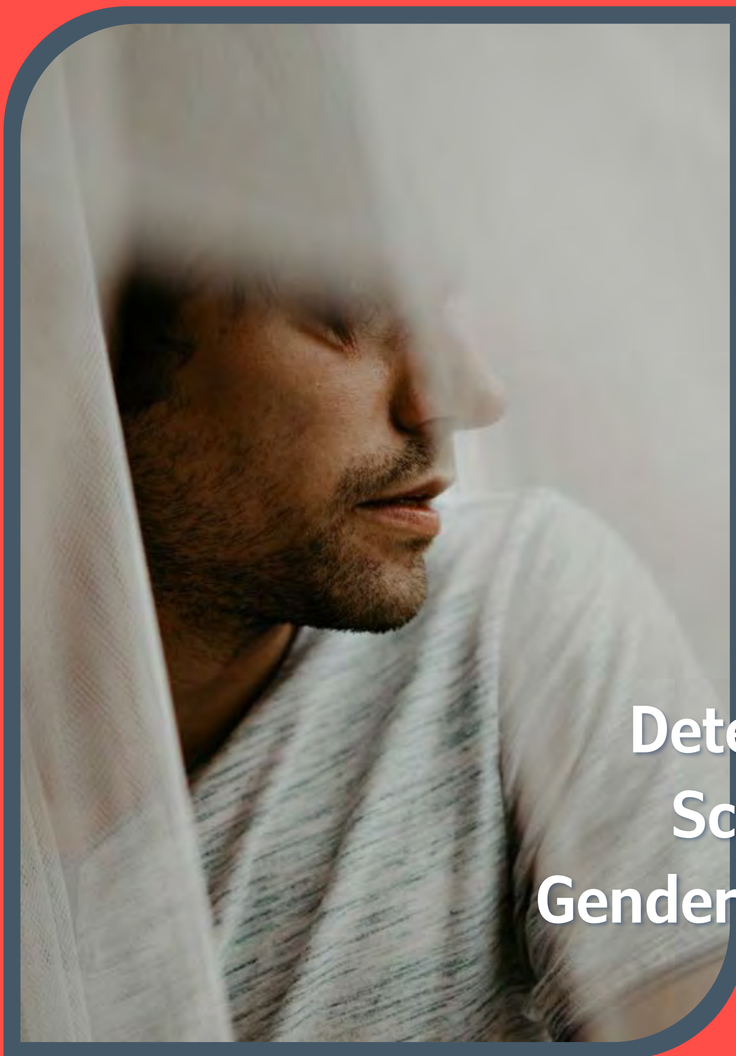
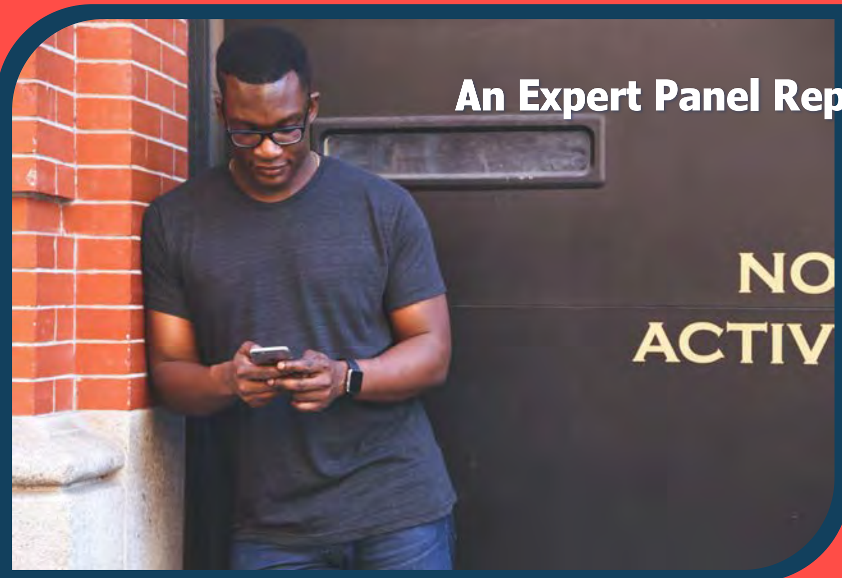


Determining the Efficacy and Scope of Behavioral Health, Gender-Specific Screening Tools

Community Involvement in Male Behavioral Health Management



An Expert Panel Report from Men's Health Network

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www.pcori.org

Disclaimer
The content of this monograph and any recorded representation of comments and opinions of the conference attendees do not necessarily represent the views of PCORI, Men's Health Network, or panel members' organizations, their directors, their board of governors, or any other organization officers or representatives.

Forwards

Forward by Men's Health Network

On behalf of Men's Health Network (MHN), we are proud to have partnered with the Patient-Centered Outcomes Research Institute (PCORI) to convene this important program E-program on September 18, 2020, and to present this report based on the proceedings. We are excited to have gathered together a group of talented, accomplished individuals to explore the topic of community involvement in the behavioral health of boys and men. As my MHN colleagues and I have spoken with various stakeholders in the field, we have been impressed with the passion, commitment, and work so many professionals and community members have done—and continue to do—to address this significant issue.

That's the good news. The bad news is that managing the emergent behavioral health issues in America's boys and men at the community level remains a significant challenge, as evidenced by the continual increase in truly tragic outcomes including addiction, depression, suicide, and violence. Our goal in organizing this meeting was not just to facilitate a vigorous discussion and a marketplace of ideas among experts but also to provide concrete examples of the outcomes of actions, programs, research, and policies that have helped address this national problem. We also wanted to highlight places where more work needs to be done, from creating male-centric diagnostic and prevention tools to developing and executing grassroots and organizational programs.

Of course, getting the word out is one of the keys to success in this area. So, we invite your comments and suggestions for how to disseminate information about outcomes-oriented activities and best practices that have made a difference in the mental and emotional health of boys and men. Your perspectives and experience will be invaluable to us and others.

PCORI supports myriad projects and research programs that help patients and those who care for them make better informed health care choices, including choices in the area of behavioral health. Men's Health Network gratefully acknowledges PCORI for providing the resources and support.

Ana N. Fadich-Tomsic, MPH, CHES
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Forward by PCORI

PCORI funds research that can help patients and those who care for them make better-informed decisions about the health care choices they face every day, with that research guided by those who need the information most. We also support projects that encourage the active integration of patients, caregivers, clinicians, and other health care stakeholders into all aspects of the patient-centered outcomes research (PCOR) process.

This conference by the Men's Health Network—which brought together community leaders, policymakers, thought leaders, men's health activists, academic researchers, and clinicians, among others—aligns with PCORI's mission. Too often in conducting research and in identifying research priorities, patients and other groups with valuable perspectives are left sitting on the sidelines. Conferences like this one, where everyone has a seat at the table, result in a more robust and complete discussion where everyone's voice is heard. The research agendas and, ultimately, the research that results from such conferences are generally more relevant to patients and more likely to be taken up in practice.

Because PCORI also strives to devote resources to reducing health care disparities, we hope the lessons learned from this conference will lead to continued dialogue and, ultimately, to PCOR that can help males and those who care for them make better-informed choices to manage their mental and behavioral health. PCORI commends all the conference's participants and hopes this report will foster continued engagement of all stakeholders in the health care community—not just clinicians—to discuss what can be done to give patients and those who care for them the tools they need to take charge of their health.

PCORI Staff

Forward by Project Principal

The struggle to deal effectively with mental health issues for boys and men in America continues to be as difficult as it is important. According to the Centers for Disease Control and Prevention, on average American males are 3.5 times more likely than females to commit suicide.[1] The rate for those aged over 65 is even higher, but since approximately 2018 the greatest increase has occurred in males aged 25 to 45 and is most prevalent in white males. Critics point out that men are half as likely as women to be clinically diagnosed with behavioral health issues, but experts in clinical care and epidemiology believe that this disparity is due largely to the reluctance of boys and men to talk about emotional issues with clinicians and the lack of adequate primary care screening standards and tools to diagnose depression, anxiety, and other mental health issues in males. This is evident by the fact that 83% of male suicide victims had no diagnosed mental health condition and were more likely to belong to a racial or ethnic minority.[2,3,4]

... men are half as likely as women to be clinically diagnosed with behavioral health issues, but experts in clinical care and epidemiology believe that this disparity is due largely to the reluctance of boys and men to talk about emotional issues with clinicians and the lack of adequate primary care screening standards and tools to diagnose depression, anxiety, and other mental health issues in males.

It is well accepted that the first line of identification, management, and triage to help those in mental health crisis or at the cusp of a crisis is most effective at the community level. Coworkers, educators, coaches, neighbors, friends, and family all have important roles to play in this work. To adequately address the alarming public health epidemic of American males' behavioral health issues and suicide, Men's Health Network (MHN) convened a conference of expert community stakeholders and leaders, which took place digitally on September 18, 2020. This monograph is based on that conference, funded in part by PCORI and intended to continue the dialogue started at a similar meeting, "Behavioral Health Aspects of Depression and Anxiety in the American Male,"5 held in May 2019. Topics from the conference in May 2019 included expansion of the panel's 2 key recommendations for advancing the care of boys

1 Hedegaard H, Curtin SC, Warner M. Suicide rates in the United States continue to increase [data brief]. Hyattsville, MD: NCHS; 2018. https://www.cdc.gov/nchs/data/databriefs/db309.pdf
2 The health of Millennials. Blue Cross Blue Shield. April 24, 2019. https://www.bcbs.com/the-health-of-america/reports/the-health-of-millennials
3 King CA, Horwitz A, Czyz E, Lindsay R. Suicide risk screening in healthcare settings: identifying males and females at risk. J Clin Psychol Med Settings. 2017;24(1):8-20. https://doi.org/10.1007/s10880-017-9486-y
4 Schrijvers DL, Bollen J, Sabbe BG. The gender paradox in suicidal behavior and its impact on the suicidal process. J Affect Disord. 2012;138(1-2):19-26. https://doi.org/10.1016/j.jad.2011.03.050
5 Giorgianni SJ, Brott A. Behavioral health aspects of depression and anxiety in the American male: an expert panel Report. Men's Health Network. 2019. https://www.pcori.org/sites/default/files/Mens-Health-Network-Conference-Summary.pdf

and men, namely the importance of community involvement and the need for male-specific tools and approaches to identifying boys and men at risk of behavioral health issues and potential suicide.

Since the initial planning of this program, our world has been dealing with the pandemic of our lifetimes caused by the novel coronavirus, COVID-19. The pandemic has produced a parallel pandemic—one of anxiety, depression, isolation, uncertainty, and fear. These emotional and mental health issues have, in turn, increased behavioral health problems, substance abuse, violence at home, and many other conditions that have exacerbated an already-difficult situation for all of us, particularly for boys and men. MHN also convened 3 extension conferences, all of which were funded in part by PCORI, to examine the specific issue COVID plays in precipitating and/or aggravating mental health issues in men and boys. Thus, this monograph, like the conference it covers, will touch on COVID-related matters only in the most cursory manner. The proceedings of the COVID-related behavioral health programs will be published and posted on the Men's Health Network website (www.menshealthnetwork.org) in the coming months.

All involved in this program intend and hope that the information, recommendations, and key action items found herein help family members and those in community leadership positions better understand what needs to be done to mitigate the male behavioral health and suicide crises and how to disseminate best practices and other results of their work.

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www.MensHealthLibrary.com

Executive Summary

Background

Men's Health Network (MHN) was established in 1992 and is a national nonprofit organization whose mission is to provide health awareness and disease prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation to men, boys, and their families where they live, work, play, and pray. PCORI provides program awards and other funding to support programs that help people make informed health care decisions and seeks to improve health care delivery and outcomes by producing and promoting high-integrity, evidence-based research guided by patients, caregivers, and the broader health care community.

Program

The authors based this report on an expert panel convened by MHN on September 18, 2020, and partially funded by the PCORI Engagement Award Initiative (EAIN 00095). Out of concern for public health safety, this conference was held virtually. The professionally moderated panel brought together a cross-section of experts from private and public entities involved in behavioral health issues, research, and care delivery, particularly as they pertain to males. The topic area was "Behavioral Aspects of Depression and Anxiety in the American Male: Identifying Areas for Patient-Centered Outcome-Oriented Needs, Practices, and Future Research."[6] The conference was structured to (1) examine what is known about community involvement in identifying and managing behavioral health issues for boys and men; (2) examine the types of programs and screening tools that have been effective thus far as well as those that will be needed to advance community

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[6] Male behavioral health discussion. Men's Health Network. May 10, 2019. https://menshealthnetwork.org/malebehavioralhealth

involvement; (3) identify key next steps toward advancing community activity in this area; and (4) identify outcomes-oriented research questions that will help advance community management programs.

This panel discussion is based on findings published by Men's Health Network in 2019 based on a similarly structured expert panel discussion. It also is based on the realization that despite significant advances in the recognition and treatment of medical conditions—and despite the growing resources dedicated to health and wellness—men and boys in America live shorter, less healthy lives than do American females. In addition, men die younger and at higher rates than women from 9 of the 10 leading causes of death in America, including suicide.

Panel Discussion Summary

The program is predicated on a general definition of *community involvement* as varying activities involving multiple levels and types of trustworthy community-based organization partnerships to plan, promote, deliver, and report on policies, programs, and services within the community setting. Community involvement may or may not have direct links to clinical or social services partnerships for triage, but most on the panel believed these partnerships are of importance in triaging at-risk boys and men into care services.

The panel dialogue touched on seven main topic areas. These were:

Important general trends and epidemiology of men's health in America were reviewed as a framework for the overall basis of these discussions on community involvement in male behavioral health. The panel felt it is important to view behavioral health in the context of broader trends in male health and how men access health care. There was also a discussion of how male health lags behind female health both in terms of mortality and morbidity, and very specifically in the area of mental health and suicide.

Particular **challenges** of various male demographics, such as minority men, millennials, older men and young boys were also discussed. Of particular importance in this area was the way mental health is viewed by these populations, the role of stigma and the underlying community factors that play a role in their behavioral health profiles in the community.
There was a good deal of discussion about the **ways boys and men express behavioral health symptoms** and how these differ from how women express them. The concepts of emotional lexicons in both males and females were also discussed. Panel members provided insight into how these differing manifestations in males can often be misunderstood by community members and leaders and how best to educate those in the community about how to more appropriately identify boys and men who may be having mental health issues.

Controversies in the types of behavioral health screening tools available in both the community and clinical settings were discussed. The panel reviewed the relevance and deficiencies of many commonly utilized screening tools in optimally identifying potential behavioral health episodes in males was a focal point of discussion in this area. There was also a discussion on the need for better guidelines on when and how often to screen males for potential mental health problems.

The pivotal role of individuals in various community settings, including educational institutions, the workplace and community organizations in identification and triage of males who may be having behavioral health challenges was discussed at length. This discussion included examples of successful community level programs that are engaged in addressing these issues.

Guidance and suggestions of how those involved at the community level can develop better skills in identifying and helping bring immediate "Emotional First Aid" and other support programs to boys and men in need were provided.

Clinical panel members provided insights and suggestions on how community leaders involved in behavioral health identification and support programs can successfully navigate the intersection between appropriate community involvement and referral of men to clinical care. This included a **discussion of some important public policy and legal considerations.**

Next Steps

The panel provided their expert perspectives on important next steps to advance successful and collaborative community involvement. In summary these included:

1. Instill a **recognition of the overall disparities between male's and female's health and wellness**, as well as the especially large disparities in life expectancy, suicide, opiate deaths, and others in which males are severely disadvantaged.
2. **Develop a centralized repository of information** on community-based initiatives to identify, manage, and report the results of programs that support the behavioral health wellness of American boys and men. Ideally, this database would be easily accessible and searchable at a level appropriate for community involvement, provide information that covers the full lifespan of males, and provide information on vulnerable subpopulations of males and a diverse range of socioeconomic, racial, and life preferences.
3. **Develop a new, contemporary concept of masculinity** that focuses on supporting and nurturing emotional literacy for boys and men.
4. **Increase accessibility of clinical, social work, and mental health professionals** with specific expertise in managing issues for boys and men.
5. **Develop medical disciplines** and educational and postgraduate training and credentialing in comprehensive male health care, including mental health care.
6. **Establish well-man visits**, similar to the well-woman visits, that are a covered component (at little or no costs) of annual physicals.
7. Establish **better alignment of reimbursement for screening and management of mental wellness** and mental illness clinical care, particularly at the primary-care level.
8. Put pressure on media of all types to better support the important role boys and men have in their own health and the health of their loved ones. **Encourage the media to provide more even-handed and positive portrayals of males,** without resorting to negatively stereotypical characterizations that create an unhealthy culture and mindset that is injurious to the development of boys and men.

Conference Background and Support

The following report is based on an expert panel convened on September 18, 2020, by MHN. This program was in part funded by the PCORI Engagement Award Initiative (EAIN 00095). PCORI (www.pcori.org) has been a leader in providing funding for work that enhances patient engagement in mental health management. To date, PCORI has funded more than 139 comparative clinical effectiveness research studies in these areas, including peer support programs, posttraumatic stress disorder (PTSD), peer navigation programs, and various topics relating to diversity. To comply with social distancing and public health safety requirements

necessitated by the COVID-19 global pandemic, this conference was held electronically. The contents of this conference and manuscript do not necessarily represent the views of PCORI, its board of governors, or its methodology committee. The conference, "Determining the Efficacy and Scope of Behavioral Health, Gender-Specific Screening Tools for Males Benefitting Front Line Community Workers," brought together a cross-section of experts from private and public entities involved at the community level in behavioral health issues, research, and care delivery, particularly as they pertain to males.

This conference builds on an expert consensus panel convened in May 2019 by MHN and partially funded by PCORI that examined in-depth the widely known yet poorly addressed issues of depression, anxiety, and suicidality in American males. It also identified key next steps toward improving the emotional wellness and care of boys and men.[6]

Conference Structure and Goals

Participants in this e-conference came from the public and private sectors and included federal, local, and community policymakers and leaders; authors and social commentators; men's health activists; academic researchers and health educators; grassroots entities; and providers who work with boys and men in a clinical setting. Participants brought many perspectives and were selected to ensure a geographically and socio-culturally diverse representation (see Participant List, Appendix I). The program was professionally moderated and followed a Socratic dialogue format. That is, the moderators followed a structured discussion guide (Appendix II) and encouraged conversation among the panel in a way specifically designed to carefully, slowly, and deliberately elicit values, perspectives, and opinions about the key topic questions. The conversations also opened additional relevant lines of discussion.

The overall goal of the conference was to discuss the important roles that community organizations, institutions, and individuals play in identifying and managing behavioral health issues, particularly depression, anxiety, and suicidality, with a specific focus on the subpopulation of boys and men within the general US population. More specifically, the conference was structured to examine how to do the following:

- Better engage community leaders in identifying boys and men at risk
- Assist community entities in more effectively doing this important work
- Disseminate current male-centric screening tools and develop new ones
- Assist in identifying and managing obstacles in community involvement
- Properly triage boys and men at risk of behavioral health issues and suicide to care
- Identify opportunities to help evaluate and report results of community-level programs
- Help better disseminate best practices and learnings about effective programs and approaches.

The professional facilitator, Lee Lynch, and the program's co-moderator, Salvatore J. Giorgianni, Jr, PharmD, encouraged robust interactive dialogue and kept the panel's discussions focused on the topic areas outlined (Appendix II). These areas include the following:

- Defining the problem of overall behavioral health in boys and men in the community and the consequences to the community of poorly managing or ignoring the problem

- Identifying how to implement behavioral health programs at the community level, programs that have done this successfully, and the utility of male-specific recognition tools used at the community and local clinical levels
- Identifying ways to disseminate programs, tools, and best practices
- Identifying key action items and research questions to help optimize community efforts.

We also hope this material will provide a framework for enhancing and providing better support to communities and community leaders as well as those who support them, by addressing the important area of male behavioral health and suicide prevention.

In this monograph, we present the comments and perspectives of the panel, along with supportive literature and examples. It is the convener's and panel's hope that this information will enhance communities' abilities to identify, manage, and triage boys and men at risk of mental health episodes. We also hope this material will provide a framework for enhancing and providing better support to communities and community leaders as well as those who support them, by addressing the important area of male behavioral health and suicide prevention. Throughout the day's discussion, panel members were asked to identify community-based key action items and specific areas for outcomes-oriented future research for male behavioral health and what types of outcomes-oriented research may also be needed; these are presented at the end of this report.

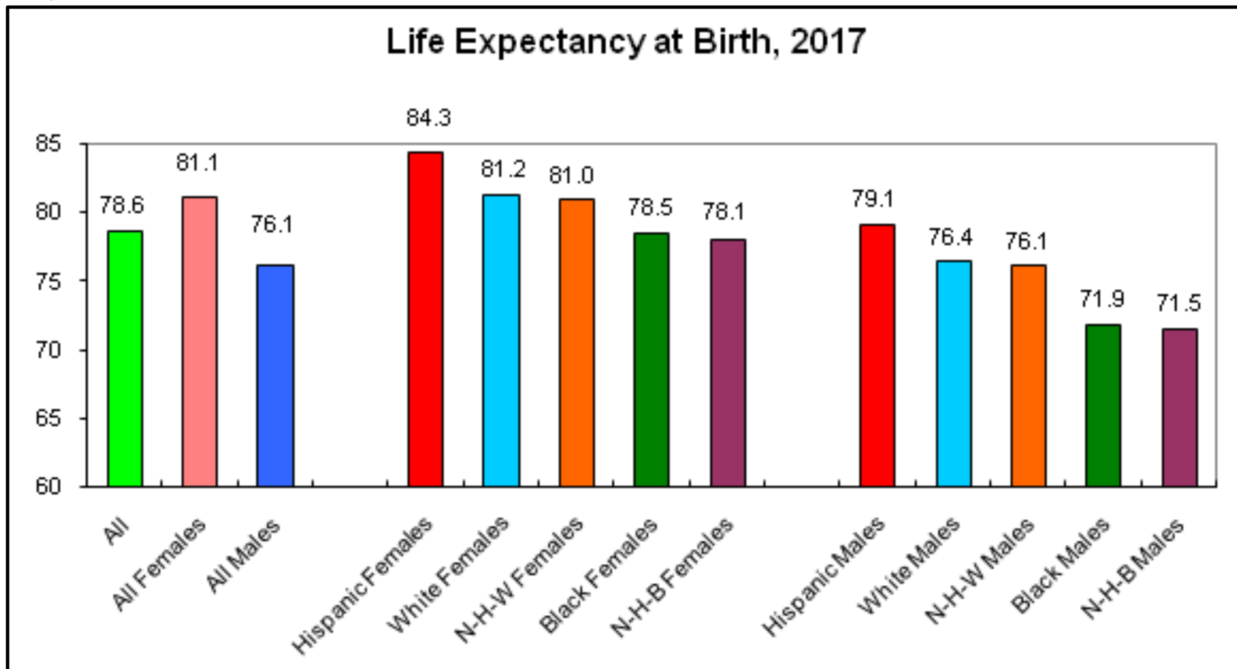
The topic of behavioral health in males—in terms of increasing awareness, diagnosis, and treatment—is complex, multifaceted, and absolutely vital. It would be impossible to do justice to this issue in a single monograph (or even a series of monographs), not only because of the volume of information to be considered but also because we are constantly learning more about the true nature of the problems and how to address them in community and clinical settings. We encourage readers of this monograph (and the others in the series) to use the information, data, and recommendations we present to help them better understand their community's needs and as a basis for constructing their own responses to the urgent, gender-specific behavioral and mental health needs of boys and men. We also encourage readers to explore the list of additional, validated resources we provide at the end of this monograph to expand their knowledge even further. The problem is too large and too important not to.

As a general starting point, the panel used a working definition of *community involvement* as "multi-entity and multisector partnerships that emphasize the pivotal role of community members in the interventions, programs, and public policies focused on behavioral health and delivery of services within community settings." As such, community involvement may or may not have direct links to clinical or social services

partnerships for triage. Most panel members believed these partnerships are important in triaging at-risk boys and men into care services.

General Trends in Male Health

Graphic 1



Source: CDC/National Vital Statistics Report Vol. 68, Number 7, June 2018[7] *NHW=Non-Hispanic White NHB=Non-Hispanic Black*

Despite significant advances in diagnosing and treating nearly all medical conditions, and despite the growing resources dedicated to health and wellness, American men continue to live shorter and demonstrably less healthy lives than American women. The US life expectancy in 1900, while decidedly shorter for both genders than it is now, was nearly the same for men and women, with women outliving men by 2 years. Over the years the gender gap gradually widened, until the 1990s when women's life expectancy was 7 years longer than for men. By the end of the 20th century, some progress had been made in addressing this health disparity and the longevity gap shrank somewhat, to 5.2 years, where it remained until 2004.[8] In 2020 this gap is, unfortunately, the same.

Digging a little deeper, in America men die younger and at higher rates than women from 9 of the 10 leading causes of death, including suicide. According to Armin Brott, MBA, a men's health expert, advocate, and syndicated columnist of *Healthy Men*, "Much of this early mortality and high degree of morbidity among males is preventable. It is not just about access or coverage, but also about the way men view their health as well as how the health system views and accommodates their unique needs and preferences."

[7] Arias E, Xu JQ. United States life tables, 2017. *National Vital Statistics Reports.* 2019;68(7). https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf

[8] Bastian B, Tejada, VB, Arias E, et al. *Mortality Trends in the United States, 1900-2018*. National Center for Health Statistics; 2020. https://www.cdc.gov/nchs/data-visualization/mortality-trends/index.htm

One important contributing factor to the increased mortality and morbidity among males is the difference in the ways males and females engage the health care system and health-related community support programs. In the health care clinical setting, men are about half as likely as women to have an encounter with a health care provider (even when controlling for women's pregnancy-related visits). According to Dr. Salvatore Giorgianni, senior science advisor to MHN and cofounder and chair-emeritus of the American Public Health Association Caucus on Men's Health, when men engage the health care system, it is usually later in the course

Graphic 2

Causes of Death by Race, Sex and Ethnicity - 2018

Cause	All Persons	Men	Women	Ratio m/w	White	White, not Hispanic or Latino	Black or A-A	American Indian or Alaska Native	Asian or Pacific Islander	Hispanic or Latino
All causes	**723.6**	**855.5**	**611.3**	**1.40**	728.3	748.7	867.8	575.8	390.6	524.1
Diseases of the Heart Total	**163.6**	**207.5**	**127.9**	**1.62**	163.3	168.1	206.9	109.6	85	112.3
Diseases of the Heart Ischemic heart disease	**90.9**	**124.5**	**64.0**	**1.95**	91.8	93.8	104.8	64.2	53	69.1
Cerebrovascular diseases	**37.1**	**37.6**	**36.1**	**1.04**	35.9	36.0	51.6	24.1	29.4	32
Malignant Neoplasms Total	**149.1**	**176.8**	**128.6**	**1.37**	151	155	171.2	96.2	92.6	107.4
Malignant neoplasms Trachea, broncus, and lung	**34.8**	**41.8**	**29.3**	**1.43**	35.8	38.2	36.3	23	18.9	15.1
Malignant neoplasms Colon, rectum, and anus	**13.4**	**15.9**	**11.2**	**1.42**	13.3	13.5	17.3	10.4	8.8	10.9
Malignant neoplasms Prostate	**18.8†**	**18.8**	**§**	**~**	17.8	~	14.2	6.3	3.6	6.2
Malignant neoplasms Breast	**20**	**0.3**	**19.7**	**0.02**	10.9	~	16.3	7.9	6.6	7.4
Chronic lower respiratory disease	**39.7**	**43.7**	**36.8**	**1.19**	42.6	45.2	30	27.1	11.6	17.0
Influenza and pneumonia	**14.9**	**17.3**	**13.1**	**1.32**	14.9	15.1	16	14.2	12.8	11.7
Chronic liver disease and cirrhosis	**11.1**	**14.7**	**7.7**	**1.91**	12	11.5	7.2	29.4	3.7	14.5
Diabetes mellitus	**21.4**	**26.9**	**16.8**	**1.60**	19.6	18.9	38.2	32.1	16.4	24.6
Kidney disease (Nephritis & related)	**12.9**	**15.8**	**10.8**	**1.46**	11.8	11.6	25.2	11.6	8.3	11.6
Alzheimer's	**30.5**	**24.5**	**34.2**	**0.72**	31.9	32.3	27	14.6	15.8	25.5
HIV disease	**1.5**	**2.3**	**0.8**	**2.88**	0.9	0.7	6.2	1.1	0.3	1.4
Unintentional injuries Total	**48**	**65.9**	**31**	**2.13**	50.9	54.3	47.5	55.1	17.4	32.7
Unintentional injuries Motor vehicle-related injuries	**11.7**	**16.9**	**6.6**	**2.56**	11.9	11.9	14	17.7	4.7	10.6
Drug overdose	**20.7**	**27.9**	**13.6**	**2.05**	25.9	23.0	21.3	26.8	3.0	11.0
Suicide	**14.2**	**22.8**	**6.2**	**3.68**	16.2	18.1	7.1	13.7	6.9	7.4
Homicide	**5.9**	**9.3**	**2.5**	**3.72**	3.4	2.8	21.4	7.2	1.6	4.9

† Rate for men only. ‡ Rate for women only. § Number not reported by the Centers for Disease Control. ~ Rates not available
Source: National Center for Health Statistics; *Health, United States, 2018 Trend Tables: With special feature on mortality. (Trend Tables)* Hyattsville, MD. 2021.*Retrieved March 4,2021*

of a disease, which makes treatment more difficult in most cases. For example, in the case of diabetes, Dr Jean Bonhomme, MD, MPH, founder of the National Black Men's Health Network as well as a member of the MHN board of scientific advisors, noted that while the symptoms are largely the same for men and women, women are typically diagnosed within a year of onset, while men aren't diagnosed until they've had symptoms for 15 years. In addition, Giorgianni added, a male medical encounter is usually focused on a particularly troubling set of symptoms or medical events. Unfortunately, mental health issues are not generally discussed or screened for during regular clinical visits. This is in part because there are no national or even professional medical association guidelines that recommend how best to screen boys and men for behavioral health issues. At the same time, Medicare and private insurance reimbursement systems de-incentivize screening boys and men for mental health conditions, since screening, diagnosing, and triaging such conditions is complex and time consuming, especially if there are positive findings, which means a provider would not be able to see as many patients.[5]

The clinical setting is not the only venue where there are marked gaps in engaging men in health-related activities. At the community level, whether in the workplace, educational environment, or civic or community volunteer organizations, men generally don't engage in health-related programs unless those programs are specifically designed to capture their attention. Even then, men tend not to attend as frequently as women do. According to Darrell Sabbs, a male patient advocate who manages several health-related programs at Phoebe Putney Memorial Hospital in rural Albany, Georgia, a notable exception are programs that screen for prostate cancer, where there is a high awareness of need by men. Sabbs noted that when health programs in his rural community include prostate cancer screenings, men turn out in large numbers. When similar programs are done without prostate cancer screenings, far fewer men attend. MHN staff worked with many organizations and institutions to design health screening and outreach programs that attract men. In the mental health and wellness areas, there are some community-level programs for boys and men but they're few and far between, according to Bonhomme. Some of these programs were highlighted during the panel discussion and will be reviewed later in this monograph. All panelists agreed that the major obstacles to creating additional mental wellness programs for boys and men are (1) lack of awareness of successful programs that could be used as models, (2) lack of skills to replicate successful programs, and, most importantly, (3) sources of funding. As with many other medical conditions, men usually don't seek help for emotional wellness issues until their symptoms are too severe to be ignored or they've had such major upheavals to their life circumstances that they're brought to care by a loved one, according to Cory Lyon, MD. Lyon, an associate professor in the department of family medicine at the University of Colorado School of Medicine and the associate program director for its Family Medicine Residency program in Denver, is also a practicing family physician who treats many boys and men with behavioral health problems.

Unfortunately, all too often, early signs of emotional illness—particularly among boys and men—aren't recognized by family, friends, or others in the community until it's too late, when the boy or man commits a crime or harms or kills someone or himself.

Unfortunately, all too often, early signs of emotional illness—particularly among boys and men—aren't recognized by family, friends, or others in the community until it's too late, when the boy or man commits a crime or harms or kills someone or himself. Nearly 40% of jail and prison inmates self-report a history of mental illness, and this prevalence is higher among those with more arrests and time served in a correctional facility. Community interventions in collaboration with the criminal justice system are well positioned to address the health disparities in justice-involved populations and the vulnerabilities to justice involvement experienced by those with mental illness.[9]

[9] Bronson J, Berzofsky M. Indicators of mental health problems reported by prisoners and jail inmates, 2011-2012. *Bureau of Justice Statistics*. 2017;1-16. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

In brief, the 2019 foundational conference identified 4 broad key action items, as follows:

1. **Assessment of Male-Specific Screening Tools**
    - Conduct a systematic survey of major validated tools to screen for behavioral health conditions.
    - Work to develop male-specific screening tools with variant structures based on male-specific demographic and cultural needs.
    - Critically reevaluate national clinical and community-level guidelines in terms of male-specific appropriateness, relevance, and their ability to be implemented.
    - Establish standards for periodic mental health screenings in the health care continuum of care.

2. **Education and Training**

    For Clinicians
    - Develop educational components in health professional curricula to establish skill sets for future practitioners.
    - Develop postgraduate and continuing education training for clinicians across disciplines.
    - Establish metrics to be applied to practices to assess their quality improvement programs.

    For Community
    - Develop site and environmentally relevant education and training for non–health care personnel in the community to recognize, understand, triage, counsel, and mitigate behavioral health issues for boys and men.

3. **Public and Private Policy**
    - Advocate for health-related legislation that supports fundamentals of well care for boys and men across the lifespan.
    - Review and revise both public-sector and private-sector reimbursement.
    - Create better guidelines for clinicians, nonclinical health care workers, and community members to use.
    - Embark on a series of public-sector and private-sector collaborative programs to better understand the link between signs and symptoms of behavioral health in boys and men and interactions with the criminal justice system.
    - Better define the role of telemedicine and telehealth.
    - Examine important implementation issues surrounding telemedicine initiatives.

4. **Dissemination**
    - Create training programs for clinicians in practice to help them better screen, diagnose, triage, communicate about, and treat male behavioral health conditions.
    - Create a series of train-the-trainer programs for community stakeholders, such as educators, law enforcement, youth program leaders and coaches, and workplace human resources personnel, on how to recognize, communicate, and triage potential behavioral health issues.
    - Create a centralized male health resource center to collect, characterize, catalog, store, and actively disseminate information.

Panelists identified 2 additional action items from the 2019 foundational conference that they felt needed to be the special and immediate focus of our September 2020 conference. Those items were as follows:

- The importance of community engagement in identifying, managing, and triaging boys and men at risk of mental health episodes, particularly suicide
- The need for tools specific to boys and men that will help community members screen and identify at-risk individuals

Overall Economic Impact of Male Health Disparities

In one of the few published papers examining the fiscal impact of these significant male health disparities, Brott et al estimated that in 2011 dollars the cost to the US public and private sectors exceeds $470 billion annually.[10] Specifically, it costs federal, state, and local governments more than $142 billion every year in lost tax revenues. It also costs US employers and society as a whole more than $156 billion annually in direct medical payments and lost productivity and an additional $181 billion annually in decreased quality of life. In another study, Mental Health America estimated that across the board serious mental illness costs America a staggering $193.2 billion per year in lost productivity, absenteeism, and direct and indirect health care costs.11 In a landmark report, the Centers for Disease Control and Prevention (CDC) estimated the medical and business costs of intentional injury.12

It found that in 2013 suicide accounted for $50.8 billion in medical care and work loss. Given the sharp increase in suicides since the publication of that report, there is no question that the fiscal costs to society have also increased. Not surprisingly, the costs associated with men—especially those aged 24 to 64—were 4 times those for women. Unfortunately, very little research has analyzed the economic and social impacts on families and communities. Clearly, there is a significant need not only to better understand the damage done

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10 Brott A, Dougherty A, Williams ST, Matope JH, Fadich A, Taddelle M. The economic burden shouldered by public and private entities as a consequence of health disparities between men and women. Am J Mens Health. 2011;5(6):528-539. https://doi.org/10.1177/1557988311421214

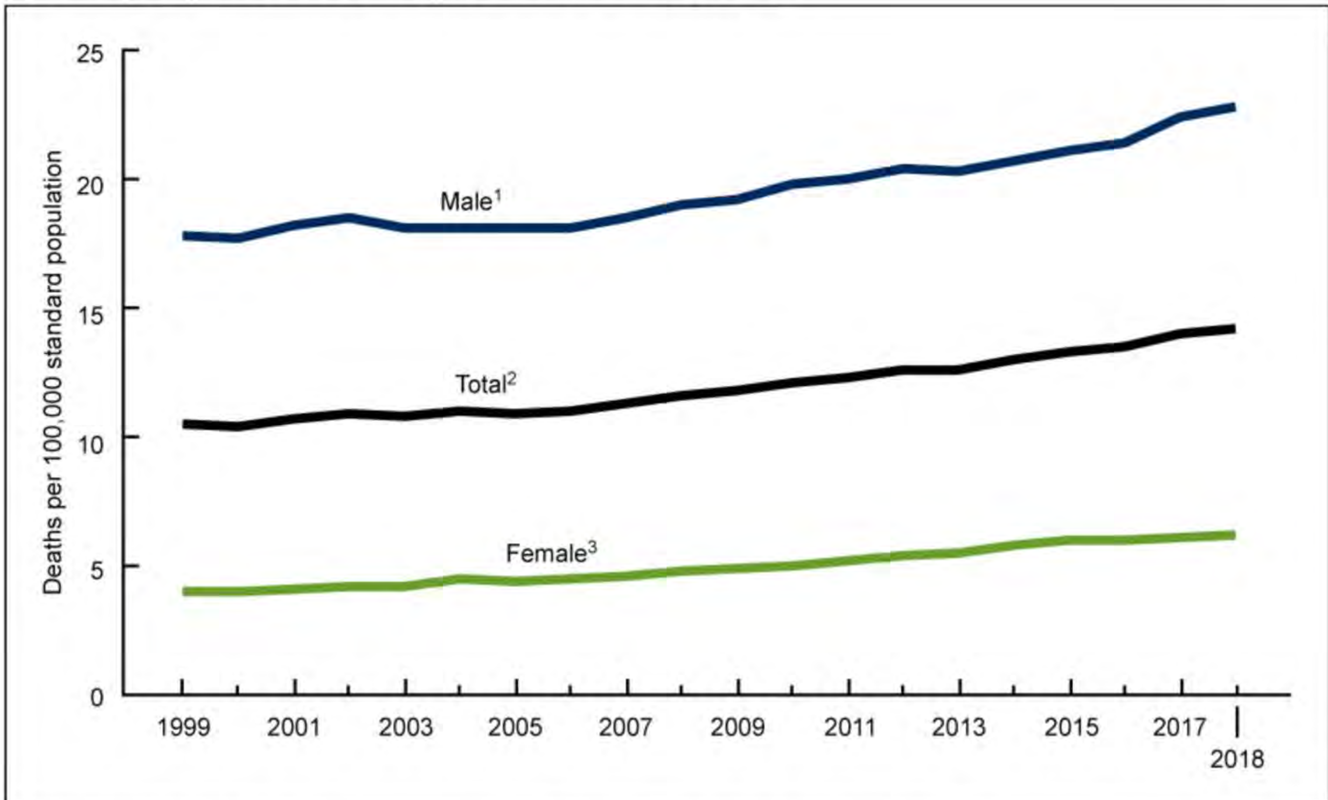
11 Mental Health America. 5 minute guide to men's mental health [infographic]. MHAnational.org. https://www.mhanational.org/infographic-mental-health-men

12 Injuries cost the US $671 billion in 2013: CDC study shows injuries and violence create substantial economic burden [press release]. US Department of Health and Human Services. 2015 Washington, DC. https://www.cdc.gov/media/releases/2015/p0930-injury-costs.html#:~:text=Injuries%20cost%20the%20US%20%24671,2013%20%7C%20CDC%20Online%20Newsroom%20%7C%20CDC

but also to determine whether broad-based suicide prevention initiatives are having an effect. The panel strongly recommended this topic as an important area for future research.

Graphic 3

Age Adjusted Suicide Rates by Sex in the US 1999-2018



[1]Stable trend from 1999 to 2006; significant increasing trend from 2006 through 2018 with different rates of change over time, $p < 0.05$.
[2]Significant increasing trend from 1999 through 2018 with different rates of change over time, $p < 0.05$.
[3]Significant increasing trend from 1999 to 2015 with different rates of change over time; stable trend from 2015 through 2018, $p < 0.05$.
NOTES: Suicides are identified using *International Classification of Diseases, 10th Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Access data for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db362-tables-508.pdf#1.
SOURCE: NCHS, National Vital Statistics System, Mortality (NVSS-M).

Overview of Mental Health Issues in American Males

Regrettably, the picture of behavioral and mental health concerns for boys and men in America, and indeed around the world, is rather bleak. Even more disturbing is that the prevalence and the ultimate tragedy of a mental health crisis, namely successful suicides, has increased.

Bonhomme summarized for the panel the problematic state of mental health issues for males in America. He noted that the need to do significantly more to help screen and identify at-risk boys and men—and to do so in a gender-specific way—is apparent in the tragic increases in the ultimate manifestation of mental health crisis, namely suicide. Thanks to a June 2018 report from the CDC, we now know that between the ages of 15 and 64 roughly 3.5 times more men than women commit suicide.13 From ages 65 to 74, male suicides outnumber female suicides by more than 4:1. For those over age 74, the difference is a startling 9.3:1. We

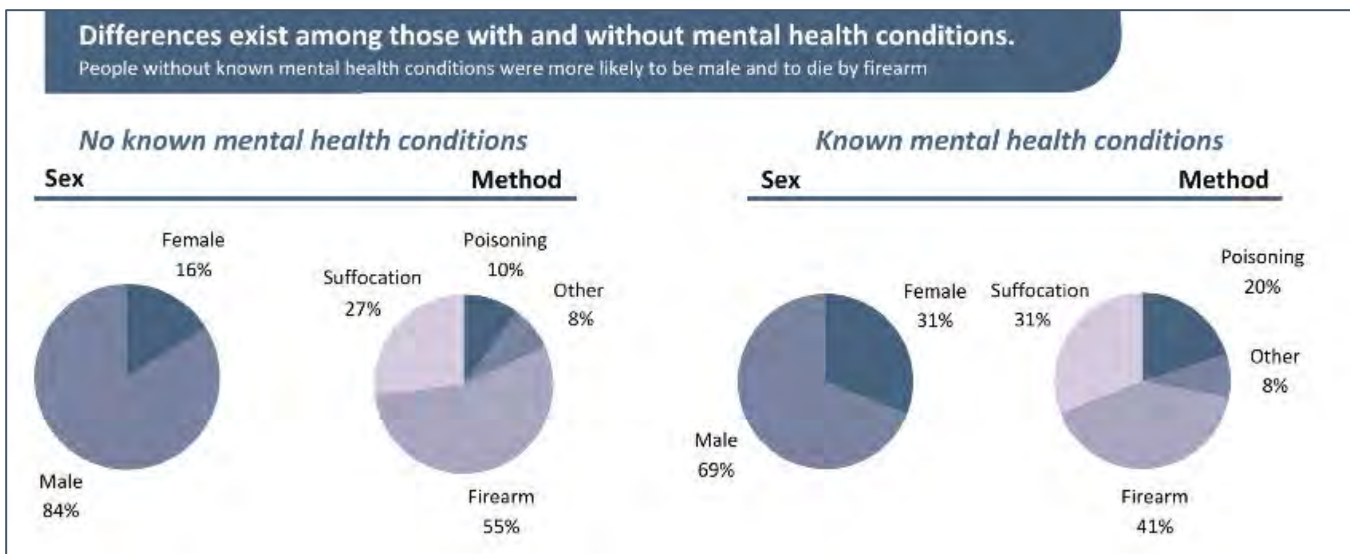
[13] Suicide increasing among American workers [press release]. Centers for Disease Control and Prevention; 2018. https://www.cdc.gov/media/releases/2018/p1115-Suicide-american-workers.html Washington, DC

recognize that females are significantly more likely to attempt suicide, but we are focusing on completed suicides because they are a far more serious—and permanent—manifestation of depression, anxiety, or other mental health condition.

Brott, a member of the American Public Health Association Men's Health Caucus, added that while there is generally an increase in suicide in men over age 65, since approximately 2018 the greatest increase has occurred in males aged 25 to 45 and is most prevalent in white males. Underscoring the true need to better understand the complex interplay between early mental health issues and suicide is the CDC's finding that the majority of males who commit suicide have no associated prior history of mental illness (see Graphic 4).

Graphic 4

Previously Undiagnosed Mental Health Condition Higher in Males



Source: CDC/National Vital Statistics

How Suicide Affects Communities

Suicide affects communities in many important ways, including the number of men and others directly and indirectly affected; suicide's impact on the community's health and vitality; its economic impact on business; and how it strains the overall delivery of health care and civic services. Of the approximately 152 million males in the United States, it is estimated that more than 6 million of them are adversely impacted by depression each year. Given the low levels of screening for depression, the true number is likely significantly higher, according to MHN advisors.

An analysis of these conditions by gender also shows that men are significantly more likely than women to suffer from behavioral health conditions of substance abuse, alcohol use disorder, hyperactivity, and psychosis.

The Mental Health Association identified the 6 most prevalent mental health problems that affect boys and men in America. Community members who have responsibility for the health and welfare of boys and men need to be aware of these conditions and have a fundamental understanding of the unique red flags and other symptoms boys and men exhibit.

Six Most Prevalent Mental Health Problems Affecting Boys and Men

(Adapted from the Mental Health Association)[6]

Depression. Male depression is not commonly diagnosed in regular medical visits because the ways boys and men express emotional hurt (such as fatigue, anger, irritability, social isolation, and loss of interest in hobbies) differ from the ways girls and women do (verbal expressions of sadness or worthlessness). As a result, typical male symptoms are often ignored and/or misdiagnosed—and definitely untreated.

Anxiety. More than 3 million men aged 18 to 54 have been diagnosed with and treated for a panic disorder, agoraphobia, or other anxiety-related phobia. Here again, part of the challenge is that because males verbalize these conditions and behave differently than women do, male symptoms too often go unrecognized—and untreated.

Bipolar Disorders. An estimated 1.2 million males have diagnosed bipolar disease. Due to the lack of adequate screening and symptom recognition, the true number of males affected is likely higher.

Psychosis and Schizophrenia. Approximately 3.1 million men over age 30 have been diagnosed with these severe and potential devastating illnesses.

Eating Disorders. Serious eating disorders, which often accompany depression or anxiety, affect approximately 28 million Americans. Boys and men account for 10% of people with anorexia or bulimia and an estimated 35% suffer from binge-eating disorders. As with many mental illnesses, men are far less likely than women to seek professional help—and health care providers are less likely to screen boys than girls.

Substance Abuse. Approximately 1 in 5 men develop alcohol dependency during their lives. Gay, bisexual, and transgender men are more likely to have higher rates of substance abuse than the general population of men. Most regrettably, male veterans experience nearly twice the rate of alcohol and drug abuse as female veterans.

Millennials are a unique demographic, in no small part due to their extensive (some might say "obsessive") use of the internet and social media in every aspect of their lives. This has been especially true in the social-distancing age of COVID-19. When compared with the national population, Millennials seem to be more affected by behavioral health conditions. This observation is highlighted in a 2019 Blue Cross Blue Shield report,14 which found that of the top 10 conditions affecting Millennials, depression ranks number one, followed by substance abuse disorder and alcohol abuse disorder.

Millennials (those born between 1981 and 1996) are an at-risk generation with seemingly few of the social support networks or community connections that were present in prior generations. In a pre-COVID-19 2018 survey of males and females by YouGov.com, researchers found an astonishing level of self-reported isolation-related behavioral health conditions [15].

Given that males are more likely than females to abuse drugs and alcohol, account for approximately 75% of opiate overdose deaths, and make up nearly 80% of suicides, the implications of these findings are highly

[14] The health of millennials. Blue Cross Blue Shield. April 24, 2019. Accessed January 21, 2019. https://www.bcbs.com/the-health-of-america/reports/the-health-of-millennials.

[15] Ballard J. Millennials are the loneliest generation. YouGov. July 30, 2019. https://today.yougov.com/topics/lifestyle/articles-reports/2019/07/30/loneliness-friendship-new-friends-poll-survey

significant for both clinical care and involvement at the community level. The YouGov.com report also drew a strong correlation between the above-mentioned mental health/isolation-related issues and Millennials' heavy reliance on social media over in-person interactions. As noted above, Millennials have far fewer or less-stable social networks for support, identification, and possible mitigation of potentially disastrous consequences of social isolation and lack of human connection. This poses a unique challenge to those in the community. In the post-COVID-19 world, many experts, including the MHN Board of Advisors, have significant concerns about how the enhanced isolation and temporary hiatus of Millennials' already-limited, pre-pandemic support networks will affect this entire generation in the years ahead.

Millennials are by no means the only demographic for which male behavioral health conditions need more attention in both community and clinical settings. For example, the demonstrably higher rate of depression and suicide in men over age 65 may be related to normal, age-related decreases in blood testosterone levels, a condition often referred to as "andropause" or "male menopause." Men with subnormal testosterone levels often suffer from mood swings, which can, when not recognized for what they are, proceed to clinical depression, anxiety, behavioral abnormalities, and, unfortunately, suicide. [16]

Community Challenges in Millennial Behavioral Health

30% of Millennials say they often or always feel lonely (versus 20% of Generation X and 15% of Baby Boomers)

25% say they have no acquaintances

22% say they have no friends at all

27% say they have no close friends

30% say they have no best friends

Susan Peschin, MHS, president and CEO at the Alliance for Aging Research, noted another confounding factor for older men. "There's ample evidence that cognitive impairment in older people may be closely linked to depression and other mental illness conditions," she said, "but not much research into this possible link has been done, and I'm not aware of any research that's specific to men." Because of the pandemic, many older men, particularly those in assisted-living facilities, have had temporary losses of important regular physical contact with family and friends and even curtailment of the structured social interaction environments so important to healthy aging. Peschin also noted the work at Alliance for Aging Research suggests that in older men suicide is most strongly associated with depression, physical pain, and other chronic illnesses. When associated with cognitive impairment and the feeling of hopelessness and guilt, the condition may worsen and become more complex to address.

Brooke Weingarden, DO, psychiatrist at the Birmingham Maple Clinic in Troy, Michigan, Oakland County Schools, and Christ Child House, stated that community-based treatment (CBT) protocols are now the standard of care in the residential treatment facilities she works with as well as in therapeutic foster homes. There are limited data on using CBT in these centers compared with other approaches, and Cantu suggested that such comparative outcomes studies need to be conducted.

[16] Krans B. What is male menopause? Healthline. https://www.healthline.com/health/menopause/male

While the Baby-Boomer generation is generally regarded as being more psychologically resilient than younger generations, the impact of COVID-19 infectious mitigation practices has also created additional social stresses, which may or may not translate into substance abuse, longer-term behavioral health issues, or increased suicide risk in an already at-risk population.

Weingarden also noted that adolescent males who have parasuicidal behaviors tend to be able to hide them more than females. While males tend to be less forthcoming about suicidal thinking or planning, if asked they are less likely to lie about it. Another distinction is the places on the body where adolescents may do harm. Males tend to harm themselves in places on the body that are less noticeable, whereas adolescent females tend to cause self-harm in more visible places, yet another distinction in how males and females express the ultimate life tragedy of suicide. Clinicians and those in the community who observe at-risk adolescents need to be aware of these differences.

The prevalence of behavioral health conditions and the lack of recognition and care in African American and Latinx boys and men are shockingly high. The panel's discussion is underscored by a comprehensive report on mental illness issued to the nation by then Surgeon General David L Satcher in 2000.[17] In this document, Satcher made several important points, including the following:

- People of color, both adults and children, are less likely than their white counterparts to receive needed mental health care. People of color also face additional barriers, such as poverty, lack of services and supports, pervasive stigma and prejudice, language barriers, and lack of cultural competence in service delivery.
- African Americans are less likely to receive diagnoses and treatments for their mental illnesses. Many tend to rely on family and religious and social communities for emotional support rather than mental health professionals.
- Asian American and Pacific Islanders show higher levels of depressive symptoms than Caucasians. However, the word "depression" does not exist in certain Asian languages. Unfortunately, Asian Americans have the lowest utilization rate of mental health services among ethnic populations.
- Latinos are identified as a high-risk group for depression, anxiety, and substance abuse. Women are more likely to experience a major depressive episode. Latinx teenage girls have more depressive symptoms than African American or Caucasian girls, and their rate of attempted suicide is higher as well.
- Between 1999 and 2017 the overall suicide rate for Native Americans increased substantially. However, for Native American males, the jump in age-adjusted suicide rates was even more startling, rising from 19.8 per 100 000 to 33.8 per 100 000 population, a 71% increase.
- American Indians and Alaska Natives express symptoms of depression much differently. Access to services is very low, with individuals having a negative opinion of non-Indian health services providers and thus utilizing more traditional healing methods.
- Americans are more likely to manifest physical illnesses related to mental health. Across a 15-year span, suicide rates increased 233% among African Americans aged 10 to 14 compared with a 120% increase among Caucasians in the same age group.

[17] Office of the Surgeon General. *Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care (November 30-December 1, 2000).* Department of Health and Human Services (DHHS); 2001. https://www.ncbi.nlm.nih.gov/books/NBK44335/?report=reader

The panel unanimously agreed that males show signs of emotional distress differently than women do. Many mental health professionals and clinicians frequently cite statistics showing that females are roughly twice as likely as males to be diagnosed with depression and other mental health issues. MHN staffers expressed concern that this number, while often quoted, does not convey the true magnitude of the male side of the problem and the true incidence of undiagnosed depression among men and boys. Jimmy Boyd, policy analyst, who is credited with the congressional passage of Men's Health Week (now Men's Health Month), and Giorgianni, chair-emeritus of the American Public Health Association Men's Health Caucus and a men's health advocate, pointed out that the 2:1 ratio may, in part, be a reflection of the fact that men present for medical encounters half as often as women do. Eliminating the 2:1 disparity in the number of visits could, theoretically, also eliminate the corresponding 2:1 difference in women's likelihood of being diagnosed with depression.

That said, there's a good chance that even if males suddenly started seeing health care providers as often as females do, the 2:1 ratio in depression and mental health diagnosis would remain. It's well known that as reluctant as males are to seek care for a physical health issue, they're even less likely to do so for mental health issues.[14,18] This hypothesis is supported, most recently, by the June 2018 CDC report of suicide in the United States, which found that mental health issues in men are dramatically underreported. One of the main reasons for this underdiagnosis, according to many clinicians and men's health advocates, is that the tools used to screen for depression and related mental health conditions tend to be crafted to enable clinicians and others to flag potential problems in females but not in males. For example, the popular Beck's Depression Inventory includes questions about more stereotypically "female" symptoms of depression, such as feeling sad, crying, and feeling old or unattractive, yet it has no questions about stereotypically "male" symptoms, such as anger, frustration, social isolation, substance abuse, or workaholism.[19]

Giorgianni noted that the significant challenges faced at the community level in identifying at-risk boys and men may be the because the verbal and physical ways boys and men express emotional hurt and discomfort (eg, social isolation, anger, overwork, substance abuse; see also Graphic 5) are generally not associated with mental illness. Giorgianni and others on the panel believe that the divergence between male- and female-specific symptoms and manifestations of emotional distress are the result of the general acculturation of views of mental illness behaviors, notions of proper masculinity (eg, "man up"), and erroneous assumptions about how males are supposed to behave or verbalize emotional hurt (eg, "big boys don't cry").

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[18] Smith DT, Mouzon, DM, Elliott M. Reviewing the assumptions about men's mental health: an exploration of the gender binary. *Am J Mens Health*. 2018;12(1):78-89. https://doi.org/10.1177/1557988316630953

[19] Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. *Arch Gen Psychiatry*. 1961;4:561-571. https://doi.org/10.1001/archpsyc.1961.01710120031004

Graphic 5

Comparison of Male and Female Behaviors with Depression

Typical Male Responses	Typical Female Responses
Blames others	Blames themselves
Feels irritable	Feels sad
Becomes unforgiving	Is frequently tearful
Has less satisfying sleep pattern	Sleeps more than usual
Exhibits heightened suspiciousness	Has feelings of vulnerability
Guarded	Is easily hurt
Overly/covertly hostile	Tries to be nice regardless
Hides depression	Shows obvious signs of depression
The world is against them	Feels set up to fail
Frequently restless/agitated	Feels nervous/slowing down
Exhibits sudden rage	Has anxiety attacks
Shows loss of anger control	Strives to maintain anger control
Shows emotional blunting/numbness	Overwhelmed by emotions
Pushes others away	Allows violation of personal boundaries
Ashamed of who they are	Feels guilt for what they do
Seeks praise/frustrated without it	Uncomfortable with praise
Denies weakness/self-doubts	Accepts weakness/self-doubt
Fears failure	Fears success
Craves Top-Dog status to feel safe	Tries to blend in to feel safe
Uses alcohol, TV, sports, and sex to cope	Uses food, friends, and love to cope
Wonder if they are "loved enough"	Wonders "Am I lovable enough?"
Feels problems resolve if others treat them better	Feels being a better person resolves problems

Adapted from https://www.atrainceu.com/node/1078)

Men tend to somaticize mental health issues to a greater extent than women do. Sara Jones, PhD, APRN, PMHNP-BC, a American Psychiatric Nurses Association board member, noted that in her work at a free clinic, her younger male patients rarely identify mood or anxiety symptoms but instead frequently point to physical discomfort. Hence, frequent or chronic physical pain in the absence of any particular cause may be a telltale sign of an emotional issue. Several of the clinicians on the panel agreed. Several panel members who work with men in the workplace believe that physical pain/discomfort is often a nonspecific indicator of an underlying emotional issue.

To help people in the community, including workplace managers, supervisors, and educators, become more knowledgeable in identifying boys and men at risk of emotional issues, they should receive some level of training in recognizing both the behavioral and somatic red flags. Maryanne J Legato, MD, professor of clinical medicine at Columbia University College of Physicians and Surgeons and founder and director of the Partnership for Women's Health at Columbia University, believes that we simply don't know how to read the

signs for men as well as we do for women.20 According to Legato, women are much more likely than men to talk with friends, family, and coworkers about their unhappiness, at least in the earlier stages of depression. Most women will engage their peer networks for help early, call their friends, ask for advice, research what medications might help them, and go to their health care professionals. Men are far less likely to do any of these things. According to Giorgianni, men tend to keep difficult feelings to themselves and, instead of reaching out for help, slowly retreat from their world or exhibit changes in behavior that too often reach a boiling point.

Jacqueline Garrick, LCSW-C, BCETS, SHRM-CP, WPA, noted that the usual passive approaches to getting men to seek help for emotional hurt have generally failed. "There are many resources available, and lots of print material available to boys and men in public places, at work, advertised as PSAs and booklets but men just do not engage," she said. A novel program that Garrick worked on in 2013-2014 while at the US Department of Defense (DoD) involved using proactive "caring contact interventions" with approximately 2500 inactive National Guard members who had lost touch with their units or the DoD. The goal was to find out how these former members were doing after their service. A team of peer-level persons working for the suicide prevention office was tasked with making informal telephone calls to the former guardsmen and delivering a short "Hey, how are 'ya?" type script. "We were able to make contact with approximately 1000 (40%) of the identified 2500. What was stunning to all of us was that of that 1000 mostly male guardsmen, 72% of them asked for some type of follow up with an issue they were having. Those who asked for some type of life-help during this single call had never been personally approached before and had never been asked before if they needed help. So, this simple action led to an amazing revelation that people actually wanted to be actively asked if they are doing well and if they needed help."

These former guardsmen needed help with various things, ranging from assistance with VA benefits to health issues that required inpatient care. This experience reinforced Garrick's belief in using Caring Contacts and peer support tools. It also suggests that our most common method of reaching out to men and boys is relatively passive and that proactive contact by trusted peer-level individuals would be far better. The next evolution in this proactive approach is likely to use predictive models to pre-identify individuals who might benefit from working with someone in their community before their small problems pile up like snowflakes, eventually creating an avalanche in the form of an emotional or mental health crisis.
Some interesting work is being done using artificial intelligence to analyze varying data sources, including social media posts, to create predictive models that can identify words or phrases that might be indicative of behaviors that could put people at risk.

[20] Lloyd S. Women versus men: why do they deal with stress differently? Empowher: Women's Health and Wellness. December 21, 2015. https://www.empowher.com/stress/content/women-versus-men-why-do-they-deal-stress-differently

Biological evolution, acculturation, stigma, lack of emotionally expressive vocabularies, and the misinterpretation or misunderstanding symptoms of emotional distress in males all contribute to drastic levels of underdiagnosis of mental health issues in boys and men.

Several panelists felt that the media, including popular action games that stress physical over emotional vocabularies, contribute to males' lack of emotional lexicon and their tendency to act out when emotionally hurt. Giorgianni pointed out that in many movies and reality programming, men undergoing emotional hurt comment, "I know I'm not supposed to cry or show emotions but . . . ." This signals a behavioral norm to boys and reinforces a behavioral norm in men that is, at best, unhealthy and, at worst, perhaps toxic. Brott noted that urging boys to suppress and even ignore their emotions starts long before children are even able to play. He cited several studies that have found mothers and fathers tend to speak more to infant girls than to infant boys, cuddle infant boys less than they do girls, and respond more quickly to an infant girl's cries than to an infant boy's. Underscoring the effect that socialization has on behavior, Brott also pointed out that observers perceive the identical behavior differently depending on whether they think they're watching a boy or a girl. In one classic experiment, researchers John and Sandra Condry showed a group of people a film of a 9-month-old child playing with a jack-in-the-box and asked them to describe the child's reaction when the jack "popped." The researchers told half the viewers that they were watching a girl and the other half that they were watching a boy. Those in the "boy" group said that the child was angry when the jack popped. Those in the "girl" group said the child was frightened. Most people would respond very differently to a frightened child than to an angry one.

Biological evolution, acculturation, stigma, lack of emotionally expressive vocabularies, and the misinterpretation or misunderstanding symptoms of emotional distress in males all contribute to drastic levels of underdiagnosis of mental health issues in boys and men. Consistent with the available literature on the topic, panelists were in general agreement that males will withdraw and become more isolated and less communicative. In addition, they will begin to change their behavior and turn to things like excessive drinking, sexual excesses, gambling, or spending hours on their computer.[i] These behaviors are all mechanisms to escape the pressures of their lives. Brott noted that the warning signs may be a change in personality, increased irritability, even turning to violence. For Millennials or others who become absorbed in smartphones and social media, technology becomes a mechanism to "shy away" from true interpersonal relationships. Giorgianni added that some who withdraw into the "ethernet reality" not only exacerbate the suppression of verbalization of emotionality but also, by nature of what is offered by the most popular simulation and adventure games on computers—namely hypercompetitive and violence-oriented shoot-and-

destroy games—use these fantasy worlds as coping mechanisms, which may, in a few susceptible individuals, morph into disastrous real-life actions.

Peschin suggested that community screeners as well as clinicians need to ask about access to lethal means, particularly firearms. She noted that men are 6 times more likely than women to die by firearms-related suicide in the United States. These firearm suicides are particularly high in men over 65 years of age. Firearms all too often become tools for men with severe emotional illness to engage in violence in the community and also harm themselves. Brott cautioned that firearms shouldn't be overemphasized. He pointed out that in Japan, which has one of the lowest gun ownership rates in the world, the suicide rate is very high, and in the United States men account for more than 70% of suicides.[21] In fact, suicide is the leading cause of death for Japanese males aged 10 to 45.[22]

Giorgianni noted that, similarly, in Canada and Greenland, which have the high rates of male suicide in the world, male suicide is a significant problem but the principal means are not firearms. In Canada, for example, most suicides are by hanging.[23,24,25] Studies in both of these countries found that the most common factors that increase the risk of male suicide are similar to those in United States, namely growing up in a home with a poor emotional environment, alcohol problems, and/or violence. Garrick noted that while gun ownership makes it easier to die, being a gun owner is not the cause per se, and one of the things that needs to go along with gun ownership is education, similar to programs she had developed at the DoD.

Weingarden noted that, in some cases, prescription drug misuse is also a potential source of lethality. She recounted situations where male patients either deliberately stopped taking essential medications, such as insulin, or deliberately overdosed on various prescription products to commit suicide. In his work, Davidson has seen situations where men intentionally stop treating a chronic condition as a means of intentional suicide. Brott stated that since it's clear men who want to kill themselves will always find a way, rather than focusing on the means of death those involved in raising, nurturing and caring for men and those who set policy need to direct their efforts to addressing the fundamental developmental and behavioral health issues that drive boys and men to kill themselves. Most members of the panel agreed.

While the COVID-19 pandemic's impact on male behavioral health will be the focus of a forthcoming MHN monograph, it's worth noting that homicide rates between June and August 2020—the height of the pandemic in many US communities—increased by 53% over the same period in 2019, and aggravated assaults went up by 14%.[26] Cal Beyer, MPA, vice president of workforce risk and worker mental wellbeing at CSDZ, added that approximately 68% of the US population, including men in the construction trades, live paycheck to paycheck, which adds to the financial pressures that can affect men's emotional wellbeing and can lead to personal and family strife, particularly in the age of COVID-19. He noted that, according to the Occupational and Safety Health Admiration (OSHA), these financial pressures can sometimes lead to feelings of inadequacy.

[21] Engelman, J. Number of suicides per 100,000 inhabitants in Japan from 2010 to 2019, by gender. Statista. January 5, 2021. https://www.statista.com/statistics/622705/japan-suicide-number-per-100-000-inhabitants-by-gender/

[22] Table 1-28: The 5 leading causes of death by sex, by age group. Japanese Ministry of Health, Labor and Welfare. https://www.mhlw.go.jp/english/database/db-hh/1-2.html

23 Sargeant H, Forsyth R, Pitman A. The epidemiology of suicide in young men in Greenland: a systematic review. Int J Environ Res Public Health. 2018;15(11):2442. https://doi.org/10.3390/ijerph15112442

24 Bjerregaard P, Lynge I. Suicide–a challenge in modern Greenland. Arch Suicide Res. 2006;10(2):209-220. https://doi.org/10.1080/13811110600558265

25 Navaneelan T. Health at a glance–suicide rates: an overview. Statistics Canada Catalogue. 2017. https://www150.statcan.gc.ca/n1/pub/82-624-x/2012001/article/11696-eng.htm

26 Rosenfeld R, Lopez E. Pandemic, Social Unrest, and Crime in US Cities. National Commission on COVID-19 and Criminal Justice; 2020. https://COVID19.counciloncj.org/2020/09/26/impact-report-covid-19-and-crime/

“When men begin to utilize an emotional lexicon and verbalize emotional pain, it’s all too often viewed as weakness by those in the best positions to help,” said Boyd, “and they’re met with less-than-supportive responses from peers, work colleagues and mangers, and other community members.” These negative signals can be verbal, communicated by body language or, in some cases, subtly but perceptibly by behavior (such as by ridiculing or ostracizing) in social circumstances. As a result, boys and men who try to express their emotions frequently discover there is no incentive to recognize their problems, speak up, or try to work with them. Lack of acceptance of boys’ and men’s emotional expressiveness both in their community and, occasionally, by health care providers is often based on outdated stereotypes about how males should react to adversity and other biases that inhibit rather than promote much-needed dialogue and support.

The negative (or, at best, neutral) feedback they receive leads many males to suffer in silence. For some, this leads to further issues such as isolation, depression, or substance abuse. For others, it can lead to self-destructive behaviors or antisocial behavior toward others. Weingarden noted that during encounters with individuals—whether to screen, provide care, or engage in a community-based intervention such as Emotional First Aid—the physical environment, as well as the provider’s body language and eye contact, are extremely important to having a successful encounter. Sara Jones, PhD, noted that as part of her periodic reviews of practices their protocol includes a review of ongoing training. One observation she frequently makes is that clinicians spend too much time looking at their computer or tablet screens and not enough time looking at the patient. This, obviously, can send the wrong message to the patient as to whether the provider actually cares. Once this dynamic is brought to the clinic’s attention, Jones’s staff is able to work with practitioners to help them make better eye contact with patients, which improves both the efficacy of the interview and any subsequent interventions. The panel agreed that maintaining proper eye contact, along with learning to speak to boys and men in a male-friendly way, should be an important part of training for community interventionists.

Bonhomme noted that many boys and men who have depression are unaware of the underlying problems that triggered the condition, a situation that complicates both the expression of symptoms and the treatment. Brott noted that boys who act out feelings of depression or other emotional hurt are often labeled by family, teachers, and clinicians untrained in dealing with behavioral health issues in males as “angry,” “a loner,” “a nerd,” “quiet,” “withdrawn,” or “shy.” Such mischaracterizations virtually ensure that boys and young men who are suffering from depression, anxiety, or other mental or behavioral health issue will be left to their own devices, their symptoms and underlying conditions ignored or untreated.

Darryl Davidson, MS, director of community engagement at the City of Milwaukee, agreed and emphasized the negative effect the seemingly innocuous labels and phrases can have on boys’ overall self-image. Davidson worked with many men who felt that being labeled “bad” or “dangerous” early in life had an overall negative impact on their social and mental outlook. Brook Weingarden, DO, an expert and clinician in adolescent and child psychiatry, added that such early, negative labeling and stigmatizing produces adolescents who tend to fight a lot, exhibit social and verbal aggression, and physically lash out. In boys in particular these behaviors may be important clues to emotional hurt or early signals of a more serious psychiatric condition. Lyon added that boys and men who are negatively labeled and pigeonholed by society and occasionally health care providers are too often punished (either by a school or the criminal justice system) instead of receiving much-needed therapy or treatment.

The importance of self-image and acceptance among peers does not begin in childhood and end in adolescence. Jones, who does a significant amount of counseling and research work with first responders, particularly firefighters, noted that acceptance by peers is very important. This acceptance extends to the ability of these men to seek and accept help from their teammates. The situation is made even more complex because men, like most large groups, are not homogenous. Sociocultural, socioeconomic, racial, educational, vocational, age, and a variety of other factors play a large role in both the predisposition to and determinants of mental health in males.

Weingarden has worked with many children who have been placed in group homes because of the terrible traumas they've experienced in dysfunctional homes. "These kids—particularly the boys—when they think about their lives and circumstances, don't sit there thinking to themselves that they're depressed or anxious or sad," she says. "I often hear terms like 'This is annoying,' 'Man, this is stressing me out,' 'I'm getting lots of stomach aches,' or 'I just wannna' punch out a wall'—or they just go out and destroy a room or engage in other physically visible signs of pain." Those who observe these kinds of physical expressions—especially self-destructive ones—need to be aware of what they're seeing and try to find the root causes, rather than immediately slotting these traumatized boys as criminals. Weingarden has also seen boys who cope with their mental health challenges by withdrawing or self-isolating mischaracterized as "just a bit shy." This leads to years of silent suffering until something changes dramatically, which, all too frequently, results in an emotional explosion.

"These kids—particularly the boys—when they think about their lives and circumstances, don't sit there thinking to themselves that they're depressed or anxious or sad...I often hear terms like 'This is annoying,' 'Man, this is stressing me out,' 'I'm getting lots of stomach aches,' or 'I just wannna' punch out a wall'—or they just go out and destroy a room or engage in other physically visible signs of pain."

Dr. Brooke Weingarden

Demetrius Porche, DNS, RN, FNP, CS, CCRN, professor and dean of Louisiana State University Health Sciences Center in New Orleans, Louisiana School of Nursing, stated that "mental health issues are rarely the presenting problem or even among the presenting signs of men I see in primary care. The hallmarks of depression and other mental illnesses come out only after the initial interview and really begin to take shape while the patient and I are talking about *physical* problem or symptoms. The word 'depression' is almost an afterthought for the patient." Porche added that the symptomatology of mental illness is not always the same with men as it is with women. "When the patient starts to talk about somatic syndromes, the clinician needs to dig deeper to determine whether they're

dealing with underlying depression or other mental health conditions. You just can't always bring out the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSM) and link it to depression with men. It's a very different kind of discussion than you would have with a female patient suspected of having a mental illness component."

Bonhomme, who practices in a substance abuse clinic outside of Atlanta, Georgia, agrees that often male depression presents in the clinic as somatic symptoms. "The clinician needs to be aware of some of the behaviors that are among the hallmarks of male depression, such as drinking, using illegal substances, or smoking. In addition, others in the community, such as managers and coaches, need to be trained to recognize these behavioral cues of possibly underlying mental health issues."

Military veterans warrant special consideration, particularly as they transition from active service back home to their communities. Giorgianni, a specialist who works with Marine Corps personnel and their families, noted that having a solid, supportive community and family are critical to making a successful transition back to civilian life.

Giorgianni and Brott (both former US Marines), and Ryan Kules, combat stress recovery director for The Wounded Warriors Project, agreed that military service affects the mental health of not only the veteran himself but also his immediate and extended families (for example, 32% of children in military families scored "high risk" for emotional and behavior problems—a level 2.5 times higher than the national average of children without military parents). Typically, the longer the service member's absence from his community, the more difficult the transition back, particularly if the veteran had little or poor family support prior to entering the military. Kules added that veterans with physical and emotional traumatic conditions face additional—and very difficult—challenges. All of the veterans (and those who work with veterans) on the panel agreed that the Veteran's Administration (VA) needs to adjust its approach to each of these different subgroups.

The suicide rate among veterans is well known. The most current statistics indicate that approximately 17 to 22 veterans, most of them men, take their own lives each day—nearly double the rate of the general population.27,28 The rate of veteran suicides has remained nearly the same for almost a decade despite much work by the DoD and the VA to reduce it. Several panel members believed that the best approach to decreasing veteran suicide may be to address community stabilizing factors, develop peer-to-peer community networks, conduct outreach to veterans, and continue the work of organizations such as the Wounded Warriors Project.

Clinical and Community Screening Tools Designed for Male Mental Health

Garrick noted that most screening instruments available for both clinical and community use are geared toward females. She recounts talking with male whistleblowers who were under great strain, not only working in with the stress of becoming a whistleblower but also because of the underlying circumstances, such as hostile work environment, racism, or corporate wrongdoing. These conversations were with very

[27] Shane L. New veteran suicide numbers raise concerns among experts hoping for positive news. *Military Times*. October 9, 2019. https://www.militarytimes.com/news/pentagon-congress/2019/10/09/new-veteran-suicide-numbers-raise-concerns-among-experts-hoping-for-positive-news/

[28] *VA Research on Mental Health.* US Department of Veteran's Affairs, Office of Research and Development. https://www.research.va.gov/topics/mental_health.cfm

rugged sorts of men—construction workers, electricians, and many combat veterans—and what struck her is just how scared these men were about talking through their emotional traumas. Garrick believes that the root cause of this was, at least in part, because these men have always been told not to talk about their feelings and were ashamed and embarrassed about what essentially was to them being bullied. These men had been presented with stoic, “tough-guy” role models early in their young careers and had been brought up to think discussing unpleasant events and feelings was a sign of weakness. Garrick discovered that when she gave these brave men a less “feminine” vocabulary—using terms like “mobbing,” “ostracizing,” or “devaluing”—it became much easier for them to talk about their stresses and circumstances. Once they had the right words to express how they felt, they could put the difficult situations they faced and the associated feelings into a context that made sense to them. That allowed them to depersonalize the situation and stop seeing themselves as weak because they had been targeted and victimized by someone else. “I see this a lot with emotional issues, so helping them give a name to it [to] create a taxonomy is very helpful, particularly for men who are not comfortable with admitting to being harassed, bullied, and taken advantage of,” said Garrick.

With emotional stoicism, “manning up,” and “playing through the pain,” such an important component of traditional “masculinity,” it’s no wonder that the contemporary behavioral health screening tools—the majority of which use words or phrases that don’t appear in the day-to-day working vocabulary of many boys and men—neither resonate with nor motivate candor.

Most panelists agreed that it is in large part because of the differences in how men express mental health issues and their lack of emotional literacy and vocabulary that more and optimized screening tools specifically for boys and men need to be designed.

The medical literature also acknowledges that some characteristics are common to so many males that they warrant the term *Male Depression Syndrome*.[29,30] MHN and many of its science and medical advisors have long believed that existing tools for mental health screening are both rhetorically and structurally designed in a way that is consistent with the way females articulate symptoms of depression. There is even some question as to whether some screening tools are deliberately designed to resonate with females to ensure they are optimizing diagnostic opportunities.

Bonhomme provided a vivid example from one of the most widely used depression screening scales, the Beck’s Depression Inventory, a multiple-choice, self-reporting psychometric test that measures the severity of depression.[20] Bonhomme cited 3 examples of questions, the phrasing of which doesn’t resonate as strongly with most boys or men as it does with girls and women.

Bonhomme emphasized that 9 of the Inventory’s 21 questions mention feelings, crying, or other symptoms that boys and men would be less responsive to. Further, he added, none of the questions focus on externalized behaviors, such as drinking, impulsivity, aggression, and social withdrawal—all of which are common ways males express depression, anxiety, and other mental and behavioral health issues.

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[29] Angeletti G, Pompili M, Innamorati M, et al. Short-term psychodynamic psychotherapy in patients with “male depression” syndrome, hopelessness, and suicide risk: a pilot study. *Depress Res Treat*. 2013. https://doi.org/10.1155/2013/408983

[30] Wålinder J, Rutz W. Male depression and suicide. *Int Clin Psychopharmacol*. 2001;16(2):21-24. https://doi.org/10.1097/00004850-200103002-00004

Beck's Depression Inventory

Question 1:
I do not feel sad.
I feel sad.
I am sad all the time and I can't snap out of it.
I am so sad and unhappy that I can't stand it.

Question 10:
I don't cry any more than usual.
I cry more now than I used to.
I cry all the time now.
I used to be able to cry, but now I can't cry even though I want to.

Question 14:
I don't feel that I look any worse than I used to.
I am worried that I am looking old or unattractive.
I feel there are permanent changes in my appearance that make me look unattractive.
I believe that I look ugly.

Other panel members pointed out another deficiency of existing screening tools: they do not take into account cultural context of male populations, thereby making them culturally irrelevant. This is of particular concern for Native American boys and men, where cultural identity is very unique.

Despite these significant concerns, there are few clinical screening tools properly validated to screen males. Many clinicians spoke about the importance of behavioral health screening to the overall care of boys and men. They also shared their successes and frustrations in doing such screenings. Topics covered included the disconnect between reimbursement and the time involved in conducting the screening and providing follow-up care for diagnosed behavioral health conditions; the lack of male-specific tools in general and particularly the lack of tools designed specifically to reach various male subpopulations; the impact of the male-unfriendly health care environment; poor professional/continuing education and training that addresses behavioral health issues in general and specifically in boys and men; and the lack of meaningful guidelines to govern both screening priorities and their timing across the male lifespan.

The group also discussed data on the many lost opportunities to provide screening and other types of care to male patients that are the direct result of annual "well-man" medical visits similar to the "well-woman" visits that are provided under most insurance plans and Medicare (usually at no cost) to all women and the lack of trained behavioral health providers, particularly in family practice environments. All panelists agreed that these and myriad other missed opportunities and challenges must be studied in depth if we as a society are to build effectiveness-oriented outcomes research. All agreed that without systematic and meaningful scientific study that is translated into practice, little progress will be made in addressing behavioral health issues in males.

One of the few validated clinical screening tools specific to the so-called Male Depressive Syndrome was developed by Rutz et al.[31] However, despite being debated and studied, the tool is still not considered as the preferred screening tool for males. Instead, non-male-specific tools, such as the Beck Depression Scale (which, as noted above, overlooks male-specific symptoms), remain standard. Many men's health experts believe that relying on supposedly "gender neutral" screening tools instead of ones designed to flag male symptoms is one of the main—yet correctible—reasons why mental health issues in males are so startlingly underdiagnosed.

Bonhomme noted a small Swedish study that compared the effectiveness of the Beck Depression scale with the Gotland Male Depression Scale.[31] This study indicated that because alcohol consumption was so high in depressed males, the Gotland Scale had an advantage over the Beck Scale when screening for depression among men. MHN recognizes that significantly more work is needed to clarify the roles of male-specific screening scales in the clinical setting. Peschin noted that it's also important to conduct research studies to compare clinical and community screening tools to find out which are most effective with men in general as well as with specific subpopulations of men. Similarly, there is a need to conduct a broader range of comparative clinical effectiveness studies on different types of standard interventions to see which are most effective with men and their subpopulations.

The good news is that more progress may be happening at the community level. Several nonmedical patient organizations that work with boys and men have developed their own tools to screen for behavioral health issues. Many of these tools are tailored to specific environments that tend to be male dominated, such as where military veterans, first responders, and construction workers are found in large numbers, in addition to more sex-balanced workplaces, such as retail spaces and offices. Jones developed such tools for firefighters and emergency medical personnel. The Prevention Institute is also finalizing similar tools and toolboxes for community work, which, according to Cantu, should be generally available in 2021. Various other tools can be accessed online; however, as Bonhomme and others on the panel noted, very few have been validated with broad-based outcomes research and even fewer are designed specifically for males.[32,33,34,35,36] As mentioned above, MHN has long maintained that a gender-neutral approach is not serving US boys and men well. Regrettably, said Giorgianni, the data on suicides and the consequences of mental health–related impacts on communities across the US support that hypothesis.

The lack of good screening tools for community members may, to a certain extent, be offset by techniques to engage boys and men in conversations that can reveal important signals about their mental or emotional status. Vocabulary is a major obstacle with boys and men. One of the things Saabs has found to be helpful in his work is to reframe the conversation a bit. What I typically talk about with African American men is how do they feel about what they're doing? Do they express pride or shame or reluctance about their sense of their daily activities? Reframing the dialogue is another way for people in community settings to get a bit of information about the mental status of boys and men they are working with.

Daniel Ellenberg, PhD, president-elect of the American Psychological Association's Society for the Psychological Study of Men & Masculinities, said that being ashamed of something about oneself is a powerful disincentive to discuss even the most important topics. "Shame literally means covering yourself so as to not be seen. Women and men both feel shame and self-disgust, but they express it differently. Women are generally more aware of this and willing to verbally express it; men just don't recognize it for what it is and thus don't verbalize it and are confused by what they are feeling," said Ellenberg. Again, this speaks to the

[31] Strömberg R, Backlund LG, Löfvander M. A comparison between the Beck's Depression Inventory and the Gotland Male Depression Scale in detecting depression among men visiting a drop-in clinic in primary care. *Nord J Psychiatry*. 2010;64(4):258-264. https://doi.org/10.3109/08039480903511407

[32] Beidas RS, Stewart RE, Walsh L, et al. Free, brief, and validated: standardized instruments for low-resource mental health settings. *Cogn Behav Pract*. 2015;22(1):5-19. https://doi.org/10.1016/j.cbpra.2014.02.002

[33] Screening tools. American Mental Wellness. https://www.americanmentalwellness.org/intervention/screening-tools

[34] Therapy notes: mental health roadmap. Annabelle Psychology. https://www.annabellepsychology.com/screening-tools

[35] Screening tools. Behavioral Health Evolution. http://www.bhevolution.org/public/screening_tools.page

[36] Screening tools for suicide prevention. Rural Health Information Hub. https://www.ruralhealthinfo.org/toolkits/suicide/2/screening-tools

need for screening skills that consider the different ways males express emotional hurt. Ellenberg believes that one of the ways to address this is to change the culture that relates to emotional pain. "I'm heartened by seeing well-known male role models, 'tough-guy' athletes and celebrities, who are speaking out about depression, suicide, and the like. This sends the important signal to boys and men that if individuals they lionize are ok talking about these issues, it's okay for them to talk about it too." Ellenberg and other panelists cautioned, however, that this type of acceptance and change is a slow process.

Saabs observed that in his work he finds that many African American youth don't expect to be heard. For many, their life experiences are such that they are often interrupted when they speak or express opinions, so when they are given the opportunity to talk candidly, they may find it a bit disarming and may need to be encouraged. Helping them engage in discussions they're not used to having and are not naturally comfortable with is very important to helping them understand that themselves—and equally important in helping service providers offer appropriate care. Those of us who work with these young men need to use these, and other discussion techniques, particularly in the community setting because we simply don't have enough screeners geared to boys or men to help us.

Next Steps

Men's Health Network believes that much more work needs to be done to create male-specific, demographically stratified screening tools for the clinical setting. MHN strongly supports funding (public, private, or both) of a broad-based research program to develop a systematic, extensive review of screening tools with a specific focus on their appropriateness and effectiveness for boys and men and their utility in both clinical and nonclinical settings. Boyd and Ana Fadich-Tomšić, vice president at MHN, pointed out that this important project is high on MHN's policy agenda.

MHN and many on the panel believe that in much the same ways as we need male-specific tools to screen boys and men for emotional and behavioral health issues, we also need to keep in mind the specific (and unique) needs of boys and men when developing health-related programs. This holds true for public policy initiatives as well. Rubin Cantu, responsible for leading projects on community trauma and mental health and wellbeing at the Prevention Institute, stated that the Prevention Institute has developed 3 such tools related to community-level prevention strategies and community determinants of health. They are as follows:

- THRIVE (Tool for Health & Resilience in Vulnerable Environments) is a framework for understanding the root causes of health inequities. Making Connections coalitions used THRIVE to strategize ways to improve mental wellbeing by focusing on specific community determinants of health, such as housing and education.[37]
- Spectrum of Prevention identifies different ways of advancing primary prevention (addressing a problem before it occurs). Making Connections coalitions used the Spectrum of Prevention to create comprehensive strategic plans for addressing the root causes of mental health inequities in their communities.[38]
- The Adverse Community Experiences and Resilience framework helps communities understand the relationship between community trauma and wellbeing. Making Connections coalitions used

[37] THRIVE: Tool for Health & Resilience in Vulnerable Environments. Prevention Institute. https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments
[38] The spectrum of prevention. Prevention Institute. https://www.preventioninstitute.org/tools/spectrum-prevention-0

the framework to elevate trauma-informed strategies that strengthen their communities' resilience while focusing on undoing structural violence.[39]

Cantu noted that 3 strategies greatly contributed to the success of Prevention Institute's programs and in achieving better community buy-in. These included getting the program's intended population involved in program planning, implantation, and evaluation; building outcomes-oriented and other metrics into each program by partnering with a local organization (preferably an academic institution) to develop and conduct evaluations that can be disseminated; and changing the focus of the program approach from looking at "What's wrong with you?" to "What happened to you?," which helped keep programs focused on driving change for the better. This last strategy is especially important when creating or running programs aimed at males.

"While changing the focus from 'What's wrong with you?' to 'What happened to you?' has been particularly powerful for our focus population of American Indian Youth, it has been especially powerful for males. We're already seeing some important results. In partnership with the school district, we've significantly improved awareness about and support for suicide prevention in this community."

David Sullivan, Anadarko Hope Squad

David Sullivan coordinates the Making Connections project, the Anadarko Hope Squad, for the Anadarko Hope Squad school-based outreach program in Oklahoma that serves a large Native American population.40 "While changing the focus from 'What's wrong with you?' to 'What happened to you?' has been particularly powerful for our focus population of American Indian Youth, it has been especially powerful for males," he said. "We're already seeing some important results. In partnership with the school district, we've significantly improved awareness about and support for suicide prevention in this community. Hope Squad members at the high-school and middle school levels have referred many students to trained mental health advisors for assistance. At the elementary school level, students have also made referrals related to bullying or students' emotional states. It has also increased the leadership skills of the young men who are at highest risk of experiencing mental health challenges."

[39] Pinderhughes H, Davis RA, Williams M. Adverse community experiences and resilience: a framework for addressing and preventing community trauma. Prevention Institute. 2016. https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing

[40] Hope Squad: how they're solving the problem. Prevention Institute. https://makingconnections.movemberprojects.com/projects/oklahoma-city-ok/)

The Hope Squad Program

According to its website (hopesquad.com), the Hope Squad is a school-based peer support team program that partners with local mental health agencies. Peers select students who are trustworthy and caring to join the Hope Squad. Squad members are trained to identify at-risk students, provide friendship, identify suicide warning signs, and seek help from adults. Hope Squad members are not taught to act as counselors but are educated on how to properly and respectfully report concerns to an adult. Once invited to be a Hope Squad member, students must submit a permission form signed by their parents and attend regular trainings.

The Hope Squad concept was started in 1997 in Provo, Utah, by Dr Gregory A. Hudnall, a high school principal who had to manage the harsh reality of a student suicide and its impact on students and the community. Since its start at one school, Hope Squads are now in more than 950 schools across 30 states and Canada. These programs have more than 30,000 members. Their objective is to be in every school to help every student in need, and their overarching mission is to reduce youth suicide through public awareness and education, training, and peer intervention. They also seek to reduce the stigma associated with seeking mental health assistance and to serve as a resource for those touched by suicide. Sullivan believes that a good part of the ongoing success and growth of the program is the emphasis that he and his colleagues place on continual improvement and innovation. “Retraining, retooling, and refreshing what we do is so important to staying on point and helping us reach students, which is at the heart of what we’re doing.”

Several members of the panel felt that the structure and success of this type of program can be utilized in many different settings at the community level. Examining and looking to study this type of model in other settings is an important area for future research (key action item) that should be considered. The panel also generally agreed that regardless of the type of program, the location, or the design, this ongoing reassessment and retraining is an important component of growth and stability as well as the ability to keep up with important new trends, techniques, and transitions in the community.

Mental Health Stigma in the Community

Elements of the Problem

A major obstacle to recognizing, diagnosing, and treating mental health issues in men and boys (and, to a lesser extent, in women and girls) is the stigma associated with seeking help. The *2000 US Surgeon General's Report*[ii] addressed this issue and its role in undermining the ability of providers, community members, and society as a whole to care for people with behavioral health conditions. In the report, Surgeon General David Satcher noted that "despite the efficacy of treatment options and the many possible ways of obtaining treatment, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is [the] stigma . . ., " which, according to Satcher, "erodes confidence that mental disorders are valid, treatable health conditions." Ultimately, "[s]tigma tragically deprives people of their dignity and interferes with their full participation in society."

Brott noted that the stigma of seeking help begins when boys are very young. "One of the first things a boy learns when he injures himself as a youngster is that he can be angry or physically hurt but talking about it will quickly get him shut down, usually with a phrase or reaction that telegraphs how he *should* behave instead, such as 'Big boys don't cry,' 'Play through it,' or 'Man up!'" One of the consequences of this, observed Brott, is that "boys often don't develop a comfortable vocabulary to help them express emotional hurt." A growing body of research supports this observation. It is well documented that, overall, parents speak more to infant girls than to infant boys. The content of that speech is even more important than the volume. In a recent study, researchers Ana Aznar and Harriet R. Tenenbaum found that both mothers and fathers use more words describing emotions with 4-year-old girls than with boys the same age.[iii]

"One of the first things a boy learns when he injures himself as a youngster is that he can be angry or physically hurt but talking about it will quickly get him shut down, usually with a phrase or reaction that telegraphs how he *should* behave instead, such as 'Big boys don't cry,' 'Play through it,' or 'Man up!'"

Armin Brott,
Author, Nationally Syndicated Columnist

Brott noted that if boys aren't given the vocabulary to understand and express their emotions, how can we be surprised when they suppress them later in life? Jones agreed with Brott. "Helping patients, particularly male patients, understand and become comfortable with the vocabulary of emotional turmoil is very helpful," said Jones. "My primary work is with firefighters and paramedics. They really don't know what's happing to them and don't understand the terms, so educating them as to the words that we commonly use to discuss emotional and mental health issues is really important to helping them understand what we're talking about. It's not that they're ignorant per se, it's just not terminology that comes natural to them."

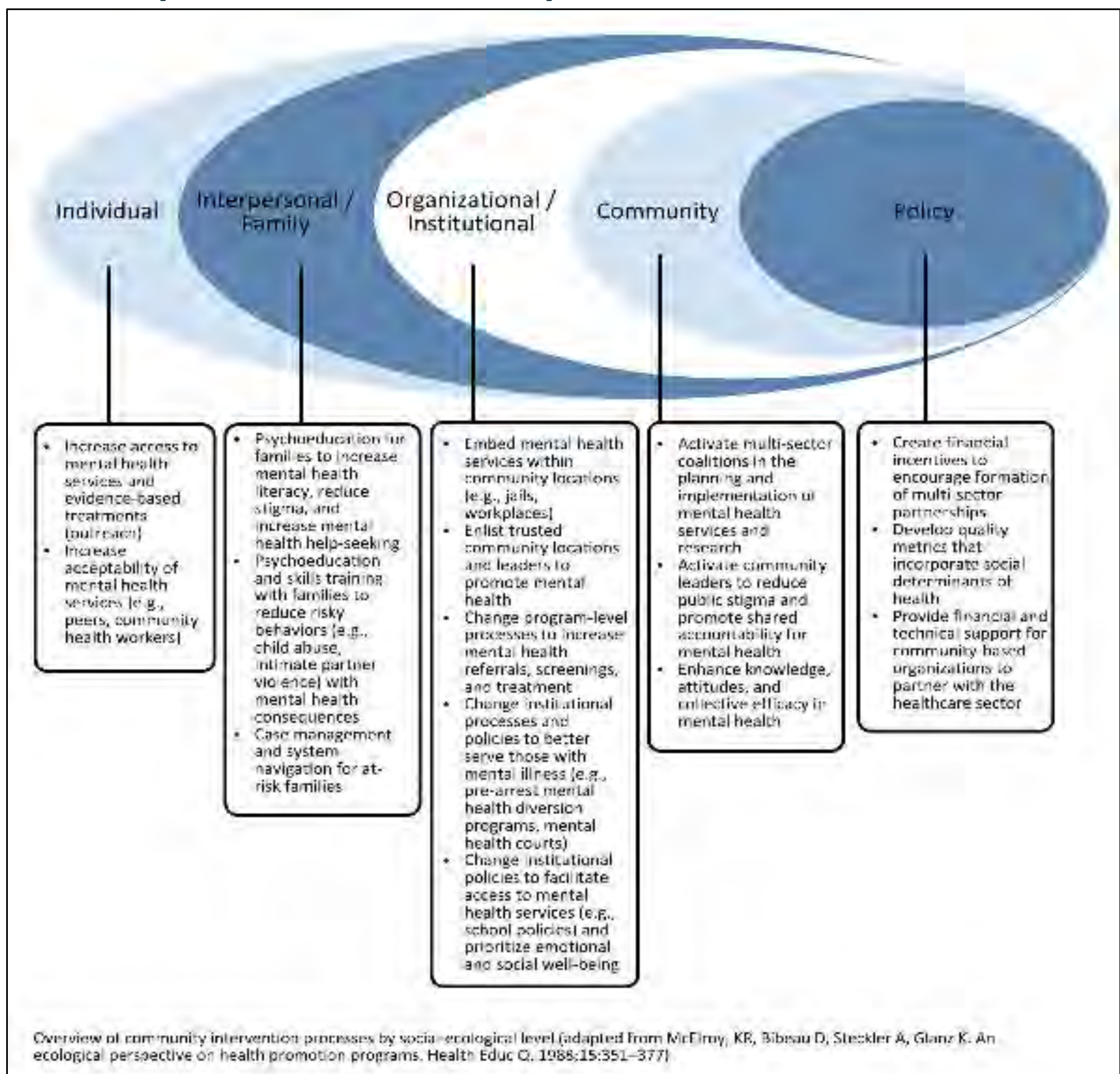
Addressing Stigma at the Community Level

Part of the challenge to addressing stigma at the community level is finding ways to help males feel that it's appropriate to express emotional hurt and to instill in them from a young age a vocabulary and approach to doing so without compromising their sense of masculinity. Yet, teaching boys to do this is difficult and there are many competing sociological cues that work against building these skills. Because a full discussion of this topic is beyond the scope of this panel and paper, we refer the reader to the additional readings and commentary in Appendix III. In addition to Cantu's aforementioned rhetorical switch from "What's wrong with you?" to "What happened to you?," Weingarden added that nonverbal cues in conversations with boys and men as well as the setting where the conversations take place are important. All this needs to be done in a way that recognizes the communications preferences of males and the different environmental cues that may be appropriate for any

particular male demographic. Giorgianni noted that it is equally important to be aware of the media images, online advertising, print materials, and other nonpersonal messages boys and men receive. In a rigorous analysis of these messages, MHN found that materials used to inform people about the early warning signs of emotional hurt are overtly or subtly designed to optimize impact on females. Boyd noted that MHN collaborated with many organizations in the public and private sector to create informational materials specifically designed with boys and men in mind. Brott (who created much of such material) noted that not only does MHN have a particular expertise in reaching out to boys and men with written resources, but it also has material designed to help women better understand how to engage men in their lives with regard to important health matters, including emotional health.

Graphic 6

Previously Overview of Community Intervention Process



Overview of community intervention processes by social-ecological level (adapted from McElroy, KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Health Educ Q. 1988;15:351–377)

Beyer referenced "The Man Therapy" program as an example of a widely accessible support program that can be used at the community level to help address the stigma of mental illness in men.[41] One of the unique aspects of this award-winning resource is its use of humor when making important and lifesaving points—an approach men generally react positively to.

The Pivotal Role of Community Organizations in Confronting Male Mental Health Issues

In this section, we will summarize community interventions by social-ecological level to promote mental health and social wellbeing. We found that most interventions reviewed promoted mental health at the individual level. Lay health worker (LHW) interventions extend access and increase acceptability of mental health services by leveraging trusted relationships. For example, Patel et al demonstrated the successful delivery of behavioral activation for depression by LHWs through relatively brief training to a population with significant barriers to health care access. Some studies adapted evidence-based models (eg, Forensic Assertive Community Treatment) to deliver treatments in nontraditional locations, such as jails, churches, and senior centers. Many individual-level interventions also simultaneously acted at the organizational/institutional level. In the successful Randomized Controlled Trials of Head Start teachers were provided with professional development and mentoring to deliver an enriched curriculum.

15 Overarching Approaches and Tactics to Help Address Behavioral Needs at the Community Level

- Understand and utilize male-centric communications materials that focus on males' verbal preferences and images.
- Utilize materials, messaging, venues, and approaches that are sensitive to different male cultural, racial, age-appropriate, and sexual preferences and lifestyles.
- Create and utilize male-friendly settings, times, and locations to conduct programming and deliver messages.
- Develop partnerships with trusted and respected community icons and places where males feel comfortable and trusting.
- Develop cobranded materials, programs, and program hosts along with trusted and respected community and men's health organizations.
- Develop partnerships with respected culturally distinctive groups and organizations in subcommunities.
- Support community-wide programs to raise awareness of male cultural diversity that fosters broad community understanding and appreciation for various cultural values.
- Develop person-to-person communication skills in community members that will help them better use nonverbal cues to encourage trust and decrease perceived judgmentalism.
- Develop programs and communications strategies that focus on actions to address problems.
- Utilize true male peer-to-peer networks that highlight role models of boys and men who have met and overcome emotional problems.

[41] Welcome to man therapy. Man Therapy. www.mantherapy.com

- Encourage peer-to-peer support networks and programs that provide male, culturally identifiable role models who have engaged successfully in their own journey of emotional health recognition and management.
- Understand the unique needs, communications preferences, and emotional pain cues for males in various high-risk occupations and professions.
- Provide opportunities to partner with experts in program structure, evaluation, and reporting to help provide needed program evaluations and dissemination to other communities across the country.
- Develop and train those who interact with males in Emotional First Aid skills across community demographics and settings.
- Create male-directed and managed networks, procedures, and training to health care providers who provide referral and triage of boys and men in crisis that are compliant with HIPAA and other legal requirements for confidentiality of personal identifiable information.

Families, employers, schools, social services organizations, faith-based institutions, and other groups play an important role in the health of the communities where they operate. These groups can also help fight health and social inequities by promoting community wellbeing and addressing the structural determinants of mental health (including public policies and other upstream forces that influence those determinants). Several published studies and review articles have shown that community and social services organizations are especially helpful when inequities play a large role in determining outcomes and when the existing health care sector is overwhelmed, which is often the case when talking about under-resourced populations and in the aftermath of a natural disaster. Regrettably, as we've noted earlier, few if any research reports—particularly in the area of mental health—provide gender stratification, which would allow a proper focus on how these programs impact males. Nevertheless, one can extrapolate from the conclusions and observations of this body of literature just how important community interventions can be.[42]

A great deal of evidence shows the effectiveness of community involvement in improving mental health and some social outcomes across social-ecological levels. Studies indicate the importance of ongoing resources and training to maintain long-term outcomes, explicit attention to ethics and processes to foster equitable partnerships, and policy reform to support sustainable health care-community collaborations.[43,44,45]

Part of the challenge in developing programs and interventions is inherent in the socioeconomic, geographic, and sociocultural diversity of boys and men. Just as our communities are rarely homogeneous blocks, neither are men and boys. Urban, suburban, rural, inner-city, and other geographic and sociocultural configurations all exist. There are also regional characteristics that need to be considered, not only in the sociocultural characteristics of the boys and men who live, grew up, or moved there but also the overall sociocultural characteristics of a region. It's easy to appreciate that while the goals, core substance, and objectives of a successfully conducted program in urban California may be portable to a location in rural Maine, the development, structure, rhetorical and graphic substance, approaches, and other regionally influenced factors

[42] Castillo EG, Ijadi-Maghsoodi R, Shadravan S, et al. Community interventions to promote mental health and social equity. *Curr Psychiatry Rep*. 2019;21(5):35. https://doi.org/10.1007/s11920-019-1017-0

[43] Chung H, Rostanski N, Glassberg H, Pincus HA. Advancing integration of behavioral health into primary care: a continuum-based framework. United Hospital Fund and Montefiore Health System. 2016. https://uhfnyc.org/assets/1476.

[44] Springgate BF, Wennerstrom A, Meyers D, et al. Building community resilience through mental health infrastructure and training in post-Katrina New Orleans. *Ethn Dis*. 2011;21(3):1-29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3731130/

[45] Springgate BF, Arevian AC, Wennerstrom A, et al. Community Resilience Learning Collaborative and Research Network (C-LEARN): study protocol with participatory planning for a randomized, comparative effectiveness trial. *Int J Environ Res Public Health*. 2018;15(8):1683. https://doi.org/10.3390/ijerph15081683

will likely differ. Part of the challenge for those looking for program models across the country is to understand how to keep the core universal attributes a program may have and then carefully "interrupt" them as they are imported to another region, culture, or, in some cases, part of the same large urban local.

One emerging area of particular interest in the behavioral health domain, which has been brought to the forefront by COVID-19-related social distancing, is the use of telehealth in many aspects of behavioral health, including screening, ongoing care, follow-up, and peer support. Telehealth has important ongoing applications in urban areas that have noteworthy transportation issues, as well as for men in rural communities. Telehealth may also be particularly useful in reaching boys and men because of the personal anonymity it can provide. Brott noted that face-to-face communications about sensitive care and wellness are certainly preferred, but any communication, whether facilitated by telemedicine, smartphone apps, or some other technology, is better than none. "Because guys are historically reluctant to engage with the health care system, we need to be prepared to meet them wherever they are, even if it is only on the other side of a smartphone or computer," he said.

> **"Because guys are historically reluctant to engage with the health care system, we need to be prepared to meet them wherever they are, even if it is only on the other side of a smartphone or computer."**
>
> Armin Brott

This is an important area for research. In one PCORI-funded project, a 2-year randomized controlled trial is comparing the use of telepsychiatry-collaborative care with telepsychiatry-enhanced referrals among patients in community health centers in rural areas. These patients have screened positive for PTSD and/or bipolar disorder and are not taking medication for these conditions.[46] Brott noted that telehealth and telepsychiatry are relatively new innovations in delivery of care. Technologic challenges, privacy, validation of credentials, and content are among the many important issues that are quickly evolving—and being closely monitored. In clinical settings, these tools are disadvantaged by lags in reimbursement for services. The COVID-19 pandemic and its impact on delivery of all manner of services provided an important stimulus to bolstering telehealth and telepsychiatry services, which, if these advances hold, should provide important maturation of this approach to care.

Impact on Communities

The panel had extensive discussions about the impacts that male mental health issues can have on communities. Cantu and Bonhomme noted that the adverse impacts seen in the community at large are often even more severe in communities of color. Within those communities, sub-demographics, such as the elderly,

[46] Comparing two approaches to provide complex mental health care for patients in rural areas – the SPIRIT study. Patient-Centered Outcomes Research Institute. https://www.pcori.org/research-results/2015/comparing-two-approaches-provide-complex-mental-health-care-patients-rural

LGBTQ, and young boys, have their own unique needs, which are too often unmet. The panel felt that community leaders responsible for helping boys and men in any particular demographic must look at generalized information, services, programs, and outreach in a way that makes sense to the particular demographic they work with.

Communities and subcommunities do much better, in terms of both health outcomes and financial prosperity, when the mental health needs of community members are adequately met. It follows that unaddressed or poorly addressed mental health problems will have a negative effect on many factors in the community, such as homelessness, poverty, employment, safety, and the local economy. They may also affect the productivity of local businesses and health care costs, impede the ability of children and youth to succeed in school, and lead to family and community disruption (several of these key adverse impacts are summarized in Graphic 8). The COVID-19 pandemic beginning in early 2020 increased the complexity of these circumstances, undoubtedly extending the impact on the mental health of men, boys, and their communities for years to come.

One of the first steps any community or subcommunity must take as it begins to tackle this problem is to conduct a needs and epidemiologic analysis. This may be particularly difficult when looking to identifying issues relevant to boys and men, as all too often data is not stratified by gender. Giorgianni noted that MHN is frequently frustrated when health statistics are reported only in the aggregate and gender information is buried or omitted. It is unnecessarily difficult to request gender-specific stratification from most sources, including US federal sources. Boyd agreed that without adequate and easily available gender stratified information, a needs analysis may not yield a realistic picture of the magnitude of the problem and how to allocate resources, let alone what must be done and even how to begin doing it.

Behavioral health problems and mental illness take enormous social and economic tolls on sectors as varied as health care, business, education, law enforcement, criminal justice, and emergency and social services. Community planners and leaders need to understand that much of the economic burden of mental illness is not the cost of care but the loss of income due to unemployment, expenses for social supports (and incarceration), and a range of indirect costs related to chronic disability. It is important that members of the community be informed of the devastating effects of the community residents' behavioral and mental health issues, and for data on the impact on specific subpopulations (in particular boys and men) to be communicated to members and trusted influencers. These steps will bolster and underscore the need for awareness and resources, particularly in communities with a general distrust of government or civic organizations.

Summary of Key Adverse Impacts Behavioral/Mental Health Issues May Have on the Community[5]

Health System

- Depression is the leading cause of disability worldwide and is a major contributor to the global burden of disease. The cost of treatment for mental health issues is equivalent to the cost of cancer care.
- Mood disorders such as depression are the third most common cause of hospitalization in the United States for both youth and adults aged 18 to 44.
- Nearly two-thirds of US adults over 18 years with any mental illness went without treatment.

Work Productivity and Lost Earnings

- Major depression is associated with more annual sick days and higher rates of short-term disability than other chronic diseases. People suffering from depression have high rates of absenteeism (in some cases, 3 times more sick days than nondepressed workers) and are less productive at work.
- Mental health issues result in an estimated $193 billion in lost earnings.
- Approximately 45% to 98% of depression treatment costs were offset by increased workplace productivity.

Family and Community Disruption

- Children of parents who suffer from chronic depression are more likely to have behavior problems at school.
- The caregiver burden associated with depression can affect workplace performance, particularly in men.
- Military service is all too often associated with behavioral and mental health issues including but not exclusively due to PTSD.

Educational Institutions

- Untreated mental illness among youth leads to school failure, delinquency, substance abuse, and involvement in the criminal justice system.
- Children and adolescents, particularly boys, frequently suffer from mental illness enough to cause impairment and contribute to barriers in learning, but not enough to be recognized and triaged to treatment for proper professional assistance.
- Many male students labeled with emotional or behavior disorders drop out of school before earning a diploma.
- Many young boys with mental illness are without employment after leaving high school.
- Few young men who do graduate from high school move on to postsecondary education.

Youth and the Criminal Justice System

- Without adequate community services, many young males end up in the criminal justice system.
- Substantial percentages of a community's budgets for criminal justice services are spent on juvenile justice, including housing mentally ill boys and young men in juvenile detention facilities.

Portals for Community Action

All panel members agreed that education, training, and the ability to recognize at-risk individuals are of paramount importance. James Craig, public health social work coordinator in the Maternal and Child Health Service, Oklahoma State Department of Health, noted that as a public health professional he tries to talk about "going upstream" as much as possible to engage in prevention. This is important in communities to

reduce the number of people who will need more intensive services later on. This would include helping create more emotionally supportive and emotionally intelligent environments at home and in schools. The hope is that such changes will encourage robust emotional learning, particularly in young boys, for whom such learning doesn't come easily or naturally. Craig noted that all cultural groups must be encouraged to develop emotional intelligence and supported in doing so.

Among the programs PCORI has funded in the area of mental health and families is one designed to help Latinx parents learn skills to manage their children's mental health care.[47] The program's interventions were successful in increasing parent or guardian activation in the day-to-day management of childhood mental health skills. The programs also yielded many secondary positive outcomes, including educational activation; increased school involvement of the parent or guardian; decreases in parental stress and depression; and increased school attendance.

Peer-to-Peer Support

The panelists engaged in much robust and encouraging discussion about the importance and success of peer-to-peer mental health–related programs. Jones noted that although there are many mental health support programs for firefighters, many don't succeed. Those that do tend to have a peer-to-peer structure. However, while peer-to-peer programs are important, so is the way training is conducted. "First Responders, like many other professionals, do ongoing training to keep up with their job skills," said Jones. "But they don't want just flat, PowerPoint-type presentations—they want an interactive experience based on real-world cases." They also have strong preferences for the type of training the mental health professional who work with them have undergone. For example, firefighters and paramedics would like to know that their trainers have come to the station, gone on "ride-alongs," and have a strong sense of what the life of a first responder is like. The rank and file also want to see that their peers and supervisory personnel have personal experience with therapy, the idea being that it comes across as disingenuous to recommend that someone go to therapy unless you've been in therapy yourself. "Real-life experiences and continuous training of councilors helps build trust and a common bond with these firefighters and Emergency Medical Techinicians,(EMTs)" added Jones. The panelists agreed that these strategies could (and should) be adopted in many other settings and might help validate the credentials and credibility of community-based mental health professionals.

Weingarden stated that peer-group programs not only help destigmatize mental health but also take advantage of the powerful technique of utilizing "trusted messengers" to deliver important messages and to serve as role models who can focus on providing solutions and a sense of achievability, particularly for those who have had little to give them confidence in their ability to achieve control over a downwardly spiraling emotional situation. Cantu emphasized that trusted messengers come from the identified community, are culturally and linguistically competent in that community, are identifiable as leaders within the defined population or sociocultural sector, and may have connections to appropriate faith-based organizations. Jones found that to be seen as trustworthy, interventions, education, and role models must come from individuals who understand the culture and are immersed in it. MHN developed a community-based program to train male community health educators. This certificate program draws on community members as trusted

[47] Thomas KC, Stein GL, Williams CS, et al. Helping Latino parents learn skills to manage their children's mental health care. Patient-Centered Outcomes Research Institute (PCORI). 2018. https://doi.org/10.25302/8.2018.AD.1211490

messengers to bring overall health messages, programing, and inspiration to the community level. This program can be tailored to most community settings.

Byer pointed out that several national labor unions have instituted peer-to-peer support programs. These include the Sheet Metal Union for Air, Rail, and Transportation; the International Union of Operating Engineers; and the International Union of Painters and Allied Trades, among others.

The panel agreed that in many situations, peers provide invaluable first-line support for boys and men who are in the early stages of behavioral health conditions. Sullivan noted that students in his programs in Oklahoma often serve as the eyes and ears of counselors and educators regarding emerging behavioral health issues in their peers in their successful Hope Teams program. Utilizing students in peer-to-peer support has increased people's understanding of potential problems and led to the development of effective support systems for students with emotional difficulties.

One of the biggest issues to face is the frequent misalignment of how we tend offer help and how people seek help. Certainly, this is a real learning curve in how clinicians and community support persons need to adjust what is offered and how it is offered and the types of cues they use to determine when men and boys are actively seeking help. These cues for males are very different than for females. One of the ways to resolve this knowledge gap is a matter of educating clinicians and community support personnel. For most people, recognizing that they need help with an emotional problem is not an immediate revelation; it is a process. This process occurs over time in many different venues within the community, with family, with peers, with supervisors, and with others. A clinician is usually the last person in this chain to hear about this need, which is another reason why community-level understanding and early interventions, such as with Emotional First Aid, is so important.

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Tomšić pointed out that it's especially important to develop and nurture Emotional First Aid programs and community-based training programs that encompass gender-specific techniques and sensitivities. She also noted that having a repository of best practices and successful program and outreach models for these

community-based programs would make it much easier for others to launch their own programs based on those best practices. The panel agreed on this point and it is included in the key action item recommendations from the program.

The organization Mental Health America (MHA) has published broadly on the topic of mental health in the workplace and has partnered with several other organizations to study this problem in terms of both its impact on people and its impact on the work environment in our communities.[48] The telltale hallmarks of the problem MHA surveys have found include the following:

- Less than one-third of Americans are happy with their work.
- Half of the workforce is "checked-out" mentally.
- Eighteen percent of workers are unhappy with their current position.
- Some members of the workplace are so unhappy that they sabotage the success of their employer.

The personnel and economic impacts of mental health issues in the workplace were succinctly summarized in a 2015 report issued by the Construction Financial Management Association.49 Leveraging Human Capital Risk Management posited that "a contractor's most important resource, and one of its leading costs, is its employees". By actively investing in employee, supervisory, and leadership development programs, corporate financial managers can expect a positive return on investment and other measurable outcomes in both its risk management and human capital investments. This intentional strategy combines organizational development practices to leverage human capital risk management and protect a company's most important asset, its people. Included in this overall approach to investment in personnel was a hard and thorough look at the impact mental health issues were having on the industry's personnel. The report goes on to state that "[a]ddressing mental health and wellbeing is a strategic leadership imperative and is a sound business strategy and practice. Investing in mental health and wellbeing has a positive return on capital investment and an even bigger ROI on your company's human capital assets—your employees."

While this report was specific to the construction industry, Beyer, one of the report's authors and a panelist for this program, felt it has broad applicability across most, if not all, industries. This CFM publication cited a meta-analysis conducted by The Centre for Economic Performance using Gallup data that included observations on the wellbeing of 1 882 131 employees and the performance of 82 248 business units and found that "employee wellbeing is consistently positively correlated with firm performance."50 The authors noted that they "focus on the financial, retail, manufacturing, and service sectors because we had fewer than 20 studies for the remaining sectors (materials and construction, personal services, real estate, and transportation and utilities), which we deem insufficient to base inference on." They concluded that the evidence suggests "a strong, positive relationship between employee wellbeing, employee productivity, and firm performance." Clearly this is an area for key action items and research not only in the area of economic and business metrics but also in the types of programs that have been successful in other environments that may be applied specifically to the business environment in the post-COVID-19 workscape.

[48] Mental Health America. Mind the workplace. MHANational.org. https://www.mhanational.org/workplace-wellness
[49] Construction Financial Management Association. Building profits. *The Magazine for Construction Financial Professionals.* May 2015. https://www.cfmabponline.net/cfmabp/20150506?pg=16#pg16
[50] De Neve JE, Krekel C, Ward G. Employee wellbeing, productivity and firm performance. Centre for Economic Performance. 2019. cep.lse.ac.uk/pubs/download/dp1605.pdf

Beyer noted that construction workers have among the highest rates of suicide in the United States. The CDC noted that in 2012 and 2015, suicide rates were highest among males in the ***Construction and Extraction*** occupational group (43.6 and 53.2 per 100 000 civilian noninstitutionalized working persons, respectively).[51] Beyer felt this is a particularly stressful work environment for this male-dominated industry. Some factors that contribute to this suicide rate—approximately 4 times that of the general population—and associated mental health conditions are as follows:

- Periods of unsteady and seasonal employment
- Low or inconsistent pay
- Mental health stigma
- Sleep disruptions
- Chronic pain caused by manual labor
- Physical strain
- Jobs that are often isolating
- Travel to remote work sites, which may separate workers from families and friends
- Access to means of committing suicide, such as sharp objects and high places
- Pressure to finish projects
- Poor working conditions

In early 2019 Walgreens began a program to train employees at several levels in the techniques of emotional first aid in the workplace.[52] This large community pharmacy company partnered with the National Council for Behavioral Health and the American Pharmacist Association to provide "Mental Health First Aid" training for a cohort of pharmacists employed by the company. This program will provide training in mental health literacy, risk factors, and warning signs for mental health and addiction as well as strategies for how to provide help to someone in a crisis situation. As part of the program, key human resource personnel will also be trained to strengthen the commitment to workplace mental health and wellness. This initiative may provide outcome information about the effectiveness of both patient care and employee wellness.[iv] As similar programs begin to populate workplaces, it would be helpful to have these other programs measure outcome results and publish them.

[51] Suicide increasing among American workers [press release]. Centers for Disease Control and Prevention; 2018. https://www.cdc.gov/media/releases/2018/p1115-Suicide-american-workers.html Washington, DC

[52] Cohn J. Walgreens completes first phase of mental health first aid training for pharmacists focused on health outcomes [press release]. Walgreens Newsroom; May 20, 2020. https://news.walgreens.com/press-releases/general-news/walgreens-completes-first-phase-of-mental-health-first-aid-training-for-pharmacists-focused-on-health-outcomes.htm Chicago, IL

Educational Institution

Research shows that youth, especially under-resourced youth, are most likely to receive mental health care in schools, given barriers to obtaining community mental health services. School infrastructures also allow for large-scale implementation of prevention interventions. Given the factors involved in delivering school interventions, however, experts urge consideration of policies, school culture and climate, and leadership structure when delivering interventions.[53,54,55]

10 Ways Organizations Can Create a Mentally Healthier Workplace

(Adapted from Mental Health America, *Mind the Workplace*, https://www.mhanational.org/workplace-wellness)

A healthy workplace is one where individuals feel valued and supported, that provides a positive workspace, and that shows respect for other aspects of a person's life. The following are some helpful tips for employers to assess whether theirs is a mentally healthy workplace:

Productive Atmosphere

- Provide clean, functional, and well-lit spaces. Keep a good working relationship with all staff. Make employees feel respected, appreciated, incentivized, and rewarded. Ensure signs of intimidation, bullying, sexual harassment, and fear are absent.

Livable Wage

Provide a livable wage encourages a committed and sustained workforce.

Reasonable Accommodation

Employers and employees have to work collaboratively to identify reasonable accommodations (not special treatment) in the workplace for physical as well as mental disabilities. From changing physical workspaces and schedules to using interpreters or technologically adapted equipment, accomodations can run the gamut.

Health, Wellness, and Environment

Provide a comprehensive health insurance plan, including smoking cessation, weight loss, and substance abuse programs.

Management Accountability

Allow employees to provide work-related feedback to their supervisors. It can be anonymous to avoid the possibility of negative repercussions.

Open Communication

Keep the communication process transparent. Creating an environment of open communication contributes to a more energetic and productive workforce where all employees can feel invested in the company.

Employee Accountability

It takes 2 to make a healthy workplace. Employees have to come with a "can-do" attitude and be willing to support each other as well as management.

Work/Life Balance

We now live in a world where technology is available to keep us connected to work around the clock. Work options such as flexible scheduling, hoteling (reservation-based unassigned seating), or telecommuting ought to be implemented if applicable.

Fitness

Offer a gym membership, fitness class or even just an exercise space that encourages employees to become physically active and stay fit. If possible, incentivize employees to access such services.

Clear and Positive Values

Be transparent and definitive about what the organization stands for. People inside and outside the company should have a good understanding of this.

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[53] Domitrovich CE, Bradshaw CP, Poduska JM, et al. Maximizing the implementation quality of evidence-based preventive interventions in schools: a conceptual framework. *Adv Sch Ment Health Promot.* 2008;1(3):6-28. https://doi.org/10.1080/1754730x.2008.9715730

[54] Hoagwood K, Johnson J. School psychology: a public health framework. *J Sch Psychol.* 2003;41(1):3-21.

[55] Lai K, Guo S, Ijadi-Maghsoodi R, Puffer M, Kataoka SH. Bringing wellness to schools: opportunities for and challenges to mental health integration in school-based health centers. *Psychiatr Serv.* 2016;67(12):1328-1333. https://doi.org/10.1176/appi.ps.201500401

Community Service Organizations

The Prevention Institute (www.preventioninstitue.org), an organization associated with the Movember Foundation, focuses on many issues related to the health and welfare of boys and men. One of its landmark programs is "Making Connections for Mental Health and Wellbeing."[56] Making Connections is a national initiative to transform community conditions that influence mental wellbeing for boys and men and their families. The program is available in 13 communities across the United States and shifts policies, practices, and norms to create greater opportunities for health and resilience. These are in rural, urban, and suburban locations throughout the United States. The focus at the local level is on improving social connections, economic and educational opportunities, assets, and the physical environment.

The program's primary focus is support of veterans and boys and young men of color. Panel member Rubin Cantu noted that, consistent with the view that programs that have the best chance of being effective with boys and men are designed with boys and men in mind, Making Connections sites' programs were developed in collaboration with men and all have adopted male-friendly approaches and male-identified preferences for engagement of men and boys and for program delivery. In addition, he noted, all of its programs are designed to reflect local community priorities and strengths. They also are designed to draw on indigenous knowledge and customs to optimize their relevance and attraction to the intended audiences. These important program structural components need to be considered and be incorporated into any community initiative. Brott noted that all too often programs presented to boys and men are not crafted or reimagined and restructured with boys and men or particular communities in mind. To be truly effective, programs should be designed for boys and men and with community targets in mind.

The panel also discussed the importance of interlacing programs being developed with the overall fabric of the community. Cantu suggested that one of the most important strategies when building programs is to tap into existing organizations that can serve as Trusted Messengers for the project work. These messengers will have networks of places, other organizations, and people that can be tapped into to help optimize participation and give the project's messages credibility. Cantu noted that his organization has been developing a tool kit to help sponsor veteran Trusted Messenger partners; this should be available in early 2021.

Faith-Based Communities

Faith-based organizations perform many important functions and are often anchors of communities. Their members are frequently called on to serve as Trusted Messengers within the communities they serve. Numerous studies have shown that spiritual beliefs and practices help people feel greater hope and connectedness and find meaning in their lives. They provide opportunities for developing positive relationships with others and can be an important source of support during difficult times. As a result, faith-based organizations are a natural setting for suicide prevention. In addition, since counseling related to suicide fits with the general role of faith community leaders, many people in the community trust and accept their clergy (and feel comfortable sharing information with them) and see them as important providers of

[56] Making connections for mental health and wellbeing among men and boys. Prevention Institute. https://www.preventioninstitute.org/projects/making-connections-mental-health-and-wellbeing-among-men-and-boys

5 Essential Emotional First Aid Skills

Reach Out
Make contact and establish rapport with the survivor or victim so that he or she feels connected to someone who cares about his or her circumstance.

Protect
Protect the survivor or victim from further injury (emotional, physical, or financial) that can be inflicted by others, circumstances, or the inability of the victim to care for himself or herself.

Reassure
Help the survivor or victim obtain the information needed to stabilize his or her situation in a timely manner.

Organize
Help the survivor or victim develop a simple plan to take action so he or she can quickly regain a sense of control over his or her situation or circumstance.

Reinforce
Identify the victim's sources of personal strengths and do what's needed to help him or her recognize these strengths, obtain them, and hold onto them.

emotional wellness and care for those who may be at risk.[57] [58] Not surprisingly, people with mental health problems, including suicide risk, often turn to their community's faith leaders for help. Those leaders, in turn, may bring in other organizations that can conduct programs and screenings. Faith communities can also provide support to the caregivers of those impacted by mental illness or suicide and have an extremely important role to play in the post-suicide affairs of family and loved ones.

Pastoral councilors are an important component of the faith-based community.[59] They are specially trained clergy of all faiths and denominations who have extensive education and training in helping individuals and families cope with very difficult and emotionally charged situations. Pastoral councilors are often seen in clinical settings and often serve as a bridge for people who have been hospitalized for an emotional break as they begin to reintegrate into their families and communities. Pastoral councilors are also important resource, acting as Trusted Messengers and helping community leaders develop programs and bring people to these programs.

A Vast Landscape of Potential Areas of Intersectionality

Many other types of entities in the public and private sectors play a role in addressing the mental health of their constituents. These entities include state and local government agencies and offices; civic organizations; athletic organizations; military and veterans' groups; senior citizen centers, communities, and residences; Native American and Alaskan Native Communities and tribal organizations; and organizations that serve LGBTQ communities. All have a role to play to address these issues, particularly for the boys and men they serve. However, a comprehensive discussion of these organizations is beyond the scope of this monograph.

[57] Alexander MJ, Haugland G, Ashenden P, Knight E, Brown I. Coping with thoughts of suicide: techniques used by consumers of mental health services. *Psychiatr Serv.* 2009;60(9):1214-1221. https://doi.org/10.1176/appi.ps.60.9.1214
[58] Brenner LA, Homaifar BY, Adler LE, Wolfman JH, Kemp J. Suicidality and veterans with a history of traumatic brain injury: precipitating events, protective factors, and prevention strategies. *Rehabil Psychol.* 2009;54(4):390-397.
[59] Helping others through faith-based therapy. Pastoral Counseling. https://www.pastoralcounseling.org/

Emotional First Aid

Among the programs being used more and more broadly are those that train community members in techniques called "Emotional First Aid" (EFA). EFA is a derivative of "Psychological First Aid" (PFA) programs as applied to non–mental health/nonmedical personnel in the community and workplace. PFA, according to the American Psychological Association, assesses the immediate concerns and needs of individuals in the aftermath of a disaster and does not provide on-site therapy.60 It utilizes an initial disaster-response intervention to promote safety, stabilize survivors of disasters, and connect individuals to help and resources. PFA is delivered to affected individuals by mental health professionals and other first responders.61 The techniques of EFA are based on a set of life skills used by lay community members and emergency responders to provide emotional support and stability to an individual who appears to be in emotional crisis following a traumatic event and to help bring that person to appropriate professional care if needed.

Examples of Training Programs for Psychological First Aid

National Child Traumatic Stress Network
Psychological First Aid Online Course
(https://learn.nctsn.org/course/index.php?categoryid=11)

National Association of County and City Health Officials Public Health Preparedness
Building Workforce Resilience Through the Practice of Psychological First Aid – A Course for Supervisors and Leaders
(https://www.pathlms.com/naccho)

Mental Health Preparedness-Psychological First Aid From Johns Hopkins University
(https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/online/mental-health-trainings.html)

According to the psychologist Guy Winch, PhD, just as we have bandages for cuts and scrapes and are taught how to dress a wound or put ice on a sprain and then seek professional care as needed once the immediate physical injury is stabilized, we should also have simple skills (see below) at our disposal to help individuals stabilize their emotional injuries from traumatic events and get them to care to prevent those acute emotional traumas from developing into long-term serious consequences.

In his book on the topic, Winch suggested 6 pragmatic things to do when working through an EFA episode: (1) recognize when you're in emotional pain; (2) be gentle and compassionate with yourself; (3) distract yourself from rumination; (4) redefine your view of failure; (5) find meaning in loss; and (6) pay attention to your psychological health on a regular basis.62
These seemingly simple steps prove difficult for many boys and men who don't have a trusted person to help guide them through the process.

Sabbs is a strong proponent of EFA. He pointed out that it's especially important to develop and nurture EFA programs and community-based training programs. He also noted that while several such training programs are available, the programs need to better encompass gender-specific techniques and sensitivities. Giorgianni agreed, noting that there are also some excellent PFA programs for mental health and emergency preparedness personnel (see Graphic 12). Fadich Tomšić pointed out that it's especially important to develop

[60] What is psychological first aid (PFA)? American Psychological Association. March 2019. https://www.apa.org/practice/programs/dmhi/psychological-first-aid
[61] The 5 emotional first aid skills. Trauma Intervention Program. http://www.whentragedystrikes.org/5_efa_skills.htm
[62] Winch G. *Emotional First Aid: Healing Rejection, Guilt, Failure and Other Everyday Hurts*. New York, NY: Plume–Penguin Group; 2014.

and nurture EFA programs and community-based training programs that encompass gender-specific techniques and sensitivities. She also noted that having a repository of best practices and successful program and outreach models for these community-based programs would make it much easier for others to launch their own programs based on those best practices. The panel agreed and included this recommendation in its list of key action items.

Garrick, founder of Whistleblowers of America (WoA), spoke about some of the stresses that affect employees who come forward and disclose inappropriate or illegal activity or fraudulent or other wrongdoing on the part of a company or organization.[63] She noted that the emotional stress of being a whistleblower, which is often protracted over extended time, can be enormous. Her organization started a Whistleblower Protection Advocate training program, part of which is devoted to suicide prevention and building emotional resiliency for whistleblowers. WoA is also looking to conduct a propensity study on whistleblowing and its psychosocial impacts.

[63] About us. Whistle Blowers of America. https://whistleblowersofamerica.org/

www.MensHealthLibrary.com

Community-Based Initiatives: Works in Progress

All panelists strongly agreed that community-based initiatives are at the heart of the needed solutions to addressing boys and men at risk of developing behavioral health issues, which, if left unaddressed, are likely to evolve into mental health crises, sometimes with disastrous results for the individuals, their families, and the community. Saabs, Cantu, and Sullivan added that developing and implementing such programs is difficult and time consuming, but the efforts are well worth it. Giorgianni pointed out that program champions often find it difficult to present persuasive outcomes-oriented data about model programs or to do pilot programs to justify broader, more-permanent initiatives. Most community organizations have neither the expertise nor the capacity to develop, analyze, and present measurable program results to potential funders. These skill deficits need to be addressed.

PCORI-Funded Initiatives in Behavioral Health and Mental Health

PCORI has been a leader in providing funding research and project work to enhance patient engagement in mental health management. To date, it has funded more than 139 comparative clinical effectiveness research studies in those areas, including those that have focused on peer support programs, PTSD, peer navigation programs, and improving diversity. Three such projects exemplify the importance and creative work being done in the community in behavioral health initiatives.[64] The first of these is “Comparing Long-Term Outcomes of Two Collaborative Care Approaches for People With Depression.” This program demonstrated that collaborative care approaches for depression show promise in improving health care quality in under-resourced communities. The second is “Peer-Navigator Support for Latinx Patients With Serious Mental Illness”; the third is “Helping Latino Parents Learn Skills to Manage Their Children’s Mental Health Care.”

Anna Radin, MPH, DPH, applied research scientist for St Luke’s Health System in Idaho, is a recent recipient of the PCORI award “Suicide Prevention Among Recipients of Care (SPARC Trial).” Radin presented her program

[64] Mental and behavioral health [infographic]. Patient-Centered Outcomes Research Institute. https://www.pcori.org/topics/mental-and-behavioral-health

to the panel. In one of her group's research projects on mental health services, Radin and her colleagues studied applying Safety Planning Intervention (SPI) techniques to her community-based hospital setting.[65] The fundamental goal of SPIs is to help patients understand their own suicide risk, so when problematic behaviors and feelings begin to escalate for them they can effectively self-intervene and create a plan that can be put into place once they leave the health care system. The essential elements of the SPI are to assist patients in self-assessing the following:

- Warning signs of emotional issues
- Coping strategies they can use
- Identifying people and social settings for distraction
- Identifying and accessing needed professional support
- Mitigating access to any lethal means for self-harm

Radin stated that when she first embarked on my work and began reviewing the literature to provide mental health support services she was struck by how much we really don't know and how much of what occurs in standard care practices is not supported by rigorous and broad research. The research field, particularly at the community hospital and the nonmedical community organization level, has ample opportunity to do important research. Even the SPI programs, which are among the most widely used interventions, have only been studied rigorously in cohort populations and are not really studied in subpopulations, including in the general male or specific subpopulations of men, nor have they been studied in various other populations based on local, rural compared to urban, sexuality, or most other definable groups. These are certainly important key action items to consider in future research funding priorities.

Radin noted that compared to patients who received usual care upon discharge, patients treated for a psychiatric component of their illness who receive SPI plus follow-up as inpatients were half as likely to engage in suicidal behavior and twice as likely to attend outpatient treatment. She did caution that SPIs must be done properly and as a true intervention along with meaningful interactions with patients rather than a simple "check-the-box" process, which unfortunately, happens all too often.

Radin and her team also studied Caring Contact Interventions (CCI) in the community hospital setting. CCI Caring Contacts is a straightforward intervention that involves sending suicidal patients brief, nondemanding expressions of care and concern over the course of a year or more.[66] In this intervention study, Radin and her team used short motivational-style messaging, such as short notes or cards. The initial CCI was developed by a practicing psychiatrist as a technique in his own practice when he started mailing short follow-up letters to patients over time and noticed those who received these letters fared better and had less recidivism than those who didn't get them. Radin noted that when compared to those who received standard care, patients who received caring text messages experienced a 44% decrease in suicidal ideation and a 48% decrease in suicide attempts.

[65] Stanley B, Brown GK. Safety planning intervention: a brief intervention to mitigate suicide risk. *Cogn Behav Pract. 2012;*19(2):256-264. http://www.sciencedirect.com/science/article/pii/S1077722911000630

[66] *Implementing Caring Contacts for Suicide Prevention in Non-Mental Health Settings*. QUERI-Quality Enhancement Research Initiative, US Department of Veteran's Affairs. https://www.queri.research.va.gov/visn_initiatives/suicide.cfm#:~:text=Caring%20Contacts%20(CC)%20is%20a,over%20a%20year%20or%20more

These ongoing research projects are important not only for the quality of the studies themselves but also because the sponsoring organization, OLSJIDF Hospital, is a community-based, non-university-affiliated institution. Clearly, such institutions can—and do—create important and fundable research in community outreach and care. Seeing the immense value in this type of research work, the panel included in its list of key action items the recommendation for greater involvement by (and funding for) community-based health provider organizations conducting formal research in the area of male behavioral health management.

During the discussion, many panel members were surprised to discover that there are many more programs in operation than they thought existed. Most agreed that finding information on other programs, even in the age of powerful web-browsing capability, is very time consuming and, because of the huge diversity of search terms, would be very difficult to do comprehensively. This led to a discussion about the need to create a central repository, along the lines of the one supported by the US National Library of Medicine directory of clinical trials (www.https://www.clinicaltrials.gov/), where researchers, clinicians, patients, and community leaders could find examples of programs, research projects, screening tools, and interventions designed with men in mind. Fadich-Tomšić stated that MHN has long believed that having a centralized repository of best practices and successful program and outreach models for these community-based programs would make it much easier for others to launch their own programs based on those best practices. Peschin and others noted that particularly pressing research is needed to conduct a broader range of comparative clinical effectiveness studies on different standard interventions to see which are most effective with men and subpopulations of men. The panel was in substantial agreement with these points and they are included in the key action item recommendations.

The Nexus of Community Involvement and Interventions and Clinical Care

The panel briefly discussed the importance of providing links between community involvement and interventions, as well as the need to comply with personal privacy requirements while appropriately triaging at-risk males to clinical settings. James Craig, LCSW, public health social work coordinator in the Office of Maternal and Child Health Service at the Oklahoma State Department of Health, is responsible for multiple programs that include a mental health component. “When we were developing, building, and planning the implementation of our programs, we were very cognizant of the need for community participation and buy-in,” he said. “So as much as possible, although we had core program elements, we worked hard to not make this a top-down development and implementation and assessment, and instead got people in the community who were going to execute the programs to participate in these structural elements. We feel this approach led to a good deal of the success we’ve had.”

Primary care plays a very important role in the process of supporting community work in health screening, including mental health screening. Historically, collaborative care models in mental health have historical roots in the Chronic Care Model (CCM) of chronic disease management. The CCM envisioned a combination of health system reforms and community-based resources to help health care settings improve outcomes for those with chronic illnesses. Many collaborative care studies, often for depression, focused on incorporating mental health services to varying degrees within primary care settings. Adaptations exist for other target populations (eg, children) and settings (eg, obstetrics/gynecology practices, mental health clinics).

Several on the panel emphasized the need to ensure that when someone at risk is identified, written policies and procedures are in place that govern how to inform the person of the risk and to assist in getting that person the most appropriate care. In some settings, this is fairly easy. For example, Davidson noted that working out of the mayor's office in Milwaukee, Wisconsin, "We have wrap-around services with mental health department providers, so we have a specific place and protocols to refer persons at risk within our city services." Programs affiliated with hospitals or other health care providers also have the ability to quickly refer. However, Saabs pointed out that these referrals, at any level, need to be efficient and easy for the patient and for the community liaison. "The last thing you want to do when you have someone who is frustrated or in a delicate emotional place is fight with a frustrating, slowly responding system," he emphasized. "These types of frustrating encounters undermine trust, not only in services, but also in the person you're working with at any particular time. Plus, word gets around about these frustrating systems that folks feel they can't trust, so it can become a widespread problem within a community."

Keeping the systems efficient and easy to understand sometimes takes a bit of housekeeping. Saabs related that one of the things they did at Phoebe Putney when evaluating their response to the opioid crisis—and again with COVID services—was to "clean out" a lot of the bureaucracy that was making access to social service in the community frustrating and overly complex. All on the panel agreed that, as with training, ongoing evaluation and development are a must. Yet, as Giorgianni noted, while there are probably as many referral system approaches as there are programs, in the real world there is an overall lack of awareness that such programs exist and very little solid research being done to assess them. This is a key area for future development.

Community-based organizations generally don't have the expertise, let alone the resources, to construct proper or even cursory study plans and metrics. In some cases, attempts are being made to provide financial justification for expenditures at the outset of a funded project. This doesn't generally rise to the level of scientifically or statistically meaningful data. If great local programs are going to grow and thrive across communities or nationally, some research and then publication, preferably in a peer-reviewed publication, will be necessary. This will take expertise, time, and funding, especially for small community programs. Partnering with local universities or research-oriented public health departments may be one approach. Another, suggested by Giorgianni, is to create microgrants for small community organizations with an interest in mental health issues. In addition to funding the actual studies, these grants could provide financial and organizational support, including guidance on how to craft, collect data, report, and publish scientifically and clinically meaningful metrics.

The referral pathway also needs to be established in the other direction, from the clinical setting back into the community setting for long-term support. Lyon discussed how this bi-directional referral framework can work in postgraduate medical education. In this environment, he said, a huge emphasis is placed on mental health and community health. "We know that if we focus only on health in the clinic, we won't be doing an adequate job, because just 20% of health care management occurs in a physician office—the rest happens out in the community setting," he said. "We do train our young doctors to understand the role of community health and how to access community resources for their patients. The clinic I work in is designed as an integrated clinic with mental health practitioners on site. This is done so we can teach our residents how to work with mental health professionals. This is not the usual setup of most teaching sites, and of course there's a general shortage of mental health professionals. So, it's not realistic to think that the model we have

here at our clinic is going to be found everywhere, but it certainly is a model to aspire to. In primary care many of the larger clinics and practices have a social worker on staff, which really helps make connections to needed referral services for our patients. We also encourage building networks of community service providers we can make direct referrals to."

The Discrepancy Between Reimbursements for Behavioral Health and Physical Health Services

> **The United States Preventive Services Task Force and American College of Obstetrics and Gynecology have good guidelines on screening new mothers for postpartum depression, but there are no similar screenings for new fathers, who experience many of the same stresses of becoming new parent and who frequently develop postpartum depression.**

There is a strong disconnect between the time primary care providers must spend to screen and provide necessary care to a patient at risk of a severe mental health episode and the amount that provider will be reimbursed. Even with the best male-focused screening tools, this disconnect acts as a disincentive to adequate primary care screening for males. Lyon and other clinicians on the panel strongly felt that reimbursement structures must be reconfigured to be more equitable. This too was seen as an important key action item to address.

Peschin noted that Medicare Annual Wellness visits are a perfect opportunity for men to be assessed for emotional wellness. Similarly, Bonhomme noted that sports and camp physicals also provide an opportunity to screen boys and men. Brott pointed out that, unfortunately, there are no national or even medical association guidelines on how or at what ages boys and men should be screened. Jones also noted that the United States Preventive Services Task Force (USPSTF) guidelines are not particularly specific, which leaves great variability in clinical practice norms. For example, the USPSTF and American College of Obstetrics and Gynecology have good guidelines on screening new mothers for postpartum depression, but there are no similar screenings for new fathers, who experience many of the same stresses of becoming new parents and who frequently develop postpartum depression. Craig noted that one of the few sources of postpartum mental health information for dads is provided by Post-Partum International.[67] Brott and other panelists suggested that this is another area where additional outcomes research is needed to examine programmatic approaches to prenatal and postnatal support programs that have been successful for women and determine how they might be adapted to provide much-needed support for new fathers. Giorgianni noted that, consistent with other learnings in development of programs for males, converting such programs requires

[67] Postpartum mental health is a men's issue. Postpartum Support International. https://www.postpartum.net/get-help/resources-for-fathers/

more than a superficial redesign. To be successful, the entire structure, delivery, components, and more must be completely reimagined. "You just can't take a program developed for women and put some blue bunting and stereotypical 'guy' photos in it and think that's enough," he said.

Unfortunately, such public policy, reimbursement, and general attitudes about the need for screening men across the lifespan—in particular during times of extreme stress—are not on the table. Fadich-Tomšić noted that the Affordable Care Act (ACA) glaringly overlooks an important potential mental wellness opportunity. She noted that while annual women's wellness visits (including mental health screenings) are a fully covered component of the ACA, no corresponding visits for men and boys are covered. This not only is a missed opportunity but also appears to be a violation of federal law, which prohibits discrimination on the basis of sex. Considering the large gender disparity between men's and women's overall morbidity and mortality, it's hard to justify the disparity in ACA coverage.

Public Policy and Legal Considerations

Given the focus on marginalized and under-resourced populations, ethical considerations are of special importance to many community interventions. Research on interventions for at-risk individuals with stigmatized conditions (eg, incarceration and homelessness) should build trust with participants and recognize structural forces that place them at higher risk for these conditions (eg, discriminatory policing and housing policies) to avoid inadvertently worsening the stigma. Developing effective partnerships and involving community stakeholders in equitable arrangements for interventions and research requires significant investments of time and processes. The expertise of community leaders and other stakeholders can be integrated equitably with that of researchers with trust, respect, and 2-way knowledge exchange. Community-based organizations, social services, and health care agencies also have different funding streams and incentives. Efforts to sustain interventions should include a focus on funding and other enabling infrastructures (eg, training, technology) for community groups to participate in intervention-related activities.

Mental and behavioral health issues have their own unique legal and public policy circumstances and strategies, including the need to develop better screening tools to address these conditions in males. In 2017, The Network for Public Health Law (TNFPHL) presented at the American Public Health Association annual conference important perspectives on these legal and policy strategies, to promote mental health and wellbeing. TNFPHL convened leaders engaged in mental health initiatives from the local, state, and national levels to workshop this important issue. Results of this discussion have been summarized by TNFPHL and include recommendations and perspectives on a range of issues, such as gaps in current research, development of needed legal and policy options to be addressed, and areas for enhanced health promotion within communities. These areas include enhancement of family home visiting services; social/emotional learning and trauma-informed educational programs; enhanced access to mental health care, particularly prevention services; mental health reimbursement parity with physical health reimbursements; integration with primary care service; broader use and reimbursement for psychiatric telehealth services; optimizing and restructuring crisis intervention and public safety teams; investing more resources in suicide prevention program enhancements and outreach; and addressing substance abuse, including prescription drug abuse.[68] Implementing these programs in the educational setting is complicated by the need for compliance with the

[68] Kreuger J. Identifying legal and public health strategies to promote mental health and wellbeing. The Network for Public Health Law. March 1, 2018. https://www.networkforphl.org/news-insights/promoting-mental-health-and-wellbeing-through-public-health-law/

unique requirements of Family Educational Rights and Privacy Act and HIPAA. in addition, developing school-based, sustainable interventions that are truly responsive to the needs of students may require years of building academic-community partnerships.69

"988" The National Suicide Prevention Lifeline Number

The new National Suicide Prevention Lifeline is an example of a nationwide program that all community-level and clinical organizations should consider actively and prominently promoting. The Federal Communications Commission is in the middle of a 2-year rollout of a new, nationwide phone number for the National Suicide Prevention Lifeline. A complete US rollout should be completed by the end of 2021.

Research has shown that suicide prevention lines are an essential and effective tool for reducing suicide. An evidence-based report by the US Substance Abuse and Mental Health Services Administration shows that not only do those who are seriously considering suicide utilize the lifeline but also that the lifeline reduced successful suicides, psychological pain, and hopelessness during the call. The report also documents evidence on the efficacy of follow-up calls. Out of 500 self-activated callers who received follow-up calls, 79.6% reported the follow-up calls "stopped them" from death by suicide. They also reported that "the initial crisis calls stopped them from killing themselves."[70]

Key Steps to Effect Change

General Precepts

- Instill a recognition of the overall disparities between male's and female's health and wellness, as well as the especially large disparities in life expectancy, suicide, opiate deaths, and others in which males are severely disadvantaged. This requires enhanced advocacy, public policy, and educational initiatives across broad sectors of American society.
- Develop a centralized repository of information on community-based initiatives to identify, manage, and report the results of programs that support the behavioral health wellness of American boys and men. Ideally, this database would be easily accessible and searchable at a level appropriate for community involvement, provide information that covers the full lifespan of males, and provide information on vulnerable subpopulations of males and a diverse range of socioeconomic, racial, and life preferences. Desirable elements of this database would include the following:
    - Information on community-based best-practices, programs, and projects that address the core issue
    - Information on funding sources, both public and private
    - A registry of experts in research design, data collection, and reporting who are willing to support work at the community level
    - A registry of training programs available for skills development and enhancement in proven techniques for managing mental health and mental illness in boys and men across living and work environments and vocations

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[69] Stein BD, Kataoka S, Jaycox LH, et al. Theoretical basis and program design of a school-based mental health intervention for traumatized immigrant children: a collaborative research partnership. *J Behav Health Serv Res.* 2002;29(3):318-326. http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=ADOLEC&lang=p&nextAction=lnk&exprSearch=12216375&indexSearch=ID

[70] Stone DM, Holland KM, Bartholo, B, Crosby AE, Davis S, Wilkins N. *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2017. https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

  - A resource list of community-level tools designed and validated for screening males for mental and emotional health status
  - Information on successful referral systems from community-based programs to clinical programs and from clinical programs to community-support programs
- Develop a new, contemporary concept of masculinity that focuses on supporting and nurturing emotional literacy for boys and men.
- Increase accessibility of clinical, social work, and mental health professionals with specific expertise in managing issues for boys and men.
- Develop medical disciplines and educational and postgraduate training and credentialing in comprehensive male health care, including mental health care.
- Establish well-man visits, similar to the well-woman visits, that are a covered component (at little or no costs) of annual physicals.
- Establish better alignment of reimbursement for screening and management of mental wellness and mental illness clinical care, particularly at the primary-care level.
- Put pressure on media of all types to better support the important role boys and men have in their own health and the health of their loved ones. Encourage the media to provide more even-handed and positive portrayals of males, without resorting to negatively stereotypical characterizations that create an unhealthy culture and mindset that is injurious to the development of boys and men.

Future Research Needs

- Develop a systematic and extensive review of the appropriateness of current screening tools with a specific focus on their effectiveness for boys and men and their utility in the clinical and nonclinical settings.
- Develop a broad range of comparative clinical effectiveness studies on different types of standard interventions and male-specific clinical and community-based tools to screen for male mental health. These evaluations need to be done not only for the general population of males but also separately on subpopulations.
- Conduct a systematic review of the comparative effectiveness of various referral systems from community-based programs to clinical programs and from clinical programs to community support programs.
- Create research reports, statistical data, and clinical case reporting on health and related subjects, to be reported in a manner that allows for appropriate gender stratified data to be presented as a core component of reporting both in summaries and in full reports.
- Foster greater involvement by community-based health provider organizations in formal research in the area of male behavioral health management.
- Increase funding opportunities for community-based male mental wellness and mental illness research.
- Research funders should set aside separate categories of competitive award applications designed for community-based organizations and set aside a specific pool of funding and/or expertise to facilitate community-based programs' ability to engage in core elements of program metrics development, data collection, and outcomes reporting.
- Increase research into the economic impact of male mental illness. Data are needed in all economic sectors and strata. This work is essential in conducting assessments of the success of programs to help manage mental illness in men.
- Study the impact that cognitive impairment in older men may have on mental status and approaches to care.

- Develop, fund, and assess the various programmatic approaches to prenatal and postnatal support programs that have been successful for women and how they may be reconfigured to provide much-needed support for new fathers.

Individual Panel Member Perspectives on Moving Forward

Panel moderator Lee Lynch, founder of Lynch Advocacy Solutions LLC, invited panel members to provide their thoughts on what needs to change to advance the recognition and management of mental health issues in males at the community level. Their candid comments and perspectives were most insightful.

Dr. Jean Bonhomme

- We need to learn how to get across important motivational messaging to men about how to engage in health care.
- Pain and fear do not work with men, much because men have been taught to "solider" through those fears, so we need to better incorporate ways to make our points to men about engaging in health care early on.
- The criminal justice system has also done a disservice to men, especially those with mental health issues. Our mental hospitals have, by in large, closed down and now our jails have become places for men who have mental health problems that led to criminality
- COVID-19 has had a devastating impact on men, including the adverse impact on their ability to earn a living, which leads to many other problems such as substance abuse, anxiety, and depression. One of the reasons for this is that men identify so strongly with the societal expectation of them as family providers. The impact of this economic collapse, particularly in black and brown communities, will have important mental health implications long after the virus itself is brought under control.

Jimmy Boyd

While men and boys in different cultures may express themselves using different languages, different vocabularies, and different body language, they all are expressing the same feelings, frustrations, insecurities, fears, and hopes in ways that are understandable in their cultures.

Armin Brott

Change also needs to come from the government side of the equation. There are, for example, no men's health offices at the federal level and only a few at the state level. It's nearly impossible to coordinate national health priorities for change without some agency or office looking at the demographic that comprises nearly half of our population. There are 5 or 6 such offices or agencies in the federal government that focus on and set priorities on health issues and policy for girls and women, and they are well funded. They have been successful over the years in improving the health and wellbeing of girls and women at many levels.

Cal Byers

We need to encourage the media to give a more realistic depiction of suicide. The workplace is generally underrepresented as a place to do research on mental health in men. We have been working with many construction-affiliated associations to help them become ready and willing to conduct research on health-related topics.

James Craig

- Men have been, for the most part, seen and portrayed as accessories to the core family unit. We need to change that and give men the message that their voices matter and are important. We need to get away from the "sit-com dad" portrayal of men as the social punching bag or foil for all bad behaviors.

- Men do not believe their health concerns seem important, particularly in health and family matters, and we need to give them a venue where their voices can be heard.

Darryl Davidson

- We do not have a standard of what is normal, healthy masculinity. We should look at this.
- We can't focus only on disease symptoms; we need to talk about the overall way to be physically and mentally healthy.
- We must find a better way to get information about best practices and the practical things that need to be done to establish programs. There are far more programs in communities than we are generally aware of.

Daniel Ellenberg

- How do we get into schools earlier and better to help educate boys to become more engaged in health matters, including mental wellness?
- We also need to help boys understand how to incorporate healthy attitudes about dealing with emotionality.
- We need better public policy advocacy for the overall psychological needs of boys and men.

David Giorgianni

What needs to change is something fundamental, and that is what boys and men think it means to be a man. It has unfortunately become unfashionable for men to talk about these emotional issues. It's not just what we personally do but also the media has to change. The media has a role to play in providing a positive issue about men speaking up and talking about men's issues, including emotional wellness, in a more positive way.

Dr. Salvatore Giorgianni

The role of media is very important and right now it feeds into a narrative that is not helping our boys, our men, or those they care for. Media is not just a window on our society but also something that profoundly shapes the views of young people about their roles in society. Media has not historically portrayed men in roles that support health in general or as people who have important roles to play in the everyday upbringing of their children. We are only now beginning to see portrayals of men in caring, nurturing roles in a few movies, television productions, and commercials. We need more responsibility from the media to help change the way boys view their role in society or what their expected behaviors should be in health overall, particularly emotional wellness and family nurturing.

Dr. Sara Jones

- We recognize that we have gender disparities in health care, but people simply do not understand that in mental health these gender disparities and inequities usually occur with males.
- We need to better understand how to utilize electronic media and social media in the area of mental health more than we have done in the past. This is not just from the perspective of reaching patients but also from community involvement as outreach to the various disciplines in health care and the communities that work in these areas. There is great potential, and need, to take advantage of these technologies.

Dr. Cory Lyon

- Insurance coverage for mental health must be brought in line with the time and expertise primary care practitioners need to spend to do the proper job for the patient.

- We need to increase the number of psychological professionals and get them into more private practices as resources to the patients for therapy and referrals in and out of our communities.

Susan Peschin

- We need to conduct more comparative clinical effectiveness research studies, such as comparison of clinical and community screening tools, to find out which are most effective with men and subpopulations of men.
- Similarly, we need to conduct more varied comparative clinical effectiveness studies on different types of standard interventions to see which are more effective with men and subpopulations of men.
- We need to become better at the techniques we use to deliver health messages to men. One very effective way is to couple health messages to boys and men while they are doing other "manly" activities like barbeques, sports outings, or pancake breakfasts.

Dr. Demetrius Porche

- We need to get men's health as a core part of every higher education curriculum, particularly in our health care positions.
- Men's health needs to be seen as a structured curriculum in education and as a recognized subspecialty in the healing professions.
- We need to create urgency about the issue of men's health needs overall and in particular men's mental health.
- We need to make skills in men's health part of the credentialing process for health care professionals.

David Sullivan

We need to have more of an openness for intercultural differences and understanding in the community. Without this openness, our young men in the NA community, and many other ethnic communities, just do not want to open up about their experiences and concerns.

A Clarion Call for a National Action Plan

The panel discussed key areas of focus as important next steps to stem the trend of increasing behavioral health issues and suicide in boys and men. Broadly, these are as follows:
Systematically and extensively review the appropriateness of current screening tools with a specific focus on their effectiveness for boys and men and their utility in the clinical and nonclinical settings.
Critically reevaluate national professional, clinical, and community guidelines for screening across the lifespan of boys and men.
Develop and implement professional degree programs and postgraduate educational and training programs to better enable clinicians across all health care disciplines to care for boys' and men's behavioral health.
Develop meaningful quality metrics for individual practices and health systems, including federal systems, to evaluate behavioral health care for boys and men.

Future Outcomes-Oriented Research Strategies

The need for all types of additional research into the areas of mental health prevention and management and, more specifically, research that focuses on the issues outlined in this monograph and its precursor

monograph, *Behavioral Health Aspects of Depression and Anxiety in the American Male: Identifying Areas for Patient-Centered Outcome-Oriented Needs, Best Practices, and Future Research,* cannot be overstated.[5] Recently, the USPSTF published its recommendations for what it considers research priorities to address evidence gaps in preventative clinical services (see Graphic 13). Many recommendations dealt with behavioral health issues. All of the clinicians on our panel agreed that while general research into behavioral health is much needed, it is even more urgent to address behavioral health in males as a specific subset. Examining the number and rate of suicides among boys and men, and their alarming growth since 2015, clearly states the case for making male mental health a public health disparity. According to the CDC, health disparities are differences in health outcomes and their causes among groups of people.[71] Reducing health disparities is one of the specific public health goals of "Healthy People 2030" and is key to achieving health equity and improving the health of all US population groups.[72]

GRAPHIC 13

The USPSTF 10th Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services[73]

The research topics highlighted in the report include the following:

- Depression in Children and Adolescents: Screening
- Suicide Risk in Adolescents, Adults, and Older Adults: Screening
- Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions
- Illicit Drug Use in Children, Adolescents, and Young Adults: Primary Care-Based Interventions
- Unhealthy Drug Use: Screening
- Obesity in Children and Adolescents: Screening

[71] *Strategies for Reducing Health Disparities.* Health Equity, Centers for Disease Control and Prevention; July 8, 2016. https://www.cdc.gov/minorityhealth/strategies2016/index.html#:~:text=Health%20disparities%20are%20differences%20in,goals%20ofHealthy%20People%202020%20

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Appendix I Conference Participant Bios

Cal Beyer, MPA
Cal Beyer is the vice president of workforce risk and worker mental wellbeing for CSDZ, a firm dedicated to construction risk management for more than 100 years. In partnership with parent company Holmes Murphy & Associates, CSDZ serves construction companies nationwide. From 2014 to 2020, Beyer served as director of risk management at Lakeside Industries Inc, a construction company, in Issaquah, Washington.

Jean Bonhomme, MD, MPH
Dr Jean Bonhomme is founder of the National Black Men's Health Network and an expert on men's health, minority health, and the impact of poor men's health on families. Since 2003, he has served as corporate president and chairman of the Steering Committee for CHAMPS (Community Health and Men's Promotion Summit), providing free health screenings to economically disadvantaged minority males. Since 2003, he has served as staff physician for Toxicology Associates of North Georgia, a drug treatment facility based in Marietta, Georgia. He has served on the editorial board of the *Journal of Men's Health* since 2004 and on the editorial board of the *American Journal of Men's Health* since 2006.

Jimmy Boyd
Jimmy Boyd is a federal- and state-level policy analyst who cofounded Father's Connection, a unique men's group therapy and support program. His leadership, coupled with a talented team of dedicated professionals, is responsible for the congressional passage of National Men's Health Week, signed into law by President Bill Clinton in 1994. Also known as International Men's Health's Week, the program has since been expanded to all of June and is now known as Men's Health Month.

Armin Brott, MBA
Armin Brott is a skilled media communicator highly sought after as a facilitator, author, lecturer, and authority on men's health, leveraging expertise with multiple media platforms to craft messages that efficiently and effectively reach their target of males. Hailed by *Time* magazine as "the superdad's superdad," Brott is a pioneer in the field of fatherhood and has been building better fathers for more than a decade. As the author of 10 bestselling books on fatherhood, he's helped millions of men around the world become the fathers they want to be—and that their children need them to be.

Ruben Cantu
Ruben Cantu has more than 20 years' experience in public health, health equity, racial justice, program and organizational management, and technical assistance and capacity building. At Prevention Institute, he leads projects on community trauma and mental health and wellbeing. Cantu provides training, coaching, and strategic support on policy development, sustainability, partner development, and communications to 13 community coalitions through Making Connections for Mental Health and Wellbeing Among Men and Boys. Making Connections seeks to transform community conditions that influence mental wellbeing among men and boys of color, veterans, military service members, and their families.

Mike Chavez
Mike Chavez serves as the community benefit specialist at INTEGRIS Health, Oklahoma's largest health system. INTEGRIS' mission leads Chavez to provide programs, classes, and events for at-risk populations in Oklahoma. Chavez also coordinates the Men's Health University Initiative at INTEGRIS.

James Craig, LCSW
James Craig is the public health social work coordinator in the Maternal and Child Health Services at the Oklahoma State Department of Health. He is also co-lead of the Infant Safe Sleep Workgroup and Maternal Mood Disorders workgroup. He is a licensed clinical social worker and has served as a professional social worker for the past 12 years.

Darryl Davidson, MS
Darryl Davidson is the director of community engagement for the City of Milwaukee. He leads the Mayor Tom Barrett–endorsed Milwaukee Fatherhood Initiative, a collaborative partnership of agencies focused on father engagement, case management toward empowerment, and strengthening communities. He oversees programs, education, and collaborative outreach activities for teen males and adult men via the Black Male Achievement Advisory Council; he also convenes and facilitates the Milwaukee's Men's Health Referral Network, dedicated to improving the physical, mental, emotional, and economic outcomes of boys and men.

Daniel Ellenberg, PhD
Daniel Ellenberg, PhD, is a leadership coach, licensed therapist, seminar leader, and group facilitator. He is a principal in the ***Rewire Leadership Institute*** and ***Relationships That Work***. He leads ***Strength With Heart*** men's groups and workshops. He is the president-elect of an American Psychological Association (APA) division of the Society for the Psychological Study of Men and Masculinities. He is also a member of the boy-in-education taskforce for his APA division. Ellenberg wrote his PhD dissertation on the psychological aspects of the male sex role. He is coauthor (with his wife) of ***Lovers for Life: Creating Lasting Passion, Trust, and True Partnership.*** He cocreated and delivered both resilience and leadership training programs for several NASA space centers. He is also coauthoring a book on men and leadership. Ellenberg is a board trustee at the Wellspring Institute of Neuroscience and Contemplative Practice. He also leads workshops on how to have courageous conversations as well as develop self-compassion.

Jacqueline Garrick, LCSW-C, BCETS, SHRM-CP, WPA
A social worker by background, Jacqueline Garrick entered the policy and program management realm upon her discharge from the US Army, where she specialized in PTSD recovery and transition assistance services. She has served in executive positions at the American Legion, the Departments of Veterans Affairs, DoD, and with the House Committee on Veterans Affairs.

David Giorgianni
David Giorgianni has more than 17 years' experience in public speaking to all levels of status, ensuring effective communication through coaching, problem solving, certifying, and educating. He also has a thorough understanding of military culture and programs as they relate to the NATOPS, Personal Financial Management (MCO 1700.37), Sponsorship (MCO 1320.11G), Transition Readiness (MCO 1700.31), and Information and Referral (MCO 1754.10).

Salvatore J. Giorgianni, Jr PharmD—Project Lead
Dr Salvatore (Sal) Giorgianni received his Bachelor and Doctor of Pharmacy degrees from Columbia University in New York City. He has extensive experience in all aspects of the practice of pharmacy and has held faculty

appointments at Columbia and Belmont Universities. He completed a clinical practice residency at Lenox Hill Hospital in New York City. Giorgianni is an expert in prescription drugs and health policy as well as the impact of media on male perceptions of health and wellness. He is the senior science adviser to Men's Health Network and is a cofounder and chair-emeritus of the American Public Health Association Caucus on Men's Health. He is president of Griffon Consulting Group Inc, a health care and industry consulting practice. He is a member of the *American Journal of Men's Health* professional review panel.

Sara Jones, PhD, APRN, PMHNP-BC

Dr Sara Jones has a broad background in psychiatric nursing, with extensive training and experience as a psychiatric RN (since 2005) and board-certified psychiatric-mental health nurse practitioner (since 2013). Her research interests have focused on associations between trauma and mental health.

Lee Lynch

Lee Lynch formed Lynch Advocacy Solutions LLC in October 2014 after spending more than 2 decades as an agency and in-house communications expert. Her many years of experience extend across advocacy, writing, public relations, public affairs, issues management, marketing, and journalism. Throughout her career she has had the pleasure of serving clients of all sizes in many different industries and leading teams of up to 25 people to develop and implement programs, initiatives, and campaigns. Above all, Lynch loves to do great work for her clients and brings other specialists into the fold to ensure her clients' goals are always met or exceeded.

Corey Lyon, DO, FAAFP

Dr Corey Lyon is an associate professor in the Department of Family Medicine for the University of Colorado School of Medicine. She serves as the associate program director for the University of Colorado Family Medicine Residency in Denver, Colorado, as well as an associate vice chair for clinical affairs in the Department of Family Medicine.

Susan Peschin, MHS

Susan Peschin is president and CEO at the Alliance for Aging Research, the leading national nonprofit organization dedicated to accelerating the pace of scientific discoveries and their application to improve the experience of aging and health. Since 2012 Peschin has been a driving force in the growth and success of the organization.

Demetrius James Porche, DNS, RN, FNP, CS, CCRN

Dr Demetrius James Porche is professor and dean of Louisiana State University Health Sciences Center in New Orleans, Louisiana, School of Nursing. He also holds an appointment in the School of Public Health at Louisiana State University Health Sciences Center. He received his Bachelor of Science in Nursing degree from Nicholls State University and his Master of Nursing and Doctor of Nursing Science from Louisiana State University Medical Center. He completed Family Nurse Practitioner postgraduate coursework at Concordia University Wisconsin. Porche earned a Doctor of Philosophy from Capella University in Organization and Management with a specialization in Leadership.

Anna Radin, MPH, DPH

Dr Anna Radin is an applied research scientist for St Luke's Health System in Idaho and the principal investigator for 2 studies funded by the Patient-Centered Outcomes Research Institute: Suicide Prevention Among Recipients of Care (SPARC Trial) and Mental Health Among Patients, Providers, and Staff in the COVID-19 Era. She has a Doctor of Public Health degree in epidemiology from Johns Hopkins University, a Master of Public Health degree in health behavior from the University of North Carolina at Chapel Hill, and more than a decade of public health research and practice experience.

Darrell Sabbs

For more than 4 decades Darrell Sabbs has served the communities of Southwest Georgia through hard work and determination, driven by the shared community belief that “service is the rent we pay for living.” From teenagers to the eldest members of society, his focus has remained strong: to recognize the struggles of the underserved and to provide tools to help them ensure a healthier future for themselves and their families.

David Sullivan

David Sullivan (Kiowa-Choctaw) has served in education as a community leader, collective action network officer, federal consultant, community trainer, district administrator, world language teacher, student equity advocate, and systemic impact leader working for intercultural, intergenerational communication between parents, students, elders, community organizations, and tribal governments for more than 25 years.

Ana N. Fadich Tomšić, MPH, CHES

Ana Fadich-Tomšić serves as vice president at MHN, where she oversees outreach, promotion, and health education to boys, men, and their families. As a certified health educator, she develops targeted disease education awareness materials and programs on men’s health topics and leads discussions to reduce health disparities and educate the consumer.

Brooke Weingarden, DO, MPH

Dr. Brooke Weingarden is a child and adolescent psychiatrist who works with Birmingham Maple Clinic in Troy, Michigan, Oakland County Schools, and Christ Child House. Her specializations include addiction in adolescents, early childhood evaluations, disruptive behavior disorders, mood disorders, anxiety, thought disorders, and ADHD. She has lectured and presented nationally on adolescent addiction and trending drugs of abuse. Weingarden also has extensive experience working with patients who have comorbid substance use disorder and mood disorders. Because of the settings where she practices, including clinics, schools, and more-intensive residential settings in the Detroit area, Weingarden has extensive experience working with patients of racial and ethnic minority backgrounds as well as low-income populations. She also conducts research of the clinical and therapeutic benefits of CBD as a Physician Affiliate for Hempworx.

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Appendix II Agenda

DISCUSSION GUIDE AND WORKING AGENDA

PCORI Conference Award EAIN 00095
Convened by Men's Health Network
September 18, 2020, E-Conference

Determining the Efficacy and Scope of Behavioral Health, Gender-Specific Screening Tools for Males Benefitting Front Line Community Workers

Pre-Convening Component
Online On-Demand Statements and Comments
MHN Welcome and Comments
PL Welcome and Comments
Moderator Comments and Instructions
Panel Profiles & Opening Comments
Name, Affiliation, Interest/Work in Content Area

Opening Comments
Online On-Demand Topical Presentation
PCORI Award Recipient Comments—20 min
Dr Anna Radin, Applied Research Scientist for St. Luke's Health System in Idaho, and the Principal Investigator for 2 studies in the area of mental health funded by PCORI

Defining the Problem
10:30-11:30 AM*
Prevalence of mental health issues in males vs females
Differences in symptoms manifested by males and females
How is it the same/different in populations such as youth, adolescents, young adults, elderly, and vulnerable postulations?
How is it the same/different in populations such as African American, Hispanic, Asian, NA, and LGBTQ?
Discussion of how current tools are aimed at identifying "female" symptoms and the results of this gap
Consequences of ignoring mental health issues in men and boys (suicide, violence, addiction, other destructive behavior)
Are there any outcomes-oriented studies that have been helpful in doing your work?

Implementation at the Community Level
11:30 AM-12:45 PM
How do you or colleagues attempt to identify people within the setting you work in (construction, schools, workplace, clinic, military [active duty}, transitioning, and veterans, first responders, etc) in the community setting with mental health issues?

What barriers—organizational, sociocultural, legal, and other—do you encounter in this work?
How have you overcome them?
Do you use specific tools, approaches, or methods to identify boys and men at risk?
If so, do they identify males?
Are there any male-specific tools that you know of to screen for behavioral health issues?
How effective are those tools at your disposal in working with boys and men?
How could they be improved?
Do you see a need for male-specific tools?
How do you handle matters of confidentiality?
Do you notify others (family, supervisors, law enforcement, and health care) of boys and men at risk?
Do you have a protocol to hand off identified individuals to appropriate resources?

Consequences of Male Depression

1:45-2:15 PM
Manifestations of mental health issues on the populations you serve?
Manifestations in the community?
What needs to change?

Moving Forward

2:15-2:45 PM
What types of outcomes & patient focused studies do you think would be helpful?
What do you need to better screen your populations?
How do programs with successful outcomes become adopted—what are drivers, what are impediments?
How to best disseminate information to stakeholders

Closing Comments and Next Steps

2:45-3:00 PM

Appendix III Additional Readings

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