Suicide and the Australian Man: Risk groups, risk factors and potentials for prevention

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World map of suicide rates in males

(latest year available on WHOSIS in 2011)
### Selected countries with highest and lowest male-to-female ratio of suicide rates

<table>
<thead>
<tr>
<th>10 countries with highest rate ratio:</th>
<th>Male-to-female suicide rate ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize (2008)</td>
<td>9.4</td>
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<tr>
<td>Puerto Rico (2005)</td>
<td>6.6</td>
</tr>
<tr>
<td>Slovakia (2005)</td>
<td>6.6</td>
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<tr>
<td>Poland (2008)</td>
<td>6.4</td>
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<tr>
<td>Mauritius (2008)</td>
<td>6.2</td>
</tr>
<tr>
<td>Greece (2009)</td>
<td>6.0</td>
</tr>
<tr>
<td>Romania (2009)</td>
<td>6.0</td>
</tr>
<tr>
<td>Malta (2008)</td>
<td>5.9</td>
</tr>
<tr>
<td>Lithuania (2009)</td>
<td>5.9</td>
</tr>
<tr>
<td>Russian Federation (2006)</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Australia (2009)</strong></td>
<td>3.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 countries with lowest rate ratio:</th>
<th></th>
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<tbody>
<tr>
<td>Peru (2007)</td>
<td>1.9</td>
</tr>
<tr>
<td>Republic of Korea (2009)</td>
<td>1.8</td>
</tr>
<tr>
<td>China (Hong Kong SAR) (2009)</td>
<td>1.8</td>
</tr>
<tr>
<td>Singapore (2006)</td>
<td>1.7</td>
</tr>
<tr>
<td>India (2009)</td>
<td>1.7</td>
</tr>
<tr>
<td>Albania (2003)</td>
<td>1.4</td>
</tr>
<tr>
<td>Tajikistan (2001)</td>
<td>1.3</td>
</tr>
<tr>
<td>China (2009)</td>
<td>1.2</td>
</tr>
<tr>
<td>Bahrain (2006)</td>
<td>1.1</td>
</tr>
<tr>
<td>Kuwait (2009)</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Data source: WHO-SIS
Australian mortality statistics system

Source: De Leo et al., 2010. Adapted from the Figure Australian Cause of Death Statistics System, Explanatory Notes to Causes of Death 2010, ABS, 2012.
Revisions of other relevant causes of death

Between 2003 and 2007,
- Suicides decreased by 22.7%
- Ill-defined causes multiplied by 2.7-times
- Undetermined intent multiplied by 15.6-times

Revisions of other relevant causes of death

After revisions....

Revisions have halved the % of deaths assigned to Ill-defined and Undetermined intent causes between 2006 and 2009.

Suicide rates by year and sex, Australia, 1964–2010

Data source: ABS
Suicide rates in males by age groups, Australia, 1964-2010

Data source: ABS
Suicide rates by age group and sex, Australia, 2001-2010

Data source: ABS
Age-standardised suicide rates by sex and state and territory, 2006-2010

Data source: ABS
Male suicide rates by States and Territories

Data source: ABS
Smoothed standardized mortality ratios for males

Distribution of suicide methods used by males, 2001-2010

- Hanging: 51.7%
- Poisoning by gas: 16.3%
- Firearms: 10.1%
- Sharps objects: 2.4%
- Drowning: 1.5%
- Fall from height: 4.1%
- Other methods: 6%
- Poisoning by drugs: 7.9%

Data source: ABS
Age-standardised rates of non-fatal suicidal behaviours by sex

Data sources: Schmidtke et al., 2004 (the WHO/EURO Study)
* Gold Coast Hospital from the WHO/START Study 2005-2010
** Updated data on Italy provided in Kõlves et al., 2011a
Age-standardised rates of non-fatal suicidal behaviours at the Gold Coast Hospital ED, by year and sex

Data sources: Gold Coast Hospital from the WHO/START Study 2005-2010
Non-fatal suicidal behaviours at the Gold Coast Hospital ED by age group and sex, 2005-2010

Data sources: Gold Coast Hospital from the WHO/START Study 2005-2010
Presentations and methods of non-fatal suicidal behaviours by sex, 2005-2010

- **Male**
  - Drugs, medicaments and biological substances: 63%
  - Solvents, gases, vapours, chemicals: 23%
  - Cutting and piercing: 4%
  - Other means: 10%

- **Female**
  - Drugs, medicaments and biological substances: 70%
  - Solvents, gases, vapours, chemicals: 21%
  - Cutting and piercing: 7%
  - Other means: 2%
<table>
<thead>
<tr>
<th>Author and name of the survey</th>
<th>Sample area and response rate(s)</th>
<th>Sample size</th>
<th>Prevalence of suicide attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Survey of Mental Health and Wellbeing (ABS, 2007)</td>
<td>Australia; response rates for contacted households were between 59% in NSW and 77% in Tasmania</td>
<td>16,015,300 persons (aged 16 to 85 years)</td>
<td>0.41% had attempted suicide in the past twelve months (22,600 males and 42,700 females)</td>
</tr>
<tr>
<td>The Australian Epidemiological Study of Self-Injury (Martin et al., 2010)</td>
<td>Australia; response rate for contacted households was 38.5%</td>
<td>12,006 persons (aged 10 to 100 years)</td>
<td>2.6% had self-injured in the past twelve months (144 males and 171 females)</td>
</tr>
<tr>
<td>The Personality and Total Health Through Life Project (PATH) (Fairweather-Schmidt and Anstey, 2012)</td>
<td>Canberra and Queanbeyan; response rates for three age cohort were: 20 to 24 years - 58.6%, 40 to 44 years - 64.6%, and 60 to 64 years - 58.3%</td>
<td>7,485 (three age cohorts: 20 to 24 age, 40 to 44 years, and 60 to 64 years)</td>
<td>0.80% had attempted suicide in the past twelve months (24 males and 36 females)</td>
</tr>
<tr>
<td>The WHO/SUPRE-MISS (De Leo et al., 2005)</td>
<td>Brisbane and Gold Coast; response rate for contacted households was 68%</td>
<td>11,572 (over 18 years)</td>
<td>0.41% had attempted suicide in the past twelve months, 4.2% attempted in lifetime (180 males and 305 females)</td>
</tr>
</tbody>
</table>
Risk factors and suicidal process
Recent research has shown that women and men are different in many fundamental ways, however, there are still many questions and a lot is unclear.

* Dopamine signalling disturbances may increase impulsivity and aggression. Men may be more vulnerable to this which, in turn, may increase their suicide risk.

* Low *testosterone* may be connected to suicidality. However, high testosterone, in association with aggression, has also been implicated.
Psychological theories & factors

- Psychological mechanisms, such as *personality and cognitive variables*, have been found to be associated with suicidality.

- The psychoanalytical perspective Freud’s theory of suicide (1917)
  Through wishing to kill the introjected object, *aggression* turns inwards and a person kills themself

- Beck and colleagues (1990) stressed that cognitive aspects of psychological functioning are central to understanding suicidal behaviours
  The existence of *hopelessness*, which was defined as negative expectations about self, others and the future

- Shneidman’s theory of suicide is one of the most comprehensive in psychology
  Suicide is caused by unbearable psychological pain — ‘*psychache*’ (Shneidman, 1993)
  This is the result of unmet and frustrated psychological needs, which include thwarted love, fractured control, assaulted self-image, ruptured relationships and excessive anger
Psychological theories & factors

The Interpersonal Theory of Suicide by Joyner (2005) suggests that the key is the presence of capability, defined as a combination of acquired fearlessness and competency (those who kill themselves not only have a desire to die, they have learned to overcome the instinct for self-preservation).

Wanting death is composed of two psychological experiences:

✓ a perception of being a burden to others - *perceived burdensomeness*
✓ social disconnection to something larger than oneself - *thwarted belongingness*

In general, males and older adults tend to have experiences that prepare them to tackle barriers of self-preservation in ways females and younger people do not.
Psychiatric factors

- Although approximately 90% of people who suicide have been diagnosed with mental disorder(s) prior to death, a recent Australian psychological autopsy study has shown that this risk factor might be over-estimated.
- Mood disorders are most prevalent in Australian male suicides, followed by substance use disorders.
- Men and women have *different symptoms of depression*, which they express differently. As a result, male depression may be *under-diagnosed*, which may leave them at greater risk of suicidal behaviours.
- Co-morbidity of mental disorders (mood disorders, substance dependence/abuse, Cluster B personality disorders) most likely place males at higher risk of suicidal behaviours.

Cluster B – histrionic, narcissistic, borderline, anti-social
There exists very limited Australian research on the relationship between somatic disorders and suicidal behaviours.

Physical illnesses in males are frequently co-morbid with psychiatric disorders, particularly depression and alcohol abuse. This makes for increased vulnerability to suicidal behaviours.

Avoiding the impacts of physical illness or being a burden seems to be the precipitating reasons for suicide among elderly males who suffer from physical illness.
Social factors - Durkheim’s four types of suicide

Social integration
(i.e. degree to which people are bound together in social networks)

Social regulation
(i.e. degree to which individual’s desires and emotions are regulated by societal norms & customs)
Social factors

- The association between suicide rates and employment rates in Australian males is complex, but individual level studies have indicated elevated suicide risk in unemployed males.
- Australian studies have shown separated males to have a high risk of suicide.
- Men appear to be most vulnerable to suicidal behaviours when changes in their employment and marital statuses occur; this is potentially mediated by masculine ideals and traditional gender expectations.
Suicidal behaviours are not attributable to one single cause. These determinants show complex interactions between biological, psychological, and social factors (Van Heeringen et al., 2000). Several models exist to understand suicidal behaviours as multidimensional complex phenomena. Most models show suicidality as a continuum, starting from suicidal ideation and gradually proceeding to the suicidal act, if an appropriate intervention does not interrupt this process. The length of the suicidal process might vary from a few days, in young people with an adjustment disorder, to lifelong for people with chronic depression, substance abuse or schizophrenia (Wasserman, 2001).
Stress-Diathesis Model of suicidal behaviour

Source: Mann, 2003
Risk groups
Aboriginal and Torres Strait Islander suicide rates in Qld

Aboriginal and Torres Strait Islander males

- In Australia, suicide rates among Aboriginal and Torres Strait Islander Peoples are higher than the other Australian population; males have higher rates of suicide while females engage more in non-fatal suicidal behaviour.
- Aboriginal and Torres Strait Islander males aged 25-34 years have the highest rates of suicide.
- Hanging is the most common suicide method among Aboriginal and Torres Strait Islander males in Australia.
- Alcohol and substance abuse, under-utilisation of health services, as well as disadvantages in social and health conditions put Aboriginal and Torres Strait Islander males at high risk of suicide.
- Aboriginal and Torres Strait Islander males are at a high risk of contagion or imitation of suicidal behaviours in their communities.
Males in Rural and Remote areas

- Male suicide rates are higher in rural and remote areas of Australia than in metropolitan areas.
- Vulnerable groups in the rural and remote areas include farmers, Aboriginal and Torres Strait Islander Peoples, and migrants.
- Identified suicidal risk factors for rural and remote males include climatic variability, political issues related to the farming industry, economic fluctuations, and the impact of mining.
AS suicide rates by the country of birth for males (15+ y)

Data source: AIHW
Migrant males

✓ Australian studies have demonstrated that suicide rates are generally higher among immigrants born in countries that have higher suicide rates (Eastern, Northern, and Western European countries) and they are lower in immigrant groups from countries with lower suicide rates (including those in Southern Europe, the Middle East, and South-East Asia).

✓ Immigrants seem to bring both suicide risk and protective factors from their home countries, including *religious, cultural, and specific genetic factors*.

✓ Suicidal behaviours among migrants are also influenced by *migration related factors*, such as the reasons for migration, circumstances that preceded it, experiences within the host country.

✓ In Australia, the prevalence of non-fatal suicidal behaviour among male *asylum seekers* is higher than in the general population and among prisoners.

✓ The *experience of detention* increases the likelihood of mental health problems such as anxiety, depression, and PTSD, as well as self-harm and suicidal ideation. These harmful impacts are particularly evident after longer detention and persist after release.
Bisexual and homosexual males

- Bisexual and homosexual males are at elevated risk of suicidal behaviour.
- Australian studies have shown that homosexual males have significantly higher levels of suicide ideation and suicide attempts compared to heterosexual males.
- Stressful experiences resulting from social stigmatisation, substance misuse, and disadvantages in economic conditions are predictive for suicide and self harm in LGBT individuals, not sexual orientation and gender identity alone.
Separated males

- Separated males have a higher risk of suicide than divorced males in Australia, particularly in younger males.
- Separation is seen as an important acute life stressor elevating the risk of suicidal behaviours.
- Separation related shame, lower education, and stressful legal negotiations place separated men at a greater risk of suicidality.

Occupation

- Social class at work predicts suicidal behaviours; lower class men are at a higher risk of suicide than higher class men.
- Male suicide rates are higher among agricultural, transport, and construction-related occupations in Australia.
- Long working hours, heavy workloads, personnel changes, low decision latitude, high psychological demand, and low social support at the workplace are predictive of male suicide but these relationships may be mediated by depression.
- Parent’s adverse work conditions and subsequent changes in family environment may influence suicidal behaviours among male children.
Help seeking

- Australian males’ help-seeking behaviours are negatively influenced by *masculine stereotypes*. This is particularly so in young males aged 16-24 years.
- Negative attitudes towards help seeking and a perceived need for autonomy are strong barriers to help seeking among young males.
- Australian males compared to females who had suicide plan are less likely to perceive the need for help.
Suicide prevention in males

The LIFE Framework (2007) aims to provide a strategic plan to reduce suicide by achieving six national action areas:

1. Improve the evidence base and understanding of suicide prevention;
2. Build individual resilience and the capacity for self-help;
3. Improve community strength, resilience and capacity in suicide prevention;
4. Take a coordinated approach to suicide prevention;
5. Provide targeted suicide prevention activities; and,
6. Implementing standards and quality in suicide prevention.

Figure. Targets of Suicide Prevention Interventions

SUICIDAL BEHAVIOR

Stressful Life Event  Mood or Other Psychiatric Disorder

Suicidal Ideation

FACTORS INVOLVED IN SUICIDAL BEHAVIOR

Impulsivity
Hopelessness and/or Pessimism
Access to Lethal Means
Imitation

Suicidal Act

PREVENTION INTERVENTIONS

A Education and Awareness Programs
   Primary Care Physicians
   General Public
   Community or Organizational Gatekeepers

B Screening for Individuals at High Risk

Treatment

C Pharmacotherapy
   Antidepressants, Including Selective Serotonin Reuptake Inhibitors
   Antipsychotics

D Psychotherapy
   Alcoholism Programs
   Cognitive Behavioral Therapy

E Follow-up Care for Suicide Attempts

F Restriction of Access to Lethal Means

G Media Reporting Guidelines for Suicide

Circled letters refer to relevant prevention interventions listed on right.

<table>
<thead>
<tr>
<th>Target groups</th>
<th>Outcomes</th>
<th>Who is involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal intervention</td>
<td>Activities that apply to everyone (whole populations)</td>
<td>Reducing access to means of suicide, altering media coverage of suicide, providing community education about suicide prevention and creating stronger and more supportive families, schools and communities.</td>
</tr>
<tr>
<td>Selective intervention</td>
<td>For communities and groups potentially at risk</td>
<td>Building resilience, strength and capacity and an environment that promotes self-help and help-seeking and provides support.</td>
</tr>
<tr>
<td>Indicated intervention</td>
<td>For individuals at high risk</td>
<td>Building strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms.</td>
</tr>
<tr>
<td>Symptom identification</td>
<td>When vulnerability and exposure to risk are high</td>
<td>Being alert to signs of high risk, adverse health effects and potential tipping points; and providing support and care.</td>
</tr>
<tr>
<td>Early treatment</td>
<td>Finding and accessing early care and support</td>
<td>Providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care.</td>
</tr>
<tr>
<td>Standard treatment</td>
<td>When specialised care is needed</td>
<td>Providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery.</td>
</tr>
<tr>
<td>Longer-term treatment and support</td>
<td>Preparing for a positive future</td>
<td>Providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects.</td>
</tr>
<tr>
<td>Ongoing care and support</td>
<td>Getting back into life</td>
<td>Building strength, resilience, and adaptation and coping skills, and an environment that supports self-help and help-seeking.</td>
</tr>
</tbody>
</table>

Restriction of means

✓ Restricting means to suicide is an effective suicide prevention method. It helps to ensure suicide methods such as firearms, drugs, or jumping sites are not readily available; it may also consequently affect whether these methods are eventually considered to be less socially acceptable.

✓ Restrictions on alcohol consumption have been associated with decreased suicide rates in high consumption countries. International studies have demonstrated that restricting access to alcohol has had a positive effect on suicide rates in Russia, Estonia, Slovenia, the United States, Denmark, Iceland
Two important events have been marked in the graph:

1. establishment of the National Committee on Violence and
2. the National Firearms Agreement

Source: Klieve et al., 2009b, p. 288
## Differences between hanging and firearms suicides in Tasmania

<table>
<thead>
<tr>
<th></th>
<th>Hanging (%)</th>
<th>Firearms (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol present</td>
<td>23.6</td>
<td>43.6</td>
<td>0.001</td>
</tr>
<tr>
<td>Previous suicide attempt</td>
<td>36.5</td>
<td>17.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Suicide note</td>
<td>22.5</td>
<td>34.9</td>
<td>0.024</td>
</tr>
<tr>
<td>Recent GP visit</td>
<td>64.7</td>
<td>47.9</td>
<td>0.013</td>
</tr>
<tr>
<td>Recent psychiatrist visit</td>
<td>41.3</td>
<td>22.8</td>
<td>0.001</td>
</tr>
<tr>
<td>Under psychiatric supervision</td>
<td>25.3</td>
<td>15.6</td>
<td>0.043</td>
</tr>
<tr>
<td>Psychiatric hosp in past year</td>
<td>37.5</td>
<td>22.6</td>
<td>0.006</td>
</tr>
<tr>
<td>In prior days:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td>15.7</td>
<td>28.2</td>
<td>0.016</td>
</tr>
<tr>
<td>Sad</td>
<td>58.4</td>
<td>41.1</td>
<td>0.003</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>25.8</td>
<td>15.8</td>
<td>0.024</td>
</tr>
<tr>
<td>Drunk</td>
<td>20.2</td>
<td>40.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Motive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>29.2</td>
<td>47.0</td>
<td>0.002</td>
</tr>
<tr>
<td>Avoiding stressful life events</td>
<td>50.6</td>
<td>34.4</td>
<td>0.004</td>
</tr>
<tr>
<td>Psychiatric symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>39.3</td>
<td>24.3</td>
<td>0.004</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>18.0</td>
<td>28.4</td>
<td>0.044</td>
</tr>
</tbody>
</table>

Media and suicide prevention

✓ Explicit descriptions of suicide methods or romanticising a suicidal act in the media may lead to vulnerable people copying the act. Media adherence to reporting *guidelines* may prevent this.

✓ *Positive examples* of people’s resilience in the face of mental health problems and suicidality in the media may help to reduce suicidal behaviours.

**Mindframe**, the Australian resource for reporting suicide and mental health issues, has also issued media guidelines on how to report suicide in a way that does not further increase the risk in vulnerable individuals

[www.mindframe-media.info/](http://www.mindframe-media.info/)
Other activities – possible campaigns?

- Exposure to suicide awareness campaigns and information about associated resources should start at an early age to combat the development of stigma attached to help-seeking; despite the limited evidence, this may be of importance to males.

- Increasing resilience and improving coping skills may be an effective method for youth suicide prevention.

- Making the general public, including high risk groups, aware of symptoms of depression or suicidal ideation, and of suicide prevention resources, has not been shown to clearly encourage help-seeking.
Selective and Indicated Interventions

Selective Interventions target groups of people or population subgroups who are potentially at risk of suicide. Indicated Interventions target individuals already at risk of suicide.

✓ None of the programs have provided evidence of reducing numbers of suicidal behaviours, and there is need for more rigorous evaluation.
Peer support

- Help from within the *community or a peer group* may be preferable to contacting professionals.
- The mental (as well as physical) wellbeing of young men can be improved through activities attractive to this target group such as *sport*, where peer-to-peer support can work well.
- Older men may benefit most from suicide prevention efforts that allow them to be *more social* and spend time with, and talk to their peers, as well as doing things that make them feel more useful to the community.
- Gay and bisexual men are at increased risk of suicide due to issues, including discrimination and feelings of isolation, and would benefit from peer support.
- Peer support appears to be beneficial when dealing with *loss and grief*. 
Telephone or online help

Telephone or online services are important resources for people in *acute crisis*, especially for those living in rural or remote areas, those who prefer anonymity and who may be reluctant to seek help. They can also aid in initiating professional help-seeking, but evaluations are needed to assess these effects.
Many suicide prevention initiatives based in rural and remote Australia tend to address the issue of suicide indirectly through *strengthening community networks*. Judging their efficacy is difficult as there have been few evaluations and reports of results. However, some programs have proven to be sustainable over long periods of time, which implies at least a perceived usefulness for the community in question.

Accessing care and support may be difficult in remote and rural Australia. *Forging ties and networks* between service providers improves service coverage and availability, and online resources may provide fast initial help in crisis.

Aboriginal and Torres Strait Islander suicide prevention efforts need to be *culturally appropriate* and incorporate culturally significant aspects to effectively reach their target audience.
Workplace

✓ Workplace culture needs to be changed so that help-seeking is seen as brave, rather than as a sign of weakness. Crisis services should be confidential to avoid stigmatisation and thereby creating barriers to help-seeking.

✓ Gatekeeper training in high-stress and high-risk workplaces appears beneficial for detecting persons who might be at risk of suicide and for supporting them in help seeking.

✓ Programs such as ASIST or Mental Health First Aid that teach people to become gatekeepers and assist others in seeking help can be useful for the wellbeing of individuals and the community and is used in several organisations.
Symptom Identification and Early Treatment

Early Treatment within suicide prevention programs and services is only possible when combined with effective Symptom Identification. These two domains remain distinct as Early Treatment is the first professional contact with health care. With the right training, Symptom Identification can be performed by anyone within the general population (Department of Health and Ageing, 2008).
Screening

- General large-scale population screening for suicidal behaviours is not advisable because of the high rate of false positive results with current questionnaires. However, screening tools can be useful in high-risk groups.

- Male-specific depression and/or suicidality screening tools are fairly new, and there is little evidence of the usefulness of their as yet. Men may respond most favourably to informal screening tools and to humour. Any screening tools must be culturally appropriate to yield reliable results.
Gatekeepers

✓ Professional or peer gatekeepers who have been trained to spot and approach individuals in suicidal crisis have been shown to effectively facilitate help-seeking and reduce non-fatal suicidal acts.

✓ Many Australians prefer to talk to their GP about mental health issues, and many people who later complete suicide visit a GP in the months or weeks before death. Consequently, GPs are in a good position to initiate appropriate treatment.

✓ Training GPs to better recognise and treat depressed individuals has been shown to reduce suicidality in female subjects of Gotland, Sweden. However, men are harder to reach and engage in discussions than women, and no such effects have been shown in male patients.
Risk assessment and management

- Australian states and territories have developed their own suicide risk assessment and management protocols and training for relevant health care staff to achieve better outcomes for suicidal patients. Management protocols should also address continuity of care and required follow-ups.

- Regular updating of knowledge about current recommended practices for recognising and helping suicidal patients is important for quality of care and to improve the confidence of health care staff in caring for such patients.
Standard Treatment of suicidality

- Psychotherapies that have a *problem-solving skills base* and a more *practical approach* appear to be effective in treating suicidal individuals. Men may prefer these types of therapies.
- Men have been underrepresented in many clinical trials investigating the effectiveness of psychotherapies, and therefore *little is known* about their engagement in such interventions, with some studies indicating that males expect to be guided in their own treatment, and others indicating that men prefer to take the initiative.
A combination of pharmacotherapy and psychotherapy appears to offer advantages over either therapy alone, as medicines may ease distress fairly quickly, making patients more receptive to problem-solving psychotherapies for the long-term.

Misconceptions and fears, as well as possible side-effects, may reduce adherence to pharmacotherapies; yet continued use may be crucial to improve long-term outcomes.

More research is needed about the effectiveness of various treatments; specifically, randomised controlled trials are needed.
Continuing care: long-term treatment and ongoing care

- On-going care and support are *recommended* for suicidal patients after discharge from hospital to reduce further suicidal behaviours.
- There is some indication that *brief interventions*, such as follow-up contacts in the form of phone calls, short personal text messages, and letters, are useful for suicidal male patients.
- There is a need for further studies to test effective follow-up strategies for suicidal people.
Thank you!