SUICIDE

While this report focuses on the need to prevent male suicide, work to prevent suicide should be gender inclusive and take into account the needs of women, girls and gender diverse people too.

MOVING BEYOND MENTAL HEALTH

For at least two decades, men's health advocates have been calling for the national drive to prevent suicide to look beyond mental health and place more focus on the social factors that put men at risk of suicide (MHIRC 2010).

In 2008, for example, a report by the founding President of the Australian Men's Health Forum, Professor John Macdonald, challenged "the popular assumption that most suicides are the result of depression or other mental illness" (WSU 2008).

According to Professor Macdonald, "it's often a combination of social factors, not initially mental health problems, which cause [six] men a day in Australia to kill themselves".

This claim is backed by coronial data, with the Queensland Suicide Register finding that while 98% of people who die by suicide have experienced a recent life crisis, only 42% of men who die by suicide have a mental health diagnosis (Leske 2019).

This is one of five key ways that male suicide is different from female suicide. According to coroners' reports in Queensland (Potts 2016) and Victoria (Clapperton 2019), while two-thirds of women who take their own lives have been diagnosed with at least one psychiatric disorder, fewer than half of men who die by suicide have been diagnosed with a mental health disorder.

The view, promoted by men's health advocates, that suicide prevention should look beyond the mental health approach, has now been adopted at the highest level. In April 2019, Suicide Prevention Australia (SPA 2019) called for a "whole-of-government" approach stating that:

"Global evidence shows that a fragmented and mental illness-specific approach doesn't work. An integrated approach to suicide prevention encompassing mental health, social, economic and community factors is the best evidence-based solution."

In response, Prime Minister Scott Morrison appointed a National Suicide Prevention Advisor, Christine Morgan, "to drive a whole-of-government approach to suicide prevention" (DPMC 2019).

Ms Morgan's initial advice confirmed that the shift to a "whole-of-government" approach was her key priority and recommended that work to prevent suicide should shift "focus from predominantly mental health interventions to a coordinated response across the full spectrum of personal life experiences and social determinants contributing to suicide" (Morgan 2019).

FOCUSING ON LIFE CRISES

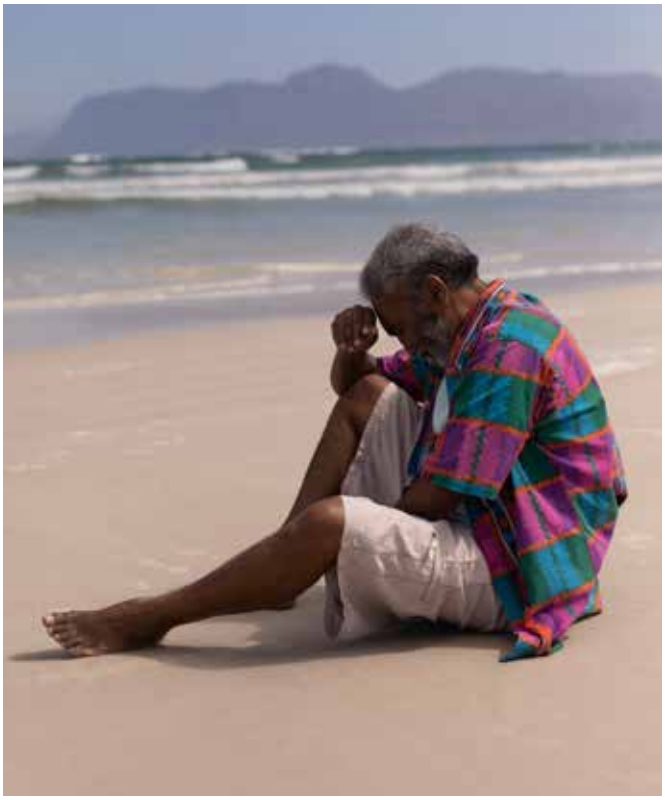
In January 2020, the Government announced $64m of funding as an early response to initial advice from the National Suicide Prevention Adviser, which it said signalled "a dramatic reform of the national approach to suicide prevention" (DoH 2020).

An analysis of the funding by the Australian Men's Health Forum concluded that the majority of this $64m went to services with a track record of reaching more women than men (AMHF 2020). While the rhetorical move from a mental health approach is welcome, it has yet to be matched with a practical shift that targets some of the key life crises that put men at increased risk of suicide.

Researchers have consistently found that the most common life crises linked to male suicide include relationship problems, work and job issues, financial stress and alcohol and substance abuse.

For example, research by Lifeline South West Victoria based on data from the Victorian Suicide Register (Morgan 2019a), identified that the key crises men were dealing with in the 12 months prior to their death included:

- Family and relationships: 71 per cent of men were not in a relationship; 37 per cent were recently separated and 25 per cent had a history of being perpetrators of intimate partner violence
- Employment status: 56 per cent were unemployed, unable to work or retired
- Substance misuse: 51 per cent had substance misuse as a significant stressor
- Financial and housing stress: 41 per cent had contact with welfare
- Mental ill-health: 37 per cent of men had a diagnosed mental illness



This follows a similar pattern to research in Queensland (Leske 2019, Potts 2016) that found approximately:

- 50% of male suicides are linked to relationship issues
- 50% of male suicides are linked to physical health issues
- 40% of male suicides are linked to alcohol
- 30% of male suicides are linked to unemployment
- 30% of male suicides are linked to depression
- 20% of male suicides are linked to money issues

In Queensland, this data is used to identify target groups and factors that can be targeted through the State's suicide prevention strategy (Leske 2019). Similarly, researchers in Victoria have called for data to be used at a local level to target suicide prevention initiatives at individuals experiencing significant life stressors (Clapperton 2019).

The same approach could be applied at a Federal level, particularly in relation to male suicide, with priority groups of men identified within a National Plan to Prevent Male Suicide.

5 RISK FACTORS FOR MALE SUICIDE

1. RELATIONSHIPS

Relationship issues are the life crisis that is most commonly linked to suicide. The majority of men who kill themselves are either not in a relationship or recently separated and more than half of suicides are linked to relationship problems or relationship, family, or interpersonal conflict. Bereavement associated with a partner, family member, friend or pet is also linked to around 1 in 10 suicides (Leske 2019).

Separation is the biggest single relationship risk factor for men with research showing nearly 3 in 10 male suicides are linked to separation. Men account for the majority of suicides (4 in 5) linked to separation and as many as half of all separated fathers experience thoughts of suicide (Leske 2019).

2. WORK/UNEMPLOYMENT

The majority of people who die by suicide are not employed, for various reasons including unemployment, retirement, being a student and caring for a relative. Being out of work is a significant risk factor for men with around 3 in 10 male suicides associated with unemployment (Leske 2019). In Queensland, six times more male suicides are linked to recent or pending unemployment than female suicides (Leske 2019) and in Victoria, nearly 9 in 10 suicides linked to involuntary job loss are male (Clapperton 2019).

Unemployed men are a high-risk group for suicide (Leske 2019) being:

- Around 2.5 x more likely to die by suicide than unemployed women
- Nearly 10 x more likely to die by suicide than men in employment
- More than 40 x more likely to die by suicide than women in employment

While work can impact everyone's health, the health risks and health benefits of work have a more profound impact on men (Assari 2018). One study in Victoria found that 17% of suicides were work-related and 87% of theses suicides were men (Routley 2012).

Common factors in work-related suicides include stress, conflict and bullying. In general terms, men in lower skilled occupations such as manual labour, machine operators and farm workers have a higher risk of suicide than highly skilled occupations (Milner 2013).

3. FINANCES

As many as 1 in 5 male suicides are linked to financial issues and male suicide is 5 times more likely to be linked to finances than female suicide (Potts 2016). It is well established that male suicide in particular increases during economic downturns (Haw 2014).

In recent years, Governments across Australia have taken action to address gender inequalities in economic security experienced by women (DPMC 2018). This important work doesn't take into account the areas where men experience low levels of economic security. For example:

- Men are less likely to own their own home (ABS 2019a) and more likely to be homeless (HA 2016)
- Single men are less likely to have superannuation cover than single women (ABS 2019a)
- Men are twice as likely to have a problem with gambling (Armstrong 2017)

Perhaps most importantly of all, men have lower levels of social capital than women, having fewer social connections, less access to government, community and social support at times of financial crisis (Reeve 2016).

4. MEN'S HEALTH

Physical health conditions are a risk factor for suicide that increases with age (Leske 2019). One study of suicide in Australian men over 65 found that 4 in 5 suicides were linked to having five or more physical health issues, while only 17% of suicides were linked to a mood disorder like depression or bipolar (Almeida et al 2016).

More broadly, around 50% of men who die by suicide have at least one physical health issue (Leske 2019) and men with a disability are a higher risk group that are generally overlooked in suicide prevention initiatives. When disability is defined as difficulty functioning in domains like self-care, mobility and challenges communicating and being understood, men in this group are 2.5 times more likely to have suicidal thoughts than non-disabled men (Milner 2018).

Mental health issues are also associated with male suicide with men accounting for 2 in 3 suicides linked to a mental health diagnosis (Potts 2016). Signs of depression in men, which are associated with 1 in 3 male suicides, are often missed by health professionals (Kilmartin 2005) as it can present in men in atypical ways (e.g. men may be more likely to express depression with anger rather than sadness).

Some disorders that mostly occur in men may warrant greater attention in suicide prevention. Research into adults with autism spectrum disorder (ASD) in New South Wales, for example, found that 50% of deaths in people with autism without intellectual disability were from accidents, injuries, poisonings and suicide. This is four times higher than the proportion of deaths in the general population (Hwang 2019).

5. ALCOHOL AND OTHER DRUGS

Alcohol and substance abuse are strongly associated with suicide in men. According to the Australian Burden of Disease study, men account for 87% of the loss of life and health from alcohol-related suicides (AIHW 2018). Around 40% of male suicides are linked to alcohol and other drug problems, with men accounting for 4 out of 5 suicides associated with alcohol and substance abuse (Clapperton 2019).

Some researchers have described alcohol reduction at a population level as the most effective male suicide prevention intervention (Wasserman 2007). Men in general are more likely to engage in risky drinking than women, with more than half (54.2%) engaging in risky drinking at least once a year. Nearly one in four men (23.7%) drink at levels that present a long-term risk to their health, compared with 8.8% of women (ABS 2018).

Men's views about 'what constitutes risky' drinking are different to the definitions of risky drinking used in national guidelines and as such, conventional health campaigns fail to connect with men (Roberts 2019). Work to prevent male suicide needs to take account of the gendered nature of alcohol and substance abuse and engage men as active participants in conversations about the links between men's risky drinking and male suicide.

LOOKING OUT FOR MEN AT RISK

The National Men's Health Strategy (DoH 2019) identifies nine priority male populations that may require specific attention when developing health interventions. These include veterans, those with a disability, males in the criminal justice system and Culturally and Linguistically Diverse (CALD) men and boys. Suicide prevention initiatives should also take account of men at different life stages from boyhood to older age.

All of these groups may warrant special attention in work to prevent male suicide and some of the issues relevant to five of these groups are highlighted below.

SOCIALLY DISADVANTAGED

Socioeconomic status is strongly correlated to suicide risk in men (Henley 2019). In contrast, women have a relatively steady rate across socioeconomic groups, with only the most advantaged women having a noticeably lower rate.

Men from all five socioeconomic groups have a rate of suicide that is around 3 to 4 times higher than for women of the same background.

The most socially disadvantaged 20% of men are:

- Around 1.8 x more likely to die by suicide that the most advantaged men
- Nearly 3.8 x more likely to die by suicide than women of the same background
- More than 5.5 x more likely to die by suicide than the most advantaged women

RURAL AND REMOTE

Close to 85% of male suicides happen in towns and cities, with major cities accounting for 61% of male suicides and inner regional towns and cities for 22%. Around 13% of male suicides occur in rural and remote towns with fewer than 4% of male suicides taking place in remote and very remote locations (AIHW 2019).

However, rates of suicide vary significantly based on remoteness of residence (AIHW 2019). When compared with men living in major cities, suicide rates are:

- 50% higher in men from inner regional areas
- Nearly 80% higher for men from outer regional areas
- More than 60% higher for men from remote areas
- Twice as high for men from very remote areas

Some of the factors linked to suicide in rural and remote communities include financial insecurity and vulnerability; the impact of drought, flood and bushfires; easy access to means such as firearms; barriers to accessing services and a limited number of rural, male-friendly interventions (NRHA 2009).

SOCIALLY ISOLATED

Social isolation has been described by some researchers as "the most reliable predictor of suicidal ideation, attempts, and lethal suicidal behaviour". Social isolation can include loneliness, social withdrawal, living alone and having few social supports (Orden 2010).

Research has found that men have smaller social networks than women, less access to informal support through friendships and family relationships, and lower levels of social contact and social support (VGDoH 2010).

Around 1 in 4 men are socially isolated, with men having lower levels of social support than women from early adulthood until their 70s and men aged 35 to 44 having the lowest level of social support (VGDoH 2010).

Social isolation can overlap with other common triggers for male suicide such as job loss and break-ups. Separated men, unemployed men, men living on their own, male students and men on a disability pension tend to be at higher risk of social isolation (Arbes et al 2014).

ABORIGINAL AND TORRES STRAIT ISLANDERS

Suicide is the leading killer of Indigenous men under 35 in Australia. It kills three Indigenous people a week and over 75% of suicide deaths are male (ABS 2019).

Based on the data available in five States/Territories, suicide kills 10 Indigenous men and boys every month at a rate of 39.6 people per 100,000 population (ABS 2019).

The Indigenous male death rate for suicide is:

- 3.3 x the rate of Indigenous females (11.9 per 100,000)
- 2 x the rate of non-Indigenous males (19.7 per 100,000)
- 6.6 x the rate of non-Indigenous females (6 per 100,000)

In 2017 there were 165 Indigenous deaths by suicide, 125 males and 40 females. Suicide is:

- The second biggest killer of Indigenous males
- The seventh biggest killer of Indigenous females
- The 10th biggest killer of non-Indigenous males
- The 21st biggest killer of non-Indigenous females

Aboriginal and Torres Strait Islander men aged 20-34 years old have been identified as being one of the most at-risk populations in the world (Ranmuthugala 2015).

DIVERSE BODIES, SEXUALITIES AND GENDERS

The needs of people with diverse bodies, sexualities and genders need to be taken into account in work to prevent suicide.

This can include gay and bisexual men, trans and gender-diverse people who are not 'cisgender' (i.e. the gender they identify with is different than was presumed at birth) and people who are intersex (i.e. born with physical characteristics that are different from typical, biological definitions of male and female).

While there is a range of research that shows higher levels of suicidality among gay, bisexual and transgender people, there is limited data on deaths from suicide. Updating the Census to include questions on gender, sexual orientation and intersex status is one step that would begin to address this gap.

Where information on suicide deaths is recorded, it tends to show greater numbers of male suicides among people with diverse sexualities, genders and bodies. For example, research by the Australian Institute of Suicide Prevention (Leske 2019) into lesbian, gay, bisexual, transgender and intersex suicides in Queensland identified 20 deaths in 2013-2015 (70% male) and 39 deaths in 2016-2018 (59% male).

SOCIAL FACTORS THAT SHAPE MALE SUICIDE

In addition to targeting men at increased risk of suicide, longer-term approaches to male suicide prevention should also consider some of the broad social determinants of male suicide. These include issues that have already been referenced in this report such as socioeconomic status, relationships, social status, men's working lives and financial hardship.

1. BOYHOOD

The foundations of good health are laid down in childhood. Some research has found that adverse childhood experiences (ACEs) are strongly associated with suicide attempts in later life, with an estimated 2 in 3 suicide attempts linked to ACEs (Dube et al 2001).

For boys, lower levels of educational attainment are also a risk factor for suicide in later life. In girls, the impact is less significant (Lorant 2005). The fact that our education system consistently delivers worse results for boys on average is a matter of concern.

There are other reasons that boys warrant specific attention. Nearly 3 in 10 boys (28%) are developmentally vulnerable when starting primary school (AIHW 2020) – twice the rate for girls (15%). Close to 1 in 10 boys (9.4%) have a disability (AIHW 2020), compared with 1 in 20 girls (5.4%).

In terms of mental health, boys (17%) are more likely to experience a mental disorder than girls (11%), with ADHD being the most common disorder (DOH 2015). Boys (52.1%) are also less likely to get informal help and support from friends and family compared with girls (64.3%) (DoH 2015).

Boys are also less likely than girls to have the support of an adult role model of the same sex, such as a father/father figure or male teacher. This is important for various reasons including the fact that boys (74%) are more likely to talk to their dads if they have a problem, than girls are (54%) (DoH 2015).

Work to improve boys' education, promote boys' emotional wellbeing and support a healthy transition into adulthood have a role to play in long-term male suicide prevention.

2. FATHERHOOD

Men's relationship with their fathers plays a major role in shaping their lives. Research shows that men who experienced low levels of emotional openness or engagement with their fathers growing up are more likely to experience poor social support networks in adulthood (Arbes 2014).

Fatherhood is an important life stage that presents many opportunities to engage with men. At present, screening for mental health conditions, alcohol and substance misuse and domestic violence is a Medicare requirement for women in the postnatal period (AMHF 2019). There is currently no screening program for new and expectant dads, despite the fact that an estimated 1 in 3 new parents who experience depression are men, with around 30,000 new dads affected every year (Fletcher 2019).

Family separation is also a key suicide risk for fathers that requires targeted intervention. Work to strengthen men's relationships with their partners and children and reduce the risk and impacts of separation could also play a role in male suicide prevention.

3. THE CRIMINAL JUSTICE SYSTEM

There is a strong case for reviewing the way the criminal justice system, in all its complexity, shapes men's risk of suicide. This includes police services, courts and correctional services.

According to Victorian research (Clapperton 2019), 1 in 6 male suicides are associated with being in trouble with the police. Research in Queensland (Leske 2019) has found that around 1 in 8 suicides are linked to pending legal matters.

A recent study at an Australian Capital Territory prison showed people in prison were 10 times as likely as the general Australian population to report a history of suicide attempts and thoughts of suicide (Butler et al 2018).

Previous research from New South Wales found that 6 times more prisoners died by suicide after they left prison, with males being particularly vulnerable in the first two weeks after being released (Kariminia et al 2007).

Suicides linked to the criminal justice system are mostly male, with men accounting for:

- Nearly 80% of suicides linked to being in trouble with the police (Clapperton 2019)
- More than 85% of suicides linked to pending legal matters (Leske 2019)
- Over 90% of prison suicides (Willis 2016)

The role that the criminal justice system could play in preventing male suicide warrants further investigation.

4. MASCULINITY

In recent years there has been a growing interest on the role that masculinity plays in male suicide. Researchers and commentators have largely focused on describing ways in which masculinity can be positioned as a risk factor for male suicide (King et al 2020).

These approaches commonly examine aspects of traditional masculinity that may hinder help-seeking in suicidal men, for example, men who strongly identify with the masculine ideal of self-reliance are more likely to report thoughts of suicide or self-harm (Pirkis 2017).

Masculinity can also be positioned as a protective factor, by highlighting the masculine strengths that men can draw on to deal with and overcome thoughts of suicide (Oliffe 2012).

Reframing help-seeking as strong and beneficial to others, focussing on the value of building emotional fitness and mental strength and acknowledging the courage required to "fight" mental health challenges are some examples of positive, non-stigmatising approaches to male suicide prevention (Oliffe et al) 2012).

Furthermore, the concept of mateship – the idea that men should look after their mates – is a strength of Australian masculinity that has been harnessed in some suicide prevention initiatives, by training men to support their peers (Ross 2019).

It is vital that we continue to develop our capacity to talk about masculinity as a risk and a protective factor for male suicide, in ways that avoid stigmatising men at risk or overshadowing the importance of other factors such as relationship problems, job loss, money issues, legal trouble and alcohol and substance abuse.

5. MALE-FRIENDLY SERVICES

While the gender stereotype that "men don't get help" is commonly presented as a key risk factor for male suicide, there is less focus on ensuring that services get better at giving help to men.

Men and boys tend to have less access than women and girls to a wide range of help-giving and health-giving services and a key way to remove barriers to access is to develop and offer male-friendly services (Poole 2020).

Further information on the importance of male-friendly services can be found on page 16.

BARRIERS TO PREVENTING MALE SUICIDE

1. WE ARE GENDER BLIND

It is well established among men's health researchers that approaches that "take account of gender differences and male sensibilities" are much more likely to work (Baker 2018).

This position has been adopted by Government in the National Men's Health Strategy (DoH 2019), which recommends a male-centred approach to health where the needs and preferences of men are consciously considered in the design, delivery, promotion and continuous improvement of programs and services.

Yet most of the suicide prevention work we do in Australia is delivered through the mental health sector, in a gender blind way, that is less effective at reaching men. According to Rosemary Calder AM, Director of the Australian Health Policy Collaboration, "mental health policy in Australia is gender-blind" in spite of all the evidence about the importance of gender (Duggan 2016).

Calder and others (e.g. Baker 2018) make the point that commercial organisations invest heavily on market research so they can target their messages and products effectively to men and women. Yet successive Governments have resisted calls to tailor and target suicide prevention in a gender inclusive way that acknowledges and addresses the differences between men and women.

2. WE LACK A POSITIVE NARRATIVE

Research on gender stereotypes has found that in situations involving harm, we are more likely to view men as intentional perpetrators/agents and see women as suffering victims/patients (Heterodox Academy 2018).

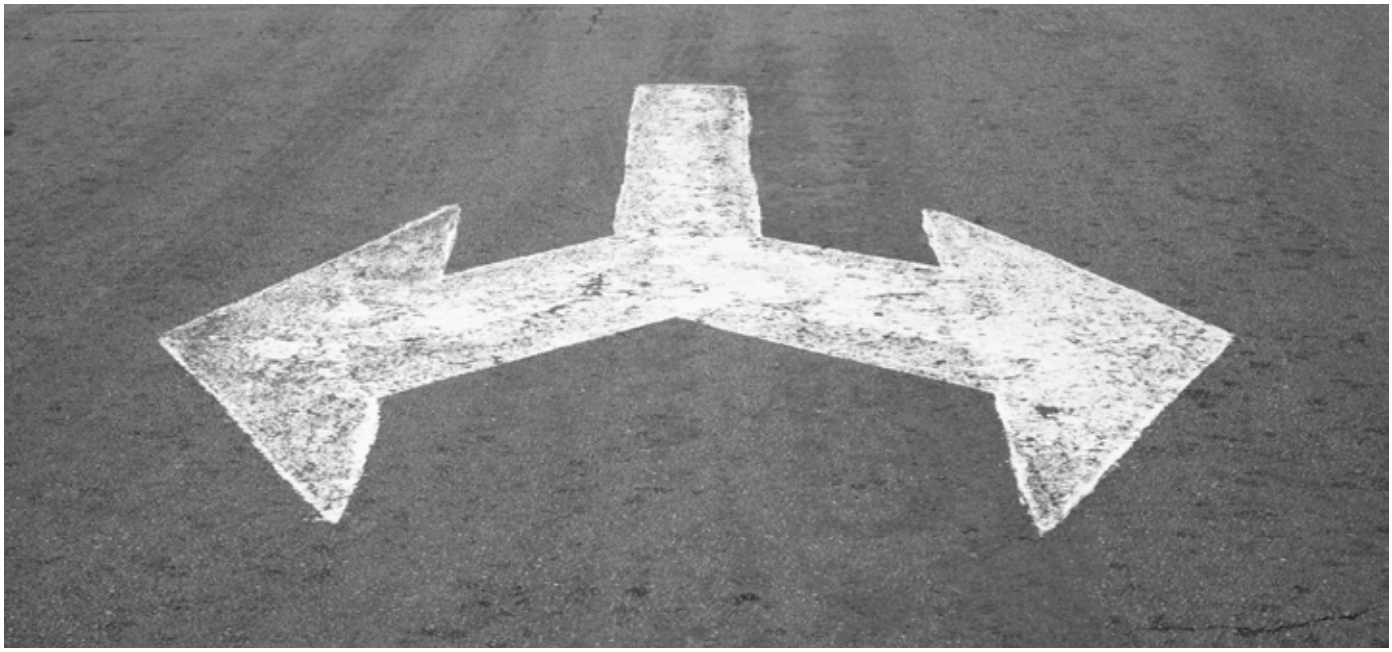
When applied to social issues, these unconscious biases mean we are more likely to see harmed men as deserving blame or punishment and harmed women as needing care, sympathy and protection.

In relation to gender issues, we experience more moral outrage, greater sympathy, a greater sense of unfairness and are less likely to blame a female victim/patient.

As the result of these gender biases, research shows we are less supportive of charitable causes and policy interventions that help men when compared to women (even for the same issue).

This stereotypical view of gender issues – sometimes described as "women have problems, men are problems" – makes it difficult for policymakers and funders to disrupt gender stereotypes by tackling men's issues like male suicide head on.

One way to challenge lazy gender stereotypes that make individual men the problem for not getting help, is to first acknowledge that we have a collective responsibility to get better at giving help to men in distress.



3. WE'RE NOT TARGETING FUNDING

The belief that "men don't need help" and should be self-reliant has been found to increase men's risk of having suicidal thoughts. The view that "men don't need help" is echoed in the way suicide prevention initiatives are currently funded.

A recent analysis of Government-funded suicide prevention projects by the Australian Men's Health Forum found that while 75% of suicides are male, the majority of Government-funded suicide prevention initiatives are more effective at reaching women (AMHF 2020).

These include StandBy (80% female clients); Kids Helpline (77%); Beyond Blue's Way Back Support Service (60%); headspace (60%) and Lifeline (around 60%).

Australia has led the world in gender responsive budgeting by publishing reports on the impact that Government spending has on women's lives for nearly 40 years. The same principle could be applied to suicide prevention funding, to give a clear picture of how much funding is reaching men (Sharp 2013).

While we do not advocate for funding to be taken away from women at risk of suicide, it is reasonable to ask that suicide prevention funding be allocated in an equitable way that reflects the fact that 3 in 4 suicides are male.

4. THERE AREN'T ENOUGH MEN INVOLVED

Australia's mental health and suicide prevention workforce lacks gender diversity. While the majority of suicides are male, the majority of people working to prevent suicide are female.

According to the Government's Workforce Gender Equality Agency (WGEA), a gender diverse workforce has a larger pool of talent to draw from; is more efficient, productive and creative and makes better decisions.

WGEA says that a gender diverse workforce brings together varied perspectives and produces a more holistic analysis of the issues they are seeking to address, spurring greater effort and motivation. They are better at promoting an environment where innovation can flourish, compared to teams of one particular gender (WGEA 2018).

Around 70% of mental health nurses, 72% of psychosocial support workers, 77% of peer support workers and 79% of psychologists in Australia are female (AIHW 2019a, HWA 2014, PC 2019). In addition, the majority of telephone counsellors and the majority of people receiving suicide prevention training are also female.

At a grassroots, community level there is an upswell of men who are stepping up to get involved in male suicide prevention by setting up, volunteering for and taking part in local peer support groups. We need to give more men a hand to get involved in male suicide prevention.

5. WE NEED TO HEAR MEN'S STORIES

In recent years there has been a growing recognition of the importance of involving people with lived experience of suicide in the development of policies and programs, as they can provide valuable insights into suicide prevention initiatives.

There are no apparent mechanisms in place to ensure that the lived experience workforce is gender diverse or provides insights into some of the common pathways to male suicide, such as relationship separation, job loss, money issues, legal problems and alcohol and substance abuse.

There are also important distinctions to be made between those who have been bereaved by suicide and those who have experienced being suicidal. Without positive action to promote the inclusion of men's lived experience of suicide, men's voices will continue to be under-represented in work to included lived experience voices in suicide prevention work.

MAKING SUICIDE PREVENTION SERVICES MALE-FRIENDLY

Australia's National Men's Health Strategy names the provision of "male-centred information, programs and services" as the first of its guiding principles (DoH 2019).

This male-centred approach is defined as "consciously considering the needs and preferences of men in the design, delivery, promotion and continuous improvement of programs and services".

Australia's men's health sector is a world leader in developing innovative, male-friendly approaches to engaging men in health services. Rather than blaming men for not accessing health services, male-friendly approaches challenge the stigmatising stereotype that men don't care about their health. They don't insist that men need to change and get better at getting help; rather they change the ways they offer and give help to men (Poole 2020).

They do this by working with archetypically masculine interests, practices, norms and roles. At their best, they also acknowledge the diverse and evolving nature of masculinity by affirming men's positive strengths and allowing for emerging masculine strengths to develop.

There are many different ways to develop male-friendly services. The Australian Men's health Forum's 10-step guide to developing male-centred health programs provides a set of tried and tested principles that can be applied universally to a general population of men as well as being tailored to the diverse needs and preferences of different populations across Australia (Poole 2020).

10-STEP GUIDE TO DEVELOPING MALE-CENTRED HEALTH PROGRAMS

PROMOTION

1	TARGET MEN DIRECTLY	If you want more men to access your service, target your service directly at men.
2	MEET MEN WHERE THEY ARE	If you want more men to go to your service, go to places where more men are.
3	USE MALE-FRIENDLY LANGUAGE	If you want men to listen, speak to them in a language they can hear.

CULTURAL

4	DON'T SEE MEN AS A PROBLEM	If you want men to be positive about your service, start by being positive about men.
5	COMBINE GETTING HELP WITH GIVING HELP	If you want men to get help, allow them to give help in the process.
6	BUILD SOCIAL CONNECTION	If you help men bond, you can build their support network for life.

STRUCTURAL

7	HELP MEN HELP THEMSELVES	Men are expected to be strong and independent. Help men help themselves.
8	SUPPORT APPROACHES "BY MEN FOR MEN"	Empower men to take responsibility for their health by supporting them to run their own programs.
9	USE MALE-FRIENDLY ACTIVITIES	Men take more interest in their health, when health programs are built around men's interests.
10	WORK WITH MEN'S STRENGTHS	Services work better for men when they work with men's strengths.

FIVE ACTIONS TO PREVENT MALE SUICIDE

1. WORK DIFFERENTLY FOR MEN

Gender blind approaches to suicide prevention that don't take account of the differences between men and women aren't working for men. By developing a National Plan to Prevent Male Suicide, the Government will, for the first time, have an opportunity to apply a gender lens to the work it is funding and begin to identify which initiatives are effective at reaching men.

A National Plan to Prevent Male Suicide would target resources at the groups of men at greatest risk; give more men a hand to get involved in male suicide prevention; work to make existing services more male-friendly; support services that are designed with men in mind and allocate an annual fund to drive down the rates of male suicide.

2. HELP MEN AT RISK

The argument that suicide prevention should look beyond mental health has been made and won. The time has come to move past the rhetoric of "dramatic reform" and invest in male-friendly initiatives that respond to some of the life crises that are known to put men at risk of suicide.

These include relationship breakdowns, job loss, money issues, legal problems and alcohol and substance abuse. The National Plan to Prevent Male Suicide should also focus on the nine priority groups listed in the National Men's Health Strategy including men who are socially disadvantaged men, rural and remote men, socially isolated men, veterans, Aboriginal and Torres Strait Islander males and people with diverse bodies, sexualities and genders.

3. GET MEN INVOLVED

For too long, women have shouldered the burden of working to prevent male suicide. The time has come to give more men a hand to step up and get involved in male suicide prevention. This could mean setting targets to increase the number of men studying or working as psychologists, mental health nurses, peer support workers and psychosocial support workers. It could also involve training more men as lived experience workers and giving more men suicide prevention training.

There is also a great opportunity to put funding into community-based peer support initiatives that are run by men for men. The recent emergence of community-led, men's mental health groups, all over Australia, is reminiscent of the early days of the men's shed movement and investing in these male community leaders now could help build sustainable, male-friendly support networks for many years to come.

4. SUPPORT SERVICES FOR MEN

If we want to prevent male suicide, we need to ensure more of the support services we fund are working for men. This means supporting providers to build their capacity to deliver male-friendly services by improving the way they promote their services to men, training support staff to work with men and ensuring workforces are gender diverse by recruiting more men if necessary.

It also means creating greater transparency by encouraging services that aren't as effective at engaging with men to set targets and report on their progress. At a minimum, suicide prevention initiatives offering a suicide prevention service that is available to men and women, should be working to ensure at least 50% of its clients are male (except for special circumstances where the at-risk population being targeted is known to be mostly female).

5. FUND MALE SUICIDE PREVENTION

For too long the majority of suicide prevention funding has gone to services that are more effective at helping women. The Government invests $5B a year into mental health services. The time has come to create an annual male suicide prevention fund to support the growth of male-friendly support services that are set up to work with the groups of men who are at greatest risk of suicide.

Australia has led the world in gender responsive budgeting by publishing reports on the impact that Government spending has on women's lives for nearly 40 years. The same principle could be applied to suicide prevention funding, to give a clear picture of how much funding is reaching men. We do not propose taking any funding away from women at risk of suicide. We are asking for suicide prevention funding to be allocated in an equitable way that reflects the fact that 3 in 4 suicides are male.

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